Final Version -

NEBRASKA SUPPORTIVE HOUSING PLAN

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A. Introduction

1. Overview of the Task/Key Objectives of the Plan -

The Nebraska Department of Health and Human Services (DHHS) Division of Behavioral Health (DBH) engaged the services of the Technical Assistance Collaborative, Inc. (TAC) to work with the Division and related state agencies to develop a Strategic Supportive Housing Plan for Nebraskans living with and recovering from serious behavioral health conditions. This plan offers recommendations in the following general categories:

- Develop and align DBH policy to promote supportive housing and community - integration as two foundational aspects of the behavioral health service system -
- Define and establish a supportive housing pipeline over a three- to five-year timeframe
- Ensure that effective and evidence-based practices and services are available to promote successful tenancy and community integration
- Establish sustainable funding sources for supportive services to individuals living in supportive housing settings
- Strengthen provider workforce capacity

Each key recommendation is broken down into specific action steps.

2. -Policy Framework for DHHS Strategy

Since the passage of the Nebraska Behavioral Health Services Act (NBHSA) in 2004,[1] Nebraska has worked to transform its behavioral health system from reliance on institutional settings to services that promote and support community integration. Between 2004 and 2009 more than 248 mental health beds were closed at state regional centers and approximately $31 million was transferred from institutional care to community services. Prior to the closures, communities had access to an array of services, including day treatment, halfway houses, emergency community support teams, and more. Between 2004 and 2010, the service array expanded[2] to include community-based capacity including dual residential, assertive community treatment, community support — mental health, community support — substance abuse, short-term residential, day rehabilitation and psychiatric residential rehabilitation in order to further support individuals in the community. Initial planning seemed to indicate that the Regional Centers would close altogether; however, services at the Lincoln Center were re-aligned to reflect its changing role within a community-based system of care. Adult behavioral health inpatient, residential, outpatient and other services were closed at regional centers in Norfolk and Hastings: three Regional Centers (in Lincoln, Norfolk and Hastings) continue to operate, providing treatment for forensic patients, individuals with sex offenses and male

[1] http://www.nebraskalegislature.gov/FloorDocs/98/PDF/Slip/LB1083.pdf
[2] http://dhhs.ne.gov/behavioral_health/Documents/RegionalCenterDischargeFollow-UpServicesFinalReportMay2010.pdf

adolescents with substance use disorders and in FY 2014 utilized 39.3 percent of DBH's annual budget.

In February 2011, the Division released a five-year strategic plan, the *Nebraska Division of Behavioral Health Strategic Plan 2011-2015* that built off of the NBHSA and the work of related Behavioral Health Oversight Commissions, and identified strategies to move DBH toward "the development of recovery-oriented systems of care that are community-based."[3] In November 2012, DBH further evaluated its approach toward supporting individuals with mental illness in integrated community settings within the context of its overall system assessment and implementation of its strategic plan. As part of this assessment process, DBH retained TAC to conduct an evaluation of DBH's activities in the context of community integration, and to provide guidance regarding ways that DBH could strengthen its approach to supporting community integration within the overall implementation of its strategic plan.

On February 5, 2013, TAC spent the day with DBH leadership and facilitated a discussion related to community integration in Nebraska. In a follow-up to the February 5 meeting, Kevin Martone, executive director of TAC, facilitated a workshop at the annual Statewide Behavioral Health Conference on May 14, 2013. The purpose was similar to the initial meeting with DBH, to present a national perspective that included the experiences of other states. Approximately 75 stakeholders, including consumers, family members, service providers, legal advocates, and state staff, attended the presentation.

In addition to the conference presentation, four feedback sessions were held at the conference on May 14 and 15 in order for TAC to directly solicit perspectives from stakeholders about community integration issues in Nebraska. Roughly 50 individuals participated in the feedback sessions.

In April 2013, Dr. Scot Adams, then director of DBH, appointed a workgroup to explore how the flow of individuals through Lincoln Regional Center (LRC) could be improved. The Systems Enhancement Initiative (SEI) workgroup members appointed by Dr. Adams consisted of LRC staff, consumers, regional emergency community systems coordinators, and DBH community-based services staff. Their work began in April 2013 and was completed in December 2013.

Subgroups of the SEI workgroup were charged with evaluating and recommending discharge plans for 40 individuals residing at LRC for more than one year. The subgroups completed a number of activities including participation in the individuals' LRC team meetings, individual meetings with LRC staff, completion of need-based and strength-based tools, face-to-face interviews with individuals, and contacts with family members and community-based providers. Subgroups presented their findings to the larger group which made further recommendations. Several recommendations to facilitate successful discharge planning were shared with the individuals' LRC treatment teams and in some cases with potential providers:

[3] http://dhhs.ne.gov/behavioral_health/Documents/NebraskaCommunityIntegrationFinal414.pdf

- Develop additional housing options
- Develop more opportunity for peer support
- Develop health information technology and telecommunication options
- Enhance community-based service options
- Enhance discharge planning

In April 2014, DBH released the report *Community Integration in Nebraska's Behavioral Health System,*[4] which provided a limited evaluation of DBH's activities in the context of community integration, identified themes that emerged during the planning process, and provided guidance regarding ways that DBH could strengthen its approach to supporting community integration within the overall implementation of its strategic plan. Overarching recommendations included:

- Initiate and lead an *Olmstead* planning process in order to develop a working '*Olmstead* Plan'
- Maximize services and funding strategies to support community integration
- Maximize housing opportunities and partnerships to support community integration

Also in 2014, DBH partnered with the Region 6 Regional Behavioral Health Authority (RBHA) to conduct focus groups with key stakeholders from Region 6 to explore strategies that would strengthen and promote recovery-oriented services and opportunities for integrated community living. (Please refer to Section C.1.a. for a further explanation of Regional Behavioral Health Authorities in Nebraska.) This initiative identified high-priority gaps within the Region 6 system and made recommendations to address these gaps. The report, *Omaha Area Adult Behavioral Health Assessment, Final Summary of Findings and Recommendations,*[5] was released in November 2014. Subsequently, each of the other five RBHAs undertook similar assessments of service gaps in their areas. Once the results of the analyses are completed, a statewide plan for addressing these gaps will be developed.

In 2015, TAC was again retained to provide further technical assistance. From May 27 to 29, 2015, six workgroups met and discussed various aspects of community integration, in these conversations and others:

- A housing focus group met to review current options for affordable housing including supportive housing, and identify possibilities for maximizing resources and partnerships between community partners.
- DBH and LRC leadership met to review the housing focus group feedback and discuss the strategic supportive housing planning process and the proposal for technical assistance from TAC.

[4] http://dhhs.ne.gov/behavioral_health/Documents/NebraskaCommunityIntegrationFinal414.pdf
[5] http://otoc.org/wp-content/uploads/2015/09/Omaha-Region-6-System-Assessment-Report-FINAL-TriWest-Group-2015_01_16.pdf

- A provider focus group received training on "building provider capacity to deliver services aligned with principles and practices of recovery, wellness, and community integration".
- An emergency services workgroup met to discuss building successful partnerships to support the coordination of recovery-oriented systems and community integration.
- The Office of Consumer Affairs (OCA) met with TAC to review the role of the OCA and the OCA People's Council.
- DBH leadership, the OCA, and the Behavioral Health Education Center (BHECN) of Nebraska met to discuss the peer support partnership between DBH and BHECN.

Following the end of the sessions, DBH received a proposal for next steps from TAC. On December 14, 2015, The Division of Behavioral Health entered into an agreement with TAC to perform five tasks to lead to the development of this Strategic Supportive Housing Plan for individuals with behavioral health challenges. The tasks included the following:

- Reviewing DHHS policy and conducting housing focus groups.
- Completing an environmental scan and reviewing current housing planning efforts.
- Researching available supportive housing services and conducting service provider workgroups.
- Consulting with the Lincoln Regional Center and the Office of Consumer Affairs.
- Developing a strategic supportive housing plan.

Over the past few years, the state of Nebraska has demonstrated its commitment to community integration by investing considerable time and resources into assessing its behavioral health system, a process which has yielded consistent recommendations for enhancing community integration. Building a system that fully supports community integration is difficult due to many factors, including competing interests for funding; a lack of affordable, appropriate housing; and limited integrated employment options.

Progress may also be slow due to the diversity of opinions on the capability of persons with mental illness to live in independent settings, and the stigma faced by people with behavioral health disorders when they live in the community. Nebraska is a large, rural state with a population of approximately 1,896,190 people,[6] making it the ninth least densely populated state in the United States. Nebraska has 93 counties and spans two time zones. For people with serious mental illness, the large, rural nature of the state can present additional challenges to integrated community living. Appendix A shows the regions within which Nebraska's behavioral health authorities provide behavioral health services.

The vision statement of the Nebraska Division of Behavioral Health is "The Nebraska public behavioral health system promotes wellness, recovery, resilience and self-determination in a coordinated, accessible consumer and family-driven system." The Nebraska Division of

[6] http://www.census.gov/quickfacts/table/PST045215/31

Behavioral Health Strategic Plan, 2011-2015 that was built from the work of the NBHSA references the Substance Abuse and Mental Health Services Administration's (SAMHSA) Four Dimensions that support a life in recovery: Health, Home, Purpose, and Community. The 2016 DBH Strategic Plan states that Nebraska strives to be the gold standard in facilitating hope, recovery and resiliency as a model of excellence in behavioral health care. As the Chief Behavioral Health Authority in the State, DBH has continued to align its overall mission, vision, and strategic planning with federal policy and recovery-oriented systems of care.

The Annual Plan is in sync with federal policy alignment:

- In June 2013, The U.S. Department of Housing and Urban Development (HUD) expressed its intent to issue guidance suggesting that in order to maximize community-based housing opportunities, HUD funds should be expended predominantly on housing and housing-related activities as opposed to support services. HUD recommends that states partner with Medicaid authorities and other funding sources to cover services and supports necessary for individuals to obtain and maintain housing. This direction applies to all HUD-funded programs, including funds to address homelessness. In addition, HUD has issued guidance on the Role of Housing in Accomplishing the Goals of *Olmstead*.[7]
- In January 2014, the Centers for Medicare and Medicaid Services (CMS) issued the Home- and Community-Based Services Final Rule,[8] which clarified that individuals receiving Medicaid-funded home- and community-based services are to have the same access to their communities as individuals who do not have disabilities.
- In June 2015, CMS issued guidance and directives[9] for how states can use Medicaid to support access to housing and housing-related services for individuals with disabilities.

Putting policy into action requires states to proactively: a) budget for integrated supportive housing and services, usually through new or repurposed funds; and b) consider statutory, regulatory, and administrative changes to accelerate the creation of new integrated housing and services in order to begin to address unmet need.

DBH is committed to strengthening the behavioral health system's ability to support individuals in the most integrated settings possible. This Strategic Plan provides Nebraska with a framework and specific recommendations to promote community integration for Nebraskans living with and recovering from serious behavioral health conditions.

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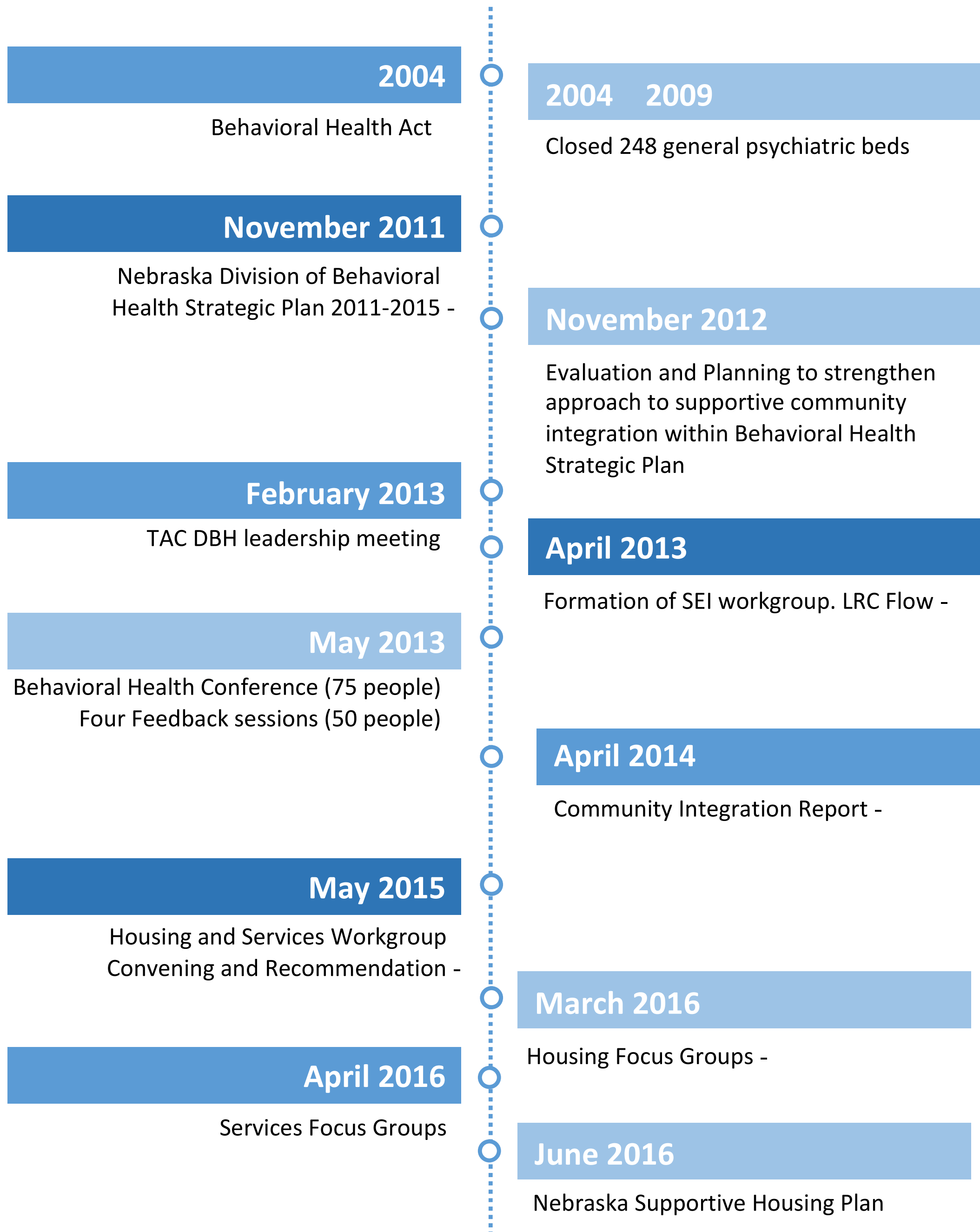
[7] http://portal.hud.gov/hudportal/documents/huddoc?id=OlmsteadGuidnc060413.pdf

[8] https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/home-and-community-based-services.html

[9] CMCS Informational Bulletin, "Coverage of Housing Related Activities and Services for Individuals with Disabilities," June 26, 2015. https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf

Nebraska DBH Timeline



B. Methodology

1. Planning with DHHS Staff and other stakeholders -

TAC approached the development of a strategic plan as furthering the system transformation work of DBH, identifying strengths and weaknesses of the current system, highlighting opportunities for growth and change, and noting the factors that will need to be addressed to achieve optimal results. DBH was clear from the outset that the process would be inclusive of broad-based stakeholder input.

TAC staff participated in planning calls with DBH leadership to frame out the activities that could be performed in order to achieve the Division's objectives. There was consensus that the engagement would build on the previous work TAC had performed for DBH over the past several years. The aim of the project has been for TAC to make recommendations that will promote and facilitate system transformation to include housing as a platform upon which recovery, wellness, and community integration are attainable for Nebraskans living with and recovering from serious behavioral health conditions.

2. Housing and Services Inventory and Analysis

TAC evaluated the current array of housing and housing-related supports in order to better understand existing pathways and operations so as to identify potential areas for improvement. The consultants reviewed budget documents, regulations, contracts, existing housing inventory information, federal housing and services data and grant information, census data, and provider documents related to DMH housing programs (See Appendix B). Staff researched and summarized supportive services that are currently available and those that could be made available to support individuals in accessing and keeping housing, with the aim of recommending strategies to leverage and maximize existing services and plan for new services that promote tenancy and community integration. Key informant interviews were conducted for both housing and services to inform the planning process and to formulate the recommendations to be contained within the Supportive Housing Strategic Plan.

3. Stakeholder Participation and Meetings with Key Informants

TAC conducted focus groups and key informant interviews in March and April 2016 to develop a comprehensive understanding of existing affordable housing resources and programs in Nebraska through federal, state, or other funding; how resources are leveraged together; the availability of housing stock; and mechanisms to link individuals with available supportive housing (building on the brief review conducted in May 2015).

TAC conducted six housing focus groups over the course of two days in Lincoln. Each group represented a cohort of stakeholders who are integral to the development, operation, and maintenance of supportive housing in Nebraska:

- Housing provider agencies
- BHS leadership housing retreat
- Community meeting with Community for a Cause members which included consumers, providers and other interested stakeholders
- HOME and community block grant managers
- Nebraska Investment Finance Authority
- Housing Developers

Each group was asked a series of questions to provide guidance and information to TAC to develop a series of recommended strategies for DBH.

In addition, interviews were conducted with representatives from behavioral health provider agencies, managed care organizations, federally qualified health centers (FQHCs), rural health centers, transition-age youth service providers, Continuum of Care (CoC) members, and the Department of Corrections. In addition, a community meeting was held to gain input from consumers, family members, advocates, and the public.

A list of persons interviewed and workgroup participants can be found in Appendix C.

Overall, focus group members were supportive of expanding and creating supportive housing solutions in Nebraska. Themes that emerged from the focus groups included:

- The need to de-link housing from mandatory services and instead making services available but optional
- Improving system coordination
- Increasing housing development, operations, and subsidy resources
- Increasing awareness of consumers in assisted living facilities
- Improving workforce competency in assisting individuals with behavioral health - disorders to obtain and sustain community integrated housing of their choice. -

4. -Assessment of Services Provided by Each Regional Behavioral Health Authority

Tenancy Support Services

The DBH contracts with each Regional Behavioral Health Authority (RBHA) to provide housing services in their region. Each RBHA has a Regional Housing Coordinator (RHC) on their leadership team. The overall array of housing services offered in each Region by the RHCs varies but all RHCs perform the standard contracted services listed below. Additional regionally directed housing services may also be performed by the RHC.

Regional Housing Coordinator Contracted Services: -

1. - Provide regional system leadership in housing
2. - Develop and maintain the Regional Program Plan for the DBH Housing Assistance - Program. -
3. - Coordinate an assessment of housing needs for adults with serious mental illness.
4. - Develop and implement strategies to ensure the program is culturally competent, and represents the ethnic and gender needs of the community.
5. - Provide approval of eligible consumers for DBH Housing Assistance Program assistance.
6. - Conduct or authorize Housing Quality Standards (HQS) inspections on the housing unit where eligible consumers live, or may live.
7. - Assure authorized payments to the landlords and utility companies for Housing Assistance Program are made. -
8. - Provide support and technical assistance to behavioral health providers and consumers in planning and locating rental housing
9. - Collect data and evaluation of housing program outcomes.
10. Facilitate communication among housing and behavioral health providers, regional systems, human service systems, and other system participants to build coalitions and ensure the region can provide access to appropriate rental assistance services and affordable housing for adults with serious mental illness.

Pre-tenancy support services assist individuals in locating and obtaining housing. Tenancy support services are available to support individuals to maintain tenancy once housing is obtained. Each RBHA Regional Housing Coordinator provides some level of pre-tenancy and tenancy support services. However, not all coordinators provide a full array of pre-tenancy and tenancy support services. If the RCH does not directly provide a service, they make a referral and facilitate interaction between consumers and their needs.

Pre-Tenancy Services may include:

- Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy.
- Communicating with the consumer and her/his behavioral health service provider regarding the consumer's individualized housing support plan and housing support crisis plan.
- Assisting with the housing search and application process.
- Identifying resources to cover expenses such as security deposit, moving costs, furnishings, adaptive aids, environmental modifications, moving costs and other one-time expenses.
- Ensuring that the living environment is safe and ready for move-in by conducting Housing Quality Standard inspections. -
- Assisting in arranging for and supporting the details of the move.
- Arranging participation in or referral to RentWise or a similar renter education program.

Tenancy Support Services may include:

- Education and training on the role, rights and responsibilities of the tenant and landlord.

- Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy.
- Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action.
- Advocacy and linkage with community resources to prevent eviction when housing is, or may potentially become, jeopardized.
- Coordinating with the tenant and their behavioral health service provider to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.

Services to Support Individuals in Independent Living Settings

According to the Network of Care directory of services for each region, there is a similar set of services that are provided by each region. However, some regions identify services that are physically located within another region as the service available for their residents. An example is Mobile Emergency Psychiatric Response.

Services which are not available in all regions are ACT teams and consumer-run drop-in centers. Services that are limited in capacity in most regions that are valuable for independent living include in vivo skill-building opportunities for living independently and transportation.

5. -Office of Consumer Affairs Consultation

Prior to this consultation, DBH created a new office at the Lincoln Regional Center titled the Office of Facilitation of Recovery in fall of 2015. This office employs a person with lived experience as a current of former recipient of behavioral health services. The office is responsible for the implementation of the Peer Bridger Program and the growth of peer support within the regional center system. On September 08, 2015, DBH entered into an agreement with the University of Nebraska-Lincoln's Public Policy Center to develop a Peer Bridger Pilot program to assist individuals with complex needs who will be transitioning from the Lincoln Regional Center to the community. The project with the Public Policy Center consisted of four phases. 1) literature review, introduction video of peer support and the Peer Bridger project, 3) Survey of Key LRC Employees, Community Providers and Certified Peer Support Workers, 4) and the final phase included a report with recommendations for next steps of implementation- which included the need to develop an implementation plan.

TAC facilitated consultation to the Office of Consumer Affairs, via subcontract with Peggy Swarbrick, Ph.D., on the development and implementation of a Peer Bridger program at Lincoln Regional Center. Dr. Swarbrick reviewed the Nebraska Wellness Bridger program[10] and the LRC Draft Peer Bridger Implementation Plan, providing recommendations for enhancements and strategies for sustaining the initiative. Consultation included providing feedback on strategies to integrate adult, family, and young adult peer services. This service should provide a level of

[10] Nebraska Wellness Bridger Pilot Program: Successful Transition from Nebraska Regional Centers to Community Living, January 2016

consumer engagement prior to discharge from the LRC, in order to facilitate willingness of consumers, families, and LRC staff to consider less restrictive housing options in the community and to facilitate more successful transitions from the LRC to community-based services and housing. The service is anticipated to begin in fall 2017 and DBH is in the process to hire a new Administrator to oversee the implementation of the Peer Bridger Program.

C. Existing Housing and Services

1. Description of Available Permanent Supportive Housing (PSH) -

a. State Resources

Housing Trust Funds

Nebraska is one of a few states that have created and funded two separate housing trust funds to address the housing needs of the state's low-income residents: the Nebraska Affordable Housing Trust Fund (NAHTF) which is administered by the Department of Economic Development (DED) and the Homeless Shelter Assistance Trust Fund (HSATF), which is administered by the Department of Health and Human Services Division of Children and Family Services (DCFS). The NAHTF receives dedicated funds from the Nebraska Documentary Stamp Tax with $.95 per $2.25 of the stamp tax dedicated to the NAHTF. This yielded close to $7 million in FY 2014. Similarly, the HSATF receives $.25 per $1,000 of the value of real estate sold in the state, yielding about $2 million annually. According to the state's Consolidated Plan 2015-2019, $9 million is anticipated annually for the NAHTF (for a total of $45M over the five years of the plan), and $1.9 million is anticipated annually for the HSATF (for a total of $9.5M over the five years of the plan). Both are used in conjunction with the federal HOME and Emergency Solutions Grant (ESG) programs, and are described in the state's Consolidated Plan 2015-2019.[11]

The Collaborative Resource Allocation for Nebraska

The Collaborative Resource Allocation for Nebraska (CRANE) program is a strategic allocation process shared by the Nebraska Investment Finance Authority (NIFA), the DED, and other resource providers in order to accomplish difficult projects. The focus and primary purpose of the CRANE program is to support and encourage the development of affordable housing. While CRANE projects are seeking Low-Income Housing Tax Credit (LIHTC) resources, the process is not competitive in the same way as the regular LIHTC funding process. Rather, assistance is requested and received from NIFA staff and others to pull all the pieces of a project together in a step-by-step, supportive way. CRANE does not require site control, permissive zoning, and financing all to be in place at the time of the application.

One of the six types of projects that can be funded by CRANE is housing for individuals with special needs (such as physical or mental disabilities, substance use issues, homelessness, or

[11] https://www.hudexchange.info/consolidated-plan/con-plans-aaps-capers/

severe economic distress), including housing for distressed populations with incomes below 30 percent of the applicable Area Median Income (AMI). At least 25 percent of the units in CRANE projects must serve individuals with special needs. Senior housing is considered special needs housing *only* if all of the units in the development serve households with incomes below 30 percent of the applicable AMI.

State Housing Assistance Program

The Nebraska DHHS Division of Behavioral Health administers the State's Housing Assistance program, which is designed to address the housing cost burden for adults who are Extremely Low Income (ELI) with a serious mental Illness diagnosis or an adult with a substance use disorder or co-occurring disorders. The Housing Assistance Program makes available funds from the Nebraska State Housing Related Assistance (HRA) program, which utilizes Nebraska state documentary stamp tax dollars to provide housing assistance to eligible individuals with a serious mental illness (or co-occurring disorder), and state general funds to serve eligible individuals with either a serious mental illness or substance abuse disorder (or co-occurring disorder). These resources can provide the following housing-related assistance: rental payments, utility payments, security and utility deposits, and other related costs and payments. The funds are administered through contracts with six Regional Behavioral Health Authorities, all of which have Regional Housing Coordinators.

According to the program manual:

A consumer shall be considered eligible for the Housing Assistance Program if he/she meets the following criteria:

1. Is an adult with serious mental illness as defined by Nebraska Revised Statute 71-812(3) or an adult with a substance use disorder or co-occurring disorders as defined by The *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*);
2. Is an adult receiving behavioral health service(s) funded by DHHS and is participating in the behavioral health service(s);
3. Is an adult in need of housing related assistance determined by:
    a. Documented efforts to fully exhaust options available for rental assistance through local housing authorities and/or other entities; and
    b. Clear demonstration of the consumer's willingness to continue to seek other sources of rental assistance if initially turned down or placed on a waiting list.
        i. Failure to honor these agreements may be grounds for termination of the Housing Assistance Program assistance.
4. Meets residency requirements by being either:
    a. A United States citizen; or
    b. A legal permanent resident or other documented immigration status allowed under DHHS policy.
    c. Documentation of immigration status is the responsibility of the individual applying for housing related assistance.

5. Has an Individual Service/Treatment Plan (ISP) developed with their authorized behavioral health service provider that includes the identified goal of independent living.
6. Meets either Priority One or Priority Two criteria as listed below.
    a. Priority One – either:
        i. A person with extremely low income (a household income between 0 and 30 percent of the applicable median family income) who is discharged from an inpatient mental health commitment, or
        ii. A person with extremely low income who is eligible to move from a residential level of care to independent living to make room for a person being discharged from an inpatient mental health commitment.

    b. Priority Two – A consumer with extremely low income who is "at risk" of an inpatient mental health commitment which could be at least in part due to a lack of affordable, independent housing.
        i. For the purposes of this section, "at risk" means the individual meets at least one of the following criteria:
            (1) a history of inpatient mental health board commitments within the last five years
            (2) subject to an emergency protective custody within the last five years
            (3) housing assistance will clearly prevent a psychiatric hospitalization
            (4) person is currently homeless
            (5) person has no income and appears eligible for SSI
            (6) the consumer is living in independent housing that is not safe, decent, or affordable
            (7) housing assistance prevents a consumer from moving into a higher level of care
            (8) is currently committed to outpatient services by a mental health board.

The projected FY 2017 RBHA Housing Assistance and Coordination budget for the program is as follows:

- Region 1: $248,572
- Region 2: $207,480
- Region 3: $420,282
- Region 4: $460,400
- Region 5: $826,733
- Region 6: $1,269,964

Regional Behavioral Health Authorities (RBHAs)

Title 206, Standards for Behavioral Health Services in Nebraska, were updated to reflect the current behavioral health trends on June 14, 2014. This action repealed Title 201, Title 203, and Title 204, which were previous governing standards. DBH also provides utilization guidelines, most recently updated in January 2016[12].These standards provide the regulatory framework for the statewide array of behavioral health services for children and adults provided by the public and private sectors and supported in whole or in part with funding received and administered by the Department of Health and Human Services.

The Division of Behavioral Health contracts with six RBHAs in Nebraska to deliver behavioral health services in the community. The RBHAs are based in Scottsbluff, North Platte, Kearney, Hastings, Lincoln, Norfolk and Omaha. They competitively bid for the delivery of mental health and SUD services throughout their regions. They are required to enroll contracted providers into their "network" and to develop policies and procedures for determining provider eligibility for enrollment.

One regional RBHA has become a direct recipient for CoC funding to help people with disabilities that are experiencing homelessness to find safe, affordable housing.

b. Federal Resources

Public Housing Authority (PHA)

Nebraska has 107 public housing agencies (PHAs) including 21 that administer the Housing Choice Voucher (HCV) program, aka Section 8 vouchers, for a total of over 20,700 units of affordable housing. Together these PHAs range from relatively small ones such as Gresham PHA, that manages just twelve units of public housing, to the Lincoln Housing Authority, that manages over 3,000 HCVs and 320 public housing units, and the Omaha Housing Authority, with over 4,800 HCVs and 2,904 public housing units. There are 22 PHAs that administer over 100 HCVs and/or public housing units. Table 1 lists the PHAs in Nebraska that administer over 200 units of housing.

Table 1: PHAs with over 200 Housing Units		
PHA Name, Phone & Fax Number	**Housing Choice Vouchers**	**Public Housing Units**
Alliance	187	60
Beatrice	203	0
Bellevue	275	49
Columbus	100	100
Douglas County	1,162	78
Fremont	164	249
Hall County	486	394
Hastings	477	0
Kearney	133	172

[12] http://dhhs.ne.gov/behavioral_health/Documents/LimeBook.pdf

Lexington	122	82
Lincoln	3,098	320
Norfolk	254	0
North Platte	0	250
Omaha	4,803	2,904
Scotts Bluff County	410	162
South Sioux City	294	0
West Central Nebraska	215	0

In addition to administering the traditional public housing and HCV programs, some of Nebraska's PHAs administer special purpose vouchers through HUD's Five-Year Mainstream Housing Opportunities for Persons with Disabilities program (Mainstream 5-Year) and Rental Assistance for Non-Elderly Disabled Vouchers (NED). Table 2 lists these PHAs and their units. These vouchers are dedicated and must be used by persons with disabilities, even upon turnover of the voucher.

Table 2: PHAs in Nebraska with Special Purpose Vouchers [13]		
PHA	**NED**	**Mainstream 5-Year**
Douglas County HA	0	125
Kearney HA	30	0
Lincoln HA	0	20
Omaha HA	0	100
Total	**30**	**245**

Federal Resources Administered by State and Local Community Development Officials

There are four communities, including the state of Nebraska, that receive an allocation of federal block grant funds available to create or support permanent supportive housing. The FY 2016 allocations by location and source are listed in Table 3.

Table 3: FY 2016 Consolidated Plan Allocations for Nebraska					
Name	**CDBG**	**HOME**	**ESG**	**HOPWA**	**TOTAL**
Bellevue	$298,768	$0	$0	$0	$298,768
Lincoln	$1,701,414	$830,622	$144,736	$0	$2,676,772
Omaha	$4,231,548	$1,586,615	$386,724	$0	$6,204,886
State of Nebraska	$9,944,180	$3,023,348	$941,814	$370,412	$14,279,754
TOTAL	**$16,524,837**	**$5,440,584**	**$1,473,274**	**$370,412**	**$23,809,107**

A full description of these programs is included in Appendix G.[14]

For the purposes of this strategic plan, the two key programs to focus on are the HOME program and the ESG program.

[13] http://www.tacinc.org/knowledge-resources/vouchers-database -

[14] Housing Scan: Nebraska, Technical Assistance Collaborative. March 2016, page 15. -

HOME

While the HOME program has experienced significant cuts in funding (over 50 percent of the program since 2010), the state as a whole receives over $5.4 million annually. Housing created with HOME funds must serve low-income and very low-income families.

HOME funds can be used for rental housing through financing acquisition, rehabilitation, new construction, and funding tenant-based rental assistance (TBRA). While Lincoln and Omaha have used some of their HOME funds in the past to create TBRA, they are not currently providing HOME TBRA and past efforts have focused on one-time assistance like deposits, rather than ongoing rental payments.

The state of Nebraska's HOME fund is administered by DED. This department primarily uses its HOME funds to leverage the state's LIHTC program and the state-funded NAHTF to create new affordable housing.

Emergency Solutions Grant (ESG)

The ESG funds provided by HUD to the state of Nebraska are combined with the state's HSAFT into the Nebraska Homeless Assistance Program (NHAP). This program excludes the ESG funds received by Omaha and Lincoln which administer their ESG allocation separately.

The Emergency *Solutions* Grant (ESG) program replaces the former Emergency *Shelter* Grant program. One new feature of ESG is the ability to fund homelessness prevention and rapid re-housing (RRH). In regard to the ESG program, the purpose of NHAP is to provide an overall "Continuum of Care" approach to address the needs of people who are experiencing homelessness and near-homelessness in Nebraska by assisting in the alleviation of homelessness; providing temporary or permanent housing for persons who are homeless; and encouraging the development of projects that link housing assistance with efforts to promote self-sufficiency. The Balance of State CoC's written standards[15] for ESG funding states:

ELIGIBILITY/PRIORITIZATION

Minimum standards for determining and prioritizing which eligible families and individuals shall receive homelessness prevention assistance and which eligible families and individuals shall receive rapid re-housing assistance are

- Rapid Re-housing (RRH) — To be eligible for RRH and Stabilization Services and Short-term and Medium-term Rental Assistance, people must:
    - Meet the federal criteria under category (1) of the "homeless" definition in 24 CFR 576.2 [ESG funded programs]
    - Meet the criteria under category (4) of the "homeless" definition in 24 CFR 576.2 and live in an emergency shelter or other place described in category (1) of the "homeless" definition [ESG funded programs]

[15] http://dhhs.ne.gov/children_family_services/Documents/CoC-ESG%20Written%20Standards%20Nebraska%20BoS%20CoC%20FINAL%20rev%20%201.pdf

- Have an annual income (at annual review) of less than or equal to 30 percent of the area median income [ESG-funded programs only]
- Meet the federal requirements under categories 1, 2, or 4 (literally homeless, imminently losing primary nighttime residence, and fleeing domestic violence) for CoC funded projects
- Lack sufficient resources or support networks to retain housing without ESG or CoC assistance.

- Homelessness Prevention (HP) ESG — To be eligible for HP housing relocation and stabilization services and short-term and medium-term rental assistance, people must require HP services to prevent moving into an emergency shelter or another place described in category (1) of the "homeless" definition in 24 CFR 576.2, have an annual income below 30 percent of the median income for the area, and:
    - Meet the federal criteria under the "at risk of homelessness" definition in 24 CFR 576.2; OR
    - Meet the criteria in category (2) or (4) of the "homeless" definition in 24 CFR 576.2.

- Priority populations for Rapid Re-housing — In providing Rapid Re-housing assistance, providers shall prioritize the following subpopulations:
    - Families with children;
    - Domestic violence survivors;
    - Single persons without long term disabilities; and
    - Veterans, especially those persons who have served in the U.S. military but are not eligible for services from the Department of Veterans Affairs (VA), or who are unable to access services from the VA.

National Housing Trust Fund (NHTF)

The National Housing Trust Fund is a new dedicated fund intended to provide revenue to build, preserve, and rehabilitate housing for people with the lowest incomes. In Nebraska, the NHTF will be administered by DED. HUD's interim regulation requires that in years in which there is less than $1 billion in the NHTF, 100 percent of both rental and homeowner units must be occupied by ELI households. The statute requires that at least 90 percent of the funds be used for the production, preservation, rehabilitation, or operation of rental housing. Nebraska's first allocation is $3 million and is anticipated to be available in 2016.

Continuum of Care (CoC)

There are three CoCs in Nebraska.[16] Each year the CoCs complete a self-reported housing inventory count of dedicated housing for people experiencing homelessness. Table 4 shows these totals for 2015.

[16] Data from: https://www.hudexchange.info/grantees

Table 4: Nebraska Continuums of Care Dedicated Housing for Homeless Persons		
Name of CoC	**Total Beds (2015)**	**Total PSH (2015)**
Nebraska Balance of State CoC	1,066	94
Omaha/Council Bluffs CoC	2,495	851
Lincoln CoC	1,034	79
Total	**4,595**	**1,024**

Table 5 includes information about the number of emergency shelter (ES), transitional housing (TH), Rapid Re-housing (RRH), and permanent supportive housing (PSH) beds across the state. Most of these housing programs are funded by HUD and have differing program qualification requirements and restrictions on length of stay. HUD-funded TH allows people who are homeless to remain for up to 24 months and the length of the program can vary. Transitional housing beds may or may not be dedicated to people with disabilities. HUD-funded PSH has no fixed time limit and is dedicated to people with disabilities who are homeless. Permanent supportive housing units may have services on-site or provided through community service providers. HUD-funded RRH provides up to 24 months' worth of tenant-based rental assistance to families in units in the community.

Table 5: Beds for People Experiencing Homelessness[17] Based on Nebraska Continuum of Care Housing Inventory Charts 2011 through 2014								
Type	**2013**		**2014**		**2015**		**Change 2013-2015**	
	Families	**Individuals**	**Families**	**Individuals**	**Families**	**Individuals**	**Families**	**Individuals**
ES	711	946	734	944	594	921	**-16%**	**-3%**
TH	1,142	847	865	813	744	648	**-35%**	**-23%**
PSH	431	613	425	608	382	642	**-11%**	**+6%**
RRH*			29	52	291	126	**+334%**	**+142%**
Other PH**			54	10	115	66	**+107%**	**+560%**

*The provider program type "Rapid Re-Housing" was added in 2014. -
**Other permanent housing (PH) consists of PH-Housing with Services and PH-Housing Only, as identified in the 2014 - HMIS Data Standards. -

Low Income Housing Tax Credit program (LIHTC)

The federal government created the LIHTC program to encourage the development of new mixed-income rental housing that would benefit low-income households. At the federal level, the program is not administered by HUD, but rather by the Internal Revenue Service within the Department of the Treasury. Housing developed under the LIHTC program must be maintained as affordable rental housing for at least 15 years. Many types of rental housing are eligible including:

- Multi-family rental housing
- Mixed-use projects that include both rental housing and commercial space
- SRO housing

[17] https://www.hudexchange.info/manage-a-program/coc-housing-inventory-count-reports/

- Scattered-sites that can be "bundled together" as one project

According to LIHTC program guidelines, the minimum number of affordable units required in each LIHTC property is determined by the following federal formulae:

- For an LIHTC project targeted to assist households at 50 percent of AMI and below, at least 20 percent of the units in the project must be affordable.
- For an LIHTC project targeted to households between 50 and 60 percent of AMI, at least 40 percent of the units in the project must be affordable.

States can choose to require deeper affordability standards, such as a requirement that a certain number of units be affordable to people with incomes at 30 percent of AMI.

The FY15-16 Qualified Allocation Plan for Nebraska provides a slight scoring advantage for those projects applying for LIHTC funds that commit to target at least 25 percent of the units in the property for persons with disabilities or special needs.

Money Follows the Person

Nebraska's Money Follows the Person (NMFP) project assists Medicaid-enrolled individuals who are residing in nursing homes or intermediate care facilities for persons with mental retardation (ICF/MR) to transition to independent living in community-based settings.

Medicaid coverage, through the use of Home and Community Based Services (HCBS) Medicaid waiver programs such as the Aged and Disabled Waiver and Developmental Disabilities Waiver, "follows" individuals from facility-based care settings to community-based living arrangements of their choice and will support their appropriate home- and community-based services. NMFP is committed to the fulfillment of these objectives:

- Assist up to 900 persons who are elders, persons with a physical disability, persons with a developmental disability, or persons with a traumatic brain injury to transition from a nursing facility or ICF/MR care to community-based settings.
- Rebalance Nebraska's long-term care continuum by increasing the use of community-based services, while decreasing the use of facility-based care.
- Promote choice and support community-based services and programs.

The work of NMFP is carried out by three transition coordinators who work in different parts of the state, engaging individuals in nursing homes or ICFs and working with them to transition to the community including identifying housing placements and offering move-in assistance.

2. -Assessment of strengths and current housing initiatives

There is a tremendous commitment on the part of many stakeholders throughout Nebraska to meet the housing needs of the state's vulnerable populations, including persons who are homeless or at risk of homelessness. This commitment is evident in the state's Consolidated

Plan 2015-2019; the Opening Doors: 10 Year Plan to Present and End Homelessness 2015-2025[18]; the continued funding of two housing trust funds with resources committed to both affordable housing and housing for homeless persons; the proactive leadership of the state's three CoCs that continue to create permanent supportive housing and rapid re-housing opportunities; and the leadership among state agency personnel who recognize the benefits of permanent supportive housing and working together to create these resources and opportunities.

SYSTEM STRENGTHS

Regional Housing Coordinators within Behavioral Health Authorities

During focus groups conducted by TAC over a period of three years, the role of the Regional Housing Coordinators in each region was seen as a positive addition to the state system. The Housing Coordinators in general have a strong understanding of the needs of consumers and the housing resources in a community including available housing stock. The Housing Coordinators serve an important role in securing and helping to maintain independent housing.

Some Housing Coordinators are active in local initiatives and proactive in seeking new resources for the consumers with whom they work or interacting with other potential support systems such as the Money Follows the Person Transition Coordinators and local Public Housing Authorities.

Money Follows the Person

The three Transition Coordinators are knowledgeable of the housing process. NMFP has been successful in getting older adults, people with physical disabilities, and people with intellectual and developmental disabilities out of institutions and into community-based housing. While their focus cannot be on people with serious mental illness living in state-funded institutions, the Transition Coordinators have the skills, knowledge of resources and processes, and connections to provide strong links to those working with people with serious mental illness living in state-funded institutions.

Homeless Planning and Data Integration

The state's three Continuum of Care communities continue to work together to align their systems. The three administer a single point-in-time count and share a methodology to capture the number and some demographics of homeless persons living in Nebraska. The Balance of State CoC and Lincoln also use a common assessment tool to determine the severity of need for assistance and the appropriate intervention to end a person's homelessness and their relative priority for assistance. This common tool will soon be used in all three CoCs.

The Nebraska Homeless Assistance Program includes two resources: the HSATF and the state's ESG funds. By consolidating these resources into one "program" the state can ensure a more

[18] http://www.neded.org/files/crd/nchh/NCHH_OpeningDoors_StateofNE10YearPlantoPreventandEndHomelessness.pdf

comprehensive level of planning and programming. The NHAP, besides funding RRH units and assisting folks in accessing housing in as short a time as possible, has also funded SOAR (SSI/SSDI Outreach, Access, and Recovery) services in the Nebraska Department of Corrections to assist prisoners who are preparing for discharge to secure these disability income benefits if they are eligible for them.

CRANE

As discussed in the focus groups and further noted in the Consolidated Plan 2015-2019, there is a need to create new rental housing units for extremely low-income persons including those with SMI and substance abuse histories. The CRANE program provides a structured, supportive way for both experienced and inexperienced developers to work on what may be more challenging or high-risk development projects.

Nebraska RentWise

Nebraska RentWise is a program designed to teach people the knowledge and skills needed to be successful tenants. The curriculum takes an active-learning approach and stresses tenant responsibility. After completing a minimum of nine hours of education, participants earn a certificate, increasing the likelihood that owners will accept them as tenants even with housing barriers in their history. The RentWise workbook/organizer helps tenants store rental records and provides how-to information on unit maintenance and creating collaborative relationships with landlords and neighbors.

During several of the focus groups, participants discussed the success of the program and the ability to convince owners to give otherwise “bad” candidates a chance. The program offers a Train the Trainer model so that community groups can offer the training in their own neighborhoods and to their own clients.

Housing Assistance Program

The Nebraska DHHS Division of Behavioral Health administers the state's Housing Assistance program, which is designed to address the housing cost burden for ELI adults with an SMI diagnosis and for adults with an SUD or co-occurring disorders. The Housing Assistance program makes funds available from Nebraska’s Housing Related Assistance (HRA) program, which utilizes Nebraska state documentary stamp tax dollars to provide housing assistance to eligible individuals with an SMI (or co-occurring disorder), and state general funds to serve eligible individuals with either an SMI or an SUD (or co-occurring disorders). These resources can provide rental payments, utility payments, security and utility deposits, and other related costs and payments. The funds are administered through contracts with the six RBHAs which all have Regional Housing Coordinators.

Currently, the program appears to be serving the priority 1 population well but needs additional funding across the state to meet the needs of priority 2 and 3 populations.

The Housing Assistance program is informally seen as a bridge program to more permanent housing resources. Formalizing this link between the Housing Assistance program and local PHA HCVs could benefit all entities. For PHAs, this link would provide a direct referral of a person with a demonstrated housing history and could expedite the PHA's timeframe to draw down administrative funds since a lengthy housing search would not be necessary. For DBH, it would result in a quicker turnover of Housing Assistance program resources, thereby allowing the program to serve additional consumers.

3. Description of Available Services & Supports

Title 206, Chapter 2 of the Nebraska Code, defines an array of services intended to be available to adults with an SMI or SUD, ranging from temporary, short-term interventions to secure, long-term community-based residential services.[19]

a. DHHS: Residential-Based

Mental Health Respite is designed to provide shelter and assistance to address immediate needs and 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. Length of stay is typically seven days.

Hospital Diversion is a peer-operated service designed to assist consumers in decreasing psychiatric distress that might otherwise 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 referrals for services as requested during and after the stay, as well as staffing a warm line. Hospital Diversion is located in a family/home setting in a residential district that offers at least four guest bedrooms and is fully furnished for comfort. Participation in the service is voluntary. Length of stay is typically four to five days, not to exceed seven days.

Secure Residential Treatment is intended to provide individualized recovery, psychiatric rehabilitation, and support as determined by a strengths-based assessment for individuals who have a severe and persistent mental illness and/or co-occurring SUD; who demonstrate a moderate to high risk for harm to self/others; and who need a secure,

[19] http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-206/Chapter-02.pdf

recovery/rehabilitative/therapeutic environment. Length of service is individualized and based on clinical criteria for admission and continuing stay, as well as the individual's progress on individual treatment/recovery goals. An individual may decline continuation of the service, unless under mental health board commitment, court order, or the care of a legal guardian.

Psychiatric Residential Rehabilitation is designed to provide individualized treatment and recovery inclusive of psychiatric rehabilitation and support for individuals with a severe and persistent mental illness and/or co-occurring disorder who are in need of recovery and rehabilitation activities within a residential setting. Psychiatric residential rehabilitation is provided by a treatment/recovery team in a 24-hour staffed residential facility. The intent of the service is to support the individual in the recovery process so that they can be successful in a community living setting of their choice. Length of service is individualized and based on clinical criteria for admission and continuing stay, as well as the individual's progress on individual treatment/recovery goals.

Halfway House is a transitional, 24-hour structured supportive living/treatment/recovery facility located in the community for adults seeking reintegration into the community, generally after they have received primary treatment at a more intense level. This service provides safe housing, structure, and support, and affords individuals an opportunity to develop and practice their interpersonal and group living skills, strengthen recovery skills, reintegrate into their community, find/return to employment, or enroll in school. Length of service is individualized and based on clinical criteria for admission and continuing stay, but individuals typically require this service for longer than six months for maximum effectiveness.

Intermediate Residential (Co-Occurring Diagnosis Capable) ASAM Level 3.3 is intended for adults with a primary SUD for whom shorter-term treatment is inappropriate, either because of the pervasiveness of the impact of dependence on the individual's life or because of a history of repeated short-term or less restrictive treatment failures. Typically, this service is more supportive than therapeutic communities and relies less on peer dynamics in its treatment approach. Services include individual, family, and group SUD counseling, educational groups, motivational enhancement and engagement strategies, provided for a minimum of 30 hours per week. The program is characterized by slower-paced interventions which are intentionally repetitive to meet special individual treatment needs, and monitoring to promote successful reintegration into regular, productive daily activity such as work, school, or family living. Length of stay is not time-limited though a year is typically needed for optimal outcomes.

Therapeutic Community (Co-Occurring Diagnosis Capable) ASAM Level 3.3 is intended for adults with a primary SUD for whom shorter-term treatment is inappropriate, either because of the pervasiveness of the impact of the SUD on the individual's life or because of a history of repeated short-term or less restrictive treatment failures. This service provides psychosocial skill-building through a set of longer-term, highly structured peer-oriented treatment activities which define progress toward individual change and rehabilitation and which incorporate a series of defined phases. Services include a minimum of 30 hours per week of individual, family, and group psychotherapy, educational groups, motivational enhancement, and engagement

strategies. The program is characterized by peer-oriented activities and defines progress through concrete phases to promote successful reintegration into regular and productive daily activity such as work, school, or family living, and monitoring of stabilized co-occurring mental health problems. Length of service is individualized and based on clinical criteria for admission and continuing stay, but individuals typically receive service for up to one year to achieve maximum effectiveness.

Short-Term Residential (Co-Occurring Diagnosis Capable) ASAM Level 3.5 is intended for adults with a primary SUD requiring a more restrictive treatment environment to prevent the use of abused substances. This service is highly structured and provides primary, comprehensive SUD treatment. Services include: counseling and clinical monitoring to promote successful reintegration into regular, productive daily activity such as work, school, or family living, including the establishment of each individual's social supports to enhance recovery; 24-hour crisis management; family education; self-help and support group orientation for a minimum of 42 hours per week; monitoring of stabilized co-occurring mental health problems; and monitoring of the individual's compliance in taking prescribed medications. Length of service is individualized and based on clinical criteria for admission and continuing stay.

Dual Disorder Residential (Co-Occurring Diagnosis-Enhanced) ASAM Level 3.5 is intended for adults with a primary SUD and a co-occurring severe and persistent mental illness requiring a more restrictive treatment environment to prevent substance use. This service is highly structured, based on acuity, and provides primary, integrated treatment to further stabilize acute symptoms and engage the individual in a program of maintenance, treatment, rehabilitation, and recovery. Therapies/interventions should include individual, family, and group psychotherapy, educational groups, motivational enhancement and engagement strategies, recreational activities, and daily clinical services provided at a minimum of 42 hours weekly; medication management and education; and consultation or referral for general medical, psychological, and psychopharmacology needs. Length of service is individualized and based on clinical criteria for admission and continuing stay.

b. DHHS Non-Residential Services and Supports

In addition to DBH-funded residential services, Nebraskans have access to an array of non-residential services and supports that can help individuals to obtain and sustain community-integrated housing.

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 the consumer, their support system, and behavioral health providers.

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 SUD 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 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 Region's behavioral health network.

Intensive Case Management is designed to promote community stabilization for consumers who have a history of frequent psychiatric hospitalization through frequent case management activities responsive to the intensity of the consumer's needs. Intensive Case Management includes mobile case management addressing illness management, peer support, crisis prevention/intervention, and appropriate utilization of community-based resources and services. Intensive Case Management is provided in the community with most contacts typically occurring in the consumer's place of residence or other community locations consistent with consumer choice/need. Length of service is individualized and based on admission guidelines and continued treatment/recovery/rehabilitation as well as the consumer's progress on individualized goals.

Intensive Community Services are designed to support consumers to develop independent and community living skills and prevent the need for a higher level of care. Services are designed for consumers with a high rate of inpatient use, including consumers with co-occurring disorders. Average length of service is six to twelve months.

Community Support is a rehabilitative and support service for individuals with primary Axis I diagnosis consistent with a serious and persistent mental illness. Community Support workers provide direct rehabilitation and support services to the individual in the community with the intention of supporting the individual to maintain stable community living, and prevent exacerbation of mental illness and admission to higher levels of care. Service is not provided during the same service delivery hours of other rehabilitation services. DBH only: For the purposes of continuity of care and successful transition of the consumer from 24-hour levels of care, for an individual already enrolled in community support, the service can be authorized 30 days following admission and 30 days prior to discharge from the 24 hour treatment setting. Length of service is individualized and based on clinical criteria for admission and continuing stay, as well as the client's progress on individual treatment/recovery goals.

Recovery Support services promote successful independent community living by supporting a consumer in achieving their behavioral health goals and increasing their ability to manage an independent community living situation. Recovery support is designed to advocate for

consumers to access community resources and foster advocacy and self-advocacy in others through the use of wellness and crisis prevention tools. Crisis relapse prevention, case management, and referral to other independent living and behavioral health services are provided to assist the consumer in maintaining self-sufficiency. Service continues until discharge guidelines are met or the consumer chooses to decline continuation of service.

The Assertive Community Treatment/Alternative Community Treatment (ACT) Team provides high-intensity services, and is available to provide treatment, rehabilitation, and support activities seven days per week, twenty-four hours per day, and 365 days per year. The team has the capacity to provide multiple contacts each day as dictated by client need. The team provides ongoing continuous care for an extended period of time, and clients admitted to the service who demonstrate any continued need for treatment, rehabilitation, or support will not be discharged except by mutual agreement between the client and the team.

Supported Employment is designed to provide recovery and rehabilitation services and supports to consumers engaged in community-based competitive employment-related activities in normalized settings. A Supported Employment team provides assistance with all aspects of employment development as requested and needed by the consumer. The intent of the service is to support the consumer in the recovery process so the consumer's employment goals can be successfully obtained. Services include individualized and customized job search with the consumer; employer contacts based on the consumer's job preferences and needs (typically provided within one month of program entry); on-site job support and job skill development as needed and requested by the consumer; diversity in job options based on consumer preference including self-employment options; and follow-along supports provided to the employer and consumer.

Community Substance Use Disorder Support is a rehabilitative and support service for individuals with primary SUDs. Community Support workers provide direct rehabilitation and support services to the individual in the community with the intention of supporting the individual to maintain abstinence and stable community living, and prevent exacerbation of illness and admission to higher levels of care. Service is not provided during the same service delivery hours of other rehabilitation services; DBH exception: For the purposes of continuity of care and successful transition of the consumer from 24-hour levels of care, for an individual already enrolled in community support, the service can be authorized 30 days in and 30 days prior to discharge from the 24-hour treatment setting. Length of service is individualized and based on clinical criteria for admission and continuing stay, as well as the client's progress on individual treatment/recovery goals.

c. Non-DHHS Programs and Services

Assisted Living Facilities (ALF)

Assisted living facilities are licensed by the DHHS Division of Public Health as facilities where shelter, food, and care are provided for payment for a period of more than 24 consecutive hours to four or more persons who require assisted living services due to age, illness, or physical

disability. [20] Care includes a minimum amount of supervision or assistance with personal care, activities of daily living and health maintenance.

In addition to the provision of food and shelter, ALFs are to provide care including:

- Activities of daily living, defined to include transfer, ambulation, exercise, toileting, eating, self-administration of medication, and similar activities;
- Health maintenance activities, defined as noncomplex interventions which can safely be performed according to exact direction, which do not require alteration of the standard procedure, and for which the results and resident responses are predictable; and
- Personal care, defined as bathing, hair care, nail care, shaving, dressing, oral care, and similar activities.

ALF services may be covered under the Aged and Disabled Waiver, Aid to the Aged, Blind and Disabled (AABD) case payment for person needs, Medicaid reimbursements for medically necessary services. While room and board is not reimbursable through Medicaid, it is likely paid for with an individual's SMI Supplemental Security Income (SSI) or SSA benefits, AABD case payment, or private funds.

Individuals with SMI who receive Supplemental Security Income (SSI) and reside in an ALF do receive a supplemental payment authorized by DHHS which provides additional payment for the ALF's services as described above. In Nebraska, SSI recipients receive $710/mo.; the SSI supplemental payment to an ALF is an additional $438/mo.[21]

The Nebraska Department of Health and Human Services has issued clarification that housing such as ALFs are not a behavioral health service, and that Housing Related Assistance funds are not intended for congregate settings such as ALFs.[22] Services outside the Assisted Living facility should be identified in the individual's service agreement.

Residents with behavioral health challenges may receive community based services such as community support, outpatient services, Assertive Community Treatment (ACT), medication management, etc.

Continuums of Care

According to a report released by the Metro Area Continuum of Care for the Homeless in 2014,[23] homeless service provider agencies are increasing their use of evidence-based practices to improve service delivery and strengthen outcomes. For example, the Heartland Housing Stability Team uses a case management model based on Critical Time Intervention (CTI), an

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[20] http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-175/Chapter-04.pdf

[21] Aid to the Aged, Blind and Disabled (AABD) -

[22] Assisted Living Facilities and the Department of Health and Human Services, Nebraska DHHS. -

[23] Opening Doors: 10 Year Plan to Prevent and End Homelessness in Douglas, Sarpy, and Pottawattamie Counties, - MACCH, 2008-2018 (Revised 2014). -

evidence-based practice to support the transition from homelessness to community-based housing. The SOAR program, an effort to streamline the processing of Supplemental Security Income (SSI) and Social Security Disability Income (SSDI) applications, is annually funded within the Continuum to facilitate access to income and health care for consumers, thereby increasing housing stability.

4. -Assessment of strengths and current services initiatives

The Division of Behavioral Health has demonstrated a strong commitment to enhance and support consumer empowerment primarily through its established Office of Consumer Affairs (OCA) as a result of the 2004 NBHSA. The OCA focuses on:

- Leading and implementing peer support initiatives and providing education and technical assistance to increase capacity of the peer support workforce
- Developing collaborative relationships
- Increasing consumer and family involvement in behavioral health service planning, delivery, and evaluation
- Advocacy — finding the best information and resources available
- Providing leadership in cross-system transformation initiatives
- Ensuring recovery principles are embedded throughout the service delivery system

Consumer and family involvement is a priority in all aspects of service planning and delivery (§ 71-803) and the Office of Consumer Affairs Council provides avenues for key stakeholders with personal lived experience to support this priority. As the Nebraska Behavioral Health system continues to transform, it is necessary to implement formal and strategic system links with other key stakeholders in order to expand consumer involvement in service planning and delivery in Nebraska. The OCA supported the creation of a consumer specialist position in each Region to provide peer support to other consumers.

The Office of Consumer Affairs also developed the People's Council, which is chartered to provide state and regional leadership while utilizing personal lived experience to advocate for systems transformation as well as identify and advocate for a Recovery Oriented System of Care. The council is chartered to serve as the: (a) planning council of the Nebraska Office of Consumer Affairs, and (b) as a subcommittee of the State Advisory Council on Substance Abuse Services (§ 71-815) and the State Advisory Committee on Mental Health Services (§ 71-814).

Recovery services and supports are available to adults, families, and transition aged youth in each region on a limited basis. Stakeholders identified the following model programs that they would like to see taken to scale.

CenterPointe

CenterPointe, located in Lincoln, provides treatment for adults and teens with mental health and SUDs. In addition, the agency provides a wide variety of behavioral health treatment, primary care, and rehabilitation and housing services for homeless and low-income people living with behavioral health disorders. CenterPointe promotes Housing First: supportive services can include case management, recovery support, and peer support, as well as access to outpatient counseling and medication management. The Transitions program provides independent living apartments for transition-age adults, 18 to 24, who are experiencing homelessness and problems with substance use, mental illness, or co-occurring disorders. This program includes dedicated case management and support for participants. The agency's website publicizes the assessed outcomes of its services as including increased number of previously homeless persons who are stably housed, reduced use of illicit drugs and alcohol, increased compliance with psychotropic medications, and participant satisfaction.

Project Everlast

Project Everlast is a statewide, youth-led initiative committed to providing resources, connections, and support to young adults as they age out of foster care. Project Everlast's foster youth services help ensure a smooth transition from foster care to adulthood. The program's goal is to empower youth to build successful lives as independent adults. There are more than 300 19-year-olds who age out of the Nebraska foster care system each year, who need ongoing support and structure but lack families to provide it.

Project Everlast brings together young people, public agencies, private funders, private providers, business partners, and concerned citizens to create a supportive community that is committed to improving lives. The organization concentrates its work in seven key areas: Permanence, Education, Employment, Housing, Physical and Mental Health, Personal and Community Engagement, and Economic Success. The strategies for Project Everlast are modeled after the Jim Casey Youth Opportunities Initiative Theory of: Youth Engagement; Partnerships and Resources; Research, Evaluation, and Communications; Public Will and Policy; and Increased Youth Opportunities.

Project Everlast's projects in Lincoln and Omaha attribute their success to:

- **Youth voice** in the form of the Project Everlast Lincoln youth council to inform all programs and practices.
- **Central Access Navigation** services to give youth one point of contact to find all the services they may need.
- **Transitional services** to assist with housing, health care, living skills, etc.
- **Opportunity Passport** program to help youth save money for and purchase assets that are critical to success.
- **Permanency services** to connect young people to caring adults from years past so they can build a dependable social network.

- **Needs-Based Fund** to provide youth with emergency cash when needed.

The organization can serve as a model for collaboration between public/private partnerships, local funders, and foundations. The Nebraska Children and Families Foundation[24] is working to expand the program to select communities across the state, planning with Grand Island/Hastings, the Panhandle, Fremont, and Norfolk to bring the community together to create a Project Everlast initiative that serves the unique needs of each community's youth.

The Orchard Drop-in Center

The Orchard is a consumer-run drop-in center in Lincoln, and is a project of the Wellbeing Initiative. The Wellbeing Initiative is a nonprofit organization dedicated to impacting the lives of individuals living with mental health challenges by providing a community that educates and empowers consumers to reach their fullest potential. Started as a pilot to serve 100 members, the Orchard now has more than 230 members.

The Orchard provides an easily accessible and inclusive environment for people in recovery to find resources, support, and encouragement; to exercise independence; and to participate in activities designed to promote recovery and give back to the community. The Center provides a place where consumers can socialize and make connections in a low-demand, trauma-informed environment.

Safe Harbor

Safe Harbor in Omaha provides walk-in assistance to adults with mental illness who are experiencing a crisis in their lives that is causing significant stress, but who do not require immediate psychiatric care or hospitalization. Peer specialists who have experience with a mental illness and are in recovery provide support and encouragement with the goal of avoiding an unnecessary hospital admission.

Keya House

Keya House is operated by the Mental Health Association of Nebraska (MHA-NE), a consumer-run, voluntary nonprofit statewide association with chapters in communities throughout Nebraska. Located in Lincoln, Keya House serves adults with mental health and substance use issues who live in the Region 5 systems service area. The program offers respite care for up to five days in a furnished four-bedroom house in a quiet and safe neighborhood. Trained peer specialists provide self-help and proactive recovery tools for guests to regain and maintain their wellness. The program is strictly voluntary and free of charge. An individual can self-refer or may be referred by a health professional or a family member.

Please refer to pages 31-33 for a further discussion of services and supports.

[24] http://www.nebraskachildren.org/

D. Estimated Need for Affordable Housing for Persons with serious behavioral health conditions living within Nebraska

1. Methodology Used to Determine Need -

This section employs a limited methodology to identify a range of housing needed for people with a behavioral health diagnosis in Nebraska. DBH could continue to identify internal and external data sources to identify specific housing and services needs for individuals with complex needs that are not currently in supportive housing. Among the populations that need further study are people with a mental health or substance use diagnosis, transition-age youth, older adults with co-occurring medical and behavioral health needs, and individuals involved with the criminal justice system.

TAC consulted numerous data sources to identify the approximate need for PSH for persons with serious behavioral health conditions.

Overall Housing Market Conditions

As part of its Consolidated Planning (Con Plan) Process, the Nebraska carries out a comprehensive assessment of housing conditions and market conditions throughout the state. This assessment includes access to data and maps provided by HUD's eCon planning suite, public comments, point-in-time data, and other statistics compiled and presented by different state agencies. The following is a summary of some of the Con Plan's key findings:

- A significant number of single-person households, particularly those who are low-income and have special needs, are in need of housing assistance.
- Approximately 81,000 persons in Nebraska live with SMI. Many of these individuals rely on SSI because their mental illness prevents them from finding employment.
- The average cost of a studio apartment in Nebraska is 73 percent of the average SSI payment, making housing unaffordable for many living with an SMI in the state.
- There is a significant unmet housing need in the state for persons with SUDs. There are approximately 9,063 individuals in Nebraska with SUDs. A majority (51.6 percent) of these persons are between the ages of 18 and 35.
- The value of housing throughout Nebraska is relatively low in comparison to the national average. As noted below, the median home value is $123,900, and has increased 43 percent since 2000, while the national average median home value is $176,700. The amount paid per month for rent is also relatively low compared to the national average. Approximately 93 percent of the population pays $999/month or less and over 47 percent of the population pays less than $500/month.

- Based on the number of households earning zero to thirty percent of the AMI, there are not enough rental units in Nebraska affordable to households earning 30 percent of HUD Area Median Family Income, with only 20,285 units available.
- Overall, more TBRA for the non-homeless special needs population is needed - throughout the state. -

Point-In-Time Count (PIT)

The three CoCs in Nebraska conduct a point-in-time (PIT) count of sheltered and unsheltered homeless on the same night during the last week in January. The results in Tables 6 and 7 are the most recent publicly available data, from the statewide point-in-time count conducted on January 22, 2015.

Table 6: Nebraska's 2015 Point-In-Time Count				
Household Type	**Emergency Shelter**	**Transitional Housing**	**Unsheltered**	**Total**
Households without children	976	563	115	1654
Households with at least one (1) adult and one (1) child	152	175	0	327
Households with only children	15	5	0	20
Total Households	**1143**	**743**	**115**	**2001**
Persons in households without children	991	579	123	1693
Persons in households with at least one (1) adult and one (1) child	481	543	0	1024
Persons in households with only children	21	6	0	27
Total Persons	**1,493**	**1,128**	**123**	**2,744**

The CoCs use a methodology to quantify those who are homeless and the special populations they represent. The following table extrapolates some of that data into the behavioral health categories of SMI, chronic substance abuse (CSA), and chronically homeless individuals (long-term homeless with a disability).

Table 7: Nebraska's 2015 Point-In-Time Count Subpopulations			
Subpopulation	**Sheltered**	**Unsheltered**	**Total**
Severely Mentally Ill	408	34	442
Chronic Substance Abuse	517	41	558

The PIT counts, while subject to uncontrollable circumstances such as weather, indicate some positive direction with a drop between 2014 and 2015 of almost 10 percent of total homeless persons. However, the data also indicates a significant number of people needing housing, including over 400 people with SMI and over 500 people with CSA.[25]

[25] The 2015 PIT estimates of people with disabilities may represent duplicated numbers of people. Each CoC would need to be consulted directly to determine an unduplicated count.

Housing Assistance Program

Housing Assistance Program served 849 people in FY 2015 which represents people with approved applications who received any type of payment from the program. The numbers served by region are as follows:

- Region 1 - 92
- Region 2 – 39
- Region 3 – 136
- Region 4 – 112
- Region 5 – 296
- Region 6 – 174

2. Projected Need

The following represents a baseline data for DBH and its partners to build upon as they continue to gather data from internal and external systems to identified priority populations and unmet needs across the Nebraska. DBH and its stakeholders can utilize the baseline affordable housing need data to project supportive housing gaps once more concrete data is available.

To project the number of people with mental illness who have the highest priority, unmet need for supportive housing, the number of non-elderly adults with mental illness receiving SSI disability payments was estimated and added to the most recent CoC PIT estimate of the number of homeless individuals with mental illness as shown in Table 8. Based on this data, 7,197 people with mental illness are projected to have the highest priority need and qualify for supportive housing.

Since many of these individuals may already be in some form of affordable housing, this figure represents an estimation of the supply of affordable housing that Nebraska should have available to meet the needs of residents with mental illness rather than unmet need.

TABLE 8: Nebraska's Highest Priority Needs for Supportive Housing	
Population Category	**Estimate**
Total SSI	27,719
SSI 18-64	19,190
SSI <65	23,295
SSI <65 with MI	8,200
SSI 18-64 with MI	**6,755**
PIT Homeless with MI	**442**
Total	**7,197**

In order to project the unmet need for supportive housing DBH and its partners will continue to gather project and system specific data to define the unmet need as they continue system

changes and complete their service needs assessment, which is currently in progress. To support this work, the Housing Assistance Payment Program annual recipients, permanent supportive housing and rapid re-housing beds were totaled and they represent 2,290 beds of the estimated 7,197 beds needed in Nebraska. As stated before, many individuals may be in some form of affordable housing that is not dedicated specifically to this population.

Living Situations

In identifying the need for housing, the following four primary settings should be considered:

- Homelessness — Persons experiencing homelessness in shelters or places not meant for human habitation like the streets, cars, or abandoned buildings.
- Institutional Settings — Persons living in an institutional setting who could live in more integrated community settings.
- At-Risk Community Housing — Persons in integrated community housing who may require additional services to remain in their housing.
- Assisted Living Facilities — Persons in assisted living facilities who desire a more independent living situation but do not have access to affordable housing and the level of community services they require.

Homelessness

The 2015 PIT count identified 442 people with serious mental illness experiencing homelessness. These individuals are likely eligible for CoC-funded RRH and PSH units.

There are currently 126 RRH units for individuals and 642 PSH units for individuals in Nebraska. These units currently prioritize individuals who are chronically homeless. Dr. Dennis Culhane, through various research studies on homeless individuals, reports that between 30 and 40 percent of persons who are chronically homeless have a serious mental illness. According to HUD's 2015 Annual Homeless Assessment Report, there were 257 chronically homeless individuals in Nebraska. Based on Dr. Culhane's research, we can estimate that between 77 and 103 Nebraskans with a SMI are chronically homeless and are eligible for the CoC PSH units.

TABLE 9: Potential PSH/RRH Dedicated to People Experiencing Homelessness in Nebraska		
PSH/RRH Units	**Annual Turnover**	**5-Year Turnover**
1024 PSH	30 - 51 (3- 5%)	150 - 255
417 RRH	42 - 63 (10-15%)	210 – 315
Subtotal	72 – 114	360 – 570
Gap	370 - 328	195 – 0*

**Need met if no additional people become homeless*

Institutional settings
The Lincoln Regional Center discharge data includes tracking for living arrangement upon discharge. It is unclear from the data how many people are currently discharged to available supportive housing but in looking at settings offer housing with mandated services or more restrictive housing placements in 2014 approximately 22%, or 39, people may have benefited from supportive housing options. DBH and its partners can work closely to refine the exit data and housing needs assessment to continue to better understand the housing needs of consumers.

Jail and prison release data also was not available specifically for DBH priority populations. DBH staff continues to discuss ways to more formally engage with jail and prison systems to provide appropriate housing for people being released.

At-Risk Community Housing
At this time, there is no formal data available for this population. On-site interviews over the years with case managers and community providers provide anecdotal evidence that many households could maintain community-based housing with additional supports.

Assisted Living Facilities
As of December 15, 2015, there were 290 licensed ALFs in Nebraska, ranging in size from 3 to 276 beds with a total of 12,146 beds.[26] State licensure data does not indicate the number of beds occupied by individuals with mental illness or other disabilities who could benefit from or would choose to live in more integrated settings. However, based on feedback reported in "The State of Nebraska, Consumer Housing Need Study of Extremely Low Income Persons with a Serious Mental Illness*:* Findings & Conclusions,*"* [27] consumers expressed concerns: a) that ALFs are the primary residential options for individuals with SMI and that insufficient options like PSH exist; b) that the quality of these ALFs is highly variable including the quality and range of services available; and c) the facilities tend to be restrictive.

E. Findings

1. Services and Supports -

Stakeholder Feedback
Based on consistent responses from the stakeholders who participated in the interviews and focus groups, it is clear that while there is an array of service options for individuals with behavioral health disorders in Nebraska, there is a perception that many individuals do not have access to the services and supports necessary for them to live in community-integrated

[26] http://dhhs.ne.gov/publichealth/Documents/ALF%20Roster.pdf
[27] State of Nebraska, Statewide Consumer Housing Need Study of Extremely Low Income Persons with a Serious Mental Illness: findings and Conclusions," Hanna: Keelan Assocs., PC, September 2003.

housing of their choice; there is considerable variation in the availability of services and supports across the six Regions.

a. - Services to Support People with an SMI or SUD

- Assertive Community Treatment (ACT) teams are available only in Lincoln, Omaha, and Hastings, and it would be optimal to expand this service into additional areas. Stakeholders perceive that individuals need to have multiple psychiatric inpatient admissions to qualify for ACT services, which excludes many individuals who could benefit from less intensive team-based care, often referred to as "ACT light." *Review of the ACT service description determined that eligibility criteria include a "history of high utilization of psychiatric services."*[28]

- Peer and Recovery Support are not Medicaid-covered services. Services are strictly grant- and state-funded; both are limited sources of funding which compromises the ability to expand capacity.

- Stakeholders perceive that there are few opportunities for skill-building. In order for consumers to live independently they need to learn/re-learn how to care for their apartments, budget money, interface with their landlords and fellow tenants, navigate their communities, etc. Learning opportunities for these skills do not exist. Many stakeholders thought that access to Chore Service[29] should be enhanced as opposed to access to services that build consumers' skills for independent living.

  Review of Nebraska Division of Behavioral Health Service definitions[30] *found that skill-building is an included component of Assertive Community Treatment Teams, Day Rehab, Peer Support, Community Support Services, Intensive Community Supports, Emergency Community Supports and Recovery Support.*

- Clubhouses are available on a limited basis; while there were mixed reviews of the service, clubhouses were described as successful with assisting people in getting jobs.

- The Orchard Drop-in Center was implemented as a pilot project, estimated to serve 100 members; it now has 230 members. The Orchard serves as a preventive support; participation keeps people from needing high-cost, deep-end services. The police have starting reaching out to them as source of support for individuals who are not connected. The Center's only location is in Lincoln; consumers want this service expanded.

[28] http://dhhs.ne.gov/medicaid/Documents/ACT.pdf
[29] http://dhhs.ne.gov/Pages/hcs_services_chore.aspx
[30] http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-206/Attachment-BHASD.pdf

Review of available consumer-run/drop-in programs determined that services were also available through Safe Harbor in Omaha and Keya House in Lincoln.

- Other services that stakeholders identified as needed include walk-in access for medication management, safe harbors, warm lines, vocational support (including jobs/transitional employment), targeted case management, and care coordination. Stakeholders consistently responded that consumers need more meaningful activities and supports.

b. - Services to Support Transition-Age Youth

- DCFS offers a bridge to independence (B2I) program for youth in out-of-home care; officials estimate that about 60 percent of these youth have behavioral health conditions. B2I provides supports with connection. Youth receive a stipend of $700 per month until age 21, so long they pursue education or employment. The initiative is viewed as highly successful but is only available for wards of the court.

- Preparation for Adult Living Services (PALS) is available for youth in foster care. DCFS is looking to expand to youth involved with Juvenile Justice and youth who run away, as members of both of these groups often have behavioral health diagnoses. PALS workers will travel into rural communities.

- DCFS and DBH are working on a policy related to serving transition-age youth. The policy will guide inter-agency collaboration to better support youth who have a behavioral health diagnosis. The attempt to create a policy is a positive first step.

- The Nebraska Division of Behavioral Health Professional Partner Program is designed to serve youth/young adults and families who are experiencing behavioral health challenges. The goals of the Professional Partner Program are to ensure the availability of an accountable individual to serve as an advocate, service broker, and liaison on behalf of the youth/young adult and his or her family when accessing needed services, to coordinate service components and all phases of treatment and support, and to ensure that the elements of treatment and supportive services are planned for and provided.

Some gaps still exist.

- Stakeholders perceive that most behavioral health services for children funded by Medicaid and DBH are targeted for children and youth with serious emotional disturbance (SED). Youth who do not meet that definition and are not under DCFS custody have little access to services and supports.
-

Further review found that Medicaid covers services for eligible children with behavioral health disorders of varying degree and severity, according to the individualized needs of the child and family.

- The Northeast sector of the state needs additional services. A participant in the transition-age youth interview pointed out that a Housing First approach hasn't been successful for these youth because they may sometimes lack the skills needed to live independently and need additional support. However, in some cases, the services and supports they need are not always available.

- Children/youth involved with Juvenile Justice were previously served in DCFS services; they are now split out from the agency, and services didn't transfer with them. These youth are not currently eligible for B2I.

c. - Services to Support Individuals who are Experiencing Homelessness

- The Continuums of Care rely on street outreach to assist individuals to find affordable housing units and resources to pay rent.

- While individuals may have health care, they are not always able to access coverage for services. Managed care authorizations can be difficult to obtain, and co-pays can be a barrier for people to access mental health services including medications, as well as dental care at FQHCs.

- There is need for more landlord liaison services to offer pre- and post-tenancy support to find units, help people to move in, ensure that people have household supplies and furnishings, and provide tenant-landlord mediation. Additionally, existing housing cannot always be preserved due to a lack of funding to cover for damages.

Addressing these gaps and variations in services, as well as expanding availability to populations that have significant needs even though they may not meet the criteria for SED or SMI/SUD, will be essential in order for supportive housing to be successful.

Service Capacity and Wait List Data Analysis

The Division of Behavioral Health monitors each Region's capacity to provide behavioral health services, as well as waiting lists, wait days, and interim services for individuals waiting to access substance abuse and/or mental health services. This is outlined in the *Capacity and Waiting List Management System Overview* draft policy, revised 3/11/2016.

Per the draft policy, the Behavioral Health network providers are required to complete the weekly substance abuse services capacity and wait list report and submit the reports to their respective Regional Behavioral Health Authorities (RBHA) each week. Each RBHA collects and analyzes the data to reveal trends and/or possible concerns at the regional level. The RBHA then aggregates provider data and submits a detailed report to the data team at the Division of Behavioral Health (DBH) via email each week.

The DBH Data Team aggregates regional data to track and report on region and statewide trends, including:

a. - Total used and total available substance abuse treatment service capacity (both capacity purchased and not purchased each region);
b. - Substance abuse treatment programs that are at or above 90% capacity;
c. - The number of individuals who are waiting for substance abuse treatment by priority population;
d. - The number of days individuals remain on the waiting list; and
e. - The interim services each individual is receiving while waiting for his/her appropriate recommended service.

Per the draft policy, the weekly substance abuse priority waiting/interim services list submitted to the DBH data team only includes those individuals who are:

a. - Waiting for admission into an ASAM substance abuse service;
b. - Eligible for regional reimbursement and fall into one of the five priority population categories; and
c. - Waiting for service at least one of the seven days in the reporting period.

The five substance abuse treatment priority populations are Pregnant Women, IV Drug Users, Pregnant Female IV Drug Users, Women with Dependent Children, and Individuals who are committed to treatment by a Mental Health Board.

The draft policy requires Behavioral Health network providers to contact individuals on the wait list at least once every seven days from the initial assessment. Providers must also arrange for individuals to receive interim services while awaiting admission into their appropriate recommended treatment. These activities are monitored via regional audits.

A capacity and wait list report is also collected for mental health services. Regions were previously required to submit the mental health services capacity and wait list report to the DBH monthly. However, Regions now submit it weekly with the weekly substance abuse services capacity report and wait list report. As with the substance abuse services report, the mental health services report is completed by the Behavioral Health network providers and submitted to the Regional Behavioral Health Authority (RBHA). The RBHA then collects and analyzes the data to reveal trends and/or possible concerns at the regional level. The RBHA aggregates the data providers submit to them and provide an aggregated regional-level report to the data team every Tuesday with the substance abuse capacity/wait list submission.

Also, as with the substance abuse services report information, the DBH data team aggregates the regional MH data to track trends on a state level and report:

a. - The total used and total available mental health treatment service capacity (both - capacity purchased and not purchased each region); -
b. - Mental health treatment programs that are at or above 90% capacity; and

c. - The number of individuals who are waiting for mental treatment by priority population.

Priority populations for mental health services reporting include persons in a Regional Center on discharge ready implementation lists (including Mental Health Board commitments and other legal statuses); persons in a community inpatient setting (acute or sub-acute) or crisis center and who are awaiting discharge; and persons committed to outpatient care by a Mental Health Board.

TAC was provided weekly reports for all regions during the month of May, 2016. Analysis of the reports identified:

- A consistent pattern of SUD services reported to be at capacity or exceeding capacity, including outpatient treatment, intensive outpatient, short-term residential; halfway house and therapeutic community beds.
- Variation in the use of SUD community support services among regions.
- SUD wait lists were highest for IV drug users and women with dependent children.
- There was considerable variation in MH service capacity across regions, though psychiatric residential rehabilitation was at or above capacity in 4 of the 6 regions.
- Some regions reported greater use of more traditional services like day habilitation, outpatient and med management while other regions reported higher rates of supported employment and transition-age youth services.
- Only one region reported any wait days for MH services for the target populations.

Based on a review of the data, TAC did not validate a lack of services funded by DBH for the target populations. This reporting activity is commendable and should be expanded to include all populations and funding streams.

2. -Supportive Housing

Based on consistent responses from stakeholders interviewed, there is not enough supportive housing available for individuals with behavioral health disorders in Nebraska. Initiatives have been started but the funding amounts are inadequate to meet the current need. Additionally, the rental housing stock in Nebraska needs to be augmented to ensure sufficient quantity for those who need it and ensure landlords maintain basic inspection standards for safe, decent housing.

- More independent supportive housing options are needed.
- There is a need for more independent living options to allow for consumer choice.
- There is a need for additional rental subsidy funds to make available housing affordable.
- There is a need for capital resources to build or rehabilitate rental housing.

- Rural areas of the state are not well served due to geographic challenges and lack of experienced housing developers.

- System staff must increase their housing practice knowledge to assist and link consumers to resources to maintain stable housing.

F. Strategic Goals

1. Initiate and lead an *Olmstead* planning process that leads to the development of a working '*Olmstead* Plan'

Legislative Bill 1033 was approved by Governor Pete Ricketts on April 18, 2016, as an "emergency" effort to address the state's lack of an *Olmstead* plan. The legislation acknowledges that "many Nebraskans with disabilities live in institutional placements where they are segregated and isolated with diminished opportunities to participate in community life." The Act proposes to address this problem through development of a comprehensive, effective plan to provide services to qualified persons with disabilities in the most integrated community-based settings possible. To develop this plan, DHHS is charged with:

a) Convening a team with representation from each of the six divisions within the department;
b) Consulting with other state agencies that administer programs serving persons with disabilities;
c) Appointing and convening a stakeholder advisory committee, with broad-based representation to assist in the review and development of the strategic plan;
d) Providing ongoing progress reports to the Legislature; and
e) Providing the strategic plan to the Legislature and the Governor by December 15, 2018.

This strategic housing plan should provide a strong foundation for the creation of an *Olmstead* plan.

2. -Maximize services and funding strategies to support community integration

Individuals with serious and chronic behavioral health disorders can live successfully in independent settings in the community as long as the services and supports they choose and need are readily available. Nebraska needs to strengthen its array of readily accessible skill-building and recovery supports within all Regions. Increased availability and capacity can be addressed through changes in policies accompanied by new and innovative funding strategies.

Policies

There are a number of policies that, if modified, could increase access to services and supports.

Community Integration

DBH can and should issue a policy statement setting forth its expectations regarding community integration. Elements of the policy should include:

- Consumer engagement prior to transition from any institutional setting
- Prohibition of discharge from an institutional setting to a known poorly-performing ALF
- Required, informed choice of living arrangements
- Person-centered service planning
- Peer support enhancements to crisis services, ACT teams, homeless outreach teams, etc.
- Priority services such as peer and recovery support, consumer-run initiatives, supported employment, supported housing

DBH may not yet be in a position to require these elements, but setting forth the expectation is an important step in system transformation.

Funding

Services funded by DBH are available to children, youth, and adults with mental health and SUDs of varying degrees of severity and complexity. However when funds are limited, the Regions have to choose which services to fund and which populations to prioritize. This likely results in non-Medicaid-eligible individuals with moderate-level disorders having less access to the full array of services. The availability of services for this population could mitigate progression to more debilitating and chronic conditions.

1. - **Objective:** Expand availability of services to under-served populations including transition-age youth with moderate-level disorders who are not wards of the court and adults with moderate-level behavioral health disorders in order to prevent further debilitation leading to chronic disorders.
    a. - **Action Steps**
        i. - Quantify the impact of lack of access to services among these populations based on the costs associated with inpatient/institutional admissions, involvement with the criminal justice system, and homelessness.
        ii. - Prepare a cross-systems fiscal analysis based on the expanded capacity to serve the population(s). Savings from stable housing can be realized for DCFS, DHHS institutional costs, corrections, and primary/medical care.
        iii. - Make a business case for additional funding to expand coverage for additional services and populations using the fiscal analysis.
        iv. - Support B2I for youth who are diagnosed with a behavioral health disorder and who are involved with the juvenile justice system or have a history of running away.

Services are more often facility-based, provider-led, and targeted to addressing crises and inpatient care — rather than focusing on providing services available to facilitate movement from deep-end services or to prevent regression to the need for such services.

2. - **Objective:** Increase the availability of rehabilitative services and supports based on evidence-based and best practices, in order to reduce reliance on high-cost, intrusive services that don't build skills for independent living or increase opportunities for recovery.
   a. - **Action Steps:**
      i. - Build on and expand model programs with successful outcomes, including approaches which have proven effective in rural states/communities.[31]
      ii. - Evaluate the outcomes of participation in day rehabilitation; repurpose funding to create "in vivo" skill-building and learning opportunities for individuals with behavioral health disorders to obtain and maintain community-integrated housing of their choice.
      iii. - Provide case managers and peer support specialists with information on service resources for skill-building assistance to transition to independent housing, to share with current ALF residents.

3. - **Objective:** Use capacity and wait list data reported by the Regions to verify service needs and target resources for service development/enhancement.
   a. - **Action Steps:**
      i. - Expand collection of data to include aggregate reporting of services reimbursed by Medicaid and other potential funding sources
      ii. - Expand data collection to include all populations, not only priority populations, in order to better establish needed service capacity enhancements
      iii. - Include capacity/wait list data for long-term residential SUD services and psychiatric residential rehabilitation programs in analysis of needed PSH capacity.
      iv. - Explore strategies to share data across agencies, such as Medicaid, DBH, COCs, Department of Correction (DOC), and DCFS in order to identify high utilizers of services across systems; target outreach and interventions to these individuals, who are likely to fall below the threshold of current service eligibility.

4. - **Objective:** To align prioritization of housing and services and supports for individuals with a behavioral health diagnosis.
   a. - **Action Steps:**

[31] Rural Assistance Center http://www.raconline.org/"*Rural Mental Health and Substance Abuse Toolkit*," Focuses on adapting programs to meet rural community needs.

i. - Review criteria for eligibility to identify common indicators.
ii. - Since there will not likely be 100 percent alignment, target a percentage of resources within the behavioral health system to support CoC priority populations.

Funding

While revising policies may expand access to services, it won't expand service capacity. Additional and/or repurposed funding will be needed to support community integration services and supports.

Medicaid

According to a report in *The Book of States, Facts and Figures*, issued by the Council of State Governments in 2012, Medicaid enrollees represented 11 percent of Nebraska's population; the national average was 16.3 percent. . As Table 10 shows, health costs per Medicaid enrollee in Nebraska, which exceeded the national average.

Table 10: Health Costs for Nebraska Medicaid Enrollees

	Health $ Per Capita	Health $/ Med enroll	Total Med Expenditures	Med Enrolls % of Pop	Med $ as % of Total State Expenditures'
Nebraska	7,048	8,228	1,649 M	11.	17.2
National Average	6,815	6,826	361,847 M	16.3	22.3

Nebraska's Medicaid program operates under a number of 1915(b) and 1915(c) waivers. The 1915(c) waivers are targeted to specific populations with targeted benefit packages for each. The behavioral health carve-out which currently operates under a 1915(b) waiver will be coming to an end on December 31, 2016. Beginning January 1, 2017, Heritage Health will be the new health care delivery system that combines Nebraska's current physical health, behavioral health, and pharmacy programs into a single comprehensive and coordinated system for Nebraska's Medicaid and Children's Health Insurance Program (CHIP) clients. Nebraska Medicaid has contracted with United Healthcare Community Plan, Nebraska Total Care (Centene), and WellCare of Nebraska for the Heritage Health program. Members will be able to choose from all three contracted plans no matter where they live in the state.

Waiver Authority

Nebraska would be well served to explore the alignment of its various waiver programs under an 1115 demonstration waiver. Not only would an 1115 provide flexibility in providing services across populations based on individuals' needs, it would also provide the opportunity to use alternative payment arrangements and to incorporate performance metrics that can be tied to provider payments in an effort to improve quality. In June 2015, CMS guidance shared with

states on using Medicaid to support housing access and services identified numerous housing-related services and supports that can potentially be covered under Medicaid. Many of these services and supports could be covered under an 1115 waiver, so long as the state can assure overall cost neutrality. DHHS would need to verify its capacity to collect significant data and to perform high-level analytics.

Benefit Package

Nebraska Medicaid covers clinical services such as mental health inpatient, outpatient and day treatment and SUD hospital-based and outpatient treatment, including medication-assisted therapy. The program also covers additional rehabilitative psychiatric services including community support (mental health and SUD), day rehabilitation, and psychiatric residential rehabilitation and ACT teams. While Magellan is encouraged also to provide "value-added" services that can include services not covered by the Medicaid state plan, it is unclear if there are sufficient reimbursement funds available to promote such additional value-added services. Many of the housing-related services and supports which have proven effective for PSH are not Medicaid-reimbursable in Nebraska.

Nebraska was selected to participate in the CMS Innovation Accelerator Program's Supporting Housing Tenancy program, which promotes innovative state strategies to support community-based housing services for Medicaid recipients. The assistance also targets collaboration with key housing partners. The DHHS divisions of Medicaid and Long-Term Care, Behavioral Health and Public Health; the Department of Economic Development; Eastern Nebraska Office on Aging; League of Human Dignity; Kearney Housing Authority; and the Nebraska Housing Developers Association are participating in the three-month web-based training series. The federal partners' goals for the program are to provide Medicaid recipients with tenancy-sustaining services, promote a collaborative relationship between state agencies and community partners, and gain a better understanding of which housing-related activities and services are covered by Medicaid.

1. - **Objective:** Explore additional Medicaid coverage for housing related services and supports so that more people can live successfully in settings integrated in the community.
    a. - **Action Steps:**
        i. - Explore Medicaid's willingness to consider an 1115 Waiver
        ii. - Work with Medicaid to obtain needed data to analyze the costs associated with the current behavioral health benefit package, and potential savings under a different Waiver authority.
        iii. - Conduct a return on investment analysis, including the costs associated with the inpatient stays at the Regional Centers, homelessness, and incarceration, for adding services and supports to the Medicaid benefit package that not only support PSH but also promote recovery. Services at minimum should include peer support, recovery coaches and mobile psychiatric rehabilitation.

iv. - Explore the opportunities for care coordination provided by the Health Home pilot programs in Nebraska to focus on housing-related services and supports.
v. - Explore the opportunities for Community Health workers to support individuals with SMI in rural areas in accessing and sustaining PSH.

State General Funds

Many of the services and supports needed for individuals with behavioral health disorders to live successfully in PSH are currently covered by state general funds in Nebraska. In 2014 behavioral health state funding per capita was $66.10, almost identical to the national average of $66.05.[32] DBH receives about $100M annually; about 60 percent of the funding provides for services in the community. Given the limited Medicaid benefit package, these funds are needed to cover emergency/crisis services, peer support, recovery support, and the variety of clinical services covered by Medicaid for people who are not Medicaid-eligible but who lack private insurance and the means to pay.

In addition to repurposing Medicaid funds, DBH should use Legislative Bill 1033 to plan for the further reduction of state-operated psychiatric beds and repurpose funding made available to support housing and related services and supports for individuals in the community.

2. - **Objective:** Provide additional housing-related, recovery-promoting services and supports using state general funds.
   a. - **Action steps:**
      i. - Maximize Medicaid coverage
      ii. - Repurpose resulting state general funds to support PSH and recovery-promoting services.
      iii. - Develop an *Olmstead* Plan to reduce the reliance on Regional Centers and assisted living facilities for individuals with serious behavioral health disorders.
      iv. - Repurpose resulting state general funds to support PSH and recovery-promoting services.

[32] NRI State Mental Health Agency Profiling System, "State MH Agency and State Substance Abuse Agency Funding from State Funds, By State," FY2014

3. Expand DBH infrastructure and community planning efforts to meet the challenges of creating a robust supportive housing system

Staffing

DBH has in place a leadership team that is committed to identifying and implementing housing solutions to offer options for people to live in the community in the type of housing of their choice. This DBH leadership team could be enhanced by the addition of a statewide housing coordinator. Also, currently each Region has a housing coordinator position to assist consumers in a variety of ways, including being the local gatekeepers for the State Rental Assistance Program. The programs and staff duties of regional coordinators vary among regions. On-site interviews with the regional coordinators revealed many promising practices that with more staffing could be brought to scale to assist consumers in living independently.

1. - **Objective:** Increase housing staffing within DBH leadership team and Behavioral Health Authority Regions
    a. - **Action Steps:**
        i. - Create a housing coordinator leadership position within DBH to work across departments to facilitate statewide system development and provide education of housing and service resources.
        ii. - Expand regional coordinator role and staffing to assist with housing placements and to assist with in-reach and system changes.

Planning

Nebraska DBH and the CoCs have multiple plans in place to address the shortage of safe, decent, and affordable housing. In order to maximize existing resources to serve the most vulnerable citizens in the least restrictive settings, DBH must continue to work with community partners to develop a system to ensure increased creation and continuation of supportive housing options. This system should include methods to evaluate the efficacy of existing housing interventions and supportive services to meet statewide goals.

2. - **Objective:** Enhance cross-department and community-level planning efforts to create targeted resources for priority populations
    a. - **Action Steps**:
        i. - Form a cross-department housing team within DBH to assure coordination of resources and cohesive planning efforts to develop supportive housing.
        ii. - Assign a Statewide Housing Director to work with leadership and regions to identify gaps and build partnerships to access existing supportive housing.
        iii. - Continue statewide planning efforts to leverage dedicated and mainstream housing funding for target population.

iv. Develop regional goals to leverage mainstream housing resources and build landlord networks.
v. Develop a prioritization strategy to target resources to the most vulnerable consumers in the most restrictive settings such as hospitals, institutions, and assisted living programs.
vi. Develop population priority criteria to target available resources.
    1. Identify consumers with three or more ALF placements in five years and target rental funds.
    2. Identify consumers with one psychiatric hospitalization in the past five years and target rental funds.
vii. Develop a report template to assess and communicate progress towards meeting established goals.

Housing Inventory

The current system of housing resources available is somewhat fragmented because the lists are managed by many different partners. DBH and its partners should work to enhance the housing inventory system to quantify the existing supportive housing inventory dedicated and available to the target population.

3. **Objective:** Enhance housing inventory systems to monitor and access dedicated and mainstream housing opportunities.
    a. **Action Steps:**
        i. Identify current housing registry platforms and assess the feasibility of combining systems to create a central repository.
        ii. Develop a formal method to quantify supportive housing program impact to request additional funding.
        iii. Develop and maintain an inventory of supportive housing options for consumers with behavioral health and substance abuse diagnoses.
            1. Inventory data should include the following:
                a. Project name
                b. Type of project
                    i. Place-based, scattered site, etc.
                c. Project location (county and/or Town)
                d. Criteria for admission (psychiatric hospital discharge, SMI, SA, HIV, etc.)
                e. Type of housing: individual or family
                f. Number of designated and total beds
        iv. Leverage existing state resources to maintain supportive housing inventory such as online housing locator (insert link) and local CoC housing inventory charts.
        v. Develop a method to track vacancies in supportive housing by exploring modifications to the housing locator service, developing a shared Google document, and partnering with local coordinated entry systems through Continuum of Care planning groups.

vi. - Develop a reporting structure to assess supportive housing development and utilization for dedicated and mainstream housing resources.

Data management and Prioritization

In order for the state to be able to track progress on how well it is meeting the supportive housing needs of its targeted population, the state must first clearly define what the target population is and then identify what the housing needs are of this target population. It would be helpful to more clearly define who the state hopes to capture through these supportive housing planning efforts. On-site interviews identified the following priority populations:

- Individuals with SMI
- Individuals with SUD
- Individuals who are homeless or at risk of homelessness
- Individuals leaving incarceration
- Transition-age youth with a behavioral health diagnosis
- Individuals over 50 with co-occurring physical and behavioral health needs

Not all individuals within these subpopulations will want or need supportive housing. Supportive housing is defined as deeply subsidized, affordable housing that provides tenancy rights, and an array of flexible community-based services that are available to assist the individuals with accessing and maintaining housing. TAC recommends utilizing agreed-upon criteria to determine who within the subpopulations is ‘in need of integrated supportive housing.’ Potential criteria include:

- ❖ Clinical/functional
    - o Presence of a disabling condition or life challenge that impedes the individual’s ability to live independently, the effects of which can be mitigated through individualized services and supports
    - o Presence of functional limitations
    - o Specific indicators of continuous high-service needs (frequent use of crisis services, visits to emergency departments, involvement with police, etc.)

- ❖ Low income: At or below a percentage of AMI determined by the Supportive Housing Planning Committee

- ❖ Preference: The individual has indicated a preference to live in supportive housing

- ❖ Prioritization
    - o Homeless or at risk of homelessness (i.e., discharge from an institution such as hospital, nursing facility, or jail with no placement option), or those living in uninhabitable or substandard housing

- Those living in short-term or transitional housing with no tenancy rights or other discharge options

- Exclusionary Criteria
  - The individual chooses and is able to live with willing family or friends
  - The services and supports needed to ensure safety and stability, as identified in a person-centered planning process, cannot be provided

In order to move forward with supportive housing planning and implementation, DBH must obtain specific housing needs data for targeted subpopulations and establish criteria for supportive housing placement. While many community agencies and regional housing coordinators may have some data on the housing needs of individuals, there is not a mechanism for aggregating and de-duplicating data across agencies to create a valid and reliable data set. This activity will require clearly defining the target population(s) and establishing criteria for who is in need of supportive housing. It will also require standard definitions across regions to ensure equal access to resources.

4. - **Objective:** Identify DBH consumers, monitor supportive housing need, and improve data utilization practices.
   a. - **Action Steps:**
      i. - Develop workgroup to assist in planning for supportive housing needs.
      ii. - Develop written definitions of target/eligible population(s).
      iii. - Identify consumers with dual diagnoses (SMI/SA or SMI/DD or SA/DD)
      iv. - Identify consumers in prison with anticipated release date using techniques such as in-reach, matching state service lists to jail rosters, and review medication costs to identify potential behavioral health consumers.
      v. - Utilize Medicaid records on an ongoing basis to identify priority consumers such as those with frequent hospitalizations and high use of emergency departments and other crisis services.
      vi. - Develop projection methods to estimate housing needs based on current utilization patterns of existing housing, admissions per year, turnover, etc. Include state hospital beds, the state rental assistance program, emergency housing placements utilizing state funds, and consumers of assisted living facilities.
      vii. - Identify a methodology to set the target number of units required to meet housing need through Fiscal Year 2019. Review this methodology semi-annually to verify assumptions, review actual housing placements, and assess consumer demand.
      viii. - Identify a plan to find known DBH consumers currently living in ALFs utilizing a multi-faceted approach including a data match between Medicaid records, State hospital records, and ALF rosters and conducting 'in-reach' at ALFs with regional housing coordinators.
      ix. - Develop a method to identify direct discharges from the state hospital to assisted living facilities including consumers who are admitted to assisted

living within 90 days of discharge, and offer ongoing transition services to find community housing.

Discharge Planning and Housing Placement Practices

Stakeholder interviews emphasized the need for consumer choice in supportive housing options. As supportive housing resources expand, local policy and procedures must be developed to ensure all staff involved in discharge planning are aware that placements should be made in the least restrictive housing setting of the consumer's choice. This is currently happening in some areas where housing is available, but there is room for growth. This may be due to the lack of housing resources and community support services but contributing factors include lack of education on new principles such as Housing First and alternate supportive housing models.

A strong discharge planning system should start exploring discharge options upon program entry to identify appropriate and available housing and service options for community integration. To achieve statewide consistency, policy must be put into practice at each institution to ensure that all housing and service options are explored. Many times discharges are made to more restrictive settings due to a lack of knowledge about alternate options. Case manager interviews revealed that some consumers are being discharged to less restrictive settings with family members but the viability of that as a long-term placement is low. These consumers may then end up in assisted living facilities not due to choice but because there is no other affordable independent housing option.

Additionally, DBH must ensure that short-term placements to assisted living facilities have adequate resources and planning support to identify community-based housing.

In order to move forward with this goal, DBH must continue to develop and maximize partnerships with leaders and staff within institutions to build a foundation for appropriate discharge planning and execution.

5. - **Objective:** Increase housing planning during discharge and create a sustainable system-wide training program.
    - **b. - Action Steps:**
        - i. - Identify all institutions currently serving people with an SMI or SUD diagnosis.
        - ii. - Create a master list of discharge planners for people with SMI or SUD who routinely seek supportive housing placements. Membership would include, but is not limited to, state mental health hospitals, local mental health hospitals, jails, prisons, and other institutions providing temporary residential treatment.
        - iii. - Review written discharge policies for identified institutions to determine if least restrictive housing placements are required, encouraged, or absent.

iv. - Convene meetings with institution leaders and appropriate discharge staff to determine barriers and opportunities to alter written policy to better focus on consumer choice for housing placement.
v. - Develop an action plan to offer consumers in the most restrictive settings housing options within their preferred community. While supportive housing stock is being developed, allocate resources to fund bridge or temporary housing paired with focused skill-building services.
vi. - Convene annual trainings for discharge planners which would include the following information-sharing and data-gathering efforts.
    1. - Review of state and regional discharge policy
    2. - List of supportive housing resources
    3. - Identification of system gaps
vii. - Once implemented, expand the Lincoln Regional Center Peer Bridger program to assist all consumers in the Centers who are interested in moving to housing in the community.

4. -Identify and create supportive housing opportunities

Developing supportive housing options will be an ongoing, long-term process to adequately build capacity to serve the entire state of Nebraska. Given the current limited supply of supportive housing, DBH and its partners will need to be aggressive in identifying and implementing strategies to expand supportive housing including locating additional resources to support the State Rental Assistance Program.

In order to meet short- and long-term housing needs, DBH and its partners will have to identify existing housing resources that can adopt a disability preference to create a link to these housing resources as well as create a pipeline of new affordable rental housing.

1. - **Objective:** Review current programs to identify weaknesses and opportunities to reduce barriers to entry, increase utilization rates, revise regulatory and programmatic requirements to create less restrictive housing options.
    a. - Action Steps:
        i. - Appoint a workgroup to review and propose modifications to assisted living regulations to remove barriers to independent living and increase quality of housing.
        ii. - Appoint a workgroup to review and propose modifications to the existing State Rental Assistance Program.
        iii. - Identify currently underperforming assisted living projects by utilizing in-house data and/or data provided by a Disability Rights Nebraska team review.

2. - **Objective:** Increase available rental subsidy funding for community based supportive housing.
    a. - Action Steps:

i. - Pilot HOME TBRA in a community with either no potential for HCV preferences or where a bridge to HCVs can be tested.
ii. - Work closely with CoCs to request rental subsidy funding for behavioral health populations in both PSH and RRH.

3. - **Objective:** Increase subsidy funding and access to existing programs to assist consumers in securing permanent supportive housing.
   a. - **Action Steps:**
      i. - Create a direct link to available HCVs by facilitating a meeting of the 20 largest PHAs to discuss potential preferences to HCVs; explore barriers to the utilization of HCVs, and strategies to address barriers including enhanced services; reasonable accommodations; and direct referrals from the State Rental Assistance Program.
      ii. - Host a meeting of private owners of HUD-assisted housing and USDA-funded housing to identify strategies to create direct links to these resources through available preferences and community-based linkages.
      iii. - Develop a method to target dedicated NED and Mainstream Housing Choice Vouchers to for high-priority consumers by pairing the vouchers with community based supportive services.
      iv. - Explore the development of a direct referral system to Housing Authorities for any NED or mainstream vouchers. Ensure full utilization of these special purpose vouchers by persons with disabilities.

4. - **Objective:** Increase the capacity of the State Housing Assistance Program to serve consumers of DBH.
   a. - **Action Steps:**
      i. - Explore additional resources to support the State Rental Assistance Program to adequately serve all priority populations identified in the current program manual.
      ii. - Expand linkages between the State Housing Assistance Program and other mainstream housing resources to encourage quicker turnover of HRA vouchers.
5. - **Objective:** Maintain and increase the development funds to increase supportive housing stock.
   a. - **Action Steps:**
      i. - Preserve the Nebraska Housing Trust Fund State Allocation to develop new affordable housing
      ii. - Partner with local advocacy groups to quantify the impact if the state-funded HTF is not funded and to seek potential for increased funding
      iii. - Pilot a project using new NHTF resources, LIHTC, CRANE, and HOME/NHTF to encourage the development of integrated housing. Require demonstrated referral links and service provider capacity.

6. - **Objective:** Increase access to housing created by private owners using various HUD and USDA resources.
    a. - **Action Steps:**
        i. - Facilitate a meeting of private owners of HUD-supported multifamily housing to discuss potential preferences.
        ii. - Do a site assessment of vacant USDA properties to match need and location.

7. - **Objective:** Create increased capacity to address the lack of available developers and contractors willing to develop supportive housing.
    a. - Action Steps:
        i. - Create a peer-to-peer technical assistance opportunity for potential developers (nonprofit and for-profit) to increase the overall capacity to create new housing opportunities through HUD's Rural Capacity Building for Community Development & Affordable Housing program.

5. -Increase knowledge of supportive housing principles and practices

It was evident during the stakeholder interviews that some providers and community members had extensive knowledge of affordable housing principles and practices while others were just becoming familiar with housing practices to help people live independently.
Housing and service providers' knowledge about tenant rights, landlord tenant law, and homeless prevention techniques to stabilize housing would benefit consumers to remain in the least restrictive housing setting of their choice.

1. - **Objective:** Expand current programs and disseminate progressive housing practices to ensure that consumers have tenancy knowledge, awareness of their rights, and staff support to secure and maintain independent housing.
    a. - **Action Steps:**
        i. - Expand the RentWise[33] program geography and scope to help ready consumers for independent housing.
        ii. - Identify resources to prevent and treat bedbug infestations that are causing people to lose housing.
        iii. - Create an education campaign about preventing bedbug infestations to lessen negative property owner and consumer experiences.
        iv. - Increase property owner outreach programs to increase access to existing rental housing.
        v. - Develop landlord risk mitigation funds and practices to secure rental units for high-risk renters.

6. -Promote community awareness and positive practices for community inclusion

Transforming a system from reliance on institutional care to a system that supports community integration requires a significant culture shift. Not only must policies be changed, services

[33] http://rentwise.org/

developed, and funding mechanisms established to support them, but training direct service staff, agency leadership, community agencies and the public is essential.

1. - **Objective:** Establish a behavioral health system that embraces community inclusion and uses evidence-based approaches in all levels of care.
    a. - **Action steps:**
        i. - Require provider agency leadership and direct care staff to participate in consumer-led training in recovery and community inclusion.
        ii. - Require DBH-funded agencies to employ at least one new evidence-based practice each year.
        iii. - Require direct care staff to be trained in evidence-based practices.
        iv. - Require all staff of the Regional Centers to participate in consumer-led training in recovery and training on DBH's policy on community inclusion.
        v. - Offer opportunities for consumer-led recovery training to local agencies including law enforcement, jails, social service agencies, primary care settings, faith-based organizations, etc.
            1. - Explore crisis intervention team (CIT) and CIT Youth training for local police forces to reduce arrests, involuntary hospital admissions, and admissions to the juvenile justice system.[34]
            2. - Explore CTI for homeless services.
        vi. - Collaborate with consumer and family advocacy organizations to promote recovery and community inclusion at local community events.

[34] https://www.nami.org/Get-Involved/Law-Enforcement-and-Mental-Health

G. Appendices

Appendix A: Nebraska Behavioral Health Regional Map

The DHHS website contains a regional map and contact information to link providers and consumers with the resources in their geographic area. The websites to access this information are http://dhhs.ne.gov/behavioral_health/Documents/Behavioral_Health_Regions_2007.pdf and http://dhhs.ne.gov/behavioral_health/pages/networkofcare_index.aspx.

Appendix B: Literature Review

1. Bellevue Consolidated Plan, 2014 - 2018
2. CDS Housing Encounter Process 2/24/2015
3. Central Nebraska Housing Developers - Rental Workout Plan
4. CMCS Informational Bulletin, "Coverage of Housing Related Activities and Services for Individuals with Disabilities," June 26, 2015 -
5. Community Integration in Nebraska's Behavioral Health System, TAC, Inc., April 2014 -
6. Community for a Cause Meeting minutes – 11/2015 and 1/2016
7. DBH 101 Lawson Leadership Presentation
8. DBH 2014 Annual Report
9. - DBH 2015 Performance Audit from Nebraska Legislature – November 2015
10. DHHS Assisted Living Facilities Flyer
11. DHHS 2016 Bridge Strategic Plan
12. DHHS Strategic Plan Progress Report, September 2014.
13. Disability Rights Nebraska Behavioral Health Position Statement – October 2015
14. Hotel Pawnee in violation of state regulations, NPTelegraph.com
15. Housing Assistance Program Manual 10/2015
16. Joint Committee Meeting – State Advisory Committee on Mental health Services (SACMHS) and State Advisory Committee on Substance Abuse Services (SACSAS) August 13, 2015 Meeting Minutes
17. Legislative Bill 1033 Related to *Olmstead*
18. Lincoln Consolidated Plan, 2013 - 2017
19. Lincoln Regional Center Peer Bridger Plan, July 2016-June 2018 (DRAFT)
20. Metro Area Continuum of Care for the Homeless 10 Year Plan to Prevent and End - Homelessness, 2008 – 2018 (Revised 2014) -
21. NAHTF Grants Awarded and Not-Awarded List for 2015
22. Nebraska Affordable Housing Program Application Guidelines 2015
23. Nebraska Division of Behavioral Health Strategic Plan, 2011-2015
24. Nebraska Housing Developers Associates FY14-15 Report
25. NEBRASKA WELLNESS BRIDGER PILOT PROGRAM: Successful Transition from Nebraska Regional Centers to Community Living - January 2016
26. Omaha Area Adult Behavioral Health System Assessment, Final Summary of Findings and Recommendations; Tri-West, January 2015
27. Omaha Consolidated Plan, 2013-2017
28. Pawnee's doors stay open, NPTelegraph.com
29. Proposed Nebraska Affordable Housing Act Qualified Allocation Plan (QAP) – 2016

30. Opening Doors – State of NE 10 Year Plan to Prevent and End Homelessness (2015-2025) and accompanying implementation plan
31. State Housing Related Assistance Program Policy (July, 1, 2010)
32. State of Nebraska Roster of Assisted Living Facilities, December 15, 2015.
33. State of Nebraska Consolidated Plan, 2015 - 2019
34. State of Nebraska: Statewide Consumer Housing Need Study, Extremely Low Income Persons with Serious Mental Illness, 2003.
35. Statues Relating to Health Care Facilities 2014
36. TAC Recommendations From Region 6 Focus Groups, December 2014
37. The DHHS Behavioral Health Division's Role in Reducing Service Gaps, Performance Audit Committee, Nebraska Legislature, November 2015.
38. Title 175, Chapter 4 Assisted Living – Nebraska Health and Human Service Licensure
39. Title 206 - Behavioral Health Services in Nebraska
40. Title 471- Chapter 20, Psychiatric Services for Individuals Age 21 and Older
41. Chapter 35, Rehabilitative Psychiatric Services

Appendix C: List of Focus Group Participants

Housing Focus Group Stakeholder	Date	Count of Participants
Housing Providers	March 8, 2016	33
NBHS Leadership	March 8, 2016	35
Community Meeting	March 8, 2016	33
Division Directors	March 9, 2016	20
Housing Developers	March 9, 2016	11
HOME and Block Grant Managers	March 9, 2016	12
Nebraska Investment Finance Authority (NIFA)	March 9, 2016	3

Service Provider Focus Group Stakeholders	Date	Count of Participants
Provider Network	April 27, 2016	20
MCO	April 27, 2016	7
FQHC, Urban/Rural Health Centers	April 27, 2016	5
Community Meeting	April 27, 2016	18
Transition Age Youth Providers	April 28, 2016	17
Continuums of Care	April 28, 2016	15

All Focus Group Participants -

Name	Organization	City/Town
Adrianne Loutsch	Disability Rights of Nebraska	Lincoln
Alicia Johnson	Families Care	Kearney
Alicia Odean	Great Plans Health	N.D.
Alan Green	Mental Health Associate- NE	Lincoln
Amanda Strobel	UHG Optum Behavioral	CA
Amy F. Prenda, J.D	Nebraska Department of Corrections	State
Angie Smith	Region 2 Housing Coordinator	North Platte
Angie Ransom	ATP Assistive Technology Partnership	Lincoln
Anthony Walters	DBH	Lincoln
Ashley Carey	Bellevue Housing	Bellevue
Barb Palmer	United Healthcare	Omaha
Betsy Vidlak	CAPWN	Gering
Betty Medinger	Nebraska Children and Families Foundation	Lincoln
Bob Doty	NE Department of Economic Development	Lincoln
Bonnie Bauer	Region 2 Professional Partner Program	North Platte
Brad Brake	Office of Public Guardian	Lincoln

Name	Organization	City/Town
Brad Meurrens	Disability Rights of Nebraska	Lincoln
Brenda Fisher	Lancaster County, Dept. of Corrections	Lincoln
Brian Craig	Disability Rights of Nebraska	Lincoln
Carolyn Pospisil	Bellevue Housing Authority	Bellevue
Kathy Foster	Nebraska DOC, Director of Soc Work	Lincoln
Charles Coley	MACCH CoC	Omaha
Charyl Lentz	Nebraska Money Follows the Person	Lincoln
Chelsea Egenberger	Local MH/SA Non-profit	Lincoln
Christina Haggar	Region 6	Omaha
Corey McGeary	CHI-LHRC	Omaha
Cynthia Harris	DBH	Lincoln
Dan Jenkins	Sen. Bolz/Reg	Lincoln
Dan Taylor	DHHS Licensure	Lincoln
Dana Grisham	Community Alliance	Omaha
David Jones	R1 Housing Coordinator	Scottsbluff
David McNew		North Platte
Dean Loftus	Sarpy County	Papillion
DeAnn Reed	AETNA Better Healthcare	Grand Island
Denis Birgenheir	Veterans Administration	Omaha, Lincoln
Denise Packard	Center Pointe	Lincoln
Dennis Hoffman	Center Pointe	Lincoln
Destenie Commuso	MHA – NE Honu House	Lincoln
Diane Amdor	NE Legislature	Lincoln
Dianne DeLair	Disability Rights of Nebraska	Lincoln
Doshie Rodgers	DHHS	Lincoln
Faith Mills	Region 1 Youth System Coordinator	Scottsbluff
Gail Anderson	Community Advocate	Lincoln
Heather Leschinksy	MLTC	Lincoln
Heather Wood	DBH	Lincoln
J. Rock Johnson	AT-LARGE	Lincoln
Jan Goracke	DBH	Lincoln
Jennifer Determan	Region 6 Housing Coordinator	Omaha
Jeromie Luginbill	O.U.R Homes	Lincoln
John Trouba	DBH	Lincoln
John Turner	Region V	Lincoln
Judy Carlin	Omaha Housing Authority	Omaha
Judy Martin	DHHS DPH	Lincoln
Judy Vohland	NE Vocational Rehabilitation	Lincoln
Karen Heng	CFS	Lincoln
Kasey Moyer	MHA-NE	Lincoln
Kathy Foster	Nebraska DCS, Director of Social Work	Lincoln

Name	Organization	City/Town
Kathy Moline	Parent	Lincoln
Ken Zimmerman	Well-being Initiative	Lincoln
Kendra Dean	Cirrus House	Scottsbluff
Kerri Anderson	O.U.R Homes	Lincoln
Kim Manning	United Health Care	Omaha
Kimberly Fonseca	Nebraska Children and Family Foundation	Lincoln
Kirstin Hallberg	Oxford House	Omaha
Kris Whisenhunt	Nebraska Children and Family Foundation	Lincoln
Kristi MCClung	DED	Big Springs
Laurie Thomas	Transition Correction R6	
Leon Merell	NMFP	Omaha
Levi	Mcharness	North Platte
Linda Twomey	VA	Omaha/Lincoln
Linda Wittmuss	DBH	Lincoln
Lori Hack	Magellan	Lincoln
Lorie Thomas	Region 6 Transition Services	Omaha
Malcom Miles	Region V Systems	Lincoln
Margaret Brockman	DHHS- Office of Rural Health Administrator	Lincoln
Mary Hepburn	IPAV Community Support Case Management	Lincoln
Mary Rittenburg	Region V Systems	Lincoln
Matt Nykodym	Region 4 Housing Coordinator	Norfolk
Melissa M Koch	Probation Admin	Lincoln
Michael Judson	DBH	Lincoln
Michelle Bobier	The Salvation Army	Omaha
Michelle Rivera	The Salvation Army	
Micki Noah	Region 6 Director of Youth and Family Programs	Omaha
Mikayla Kuhlen	DHHS DBH – Emergency System Manager	Lincoln
Miles Glasgow	Region 6	Omaha
Molly Klocksin	Disability Rights of Nebraska	Lincoln
Nathan Busch	DHHS	Lincoln
Pat Talbott	Mental Health Assoc -NE	Lincoln
Patrick Paulsen	DBH	Lincoln
Phyllis McCaul	Region 5	Lincoln
Rachel Pinkerton	Housing Developer	Lincoln
Renee Faber	DBH	Lincoln
Robyn Burnett	Community Alliance	Omaha
Robyn Sederstom	Community Alliance	Omaha
Roger Donovick	DBH	Lincoln
Scott Loder	DHHS / LRC	Lincoln
Shannon Fortney	DED	Lincoln
Sheri Dawson	DBH Director	Lincoln

Name	Organization	City/Town
Sherri Lovelace	DBH	Lincoln
Shirleen Smith	Ash House	North Platte
Stan Wiegert	Adult Parole	Lincoln
Stephanie Crouch	DHHS MLTC MFP	Lincoln
Sue Adams	DBH	Lincoln
Suzanne Davis	Region 3 Housing Coordinator	Kearney
Tamara Gavin	DBH	Lincoln
Tamara Martin-Linnard	Great Points Health Hosp	North Platte
Tara Lorenson	Our Homes	Lincoln
Ted Simpson	Nebraska Investment Finance Authority	Lincoln
Teri Chasten	DHHS CFS	Lincoln
Terri Kostal	USDA Rural Development	Lincoln
Tesia Risk	AETNA Better Healthcare	Omaha
Todd Stull	DHHS DBH	Lincoln
Tommy Newcombe	Region 4 BHS	Norfolk
Will McGlothlin	Lancaster County dept of corrections	Lincoln

Appendix D: Housing First Handout

HOUSING FIRST IN PERMANENT SUPPORTIVE HOUSING
(Excerpt from HUD Brief)

Housing First is an approach to quickly and successfully connect individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry, such as sobriety, treatment or service participation requirements. Supportive services are offered to maximize housing stability and prevent returns to homelessness as opposed to addressing predetermined treatment goals prior to permanent housing entry.

Core Components of Housing First

The core features of Housing First in the context of permanent supportive housing models are as follows:

- ***Few to no programmatic prerequisites to permanent housing entry*** – People experiencing homelessness are offered permanent housing with no programmatic preconditions such as demonstration of sobriety, completion of alcohol or drug treatment, or agreeing to comply with a treatment regimen upon entry into the program. People are also not required to first enter a transitional housing program in order to enter permanent housing.

- ***Low barrier admission policies*** – Permanent supportive housing's admissions policies are designed to "screen-in" rather than screen-out applicants with the greatest barriers to housing, such as having no or very low income, poor rental history and past evictions, or criminal histories. Housing programs may have tenant selection policies that prioritize people who have been homeless the longest or who have the highest service needs as evidenced by vulnerability assessments or the high utilization of crisis services.

- ***Rapid and streamlined entry into housing*** – Many people experiencing chronic homelessness may experience anxiety and uncertainty during a lengthy housing application and approval process. In order to ameliorate this, Housing First permanent supportive housing models make efforts to help people experiencing homelessness move into permanent housing as quickly as possible, streamlining application and approval processes, and reducing wait times.

- ***Supportive services are voluntary, but can and should be used to persistently engage tenants to ensure housing stability*** - Supportive services are proactively offered to help tenants achieve and maintain housing stability, but tenants are not required to participate in services as a condition of tenancy. Techniques such as harm reduction and motivational interviewing may be useful. Harm reduction techniques can confront and mitigate the harms of drug and alcohol use through non-judgmental communication while motivational interviewing may be useful in helping households acquire and utilize new skills and information.

- ***Tenants have full rights, responsibilities, and legal protections*** –Permanent housing is defined as housing where tenants have leases that confer the full rights, responsibilities, and legal protections under Federal, state, and local housing laws. Tenants are educated about their lease terms, given access to legal assistance, and encouraged to exercise their full legal rights and

responsibilities. Landlords and providers in Housing First models abide by their legally defined roles and obligations.

- ***Practices and policies to prevent lease violations and evictions*** – Housing First supportive housing programs should incorporate practices and policies that prevent lease violations and evictions among tenants. For instance, program policies consistent with a Housing First approach do not consider alcohol or drug use in and of itself to be lease violations, unless such use results in disturbances to neighbors or is associated with illegal activity (e.g. selling illegal substances.) Housing First models may also have policies that give tenants some flexibility and recourse in the rent payment, which in many subsidized housing programs is 30 percent of the participant's income. For example, rather than moving towards eviction proceedings due to missed rent payments, programs may allow tenants to enter into payment installment plans for rent arrearages, or offer money management assistance to tenants.

Appendix E: Essential of Housing

Essential Components of Housing

Although there is no one model of housing, there are three fundamental components of permanent supportive housing affordability, independence, and accessibility.

Affordability
Housing must be affordable. Ideally, tenants should not have to pay more than 30 percent of their income toward these housing costs.

Independence
Independence is less tangible than affordability, but equally important. One component of independence is that people *choose* their housing, including its location and model. Independent housing provides occupants with a clear sense of rights, including rights of tenancy.

Accessibility
Housing must meet a range of accessibility needs: physically and access to needed services

What are the costs to create new housing?

Affordability: either rental assistance or operating support since tenant rent is often not sufficient to cover the housing costs/lease.

Capital: If you want to build or renovate housing, you will need resources to cover these costs.

Tenancy Supports: Move in assistance; homelessness prevention activities

What resources are available to fund housing development?

Affordable housing usually requires a mix of public and private resources. Federal resources, provided either directly to a project or through a state or local government, are commonly used resources. These federal programs include:

- **Continuum of Care Program**
  Money to buy, renovate or construct housing -
  Rental assistance or leasing
  Operating funds
  Supportive services

- **HOME**
  Build or renovate rental housing;

Finance homeownership opportunities; -
Repair homes including making buildings physically accessible; or -
Provide rental subsidies to eligible households. -

- **Community Development Block Grant (CDBG)**
  Housing rehabilitation (loans and grants to homeowners, landlords, non-profits, developers)
  New housing construction (only if completed by nonprofit groups)
  Acquisition of land and buildings
  Making buildings accessible to the elderly and people with disabilities
  Public services (capped at 15 percent of a jurisdiction's CDBG funds) such as case management, employment services, and health and child care

- **Low Income Housing Tax Credits (LIHTC)**
  Resources for development

- **National Housing Trust Fund (not available yet)**
  Resources for development of housing

- **Housing Choice Vouchers (aka Section 8)**
  Rental assistance

Samples of Housing Programs

Scattered site housing

HOME funds create a tenant based rental assistance program that serves as bridge funding for program participants. A housing navigator assists the participant to complete the HOME application, seek housing in the community, complete housing applications, and move into a unit. The Housing Navigator continues to work with the participant to apply for long term assistance through local housing authorities. Ongoing services are provided at the local community mental health center and other referrals as needed. Each landlord is given a contact in case of crisis or emergencies.

CoC rental assistance funds provide tenant based rental assistance. A sponsor agency assists the participant to locate housing and move into the unit. The sponsor makes referrals or provides services directly depending on the tenant choice.

Mixed-use housing

Project-based rental assistance is obtained either through a local PHA or CoC for about 10 of 50 units in a housing development. The 10 units were created through a required set aside since the development obtained HOME funds and LIHTCs. The subsidies ensure affordability for extremely low income participants. The residents have access to a resident coordinator (part time) who provides referrals to area services.

Site based Housing

A nonprofit service provider partners with a developer to create a 15 unit development that includes 15 one-bedroom units. The project receives HOME, LIHTC and HIF funds to cover development costs. Federal Home Loan Bank Affordable Housing program funds are also obtained. Participants pay 30 percent of their income to the service provider to cover rent. Additional operating support is obtained from CDBG, HOPWA and some state resources.

Appendix F: Questions Used to Guide Interviews Regarding Services and Supports for Individuals with Behavioral Health Disorders in Nebraska

DHHS has contracted with TAC to develop a Strategic Supportive Housing Plan. We have been tasked to:

- Inventory current housing resources/capacity as well as community services and supports available to promote attainment of and sustainment in supported housing(SH);
- Identify barriers that may inhibit access to SH;
- Identify gaps in housing and services; and
- Make recommendations to assure that persons who want to live in SH have access to it.

TAC had staff onsite in March that conducted interviews and workgroups that focused on Housing. I am here to gather stakeholder perspectives on services and supports - those administered by DHHS as well as other agencies that may be available throughout communities to support individuals with behavioral health disorders in community-integrated settings.

1. - How do you interface with the community behavioral health system?

2. - What services/supports are exist in your community to support individuals with - behavioral health disorders to live in settings integrated into the community? -

    a. - Are services aligned with principles and practices of recovery, wellness and community integration?

    b. - Are these services readily available and accessible or do you need more?

3. - If services do exist, are there barriers to accessing them? (waiting lists, limited hours of operation, cultural/linguistic, co-pays/lack of coverage)

4. - Are there services that don't exist that would help individuals to live more - independently? -

5. - Are there policies or regulations that need to be changed in order for individuals to live more independently in the community?

6. - Do funding levels and/or payment practices need to change?

7. - Who would benefit most from training in PSH/community integration? Those within the behavioral health system? Those outside of the behavioral health system?

8. - Is there anything I haven't asked about the community behavioral health system that you think would be helpful for me to know in creating a strategic supportive housing plan for Nebraska?

Appendix G: Housing Scan: Nebraska

The attachment below is housing scan which summarizes the housing resources available in Nebraska as of March 2016.

Housing Scan: Nebraska

Developed by the Technical Assistance Collaborative
March 2016

I. Housing Affordability Gap

According to TAC's "Priced Out in 2014: The Housing Crisis for People with Disabilities", in Nebraska a person with a disability received SSI benefits equal to $726 per month. Statewide, this income was equal to 18.9% of the area median income (AMI).[1] A person with a disability receiving SSI would have to pay 61% of their monthly income to rent an efficiency (studio) unit and 76% of their monthly income for a one-bedroom unit at the Fair Market Rent (FMR) established by the U.S. Department of Housing and Urban Development (HUD). Table 1 below indicates that within Nebraska's federally defined housing market areas, the cost of a one-bedroom rental unit ranged from a low of 65% of monthly SSI payments in the Seward County to a high of 88% in the Omaha/Council Bluffs housing market area. There is nowhere in Nebraska where a person could rent a modest apartment within the federal affordability guidelines (e.g., spending no more than 30-40% of income for housing costs).

TABLE 1[2]

***Priced Out in 2014* Data for Nebraska**

HUD Housing Market Areas[3]	SSI Monthly Payment	SSI as % of Median Income	% SSI for 1-Bedroom	% SSI for Efficiency
Lincoln	$726	18.3%	73%	57%
Omaha/Council Bluffs	$726	17.0%	88%	66%
Saunders County	$726	16.9%	73%	59%
Seward County	$726	16.3%	65%	50%
Sioux City*	$726	20.8%	76%	58%
Non-Metropolitan Areas	$726	20.7%	66%	57%
Statewide	**$726**	**18.9%**	**76%**	**61%**

**Indicates that this housing market area crosses state boundaries*

As Table 2 indicates, a person with a disability receiving SSI payments in Nebraska had income equivalent to an hourly wage of $4.19 – $3.06 less than the federal minimum wage of $7.25. In 2014, a person had to earn $10.50 per hour to be able to afford a one-bedroom rental unit based on HUD's FMR (referred to by the National Low Income Housing Coalition as the Housing Wage). [4]

[1] The area median income (AMI) is used to determine the eligibility of applicants for federally-funded housing programs (and many local programs as well). It sets the maximum limit that a household can earn to be eligible for federal programs, essentially defining who can be served by a particular funding source. HUD publishes median income, by geographic area and family size, each year. These data are available online at www.huduser.org/datasets/il.html.

[2] Data from: http://www.tacinc.org/knowledge-resources/priced-out-findings/

[3] Areas listed are the official housing market areas defined by the U.S. Department of Housing and Urban Development (HUD) for establishing Fair Market Rents (FMRs.)

[4] More information about the Housing Wage can be found in *Out of Reach* published by the National Low Income Housing Coalition, available online at www.nlihc.org

TABLE 2[5]
2014 SSI Payments as an Hourly Wage – Nebraska

Housing Market Area	SSI As Hourly Wage	NLIHC Housing Wage
Lincoln	$4.19	$10.19
Omaha/Council Bluffs	$4.19	$12.35
Saunders County	$4.19	$10.42
Seward County	$4.19	$9.10
Sioux City*	$4.19	$10.58
Non-Metropolitan Areas	$4.19	$9.25
Statewide	**$4.19**	**$10.72**

II. Housing Resources

A. U.S. Department of Housing and Urban Development (HUD)

HUD provides a variety of resources to states, local governments, and nonprofit housing agencies to provide access to or to develop affordable housing. This housing scan describes some of those resources, focusing on those that expand housing options for persons with disabilities and elders including:

- Housing Choice Vouchers (HCV), including special purpose vouchers
- Federal Public Housing Units
- Home Investments Partnership Program
- Community Development Block Grant (CDBG) Program
- Section 811 Supportive Housing for Persons with Disabilities Program
- Section 202 Supportive Housing for the Elderly Program
- Continuum of Care (CoC) Program
- Emergency Solutions Grants (ESG) Program
- Housing Opportunities for Persons with AIDS (HOPWA) Program

1. Resources Administered by Public Housing Agencies (PHAs)

PHAs are public agencies overseen by a Board of Commissioners that is either elected or appointed by the city or town. PHAs were created with passage of the first Housing Act in 1937 to develop, own, and manage public housing under contract with HUD. PHAs can administer conventional public housing units, Housing Choice vouchers, or both, as well as numerous other affordable housing programs.

a. Housing Choice Voucher Program

The Housing Choice Voucher (HCV) program is the major federal program for assisting low-income families, the elderly, and people with disabilities to obtain decent, safe, and affordable housing in the community. Vouchers are commonly referred to as tenant-based rent subsidies because they are provided to eligible applicants to use in private market rental housing of their choice that meets the HCV program requirements. The HCV household pays a portion of monthly housing costs that is based on the income of the household. The household's portion is usually, but not always, equal to 30-40% of its monthly-adjusted income. This subsidy is based on the cost of moderately priced rental housing in the community and is provided by a PHA under a contract with HUD.

[5] Data from: http://www.tacinc.org/knowledge-resources/priced-out-findings/

At the present time, there are 107 PHAs in Nebraska. Of these, 9 PHAs administer only an HCV program, 82 PHAs administer only public housing units, and 16 PHAs administer both an HCV and public housing program. The PHAs in Nebraska administer a total of 12,995 vouchers and own and operate a total of 7,710 units of federally funded public housing. A list of Nebraska PHAs, and the resources they control, is included in Table 3.

TABLE 3[6]
PHA Contacts for Nebraska

PHA Name, Phone & Fax Number	Address	Housing Choice Vouchers	Public Housing Units
Ainsworth Housing Authority Phone: (402) 387-2550 Fax: (402) 387-1696	524 E 4th Street Ainsworth NE 69210	0	30
Albion Phone: (402)395-2224 Fax: (402)395-6534	827 W Columbia Street Albion NE 68620	0	40
Alliance Phone: (308)762-5130 Fax: (308)762-5132	300 S Potash Ave #27 Alliance NE 69301	187	60
Alma Phone: (308)928-2161 Fax: (308)928-2161	1103 4th Street Alma NE 68920	0	20
Ansley Phone: (308)935-1632 Fax: (308)935-9101	715 Main Street Ansley NE 68814	0	20
Auburn Phone: (402)274-4525 Fax: (402)274-4946	1017 H Street Auburn NE 68305	0	51
Aurora Phone: (402)694-3292 Fax: (402)694-5492	1505 P St Aurora NE 68818	0	38
Bassett Phone: (402)684-3329 Fax: (402)684-2614	400 Panzer St Bassett NE 68714	0	20
Bayard Phone: (308)586-1512 Fax: (308)586-1512	501 E 6th St Bayard NE 69334	0	20
Beatrice Phone: (402)223-3809 Fax: (402)223-4432	205 N 4th St Beatrice NE 68310	204	0
Beemer Phone: (402)528-3553 Fax: (402)528-3553	400 Blaine Street Beemer NE 68716	0	20

[6] Data from: HUD PHA Contact Information http://portal.hud.gov/hudportal/HUD?src=/program_offices/public_indian_housing/pha/contacts and HUD Housing Authority Profile database https://pic.hud.gov/pic/haprofiles/haprofilelist.asp

PHA Name, Phone & Fax Number	Address	Housing Choice Vouchers	Public Housing Units
Bellevue Phone: (402)734-5448 Fax: (402)734-4358	8214 Armstrong Circle Bellevue NE 68147	275	49
Benkelman Phone: (308)423-2125 Fax: (308)423-2128	100 Rainbow Fountain Park Benkelman NE 69021	0	40
Blair Phone: (402)426-4552 Fax: (402)426-4820	758 S 16th Street Blair NE 68008	0	100
Blue Hill Phone: (402)756-2621 Fax: (402)756-2620	705 W Seward St Blue Hill NE 68930	0	38
Bridgeport Phone: (308)262-1690 Fax: (308)262-9952	310 W 5th St Bridgeport NE 69336	0	20
Broken Bow Phone: (308)872-2850 Fax: (308)872-5306	825 S 9th Avenue Broken Bow NE 68822	0	85
Burwell Phone: (308)346-5136 Fax: (308)346-5308	400 N 8th St Burwell NE 68823	0	68
Cairo Phone: (308)485-4722 Fax: (308)485-4400	420 S. High Street Cambridge NE 68824	0	18
Cambridge Phone: (308)697-3819 Fax: (308)697-3819	209 Nelson Street Cambridge NE 69022	0	20
Central Nebraska Phone: (308)745-0780 Fax: (308)745-0824	626 N Street Loup City NE 68853	76	0
Chadron Phone: (308)432-3340 Fax: (308)432-8104	740 Pine St Chadron NE 69337	40	0
Chappell Phone: (308)874-2715 Fax: (308)874-2419	702 Hayward Street Chappell NE 69129	0	30
Clarkson Phone: (402)892-3416 Fax: (402)892-3263	218 Czech Dr Clarkson NE 68629	0	30
Clay Center Phone: (402)762-3503 Fax: (402)762-3503	114 E Division Street Clay Center NE 68933	0	30

PHA Name, Phone & Fax Number	Address	Housing Choice Vouchers	Public Housing Units
Coleridge Phone: (402)283-4222 Fax: (402)283-4222	106 E Douglas St Coleridge NE 68727	0	26
Columbus Phone: (402)564-1131 Fax: (402)564-1648	2554 40th Avenue Columbus NE 68601	100	100
Cozad Phone: (308)784-3661 Fax: (308)784-3287	421 W 9th Street Cozad NE 69130	59	40
Creighton Phone: (402)358-5668 Fax: (402)358-3791	1106 Millard Avenue Creighton NE 68729	0	35
Crete Phone: (402)826-2678 Fax: (402)826-5314	1600 Grove Avenue Crete NE 68333	25	40
Curtis Phone: (308)367-4168 Fax: (308)367-4163	501 Crook Ave Curtis NE 69025	0	24
David City Phone: (402)367-3587 Fax: (402)367-3641	1125 N 3rd Street David City NE 68632	0	54
Deshler Phone: (402)365-7288 Fax: (402)365-7288	313 Willard Street Deshler NE 68340	0	30
Douglas County Phone: (402)444-6203 Fax: (402)444-6600	5404 N 107th Plaza Omaha NE 68134	1,162	78
Edgar Phone: (402)224-3915 Fax: (402)224-3915	406 North B Street Edgar NE 68935	0	20
Emerson Phone: (402)695-2557 Fax: (402)695-3106	207 E 5th St Emerson NE 68733	0	20
Fairbury Phone: (402)729-3451 Fax: (402)729-3451	105 W 5th Street Fairbury NE 68352	0	60
Fairmont Phone: (402)268-2891 Fax: (402)268-3081	255 E Street Fairmont NE 68354	0	20
Falls City Phone: (402)245-4204 Fax: (402)245-6126	800 E 21st Street Falls City NE 68355	0	84
Fremont Phone: (402)727-4848 Fax: (402)727-4751	2510 No. Clarkson Fremont NE 68025	164	249

PHA Name, Phone & Fax Number	Address	Housing Choice Vouchers	Public Housing Units
Friend Phone: (402)947-6371 Fax: (402)947-2242	1027 2nd Street Friend NE 68359	0	28
Genoa Phone: (402)993-2493 Fax: (402)993-6552	301 E Willard Avenue Genoa NE 68640	0	20
Gibbon Phone: (308)234-3000 Fax: (308)237-3113	413 1st St Gibbon NE 68840	0	40
Goldenrod Phone: (402)529-6278 Fax: (402)529-6478	1017 Avenue E Wisner NE 68791	137	0
Gordon Phone: (308)282-0202 Fax: (308)282-2896	109 N Cornell Street Gordon NE 69343	0	25
Gothenburg Phone: (308)537-7275 Fax: (308)537-3695	810 20th Street Gothenburg NE 69138	25	68
Grant Phone: (308)352-4346 Fax: (308)352-4346	300 Warren Avenue Grant NE 69140	0	20
Greeley Phone: (308)428-4375 Fax: (308)428-4375	300 E Oconnor Greeley NE 68842	0	14
Gresham Phone: (402)735-7292 Fax: (402)735-7295	120 Maud Street Gresham NE 68367	0	12
Hall County Phone: (308)385-5530 Fax: (308)385-5533	1834 W 7th St Grand Island NE 68803	486	394
Harvard Phone: (402)772-4091 Fax: (402)772-5308	502 E Walnut St Harvard NE 68944	0	20
Hastings Phone: (402)463-1061 Fax: (402)463-5250	2727 W 2nd St Hastings NE 68901	477	0
Hay Springs Phone: (308)638-4516 Fax: (308)638-4516	304 North Third Street Hay Springs NE 69347	0	20
Hemingford Phone: (308)487-5322 Fax: (308)487-3309	410 Box Butte Ave Hemingford NE 69348	0	20

PHA Name, Phone & Fax Number	Address	Housing Choice Vouchers	Public Housing Units
Henderson Phone: (402)723-4250 Fax: (402)723-4271	1030 15th Street Henderson NE 68371	0	20
Hooper Phone: (402)654-2229 Fax: (402)654-2229	100 E Maple Street Hooper NE 68031	0	25
Humboldt Phone: (402)862-3201 Fax: (402)862-3203	626 Parkview Drive Humboldt NE 68376	0	30
Imperial Phone: (308)882-5321 Fax: (308)882-4367	320 W 10th St Imperial NE 69033	0	20
Indianola Phone: (308)364-2423 Fax: (308)364-2621	125 N 2nd Street Indianola NE 69034	0	25
Kearney Phone: (308)234-3000 Fax: (308)237-3113	2715 Avenue I Kearney NE 68847	133	172
Lexington Phone: (308)324-4633 Fax: (308)324-4360	609 E 3rd St Lexington NE 68850	122	82
Lincoln Phone: (402)434-5500 Fax: (402)434-5502	5700 R Street Lincoln NE 68505	3,098	320
Loup City Phone: (308)745-0624 Fax: (308)745-0878	1048 K St Loup City NE 68853	0	40
Lynch Phone: (402)569-2910 Fax: (402)569-2911	121 N 2nd Street Lynch NE 68746	0	16
Lyons Phone: (402)687-2633 Fax: (402)687-2633	345 N 3rd Street Lyons NE 68038	0	20
McCook Phone: (308)345-3605 Fax: (308)345-3243	502 Missouri Avenue Circle McCook NE 69001	77	30
Minden Phone: (308)234-3000 Fax: (308)237-3113	849 E 2nd St Minden NE 68959	0	31
Nebraska City Phone: (402)873-5451 Fax: (402)873-7383	200 N 3rd Street Nebraska City NE 68410	0	81

PHA Name, Phone & Fax Number	Address	Housing Choice Vouchers	Public Housing Units
Neligh Phone: (402)887-4912 Fax: (402)887-5247	500 P Street Neligh NE 68756	0	40
Nelson Phone: (402)225-3611 Fax: (402)225-3611	151 S East St Nelson NE 68961	0	20
Newman Grove Phone: (402)447-6141 Fax: (402)447-6461	402 Railroad Ave Newman Grove NE 68758	0	17
Niobrara Phone: (402)857-3411 Fax: (402)857-3413	255 Willow Lane Niobrara NE 68760	0	20
Norfolk Phone: (402)844-2080 Fax: (402)644-2587	110 N 4th St Norfolk NE 68701	254	0
North Loup Phone: (308)496-4200 Fax: (308)496-4200	702 W 3rd St North Loup NE 68859	0	20
North Platte Phone: (308)534-4887 Fax: (308)534-4896	900 Autumn Park Drive North Platte NE 69101	0	250
Northeast Nebraska Phone: (712) 279-6286	1122 Pierce Street Sioux City IA 51101	73	0
Oakland Phone: (402)685-5440 Fax: (402)685-5440	100 N Aurora Avenue Oakland NE 68045	0	23
Omaha Phone: (402)444-6900 Fax: (402)444-4887	540 27th St Omaha NE 68105	4,803	2,904
Ord Phone: (308)728-3770 Fax: (308)728-7824	2410 K Street Ord NE 68862	0	118
Oshkosh Phone: (308)772-3941 Fax: (308)772-3956	404 W 6th St #21 Oshkosh NE 69154	0	20
Oxford Phone: (308)824-3188 Fax: (308)824-3188	103 W North Railway Street Oxford NE 68967	0	20
Pawnee City Phone: (402)852-2133 Fax: (402)852-2133	418 11th Street Pawnee City NE 68420	0	64

PHA Name, Phone & Fax Number	Address	Housing Choice Vouchers	Public Housing Units
Plattsmouth Phone: (402)296-3380 Fax: (402)296-3380	801 Washington Avenue Plattsmouth NE 68048	0	60
Ravenna Phone: (308)452-4233 Fax: (308)452-9115	1001 Grand Ave Ravenna NE 68869	0	20
Red Cloud Phone: (402)746-2262 Fax: (402)746-2262	59 N Chestnut St Red Cloud NE 68970	0	55
Sargent Phone: (308)527-4204 Fax: (308)527-9116	701 W Anna Sargent NE 68874	0	20
Schuyler Phone: (402)352-2431 Fax: (402)352-3480	712 F Street Schuyler NE 68661	0	59
Scotts Bluff County Phone: (308)632-0473 Fax: (308)632-0476	89a Woodley Park Road Gering NE 69341	410	162
Shelton Phone: (308)234-3000 Fax: (308)237-2573	306 C Street Shelton NE 68876	0	19
South Sioux City Phone: (402)494-7514 Fax: (402)494-7593	2601 Cornhusker Drive Suite 7 South Sioux City NE 68776	294	0
St. Edward Phone: (402)678-2288 Fax: (402)678-2319	1002 Water Street St Edward NE 68660	0	20
St. Paul Phone: (308)754-5251 Fax: (308)754-4669	420 Jay Street St Paul NE 68873	0	40
Stanton Phone: (402)439-2005 Fax: (402)439-2259	1109 Ivy Street Stanton NE 68779	0	30
Stromsburg Phone: (402)764-6521 Fax: (402)764-6522	517 E 7th St Apt 100 Stromsburg NE 68666	0	36
Sutherland Phone: (308)386-4864 Fax: (308)386-4864	1200 2nd Street Sutherland NE 69165	0	20
Syracuse Phone: (402)269-2851 Fax: (402)269-2851	990 Walnut Street Syracuse NE 68446	0	24

PHA Name, Phone & Fax Number	Address	Housing Choice Vouchers	Public Housing Units
Tecumseh Phone: (402)335-2866 Fax: (402)335-2868	800 Broadway Ofc Tecumseh NE 68450	0	24
Tekamah Phone: (402)374-1740 Fax: (492)374-2091	211 S 9th Street Tekamah NE 68061	0	26
Tilden Phone: (402)368-7714 Fax: (402)368-5921	600 South Giles Creek Lane Tilden NE 68781	0	20
Verdigre Phone: (402)668-2237 Fax: (402)668-2257	615 S Main St Verdigre NE 68783	0	20
Wayne Phone: (402)375-2868 Fax: (402)375-1547	409 Dearborn Street Wayne NE 68787	0	38
Weeping Water Phone: (402)267-6565 Fax: (402)267-6565	309 W River St Weeping Water NE 68463	0	20
West Central Nebraska Phone: (308)284-6078 Fax: (308)284-6070	333 E 2nd St Ogallala NE 69153	215	0
Wilber Phone: (402)821-2298 Fax: (402)821-2298	316 N Shimerda Street Wilber NE 68465	0	30
Wood River Phone: (308)583-2405 Fax: (308)583-2405	1413 Main Street Wood River NE 68883	0	19
Wymore Phone: (402)645-8241 Fax: (402)645-8245	300 N 7th St Wymore NE 68466	0	30
York Phone: (402)362-4481 Fax: (402)362-6727	215 N Lincoln Avenue York NE 68467	99	82
	TOTAL	12,995	7,710

i. *Special Purpose Vouchers*

In addition to regular Housing Choice Vouchers, there are special purpose vouchers that have been appropriated by Congress exclusively for people with disabilities. Because of various requirements imposed on these vouchers by law and by Congressional appropriations language, these vouchers are an invaluable resource for meeting the housing needs of people with disabilities since they must continue to be set aside for people with disabilities even when they turnover and are re-issued. As documented in Table 4, of the 12,995 vouchers administered by PHAs in Nebraska, 2% (275 vouchers) are targeted exclusively to people with disabilities through the following programs:

- **Five-Year Mainstream Housing Opportunities for Persons with Disabilities**
  Five-Year Mainstream vouchers are set aside exclusively for people with disabilities. These vouchers are

funded through the Section 811 tenant-based rental assistance program (25% of the program's appropriations have been used for tenant-based rental assistance) and PHAs received five-year annual contributions contracts.

- **Rental Assistance for Nonelderly Persons with Disabilities ("NED" Vouchers)**
  Over the past decade, HUD has awarded over 55,000 other vouchers targeted to nonelderly people with disabilities, now referred to as NED vouchers.[7]

TABLE 4[8]
PHAs in Nebraska with Special Purpose Vouchers

PHA	NED	Mainstream 5-Year Vouchers
Douglas County HA	0	125
Kearney HA	30	0
Lincoln HA	0	20
Omaha HA	0	100
TOTAL	**30**	**245**

On June 14, 2011, HUD published PIH Notice 2011-32, a critical document for ensuring the effective utilization of all the NED vouchers described above. All PHAs should now be clear that, upon turnover, those vouchers must continue to be provided ONLY to nonelderly disabled households.

ii. *HCV Utilization Rates*

Data related to the utilization of Housing Choice Vouchers by PHAs in Nebraska is located in Table 5. As illustrated below, the rate of utilization of vouchers by nonelderly disabled individuals was lower than the national rate of 20% at 6 PHAs (24%) in the State.

For elderly households, the utilization rate by elderly disabled individuals was lower than the national rate of 14% in 29 of the PHAs (24%) in the State while the utilization rate by elderly disabled individuals in 18 of the PHAs (72%) was lower than the national rate of 7%.

TABLE 5[9]
Housing Choice Voucher Utilization Rates
by Nonelderly Disabled and Disabled Households

PHA	Nonelderly individuals with disabilities	Elderly individuals with disabilities	Elderly individuals without an identified disability
Alliance HA	22%	18%	10%
Beatrice HA	35%	13%	2%
Bellevue HA	20%	8%	7%
Central Nebraska HA	25%	9%	21%
Chadron HA	17%	15%	7%
Columbus HA	38%	8%	6%
Cozad HA	29%	6%	9%
Crete HA	35%	0%	18%
Douglas County	37%	11%	5%

[7] NED vouchers include those vouchers previously known as Designated Housing vouchers, Certain Developments vouchers, Project Access vouchers, and 1-year Mainstream vouchers.
[8] Data from http://www.tacinc.org/knowledge-resources/vouchers-database
[9] Data from: HUD Resident Characteristics Report on March 31, 2016: http://portal.hud.gov/hudportal/HUD?src=/program_offices/public_indian_housing/systems/pic/50058/rcr

PHA	Nonelderly individuals with disabilities	Elderly individuals with disabilities	Elderly individuals without an identified disability
Fremont HA	35%	11%	16%
Goldenrod HA	21%	20%	23%
Gothenburg HA	33%	28%	0%
Hall County HA	18%	13%	18%
Hastings HA	24%	12%	16%
Kearney HA	31%	9%	14%
Lexington HA	11%	8%	46%
Lincoln HA	81%	6%	0%
McCook HA	30%	11%	20%
Norfolk HA	31%	6%	6%
Northeast Nebraska HA	26%	4%	3%
Omaha HA	17%	9%	2%
Scotts Bluff County HA	28%	21%	11%
South Sioux City HA	16%	22%	3%
West Central Nebraska HA	34%	19%	19%
York HA	15%	7%	21%
State Average	**23%**	**11%**	**7%**
National Average	**20%**	**15%**	**7%**

iii. *Public Housing Utilization Rates*

According to data from HUD, as of March 31, 2016, 19% of the public housing units owned and operated by PHAs in Nebraska were occupied by nonelderly individuals with disabilities, which is slightly higher than the national utilization rate of 17%. Elderly disabled individuals occupied 11% of units while 22% of the units were occupied by elderly non-disabled households.[10] The national public housing penetration rates for elderly individuals with disabilities and elderly non-disabled individuals are both 15%.

TABLE 6[11]
Public Housing Unit Utilization Rates
by Elderly, Non-Elderly Disabled, and Elderly-Disabled Households

PHA	Non-elderly individuals with disabilities	Elderly individuals with disabilities	Elderly individuals without an identified disability
Ainsworth HA	30%	17%	47%
Albion HA	8%	10%	52%
Alliance HA	0%	4%	2%
Alma HA	7%	21%	57%
Ansley HA	33%	6%	39%
Auburn HA	12%	10%	54%
Aurora HA	24%	32%	39%
Bassett HA	6%	24%	35%
Bayard HA	16%	21%	58%

[10] Data from: HUD Resident Characteristics Report on March 31, 2016: http://portal.hud.gov/hudportal/HUD?src=/program_offices/public_indian_housing/systems/pic/50058/rcr
[11] Data from HUD Resident Characteristics Report on March 31, 2016: http://portal.hud.gov/hudportal/HUD?src=/program_offices/public_indian_housing/systems/pic/50058/rcr

PHA	Non-elderly individuals with disabilities	Elderly individuals with disabilities	Elderly individuals without an identified disability
Beemer HA	6%	0%	38%
Bellevue HA	2%	5%	0%
Benkelman HA	8%	3%	38%
Blair HA	17%	12%	40%
Blue Hill HA	9%	3%	51%
Bridgeport HA	29%	6%	53%
Broken Bow HA	13%	9%	16%
Burwell HA	8%	7%	30%
Cairo HA	19%	0%	25%
Cambridge HA	14%	7%	21%
Chappell HA	14%	21%	32%
Clarkson HA	9%	5%	36%
Clay Center HA	22%	4%	17%
Coleridge HA	14%	7%	43%
Columbus HA	17%	20%	63%
Cozad HA	30%	12%	28%
Creighton HA	12%	9%	75%
Crete HA	28%	21%	44%
Curtis HA	25%	10%	20%
David City HA	15%	13%	48%
Deshler HA	10%	7%	14%
Douglas County HA	33%	14%	4%
Edgar HA	0%	11%	58%
Emerson HA	17%	6%	28%
Fairbury HA	22%	9%	26%
Fairmont HA	6%	0%	50%
Falls City HA	16%	8%	47%
Fremont HA	31%	13%	35%
Friend HA	7%	18%	57%
Genoa HA	20%	5%	55%
Gibbon HA	17%	17%	31%
Gordon HA	4%	8%	52%
Gothenburg HA	6%	9%	38%
Grant HA	19%	19%	44%
Greeley HA	23%	0%	23%
Gresham HA	25%	8%	17%
Hall County HA	7%	14%	13%
Harvard HA	36%	0%	7%
Hay Springs HA	0%	224%	71%
Hemingford HA	13%	13%	60%
Henderson HA	6%	12%	35%
Hooper HA	3%	8%	29%
Humboldt HA	30%	9%	9%
Imperial HA	10%	5%	75%
Indianola HA	9%	4%	39%
Kearney HA	26%	21%	23%
Lexington HA	13%	7%	8%

PHA	Non-elderly individuals with disabilities	Elderly individuals with disabilities	Elderly individuals without an identified disability
Lincoln HA	No data available		
Loup City HA	12%	12%	55%
Lynch HA	14%	0%	86%
Lyons HA	15%	0%	69%
McCook HA	27%	13%	33%
Minden HA	43%	18%	29%
Nebraska City HA	18%	4%	51%
Neligh HA	20%	27%	50%
Nelson HA	14%	21%	29%
Newman Grove HA	13%	0%	53%
Niobrara HA	12%	0%	41%
North Loup HA	0%	6%	78%
North Platte HA	5%	12%	23%
Oakland HA	11%	17%	50%
Omaha HA	20%	10%	3%
Ord HA	19%	4%	29%
Oshkosh HA	6%	28%	61%
Oxford HA	25%	25%	35%
Pawnee City HA	25%	11%	33%
Plattsmouth HA	28%	19%	43%
Ravenna HA	26%	21%	32%
Red Cloud HA	11%	9%	30%
Sargent HA	20%	10%	60%
Schuyler HA	6%	0%	10%
Scotts Bluff County HA	24%	16%	9%
Shelton HA	40%	7%	13%
St. Edward HA	7%	13%	40%
St. Paul HA	13%	10%	56%
Stanton HA	11%	4%	79%
Stromsburg HA	5%	20%	35%
Sutherland HA	10%	20%	55%
Syracuse HA	33%	0%	67%
Tecumseh HA	4%	9%	87%
Tekamah HA	22%	0%	78%
Tilden HA	24%	18%	29%
Verdigre HA	0%	0%	87%
Wayne HA	15%	12%	41%
Weeping Water HA	39%	17%	28%
Wilber HA	4%	4%	74%
Wood River HA	6%	18%	35%
Wymore HA	8%	12%	76%
York HA	45%	15%	20%
State Average	**19%**	**11%**	**22%**
National Average	**17%**	**15%**	**15%**

2. Resources Administered by State and Local Community Development Officials

Each year, Congress appropriates billions of dollars (nearly $4.5 billion for federal Fiscal Year (FY) 2016) that go directly to all states, most urban counties, and communities "entitled" to receive federal funds directly from HUD. Before states and communities can receive these funds they must have a HUD-approved Consolidated Plan (ConPlan). A list of the HUD-approved Consolidated Plans from Nebraska, along with contact persons can be found online at: https://www.hudexchange.info/consolidated-plan/con-plans-aaps-capers/.

The ConPlan must outline a plan for the use of federal housing funds including:

- Community Development Block Grant (CDBG)
- HOME Investment Partnerships Program (HOME)
- Housing Opportunities for Persons with AIDS (HOPWA)
- Emergency Shelter Grant (ESG)

Table 7 below documents the FY 2015 ConPlan formula allocations for the entire state.

TABLE 7[12]
FY 2016 Consolidated Plan Allocations for Nebraska

Name	CDBG	HOME	ESG	HOPWA	TOTAL
Bellevue	$298,768	$0	$0	$0	$298,768
Lincoln	$1,701,414	$830,622	$144,736	$0	$2,676,772
Omaha	$4,231,548	$1,586,615	$386,724	$0	$6,204,886
State of Nebraska	$9,944,180	$3,023,348	$941,814	$370,412	$14,279,754
TOTAL	**$16,524,837**	**$5,440,584**	**$1,473,274**	**$370,412**	**$23,809,107**

a. HOME Investment Partnerships Program

The federal government created the HOME Investment Partnerships Program (HOME) in 1990. The HOME program is a formula grant of federal housing funds given to states and localities (referred to as "participating jurisdictions" or PJs). Nebraska received over $5 million in HOME funds in FY 2016. This formula funding was allocated to 3 PJs and the State of Nebraska.

HOME funds can be used to:

- Build, buy, and renovate rental housing;
- Finance homeownership opportunities;
- Repair homes, including making buildings physically accessible; or
- Provide rental subsidies to eligible households.

Specifically, HOME resources can be used to cover the cost of acquiring land and buildings, renovating properties, as well as constructing new rental housing. However, HOME funds cannot be used to fund ongoing housing operating costs. Funds can be provided for projects developed by both for-profit and nonprofit developers and can be made available in the form of grants or loans, which are designed to ensure affordability.

The rental housing developed using HOME funds can take on many forms. The units can range in size from Single Room Occupancy (SRO) units or efficiencies (studios) to multi-bedroom apartments. HOME-funded rental housing can be as small as a single family home or as large as an apartment complex with hundreds of units.

All housing developed with HOME funds must serve low- and very low-income individuals and families. For rental housing, at least 90% of HOME funds must benefit families whose incomes are at or below 60% of AMI; the remaining

[12] Data from: http://portal.hud.gov/hudportal/HUD?src=/program_offices/comm_planning/about/budget/budget15

10% must benefit families with incomes at or below 80% of AMI. However, the fact that HOME funds cannot be used to subsidize the operating costs of rental housing can be a barrier to using the program for people with extremely low-incomes (i.e., below 30% of the AMI) including extremely low-income people with disabilities and elders.

Table 9 below demonstrates how HOME funds were used in Nebraska to assist people with very low- and extremely-low incomes. Without a link to ongoing subsidy funding through programs like HCV assistance or a state funded subsidy, it is difficult to use HOME funds to develop permanent and affordable rental housing for people with incomes below 30% of AMI. Despite this fact, some of the PJs in Nebraska have developed deeply subsidized housing for extremely low-income people. State of Nebraska PJ allocation is administered by Department of Economic Development.

TABLE 8[13]
Number of HOME-Funded Tenant-Based Rental Assistance Vouchers in Nebraska

Participating Jurisdiction	Number of Households since 1992	Number of Households from July - September 2015
Lincoln	1,039	0
Omaha	1,608	0
State of Nebraska	0	0
Total	**2,588**	**0**

TABLE 9[14]
Incomes of Renters in HOME-Funded Rental Housing in Nebraska as of 3/31/15

Participating Jurisdiction	FY15 HOME Funding	% of tenants of HOME-funded rental housing whose income is 0-30% of AMI (as compared to other renters)	% of tenants of HOME-funded rental housing whose income is 0-50% of AMI
Lincoln	$830,622	60%	86%
Omaha	$1,586,615	42%	82%
State of Nebraska	$3,023,348	60%	71%
STATE		**47%**	**83%**
NATIONAL		**47%**	**83%**

b. Community Development Block Grant (CDBG) Program

Authorized by Title I of the Housing and Community Development Act of 1974, the Community Development Block Grant (CDBG) Program is one of the longest continuously run programs at HUD. The funds are a block grant that can be used to address critical and unmet community needs including those for housing rehabilitation, public facilities, infrastructure, economic development, public services and more. Since 1974, it has invested $144 billion in communities nationwide and each year approximately 95% of funds are invested in activities that primarily benefit low- and moderate-income persons.

HUD determines the amount of each grant by using a formula containing several measures of community need, including the extent of poverty, population, housing overcrowding, and age of housing. The annual CDBG appropriation is allocated between states and local jurisdictions called "non-entitlement" and "entitlement" communities, respectively. Entitlement communities consist of central cities of Metropolitan Statistical Areas (MSAs); metropolitan cities with populations of at least 50,000; and qualified urban counties with a population of 200,000 or more (excluding the populations of entitlement cities). States distribute CDBG funds to non-entitlement localities not qualified as entitlement communities.

[13] Data from https://www.hudexchange.info/grantees/
[14] Data from: https://www.hudexchange.info/manage-a-program/home-performance-snapshot-and-pj-rankings-reports/

Each grantee receiving CDBG funds is free to determine what activities it will fund as long as certain requirements are met. Each activity must be eligible according to HUD regulations and meet one of the following national objectives:

- Benefits persons of low- and moderate-income;
- Aids in the prevention or elimination of slums or blight; or
- Meets an urgent housing/community development need[15] that the grantee is unable to finance on its own or with other funding sources.

Many states and communities use CDBG resources to support essential public services such as operating homeless shelters, providing support services to special needs populations, and making accessibility modifications to housing for people with disabilities. Nebraska received over $16 million in CDBG funds in State of Nebraska allocation is administered by Department of Economic Development. FY 2016. Table 10 shows the percentage of total CDBG expenditures used for public services in Nebraska during program year 2013-2014.

Table 10[16]

Percent (%) of CDBG Expenditures for Public Services as of 9/30/2014*

Participating Jurisdiction	Total CDBG Expenditures for Public Services
Bellevue	0%
Lincoln	8%
Omaha	7%
State of Nebraska	>1%

**Most recent performance reports available at time of housing scan.*

TABLE 11[17]

Nebraska Indian Community Development Block Grants

Year	Recipient	City	Project Description	Amount Funded
2008	Santee Sioux HA	Niobrara	Construct a new office facility	$286,000
2009	No awards			
2010	Northern Ponca HA	Norfolk	Rehabilitation of 150 homes	$1,100,000
2011	No awards			
2012	Ho-Chunk Community Development Corporation	Winnebago	Rehabilitation of 15 single family homes	$695,270
2013	Northern Ponca HA	Norfolk	Rehabilitation of 69 rental units	$700,000
			TOTAL	$2,781,270

c. Housing Opportunities for Persons with AIDS Program (HOPWA)

[15] Urgent development is defined as posing a serious and immediate threat to the health or welfare of the community in the past 18 months.

[16] Data from: https://www.hudexchange.info/manage-a-program/cdbg-performance-profiles/

[17] Data from https://www.federalregister.gov /

HOPWA funding provides housing assistance and related supportive services by grantees who are encouraged to develop community-wide strategies and form partnerships with area nonprofit organizations. HOPWA funds may be used for a wide range of housing, social services, program planning, and development costs. These include, but are not limited to, the acquisition, rehabilitation, or new construction of housing units; costs for facility operations; rental assistance; and short-term payments to prevent homelessness. HOPWA funds also may be used for health care and mental health services, chemical dependency treatment, nutritional services, case management, assistance with daily living, and other supportive services.

HOPWA funds are awarded through the Consolidated Plan as a block grant to states and larger metropolitan areas based on the incidences of AIDS in these areas and competitively through an annual Notice of Funding Availability (NOFA). State of Nebraska allocation is administered by DHHS Division of Public Health .In FY 2016, Nebraska received $370,412 in HOPWA block grant funding. Table 12 below includes data regarding how these funds are used in Nebraska.

TABLE 12[18]
Utilization of HOPWA Formula Funding in 2014-2015*

	% of Expenditures			
	Supportive Services	**Housing Assistance**	**Housing Information Services**	**Admin**
State of Nebraska	36%	46%	2%	16%

**Most recent performance reports available at time of housing scan.*

d. Emergency Solutions Grant (ESG)

On May 20, 2009, President Obama enacted the Homeless Emergency and Rapid Transition to Housing (HEARTH) Act of 2009. The HEARTH Act provides communities with new resources and better tools to prevent and end homelessness, including revamping the ESG program. The key changes that reflect this new emphasis are the expansion of the homelessness prevention component of the program and the addition of a new rapid re-housing assistance component.

The current ESG program provides federal grants to states and localities based on a formula. To receive ESG funds, each state/entitlement community must submit a Consolidated Plan to HUD describing how the ESG resources will be used to meet local needs.

Under HEARTH, ESG eligible components include:

- Street Outreach
- Emergency Shelter
- Homelessness Prevention
- Rapid Re-Housing
- Homeless Management Information Systems (HMIS)
- Administration (up to 7.5% of ESG allocation)

Some of these activities, specifically Rapid Re-Housing and HMIS, are new allowable activities under ESG.

In FY 2016, Nebraska received over $1.4 million in ESG resources which is administered through DHHS Division of Children and Family.

3. Section 811 Supportive Housing for Persons with Disabilities Program

[18] Data from: https://www.hudexchange.info/manage-a-program/hopwa-performance-profiles/

The Section 811 program funds the development of supportive housing for people with disabilities between the ages of 18 and 62. Historically, the program created group homes and congregate living situations for persons with disabilities. As part of this traditional Section 811 program, HUD published a Notice of Funding Availability (NOFA) each year that specified the number of Section 811 units allocated to each HUD jurisdiction (based on needs factors that include the number of people age 18 years or older with disabilities). Only nonprofit organizations were eligible to apply. As seen in Table 13, Nebraksa was successful in obtaining 47 Section 811 traditional housing units since 2001.

TABLE 13[19]
Section 811 Supportive Housing for Persons with Disabilities Program
Awards for Nebraska FY 2001-2014

Year	Sponsor	City	Rental Subsidy	Capital Advance	# Units Awarded
2005	Panhandle Community Service	Sidney	$89,500	$595,100	6
2006	CenterPointe	Lincoln	$93,000	$882,100	10
2007	Mosaic	Beatrice	$96,000	$1,130,600	10
2008	Liberty Centre Services, Inc.	Norfolk	$99,600	$1,097,700	10
2009	No awards				
2010 and 2011	Sheltering Tree, Inc.	Bellevue	$115,500	$1,604,300	11
		TOTAL	**$493,600**	**$5,309,800**	**47**

In January 2011, President Obama signed into law the Frank Melville Supportive Housing Investment Act of 2010, legislation to revitalize and reform the Section 811 program. The "traditional" option remains authorized within the reformed Section 811 program. However, the program includes two new approaches to creating integrated permanent supportive housing: the Modernized Capital Advance/Project Rental Assistance Contract (PRAC) multifamily option, and the Project Rental Assistance (PRA) option. Both options require that properties receiving Section 811 assistance limit the total number of units with permanent supportive housing use restrictions to 25% or less. Although all of these options are authorized in the legislation, the FY 2012, 2013, and 2014 appropriations direct that all funding for new Section 811 units be provided solely through the PRA option.

Late in FY 2012, HUD issued the first NOFA for PRA Demonstration funds and in February 2013 announced awards of $88 million to 12 states for the development of 2,443 units.[20]

In the FY 2013 budget, Congress provided funds for renewals of existing projects but funds for new units only through the PRA component of the Section 811 Program. HUD announced the award of $150 million in March 2015 to 24 states and the District of Columbia for the development of 4,584 units.[21]

4. Section 202 Supportive Housing for the Elderly Program

The Supportive Housing for the Elderly program (Section 202) helps expand the supply of affordable housing with supportive services for elderly people (age 62 and older). This program provides capital advances to finance the construction and rehabilitation of structures that will serve as supportive housing for very low-income elderly people and provides rent subsidies for the projects to help make them affordable. Section 202 capital advances finance

[19] Data collected from U.S. Government Federal Register and HUD Press Releases.
[17] Data from: https://www.hudexchange.info/programs/811-pra/pra-program-grantees-and-awards/
[18] Data from: http://portal.hud.gov/hudportal/HUD?src=/press/press_releases_media_advisories/2015/HUDNo_15-026&utm_source=HUD+Exchange+Mailing+List&utm_campaign=e46c079783-HUD_Awards_150_Million_3_3_2015&utm_medium=email&utm_term=0_f32b935a5f-e46c079783-19228065

property acquisition, site improvement, conversion, demolition, relocation, and other expenses associated with supportive housing for the elderly. The capital advance does not have to be repaid as long as the project serves very low-income elderly persons for 40 years. Section 202 project rental assistance covers the difference between the HUD-approved operating cost per unit and the tenant's rent. Project rental assistance contract payments can be approved up to five years. However, contracts are renewable based on the availability of funds.

As with the 811 program, each year HUD publishes a NOFA for the Section 202 funding appropriated by Congress. The NOFA specifies the number of Section 202 units allocated to each HUD jurisdiction and only nonprofit organizations are eligible to apply. Nebraska has had success in obtaining new Section 202 resources. As documented in Table 14 below, from FY 2002-2011, Nebraska received funding for 164 new units of supportive housing though the Section 202 program.

In January 2011, the Section 202 Supportive Housing for the Elderly Act of 2010 (referred to as S.118) was enacted. This act provides the opportunity to streamline and simplify the program to allow for increased participation by nonprofit developers, private lenders, investors and state and local funding agencies.

TABLE 14[22]
Section 202 Supportive Housing for the Elderly Program
Awards for Nebraska FY 2005-2011

Year	Sponsor	City	Rental Subsidy	Capital Advance	# Units Awarded
2005	Evangelical Lutheran Good Samaritan Society	Alliance	$149,000	$872,200	10
	Evangelical Lutheran Good Samaritan Society	Alliance	$208,500	$1,221,000	14
	Immanuel Health Systems	Papillion	$297,500	$1,724,500	20
2006	Immanuel Health Systems	Papillion	$185,700	$1,813,700	20
2007	Immanuel Health Systems	Papillion	$192,000	$2,046,300	20
2008	Immanuel Health Systems	Papillion	$199,200	$2,240,000	20
2009	Immanuel Health Systems	Papillion	$203,400	$2,409,300	20
2010 & 2011	Immanuel Health Systems	Papillion	$419,400	$5,726,800	40
		TOTAL	**$1,854,700**	**$18,053,800**	**164**

5. Continuum of Care (CoC)

In 1987, Congress passed the first federal law specifically addressing homelessness. The Stewart B. McKinney Homeless Assistance Act of 1987, later renamed the McKinney-Vento Homeless Assistance Act, provides federal financial support for a variety of programs to meet the many needs of individuals and families who are homeless. The housing programs it authorizes are administered by HUD's Office of Special Needs Assistance Programs.

The Continuum of Care planning process was designed to promote the development of comprehensive systems to address homelessness by providing communities with a framework for organizing and delivering housing and services. The overall approach is predicated on the understanding that homelessness is not caused merely by a lack of shelter, but involves a variety of underlying, unmet needs: physical, economic, and social.

As an entity, a Continuum of Care serves two main purposes:

[19] Data collected from U.S. Government Federal Register and HUD Press Releases.

- To develop a **long-term strategic plan and manage a year-round planning effort** that addresses the identified needs of homeless individuals and households; the availability and accessibility of existing housing and services; and the opportunities for linkages with mainstream housing and services resources.
- To prepare an **application** for McKinney-Vento Homeless Assistance Act (McKinney-Vento) competitive grants.

These resources are invaluable in providing housing and supportive services for people who are homeless. These funds are made available through a national competition announced each year in HUD's Notice of Funding Availability. Applications should demonstrate broad community participation and identify resources and gaps in the community's approach to providing outreach, emergency shelter, and transitional and permanent housing, as well as related services for addressing homelessness. An application also includes action steps to end homelessness, prevent a return to homelessness, and establishes local funding priorities.

There are 3 Continuum of Care planning groups in Nebraska.[23] Table 15 below includes information about the number of emergency shelter, transitional housing (TH) and permanent supportive housing beds across the state. Most of these housing programs are funded by HUD and have different program qualification requirements and restrictions on length of stay. HUD-funded Transitional Housing allows people who are homeless to remain up to 24 months and the length of the program can vary depending on program design. TH beds may or may not be dedicated to people with disabilities. HUD-funded Permanent Supportive Housing (PSH) has no fixed time limit and is dedicated to people who are homeless with disabilities. PSH units may have services onsite or provided through community service providers. HUD-funded Rapid Re-Housing (RRH) provides up to 24 months' worth of tenant-based rental assistance to families in units in the community.

This Housing Inventory Count (HIC) is self-reported by the Continuum of Care each year. Table 16 documents the beds and units dedicated to serve persons who are homeless and is categorized by program types: Emergency Shelter (ES); Transitional Housing (TH); Permanent Supportive Housing (PSH); and Rapid Re-housing (RRH).

TABLE 15
Nebraska Continuums of Care

Name of CoC	Total Beds (2015)	Total PSH (2015)
Nebraska Balance of State CoC	1,066	94
Omaha/Council Bluffs CoC	2,495	851
Lincoln CoC	1,034	79
TOTAL	**4,595**	**1,024**

TABLE 16[24]
Beds for People Experiencing Homelessness
Excerpt from Continuum of Care Housing Inventory Charts – 2013 through 2015

Type	2013		2014		2015		Change 2013-2015	
	Families	Individs.	Families	Individs.	Families	Individs.	Families	Individs.
ES	711	946	734	944	594	921	**-16%**	**-3%**
TH	1,142	847	865	813	744	648	**-35%**	**-23%**
PSH	431	613	425	608	382	642	**-11%**	**+6%**
RRH*			29	52	291	126	**+334%**	**+142%**
Other PH**			54	10	115	66	**+107%**	**+560%**

*The provider program type "Rapid Re-Housing" was added in 2014.
**Other PH consists of PH-Housing with Services and PH-Housing Only, as identified in the 2014 HMIS Data Standards.

B. Low Income Housing Tax Credit Program (LIHTC)

[20] Data from: https://www.hudexchange.info/grantees
[21] Data from: https://www.hudexchange.info/manage-a-program/coc-housing-inventory-count-reports/

The federal government created the LIHTC program to encourage the development of new mixed-income rental housing that would benefit low-income households. At the federal level, the program is not administered by HUD, but rather by the Internal Revenue Service (IRS) within the Department of Treasury. Housing developed under the LIHTC program must be maintained as affordable rental housing for at least 15 years. Many types of rental housing are eligible including:

- Multi-family rental housing;
- Mixed-use projects that include both rental housing and commercial space;
- SRO housing; and
- Scattered-sites that can be "bundled together" as one project.

According to the LIHTC program guidelines, the minimum number of affordable units required in each LIHTC property is determined by the following federal formula:

- For a LIHTC project targeted to assist households at 50% of AMI and below, at least 20% of the units in the project must be affordable; or
- For a LIHTC project targeted to households between 50-60% of AMI, at least 40% of the units in the project must be affordable.

States can choose to require deeper affordability standards, such as a requirement that a certain number of units be affordable to people with incomes at 30% of AMI.

In addition, newly constructed or substantially rehabilitated properties financed with LIHTC are required have 5% of the units accessible to people with mobility impairments and an additional 2% of the units accessible to people with sensory impairments. Because of the accessibility standards and the opportunity to create more deeply subsidized housing, the LIHTC program is a valuable resource for creating housing for people with disabilities. In Nebraska, the Nebraska Investment Finance Authority is the agency responsible for administering the Low Income Housing Tax Credit program (http://nifa.org/programs/programs.html?pi=407&search_var=prog&prog_name_sent=lihtc+(tax+credits)).

The LIHTC program includes a requirement that states develop a strategic planning document describing how the LIHTC program will be utilized to meet the housing needs and housing priorities of the state. This plan, known as the Qualified Allocation Plan (QAP), must be submitted to the Department of Treasury/IRS each year in order for the state to receive its LIHTC allocation from the federal government. The final 2015-2016 QAP for Nebraska is available online at http://nifa.org/downloads/2015qap.pdf .

Many states use the Low Income Housing Tax Credit program as a mechanism for creating new units of affordable housing for people with disabilities, elders, and other very low-income people with special needs. A review of LIHTC policies that encourage or incentivize permanent supportive housing can be found in *Housing Credit Policies in 2015 that Promote Supportive Housing*.[25] The FY 15-16 QAP for Nebraska provides a slight scoring advantage for those projects applying for LIHTC funds that commit to target at least 25% of the units in the property for disabled or persons with disabilities or special needs.

C. Veteran Housing Options

According to HUD's 2015 Annual Homeless Assessment Report, there were an estimated 247 homeless Veterans in Nebraska on any given night in time. These veterans represented 9% of all homeless people in the state.[26]

1. VA Supported Housing Program (VASH)

VASH is a joint project between the Department of Veteran Affairs (VA) and the Department of Housing and Urban

[22] Published by the Corporation for Supportive Housing and available at http://www.csh.org/resources/12959/ .
[23] Data from: https://www.hudexchange.info/resources/documents/2015-AHAR-Part-1.pdf

Development (HUD). The goal of the program is to transition veterans from homelessness to having permanent, secure, safe housing so that they may rebuild their lives. The clientele in VASH vary from families to single veterans and from Vietnam era to returning Operation Iraqi Freedom/Operation Enduring Freedom veterans. This program consists of a housing voucher from HUD for veterans to rent a home or an apartment and intensive case management services provided by the VA for five years. After the five years, the veteran may turn his or her VASH voucher into a conventional housing choice voucher to maintain their apartment, freeing up the VASH voucher and case management for another veteran. The Case Management services are administered for five years and are highly individualized to support the veteran and/or family to reach self-sufficiency and success.

As of March 2016, there were 405 VASH vouchers in Nebraska administered by 4 different PHAs.

TABLE 17[27]
VASH Vouchers

PHA	VASH Vouchers
Douglas County Housing Authority	115
Hall County Housing Authority	13
Lincoln Housing Authority	145
Omaha Housing Authority	132
TOTAL	**405**

2. Grant and Per Diem Program (GPD)

Veteran Affair's Homeless Providers Grant and Per Diem Program is offered annually (as funding permits) by the Department of Veterans Affairs Health Care for Homeless Veterans (HCHV) Programs to fund community agencies providing services to homeless veterans. The purpose of the program is to promote the development and provision of supportive housing and/or supportive services with the goal of helping homeless veterans achieve residential stability, increase their skill levels and/or income, and obtain greater self-determination. The program provides transitional supportive housing for up to 24 months for veterans. Table 18 below includes a list of some GPD programs Nebraska.

TABLE 18[28]
GPD Programs in Nebraska

Agency	City	# GPD Beds
Christian Worship Center	Omaha	26
Salvation Army	Omaha	10
Stephen Center	Omaha	4
People's Mission	Lincoln	18
People's Mission	Lincoln	12
	TOTAL	**70**

Homeless liaisons at the VA Medical Centers are the main point of contact for all other VA services and housing programs.

3. Support Services for Low-Income Veterans Families (SSVF)

The Supportive Services for Veteran Families (SSVF) Program is a new VA program that awards grants to private nonprofit organizations and consumer cooperatives that will provide supportive services to very low-income veterans and their families residing in or transitioning to permanent housing. The grantees provide a range of supportive services designed to promote housing stability.

[24] Data from: http://www.tacinc.org/knowledge-resources/vouchers-database/
[25] Data from: http://www.va.gov/HOMELESS/docs/Homeless_Resource_Guide.pdf

In 2014, the VA released a NOFA for SSVF that included "surge" funding that provided an additional $300 million over the next three years to 78 communities that have the highest need based on number of homeless veterans, veteran population, economic levels, and unmet needs. Table 19 documents the history of SSVF awards in the state.

TABLE 19[29]
SSVF Grant Awards

Award Year	Sponsor	City	Grant Award
2012	Central Nebraska Community Services	Loup City	$146,348
2013	Central Nebraska Community Services	Loup City	$192,235
	Northeast Nebraska Community Action Partnership	Pender	$199,302
	Blue Valley Community Action, Inc.	Fairbury	$134,001
2014	Central Nebraska Community Services	Loup City	$194,530
	Northeast Nebraska Community Action Partnership	Pender	$203,001
	Blue Valley Community Action, Inc.	Fairbury	$134,231
		Total	$1,203,648

D. United States Department of Agriculture (USDA) Housing and Community Assistance

The USDA administers a variety of housing programs designed to serve people living in rural areas who have low or very low incomes. The USDA website for Nebraska is http://www.rd.usda.gov/ne .

The following programs target resources for people who are elderly and/or disabled to gain access to rental housing or remain in their own modified housing.

- Rental Assistance Program (RA) – Provides rental assistance for Rural Rental Housing projects for persons with very low and low incomes, the elderly, and people with disabilities if they are unable to pay the basic monthly rent within 30% of adjusted monthly income.
- Rural Rental Housing (Section 515) – Provides mortgage loans to provide affordable multi-family rental housing for very low-, low-, and moderate-income families, the elderly, and people with disabilities.
- Rural Repair and Rehabilitation Program – Provides loans and grants to very low-income owners who are 62 years or older to make repairs or improvements to remove health and safety hazards or to complete repairs to make the dwelling accessible for household members with disabilities.

Between 2009 and 2014 Nebraska has received between $5.8 and $6.8 million of USDA Rental Assistance Program funding each year including between $3.3 million in Rural Rental Housing funding.[30]

A list of the Nebraska USDA Rural Development Offices is included in Table 20. They can be contacted for more

[27] Data from: http://www.va.gov/HOMELESS/docs/SSVF/FY2012_SSVF_Awards_7172012_2.pdf; http://www.va.gov/homeless/docs/ssvf/2013_ssvf_awards_final_71113.pdf; http://www.va.gov/HOMELESS/ssvf/docs/2014_SSVF_Award_List.pdf; http://www.va.gov/HOMELESS/ssvf/docs/SSVF_FY15_Grant_Awards_List_by_State.pdf
[28] Data from: http://www.rd.usda.gov/files/RD2014ProgressReport.pdf

information about the programs available for each area of the state.

TABLE 20[31]
USDA Rural Development Office Contact

Office	Address	Service Area
Kearney Office	4009 6th Avenue, Suite 1 Kearney, Nebraska 68845-2386 308.237.3118 Phone 855.207.0384 FAX	Central Servicing Counties: Adams, Blaine, Boyd, Brown, Buffalo, Cherry, Custer, Dawson, Franklin, Furnas, Garfield, Gosper, Grant, Greeley, Hall, Harlan, Holt, Hooker, Howard, Kearney, Keya Paha, Loup, Phelps, Rock, Sherman, Thomas, Valley, Webster and Wheeler.
Norfolk Office	2601 Lakeridge Drive, Suite 2 Norfolk, Nebraska 68701 402.371.5350 Phone 855.207.0384 FAX	Eastern Service Counties: Antelope, Boone, Burt, Butler, Cass, Cedar, Clay, Colfax, Cuming, Dakota, Dixon, Dodge, Douglas, Fillmore, Gage, Hamilton, Jefferson, Johnson, Knox, Lancaster, Madison, Merrick, Nance, Nemaha, Nuckolls, Otoe, Pawnee, Polk, Pierce, Platte, Richardson, Saline, Sarpy, Saunders, Seward, Stanton, Thayer, Thurston, Washington, Wayne and York.
Scottsbluff Office	818 Ferdinand Plaza, Suite B Scottsbluff, Nebraska 69361-4401 308.632.2195 Phone 855.207.0384 FAX	Western Servicing Counties: Arthur, Banner, Box Butte, Chase, Cheyenne, Dawes, Deuel, Dundy, Frontier, Garden, Hayes, Hitchcock, Keith, Kimball, Lincoln, Logan, McPherson, Morrill, Perkins, Red Willow, Scottsbluff, Sheridan and Sioux.

[29] Data from: http://www.rd.usda.gov/contact-us/state-offices/ne