

Nebraska Division of Behavioral Health

**Office of Consumer Affairs People's Council**

August 2, 2016 9:00 am-3:15 pm  
801 W. Prospector & Folsom  
Building #14- Wayne George Training room, 3rd Floor  
Lincoln, Nebraska

**I. Call to order, welcome, housekeeping, meeting minutes** *Chairman Lisa Casullo/ Cynthia Harris*

Chairperson, Lisa Casullo, called the meeting to order at 9:00 AM, August 02, 2016. Cynthia Harris, Division of Behavioral Health Office of Consumer Affairs (DBH OCA) Council Facilitator, welcomed committee members and others present to the meeting.

The Open Meetings Law was posted in the meeting room and it was noted that public comment is welcomed throughout the meeting. Lucy Flores instructed attendees to sign in. Roll call was conducted and a quorum was determined. Harris reviewed the agenda (handout A) and asked if there were any comments. Hearing no corrections, the agenda was approved.

Council Members in Attendance: Phyllis McCaul, Raevin Bigelow, Amy Weaver, Tommy Newcombe, Mary Thunker, Kimberly Strong, Jennifer Ihle, Jonathan Koley, Ryan Kaufmann, Lisa Casullo, Tammy Fiala, and Scott Loder.

DHHS Staff present: Cynthia Harris, Lucy Flores, Linda Wittmuss, Mikayla Johnson, Lisa Neeman, Stacey Werth-Sweeney, and Carmen Bachle.

Harris introduced the minutes from May 12, 2016 (handout B). Hearing no significant corrections to the revised meeting minutes or comments, Chairperson Casullo called for a motion to approve the May 12, 2016 meeting minutes. Motion to approve was made by Kaufmann and seconded by Newcombe, the motion passed.

**II. Executive Committee Update.** *Casullo, Ihle, Loder*

The executive committee addressed the group. Vice chairman Loder gave an overview of the logistics for traveling to the cemetery for the ceremony.

Chairman Casullo discussed the open seat on the council for the family member/caregiver seat. She stated that she will continue to reach out to assist in filling the seat.

Harris announced that Jennifer Ihle was named the program coordinator for the Office of Facilitation of Recovery, which would oversee implementation of the Peer Bridger program. There were a total of 55 applications and it was a very competitive process. Ihle stated that this was her last meeting and she was stepping down as a member of the council.

Hearing no other updates from the executive committee Harris gave some OCA updates. Harris discussed with the group that if people were interested she would like to have small work groups where people can help with some of the OCA initiatives. There is a great deal to move forward however OCA is short on positions so help is needed. The group as a whole agreed to be a part

of the work. Harris said she would talk to others across the state and that she would be in touch in the near future with more information.

Harris stated that currently as of August 2, 2016 OCA has the following contracts in place: Speak out, Families Care, Parent to Parent, Families Inspiring Families, Nebraska Family support Network, Annual Behavioral Health Conference – Orion, Nebraska Family Helpline, Trilogy (Network of Care), League of Human Dignity, and trauma informed care implementation with Kim Carpenter. OCA hopes to have additional contracts as the year goes on such as with NAMI, FREDLA, etc.

### **III. Cemetery Ceremony**

*Rachel Johnson- LRC Religious Coordinator*

The council traveled to the Haines Branch Cemetery, 2550 SW 12<sup>th</sup>, Lincoln, NE, to take part in a ceremony to honor Anna Cox. Anna Cox was born June 7, 1872 and passed away at the Lincoln Regional Center on October 19, 1947.

### **IV. 2016 Nebraska Peer Support Workforce Report**

*Harris, Sarwar, Casullo*

Harris introduced the 2016 Nebraska Peer Support Workforce Report (handout C). Harris and Sarwar gave an overview of the project history, timeline, and key data points of the report. Harris stated that Casullo would be pulling the council into two groups to review the information and recommended action steps that were within the scope of OCA. These action steps could be a part of OCA initiatives to support the workforce over the next couple years.

Based on the data the council provided the following feedback.

Group one: Presented out by Ihle

- Identify grants to support full time employment of peers
- Identify provider education
- Identify personal development opportunities such as computer skills
- Identify opportunities to further develop core competencies
- Connect with nontraditional employers and educate on peer support
- Identify a way to train more facilitators
- Career Ladder
- Way to enhance current certification- such as another level of certification and having to recertify

Group one: Presented out by Casullo

- Collect more data on why some were not satisfied
- Administer this survey on annual basis
- Track trends over the years such as length of time in field, demographics, satisfaction, etc.
- Would like to learn about the job description of peers in different organizations
- Would like to learn more about the difference between volunteer versus paid
- Group would like to know what support peers receive when transitioning into roles.

Harris thanked the group and noted that the 2014 survey is included in the report as attachment B.

## **V. Director's Update**

*Deputy director Linda Wittmuss in place of Director Dawson*

- The DHHS Business Plan was recently announced at a press conference with the governor, stating that this plan, with target dates, assists with the removal of silos between divisions and has us all working together as a team (handout D).
- The Federal Site Visit went very well. It was suggested that Nebraska is one of the top states in the nation in terms of behavioral health integration. Dawson and Renee Faber have been invited to speak at the SAMHSA's national block grant meeting in August.
- The Annual Behavioral Health Conference, held on May 31 – June 2, 2016 at the Cornhusker Hotel in downtown Lincoln, was very well attended, with over 500 people visiting the booths and attending the break-out sessions. The 2017 conference is slated for April 2017.
- Nebraska will be holding an Opioid Symposium on October 14 focusing on prevention, treatment, and law enforcement through direct collaboration with the public health, medical and law enforcement communities operating in Nebraska. DHHS has already begun several key initiatives to combat opioid abuse and addiction.
- SAMHSA has indicated they would like to see specific planning in place to serve veterans. To facilitate this project, there will be strategic planning workshops scheduled on September 8 and 9.
- Leslie Hays of Hays Consulting was in Lincoln on Monday, June 27 to work with staff on Emergency System Mapping, to identify steps in the Emergency Protective Custody procedures.
- Legislative Resolution 413 identifies a mandated task force on "behavioral and mental health," which was proposed as a result of last fall's legislative audit. Senator Bolz is Chair of this committee and they are meeting monthly. The task force is primarily interested in policy and funding issues and are especially interested in the results of the comprehensive needs assessment.

Wittmuss also spoke of the Comprehensive needs assessment – the first draft should be complete by the end of June. Currently in the process of summarizing the data. Wittmuss asked the group what kind of data they would like to see. The group responded that they would like to see how well people are doing in life domains, length of time in services, waitlist data, steps towards integration, access to services, employment, suicide prevention, rural and urban barriers, SAMHSA recovery domains, etc.

## **VI. Heritage Health**

*Lisa Neeman & Carmen Bachle of DHHS M&LTC*

Neeman and Bachle presented an overview of Heritage Health (Handout E). In addition to the information provided in the presentation, the group was interested in learning more about how recovery oriented services are defined. Neeman indicated that the RFP has a great deal of information on how each of the plans will incorporate recovery principles and holistic care. It was recommend to the group to review the information in the plan.

## **VII. Council member updates**

*Group*

Due to running behind schedule, this conversation was moved towards the end with the open discussion agenda item.

Johnson gave an overview of the emergency system, including current initiatives such as the Cross Division Solutions Team (see page 14 of business plan) and emergency system mapping project.

DHHS developed the Cross-Division Solutions Team (CDST) to find solutions for individuals and/or families who have complex issues and who may need services or supports from multiple Divisions within DHHS. The Divisions of Behavioral Health, Children and Family Services, Developmental Disabilities, and Medicaid and Long- Term Care, as well as Legal Services and Internal Audit meet weekly to review these cases. The Division of Public Health is involved as needed. Referrals for the CDST come from the DHHS CEO, the Division Directors, Ombudsman's office, senators' offices, and other system partners. The goals are to:

- Evaluate each individual's and/or family's complex needs to determine how the Divisions can work together to increase accessibility
- Identify system gaps and make recommendations resulting in better outcomes
- Increase participant knowledge on available

The route to improved outcome achievement for the emergency system centers around the collection and analysis of data—across all regions—that can be used to directly measure existing strengths and gaps. The Emergency Service System Mapping Workgroup will use a performance measurement process that follows a clear five-step path.

1. Identify desired outcomes & indicators
2. Define data that measures indicators:
3. Collect data
4. Analyze data against target benchmarks
5. Recommended changes for improve outcome achievement

Draft indicators

- Number of EPCs in a 12 month period
- Timely completion of crisis evaluations
- Timely completion of MHB commitment hearings
- Timely engagement with recommended treatment

Johnson is working with Leslie Hays of Hays Consulting on Emergency System Mapping, to identify steps in the Emergency Protective Custody procedures and other data elements to support this initiative.

**IX. Open Discussion/Updates**Casullo

The group discussed that they would like for the meeting to be held at the Lincoln community foundation building because the set up was conducive for the meeting. They would like to have an agenda item related to TAY and would like to spend more time on action items at the next meeting.

Kaufmann stated that UNL is accepting nominations for Veterans to be honored at the November 12<sup>th</sup> football game and that people should contact [marelene.sorensen@va.gov](mailto:marelene.sorensen@va.gov) to learn more.

Harris introduced handouts F & G for the members review. Harris invited members to attend the upcoming Joint Advisory Committee Meeting: State Advisory Committee on Mental Health Services (SACMHS) & State Advisory Committee on Substance Abuse Services (SACSAS), August 18, 2016 at 9:00, Lincoln, NE – Country Inn & Suites.

The next OCA People’s Council meeting is scheduled November 01, 2016 at 09:30 am – 3:00 pm. The meeting location will be at the Lincoln Community Foundation Building, 215 Centennial Mall S, Lincoln, NE.

Meeting was adjourned

*Minutes prepared by the Division of Behavioral Health, Nebraska Department of Health and Human Services. Minutes are intended to provide a general summary of the proceedings. 08-02-2016 Meeting Minutes*

DRAFT

Nebraska Office of Consumer Affairs People's Council  
 Lincoln Regional Center  
 801 W. Prospector & Folsom  
 Building # 14- Wayne George Training Room, 3<sup>rd</sup> Floor \*  
 Lincoln, Nebraska  
 August 02, 2016  
 9:00 AM – 03:15 PM

For access to building #14 please call 402 405 2954 upon your arrival \*  
 Public comments are welcome throughout the meeting.

Chairman Casullo & Cynthia Harris	Welcome, Open Meetings Law, public comment, attendance, quorum, housekeeping, & review of past meeting minutes.	9:00 am – 09:20 am
Executive Committee	Executive Committee Update	09:20 am -09:35 am
Scott Loder	Break and Travel to Haines Branch Cemetery	09:35 am -10:00 am
Rachel Johnson- LRC Religious Coordinator	Cemetery Ceremony – <b>Haines Branch Cemetery</b> <b>2550 SW 12<sup>th</sup> , Lincoln, NE</b>	10:00 am - 11:00 am
Lunch on your own and travel back to LRC	Meeting will resume at the Lincoln Regional Center after lunch	11:00 pm – 12:15 pm
Cynthia Harris & Chairman Casullo	2016 Nebraska Peer Support Workforce Report: Review and provide feedback. Small group work	12:15 pm -01:00 pm
Linda Wittmuss- DBH Deputy Director	Director's update	01:00 pm - 01:20 pm
Break		01:20 pm -01:30 pm
Lisa Neeman & Carmen Bachle Medicaid and Long Term Care	Heritage Health	01:30 pm – 02:00 pm
Council Member Updates	Updates on Regional Work and Recovery Month Activities	02:00 pm - 02:20 pm
Break		02:20 pm – 02:30 pm
Mikayla Johnson – DBH Emergency Systems Coordination	Emergency System overview, including current initiatives such as the Cross Division Solutions Team and Emergency System Mapping	02:30 pm – 03:00 pm
Chairman Casullo	Open Discussion	03:00 pm – 03:15 pm

If you have any questions or would like more information, please feel free to contact:

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## Nebraska Division of Behavioral Health

**Office of Consumer Affairs People's Council**May 12<sup>th</sup>, 2016

9:30 AM – 03:15 PM

Lincoln Community Foundation Building

215 Centennial Mall south, 5<sup>th</sup> Floor

Meeting Minutes

**I. Meeting Minutes Call to Order/Welcome/Roll Call/Meeting Minutes** *Chairman Lisa Casullo/ Cynthia Harris*

Chairperson, Lisa Casullo, called the meeting to order at 9:40 AM, May, 12, 2016. Cynthia Harris, Division of Behavioral Health Office of Consumer Affairs (DBH OCA) Council Facilitator, welcomed committee members and others present to the meeting.

The Open Meetings Law was posted in the meeting room and it was noted that public comment is welcomed throughout the meeting. Lucy Flores instructed attendees to sign in. Roll call was conducted and a quorum was determined. Harris noted the agenda (handout A) no changes needed.

Council Members in Attendance: Phyllis McCaul, Raevin Bigelow, Amy Weaver, Tommy Newcombe, Mary Thunker, Kimberly Strong, Jennifer Ihle, Jonathan Koley, Ryan Kaufmann, Lisa Casullo, Tammy Fiala, and Scott Loder.

DHHS Staff present: Cynthia Harris, Loretta (Jan) Goracke, Lucy Flores, and Sheri Dawson

**Motion to Approve Minutes** *Cynthia Harris and Chairperson Lisa Casullo*

Harris introduced the minutes from Feb 9, 2016 (handout B). Hearing no significant corrections to the revised meeting minutes or comments, Chairperson Casullo called for a motion to approve the Feb 9, 2016 meeting minutes. Motion to approve was made by Kaufmann and seconded by Ihle, the motion passed.

**II. Executive Committee Update.** *Casullo, Ihle, Loder*

The executive committee provided an update of the recent activity since the last OCA People's council meeting. They provided information on the council presentation at the State Advisory Council on Substance Abuse Services (§ 71-815) and the State Advisory Committee on Mental Health Services (§ 71-814) on Feb 18<sup>th</sup>. This was the first formal introduction as an official subcommittee of the State Advisory Council. The executive committee also discussed the review of the recent applications for appointments to the OCA People's Council. Three members were appointed. The family member seat is still open at this time and the Division is still accepting applications. The new members have been invited to be a part of a mentorship program, where they can sit alongside an existing member and learn more hands on about their role with the council. All members received training and orientation to the council.

### **III. Director update**

*Dawson*

- Director Sheri Dawson welcomed the new members and recognized the experience that they brought to the table. Amy Weaver of Omaha and Raevin Bigelow of Lincoln have been appointed to the Transition Age Youth Positions and Tommy Newcombe of Norfolk has been appointed as the Region 4 Representative.
- Director Dawson announced that Cynthia Harris is the new administrator for the Office of Consumer Affairs. Dawson received recommendations on the interview process from council members and she thanked them for being a part of the process.
- Hiring for the Office of Facilitation for Recovery position, located at the Lincoln Regional Center, will be taking place in the near future. Under the direction of the Office of Consumer Affairs, the Office of Facilitation for Recovery will be the driver of the peer bridger program.
- Director Dawson updated the committees on a series of new contracts with a number of family organizations who deliver family and peer support, adding that there is great impact with family members sharing lived experiences. Dawson explained that the contract with the Federation of Families has ended and DBH is contracting individually with family organizations across the state.
- The DBH Centralized Data System is now operational and allowing interface with providers as a built-in authorization system. The system is garnering national attention, with presentations requested at several conferences.
- Legislative Resolution 413 identifies a mandated task force on “behavioral and mental health,” which was proposed as a result of last fall’s legislative audit. Senator Bolz is Chair of this committee and they are meeting monthly. Director Dawson noted the task force is primarily interested in policy and funding issues and are especially interested in the results of the comprehensive needs assessment. Anyone seeking more information about the task force and its members may contact Deb Sherard and she will get the information out to you.
- DBH is currently in a Federal Block Grant review. This is an opportunity for quality improvements and ways to look at identifying strengths.
- DBH is working with the is collaborating with the University of Nebraska Medical Center College of Public Health for a survey designed to help provide Nebraskans with the most effective and timely service. The survey seeks input from individuals who are currently or have received behavioral health services in Nebraska and their families, behavioral health providers and other professionals who have working knowledge of the behavioral health system in Nebraska and the general population across the state. Director Dawson asked for assistance on the evaluation. Dawson explained that the council will be called upon to help prioritize results from the needs assessment and to develop a realistic work plan for the new strategic plan moving forward.
- Director Dawson updated the committees on a series of new contracts with a number of family organizations who deliver family and peer support, adding that there is great impact with family members sharing lived experiences. Dawson explained that the contract with the Federation of Families has ended and DBH is contracting individually with family organizations across the state. DBH will be entering into a contract with FREDLA to provide technical assistance to the family organizations in NE.
- Director Dawson gave an overview of Heritage Health, which is a 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

CHIP clients.

- Director Dawson then gave the floor to Annette Dubas, former Nebraska State Senator. She spoke about her role as the first Executive Director for the Nebraska Association of Behavioral health Organizations (NABHO). NABHO is Nebraska's largest behavioral health organization and they advocate on behalf of providers and consumers for a strong, effective and stable behavioral health system of care. Ms. Dubas indicated that NABHO is interested in how DBH, as well as this Council, could work together more.

#### **IV. SAMHSA Block Grant Site Visit.**

*SAMHSA Project Officer*

Harris pointed to the Block Grant handout (handout c). The SAMHSA project officer facilitated a dialogue based on the following questions and topic areas.

1. Access to Care – Rural versus urban challenges
2. If you are in Scottsbluff and having a MH crisis- what are the steps in getting care?
3. Are there waitlist challenges?
4. Where can there be better communication?
5. Discussion on “system clog”
6. Discussion on wraparound care and peer support.
7. Lack of peer jobs
8. Integrated care- What work needs to be done?

A draft report will be issued 70 days after the site visit, with a final report coming after DBH reviews.

#### **V. Office of Consumer Affairs updates: DBH 2016 Strategic Plan, Bridger document”.**

Harris

The council was presented with the DBH 2016 Strategic Plan, referred to as the Bridger document, (handout d). Harris reported out activities that have been accomplished to date related to the OCA and the 2016 DBH Strategic Plan

1. Identify and implement strategies to strengthen the Peer Support Workforce by December 31, 2016.
  - Conduct a peer support workforce survey.
  - Analyze Office of Consumer Affairs Peer Support training evaluation data.
  - Explore next steps for enhancing the current certification mechanism.
  - Conduct Peer Support trainings and certification exams.
2. Implement formal and strategic system links with other key stakeholders to expand consumer involvement in service planning and delivery in Nebraska by December 31, 2016.
  - Strengthen the organization and infrastructure of the DBH OCA People's Council.
  - Develop charter, bylaws and application procedures and identify participation expectations.

- Serve 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).
3. Provide opportunity to build partnerships and collaborative relationships through facilitation of annual Behavioral Health Conference (Spring 2016) and other trainings.
  4. Finalize the development of the Peer Bridger Pilot Program specific to transitioning from Lincoln Regional Center to community-based services, including supported housing by March 31, 2016.
    - Analyze results of survey completed in 2015 of key LRC employees, community providers and Certified Peer Support Workers (CPSW) and provide to pilot program work team.
    - Finalize plan with work team for implementation of pilot program including staff responsibilities, tasks and timeline for execution.
  5. Further cross-system collaboration to increase system-wide capacity for Trauma-Informed Care (TIC) by December 31, 2016.
    - Secure consultant, develop assessment process/procedure.
    - Conduct agency assessment within DBH using TIC tool.
  6. Initiate a planning process that leads to the development of three-year strategic plan for community-integrated supported housing for behavioral health consumers by June 2016. Under the current contract, the Technical Assistance Collaborative (TAC) will:
    - Review current DHHS policies and conduct housing focus groups.
    - Conduct environmental scan and review of current housing planning efforts.
    - Research available supported housing services and conduct housing workgroup.
  7. Review the policies and procedures of the Diversity Committees at the Hastings, Norfolk and Lincoln Regional Centers by December 31, 2016.
    - Secure Cultural and Linguistic Services (CLS) consultant(s).
    - Conduct review and provide recommendations to DHHS/DBH leadership.

**VI. Provide recommendations for work of the OCA**

*Casullo*

Casullo facilitated a follow up conversation of the discussion from the block grant site visit. Casullo lead the group in a conversation about access to care, residential programs for youth, out of state placement, inappropriate use of services, etc.

**VII. Consumer involvement at the 2016 Annual Behavioral Health Conference**  
*Regional Consumer Specialists*

The regional consumer specialists discussed their challenges with the scholarship process for this year's Behavioral Health conference. Each region was responsible for the coordination of scholarships, which is a change from previous years. There were some bumps, but overall learning opportunities on how to make the process smoother in the years to come. The annual Behavioral Health Conference will take place on May 31<sup>st</sup> - June 2<sup>nd</sup>, in Lincoln, NE at the Cornhusker Hotel.

Koley facilitated a conversation about a pilot project focused on creating an independent consumer community and was curious if the council had thoughts on how it can be brought to scale statewide. The community would provide opportunities for consumer involvement and provide a place where meaningful feedback can be gathered. Koley also discussed peer support development. He stated that peer support is not a service, but a profession. In his experience with Region 6 Behavioral Health he found that implementing peer service definitions was a challenge because peer support was not delivered the same way in each place. This makes maintaining fidelity a challenge. Instead the approach should be that we look at employing peer providers and embedding them within the existing service delivery system. Koley also discussed the need for moving towards credentialing opportunities for the peer workforce. Possibly looking at different levels of certification based on the different levels of education.

**IX. Adjournment***Casullo & Harris*

Harris introduced handouts E, F, G, H, & I for the members review. Harris invited members to attend the upcoming Joint Advisory Committee Meeting: State Advisory Committee on Mental Health Services (SACMHS) & State Advisory Committee on Substance Abuse Services (SACSAS), June 23, 2016/ 9:00 am – 3:40 pm Lincoln, NE – Country Inn & Suites.

The next OCA People’s Council meeting is scheduled August 02, 09:30 am – 3:00 pm. The meeting location will be at the Lincoln Community Foundation Building, 215 Centennial Mall S, Lincoln, NE.

Meeting was adjourned

*Minutes prepared by the Division of Behavioral Health, Nebraska Department of Human Services. Minutes are intended to provide a general summary of the proceedings. 02-09-2016 Meeting Minutes*



# 2016 Nebraska Peer Support Workforce Report

Nebraska Department of Health and Human Services  
Division of Behavioral Health  
Office of Consumer Affairs

Prepared by:

Cynthia Harris, M.S., CPSWS  
Administrator

&

Mazen Sarwar, M.A.

Student Extern Quality Improvement and Data Performance

June 2016

AA/EOE/ADA

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A- 2016 Nebraska Peer Support Workforce Survey	
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## INTRODUCTION

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

**Simply Said:** Nebraska strives to be the gold standard in facilitating hope, recovery and resiliency as a model of excellence in behavioral health care.

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

**Simply Said:** DBH assists systems that help people recover.

The Nebraska DHHS Division of Behavioral Health (DBH) promotes activities that improve the quality of behavioral health services and increases opportunities for recovery and wellness. DBH administers, oversees and coordinates the state public behavioral health system which addresses the prevention and treatment of mental health and substance use conditions. DBH strives to ensure services meet the complex needs of individuals with co-occurring disorders. DBH believes that to ensure services meet the needs of those we serve, we must identify and implement strategies to strengthen the Peer Support Workforce and collect meaningful data that can support the field.

**Project History and Timeline** In 2007, the International National Association of Peer Specialists (iNAPS) conducted a nationwide survey to gather data from peer specialists throughout the U.S. The goal was to determine the variety of tasks, how satisfied peer specialists were with their work, compensation levels, outlook for the future, and what motivated them in their work. In 2014, a follow-up survey was conducted with questions about location, education, training, and supervision added to the original 2007 survey ([https://na4ps.files.wordpress.com/2014/07/2007-2014\\_comparisonreport1.pdf](https://na4ps.files.wordpress.com/2014/07/2007-2014_comparisonreport1.pdf)).

In 2014 DBH Office of Consumer Affairs (OCA) conducted a peer support survey to learn more about what Peer Support Services may exist in Nebraska, what opportunities and barriers may exist to providing them and perspectives about the ongoing development and growth of peer support. A report of this data can be found in Attachment B. During December 2015, OCA reached out to Peer Support Specialists across Nebraska to gather comparable state-specific workforce data as it relates to various topics, including: training, hours worked per week, number of people you support, job satisfaction, service provision, organization type, demographics. OCA was interested in utilizing data collected from the Nebraska workforce survey to make comparisons to various national trends as identified through the surveys completed by iNAPS in 2007 and 2014. The Peer Support Workforce Survey collects data about the current workforce environment for

- Employed/volunteer peer support providers,
- Those who have worked in the past as a peer support provider,
- And those who are currently seeking a position as a peer support provider.

The following report is an illustration of the power of partnerships and the commitment of peer providers as we continue to move our system forward.

Sincerely,

Cynthia Harris, M.S., CPSWS  
Nebraska Department of Health and Human Services  
Administrator of the Office of Consumer Affairs  
[Cynthia.Harris@nebraska.gov](mailto:Cynthia.Harris@nebraska.gov)  
402-471-7766 / 402-471-7859 (fax)

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## METHODOLOGY AND SAMPLE

The sample for this survey is a convenience sample identified through postings on the OCA's CPSWS listserv and the Nebraska Peer Support Facebook Group. In addition, information about the survey was sent to Speak out, Families Care, Parent to Parent, Families Inspiring Families, Healthy Families Project, Nebraska Family Support Network, the Regional Behavioral Health Authorities, Mental Health Association of NE, NAMI-NE, Partners in Recovery, Women's Center for Advancement, Peer Run organizations in Nebraska, the Veterans Administration, Nebraska Children and Families Foundation, OCA People's Council, and the Mental Health and Substance Abuse Advisory Committees. An estimate on the sample size of people receiving the link is about 600 individuals. Since the survey was sent through an open link it was not possible to determine an exact number of people who would have known about the survey. An original request for participation was delivered on December 8, 2015 via these sources, containing a link to the survey. Follow-up reminders to encourage participation were also sent. Data collection ended in January 11, 2016.

There were a total of 106 completed or partially completed surveys. Data was analyzed using SPSS statistical software.

Results are confidential and have been tallied to create this overall report. Due to small sample sizes, analysis for this report is limited. For the purpose of easy to read analysis, percentages are rounded to the nearest whole number.

It is important to remember that since this survey uses a convenience sample, the results are not necessarily generalizable to the peer support workforce in Nebraska. The results should be looked at as a general overview of survey participants.

For purposes of this survey, peer support providers are inclusive of those who serve children, family, youth, adults, and/or veterans in the State of Nebraska while utilizing their personal lived experience with a behavioral health condition, as a parent of a child with behavioral health challenges, and/or trauma to support others. This survey assess the following three groups.

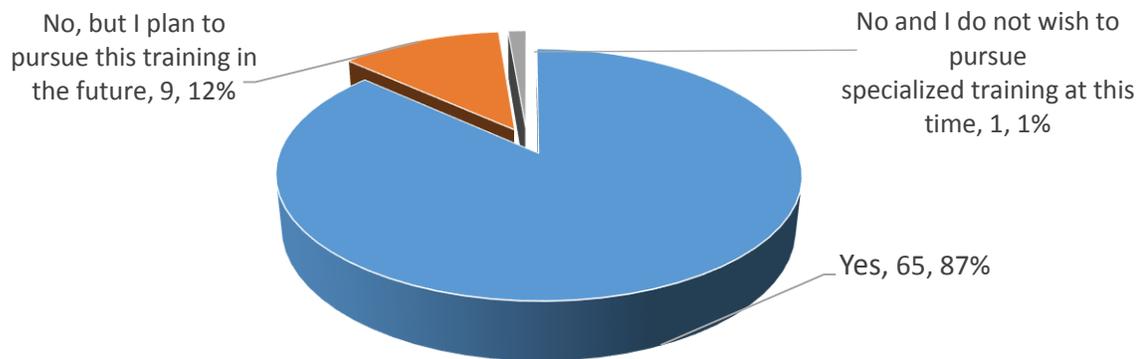
- Employed/volunteer peer support providers
- Those who have worked in the past as a peer support provider
- Those who are currently seeking a position as a peer support provider

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## TRAINING AND CERTIFICATION

The vast majority of survey respondents have completed 40 hours of specialized peer support training (87%, n=65). 12% of respondents have not completed the training, but plan to do so in the future (n=9). Only one respondent indicated that they do not wish to pursue specialized training at this time. (Note: Excludes respondents not currently employed as peer support specialists.)

Figure 1: Have you received 40 hours of specialized peer support training? (n=75)



Source: 2016 Nebraska Peer Support Workforce Survey

When asked about certification, the most commonly earned certification noted by survey respondents was the Certified Peer Support and Wellness Specialist (CPSWS) certification, offered through the Nebraska Division of Behavioral Health Office of Consumer Affairs (71%, n=53). One respondent completed the Certification for Parent Support Providers (CPSP®) offered through the National Federation for Parent Support Providers. Other certifications earned by respondents include the Depression and Bipolar Support Alliance Peer Specialist Training (DBSA), Whole Health and Wellness, Middle Management Training, Voice Healers, Emotional CPR (eCPR), Wellness Recovery Action Plan (WRAP), and Individual Placement and Support (IPS).

## JOB CHARACTERISTICS

### *Paid or Volunteer (n=98)*

A little over three-fifths of survey respondents were currently employed in paid positions as peer support providers (63%, n=62) while 13% of respondents indicated that they are currently employed in volunteer positions (n = 13). About 9% of respondents indicated that they are not currently employed as a peer support provider, but have worked as one in the past (n=9). An additional 9% indicated that they are currently not employed as a peer support provider, but are currently seeking a position (n=9). 5% of respondents had never been employed as a peer support provider and were not looking for a position (n=5).

Figure 2: As a peer support provider, are you currently...

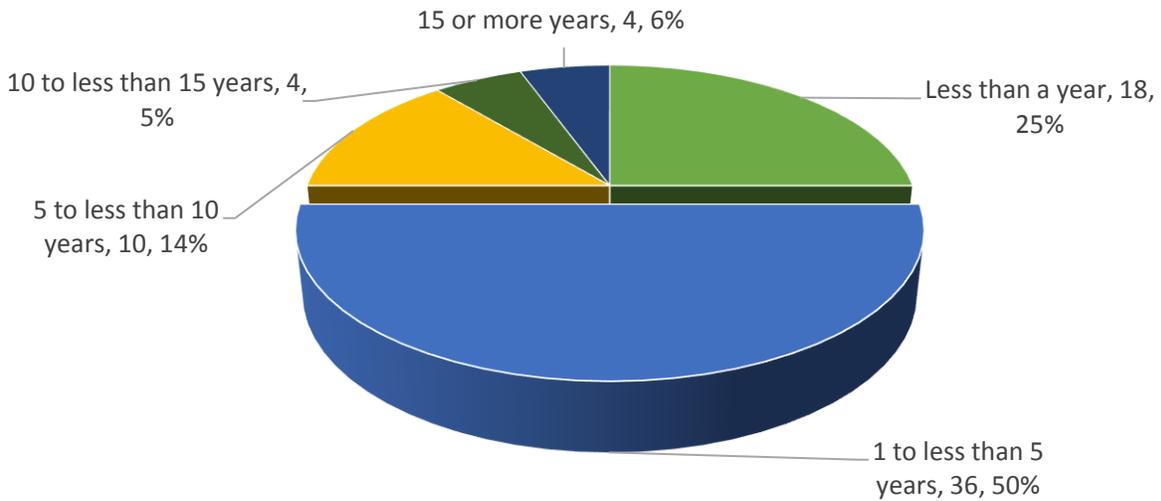


Source: 2016 Nebraska Peer Support Workforce Survey (\*Label truncated, please see description)

**Length of Time Working at Current Organization (n=72)**

Respondents were asked how long they have been working in their current organization. When removing cases where individuals reported working less than 1 year, the average length reported was 5.2 years. Answers ranged from one to thirty-six years. About a quarter of respondents indicated that they have worked for their current organization for less than year (24%, n=18).

Figure 3: Within your current volunteer paid position as a peer support provider, how many years have you been with the organization?



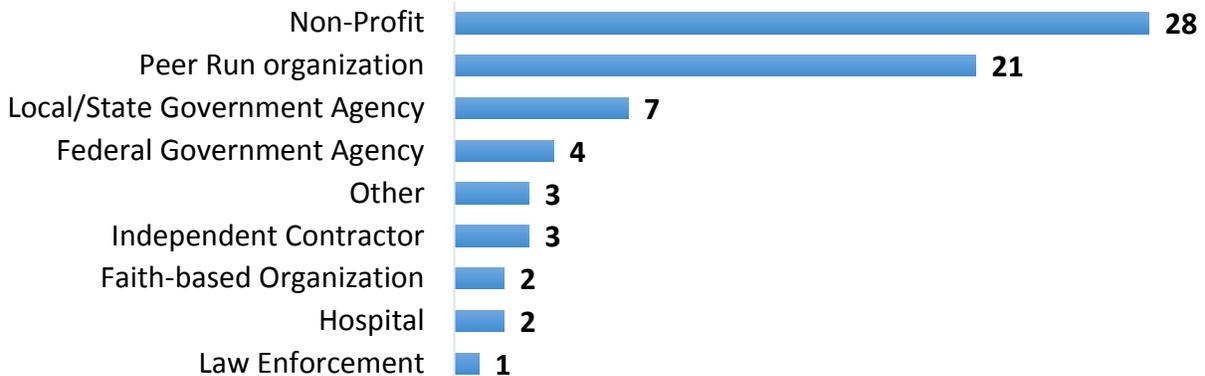
Source: 2016 Nebraska Peer Support Workforce Survey

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### Organization Type (n=71)

When describing the type of organization they work for, 39% of respondents indicated that they work for a non-profit organization (n=28). 30% of respondents work for a peer run organization (n=21) and 16% work for a local, state or federal government agency (n=11). Other organization types that were selected included independent contractor (4%, n=3), faith-based organization (3%, n=2), hospital (3%, n=2), and law enforcement (1%, n=1).

Figure 4: Within your current volunteer/paid position as a peer support provider, which **best describes** the type of organization you work for?



Source: 2016 Nebraska Peer Support Workforce Survey

### Primary Role (n=73)

When asked about their primary role within their current paid or volunteer position, the majority of survey respondents selected Direct Service Provider (56%, n=41). About 12% of respondents selected Program Manager (n=9), 7% selected Agency Director (n=5), 6% selected Systems Transformation Advocate (n=4), 4% selected Education/Training Provider (n=3), 1% selected Administrative Support (n=1) and 14% selected Other (n=10). Under the “Other” category, responses included youth support, support group facilitator, lead recreational activities, peer to peer support, and family advocate.

Figure 5: Within your current volunteer/paid position as a peer support provider, what is your **primary** role? Please select one.



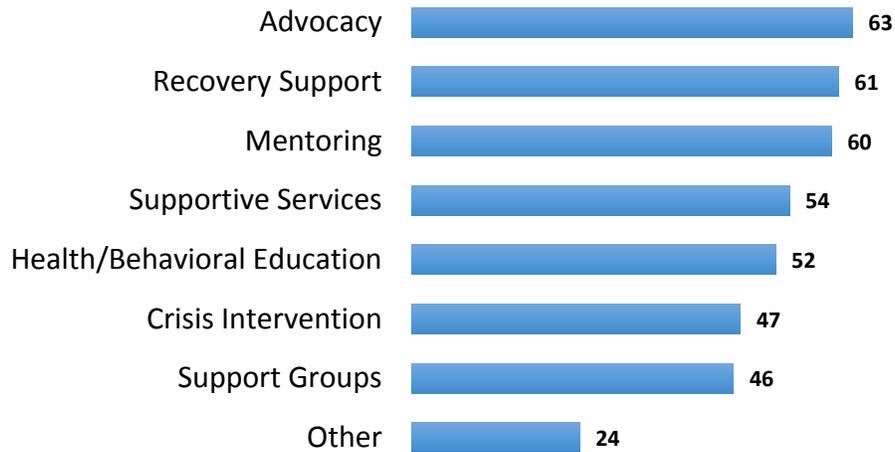
Source: 2016 Nebraska Peer Support Workforce Survey

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### ***Support Services Provided (n=75)***

Survey respondents were asked to identify which types of support services they provide in their current position. The most frequently selected option was *Advocacy* (84%, n=63), followed by *Recovery Support* (81%, n=61), and *Mentoring* (80%, n=60). Other options selected included *Supportive Services* (n=54, 72%), *Health/Behavioral Education* (n=52, n=69%), *Crisis Intervention*, (n=47, 63%), and *Support Groups* (n=46, 61%). 32% of respondents selected the *Other* option (n=24), with the most frequently cited service being *Transportation*. Other responses cited included skills/tools for independent or daily living, recreation, and resources.

*Figure 6: Within your current volunteer/paid position as a peer support provider, what type of support services do you provide? Please select all that apply.*



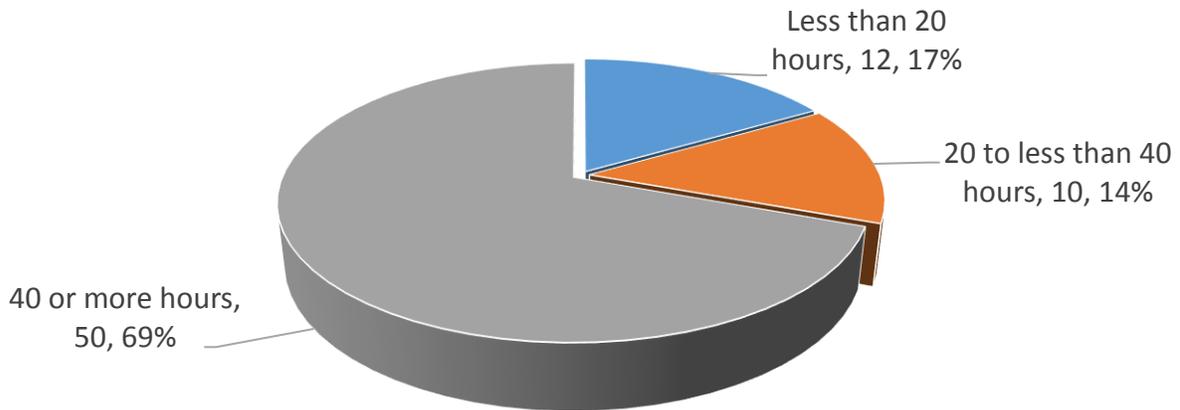
*Source: 2016 Nebraska Peer Support Workforce Survey*

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### ***Hours Worked (n=72)***

Hours worked by survey respondents varied, with an average employee working 34.2 hours in a peer support provider position each week. Responses ranged from 2-60 hours a week. Almost seven out of ten survey respondents worked forty hours or more per a week as a peer support provider (69%, n=50). About 14% of survey respondents worked between 20 and 40 hours a week (n=10) and about 17% of survey respondents worked less than 20 hours a week. (Note: If a range was provided by the respondent, the midpoint of their response was used.)

*Figure 7: Within your current volunteer/paid position as a peer support provider, on average, how many hours per week do you work?*



*Source: 2016 Nebraska Peer Support Workforce Survey*

### ***Hourly Wage (n=52)***

Hourly wage for survey respondents was quite variable. The average hourly wage reported was \$16.72 an hour and the median reported wage was \$16.00. 42% of survey respondents earned between \$10-14.99 hourly (n=22), 31% earned between \$15-19.99 hourly (n=16), and 27% earned \$20.00 or more hourly (n=14).

### ***Number of People Supported Each Week (n=75)***

When asked about the number of people supported each week, responses were quite variable. A number of respondents provided a range, indicating that for many respondents, the number of people supported each week can change depending on the week. Responses ranged from one to sixty individuals, with a mean of 17 individuals provided services a week.

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***Current Title***

This question was an open-ended question. All responses have been included in this report to illustrate the variety of positions in the existing workforce. Duplicates have been removed.

***N=65***

Volunteer Manager Recovery Consumer Specialist  
Program Youth Peer Support Community  
Executive Director Advocate

- Addiction Support Peer Specialist
- Behavioral Health Outreach Advocate
- Certified peer support and wellness specialist
- CFFS
- Community Readiness Consultant
- Community Support Provider
- Consumer Affairs Manager
- Consumer Specialist
- Direct Care Staff
- Director of Consumer Recovery
- Employment Specialist
- Executive Director
- Family Advocate
- Family Navigator
- Family Peer Support Specialist
- Family Peer Support/Advocate
- Independence Coordinator
- Peer Companion
- Peer Partner
- Peer Recovery Facilitator
- Peer Support and Wellness Specialist
- Peer Support Specialist
- Peer support volunteer
- Peer Supporter
- Peer to Peer Mentor/Family Advocate
- Program Administrator
- Program Coordinator
- Program Specialist-Recovery Specialist
- REAL Program Coordinator
- Recovery specialist
- Recovery Support Specialist
- Recovery support team leader
- Statewide Program Manager
- Supervisor of Peer Support
- Support group co-facilitator
- Volunteer
- Volunteer - Freelance provider to military members, spouses, and teenage children as needed
- Youth Advisor
- Youth and Family coordinator
- Youth Peer Support Specialist

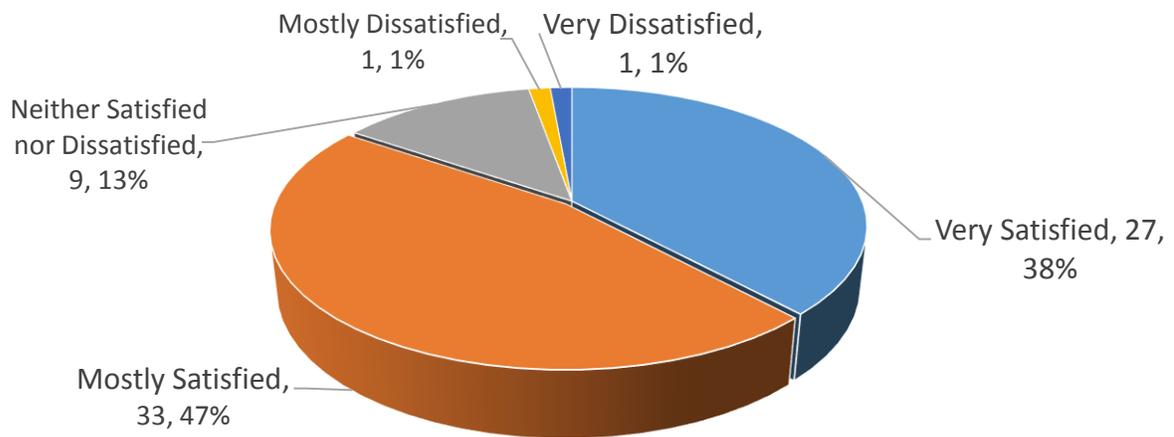
## JOB SATISFACTION AND MOTIVATION

Survey respondents were asked several questions to measure their current job satisfaction and motivations behind working as a peer support provider. The descriptions of the questions and the frequencies of responses are presented below.

### **Overall Job Satisfaction (n=71)**

When asked to rate their job satisfaction in their current volunteer/paid position as a peer support provider, the majority of respondents indicated that they are “mostly satisfied,” (n=33, 47%). Almost four in ten respondents indicated that they are “very satisfied,” (n=27, 38%). 13% indicated that they are “neither satisfied nor dissatisfied,” (n=9), 1% indicated that they are mostly dissatisfied (n=1) and 1% indicated that they are very dissatisfied (n=1).

Figure 8: Within your current volunteer/paid position as a peer support provider, how would you rate your job satisfaction?



Source: 2016 Nebraska Peer Support Workforce Survey

### **Respected in the Workplace (n=70)**

When asked how much they agree or disagree with the following statement, “I am respected by my supervisor and colleagues when I am working a peer support provider,” most survey respondents strongly agreed (64%, n=45). 14% of respondents marked “somewhat agree,” (n=10). 11% of respondents marked “neither agree nor disagree,” (n=8). 7% of respondents marked “somewhat disagree,” (n=5) and 3% marked “strongly disagree” (n=2).

Figure 9: How much do you agree or disagree with the following statement: I am respected by my supervisor and colleagues when I am working as a peer support provider. (Source: 2016 Nebraska Peer Support Workforce Survey)

Strongly Agree	Somewhat Agree	Neither Agree nor Disagree	Somewhat Disagree	Strongly Disagree
64%	14%	11%	7%	3%

**Equal Member of the Team (n=71)**

When asked how much they agree or disagree with the following statement, “I am treated as an equal member of the team when I am working as a peer support provider,” nearly half of all survey respondents strongly agreed (49%, n=35). An additional 24% of respondents marked that they “somewhat agree” with this statement (n=17). 14% of respondents indicated that they “neither agree nor disagree,” (n=10), 7% marked that they “somewhat disagree,” (n=5) and 6% marked that they “strongly disagree,” (n=4).

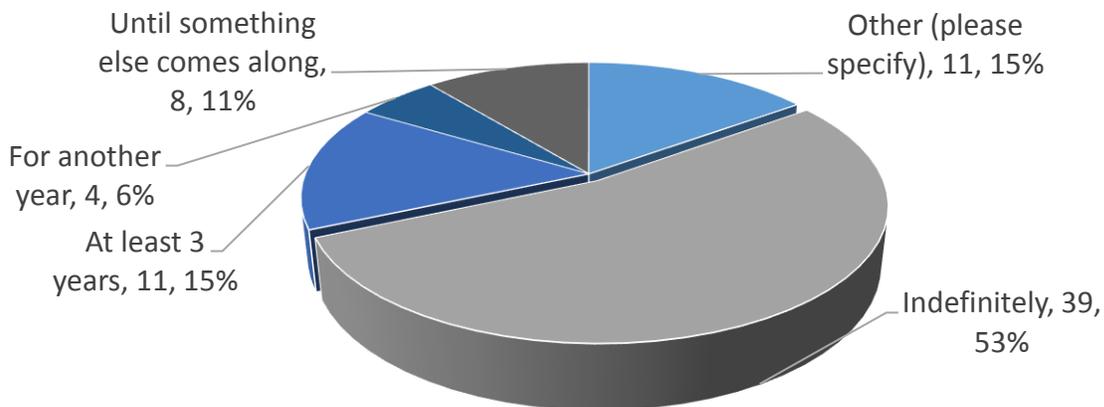
Figure 10: How much do you agree or disagree with the following statement: I am treated as an equal member of the team when I am working as a peer support provider. (Source: 2016 Nebraska Peer Support Workforce Survey)

Strongly Agree	Somewhat Agree	Neither Agree nor Disagree	Somewhat Disagree	Strongly Disagree
49%	24%	14%	7%	6%

**Job Outlook (n=73)**

Respondents were asked how long they expect to remain in their current volunteer/paid position. A little over half of respondents indicated that they plan to stay in their current position indefinitely (53%, n=39). Just over 15% indicated that they intend to stay at least 3 more years (n=11), and 6% indicated that they plan to stay for another year (n=4). 11% of respondents indicated that they staying in their current position until something else comes along (n=8). Just over 15% of respondents indicated another reason (n=11), the most common being that they are looking to transition into a full-time or paid position when one becomes available. Some uncertainty was mentioned by respondents who selected other, such as being unsure of how long they would stay or whether funding would be available to keep working in their current position.

Figure 11: How long do expect to remain at your current volunteer/paid position?



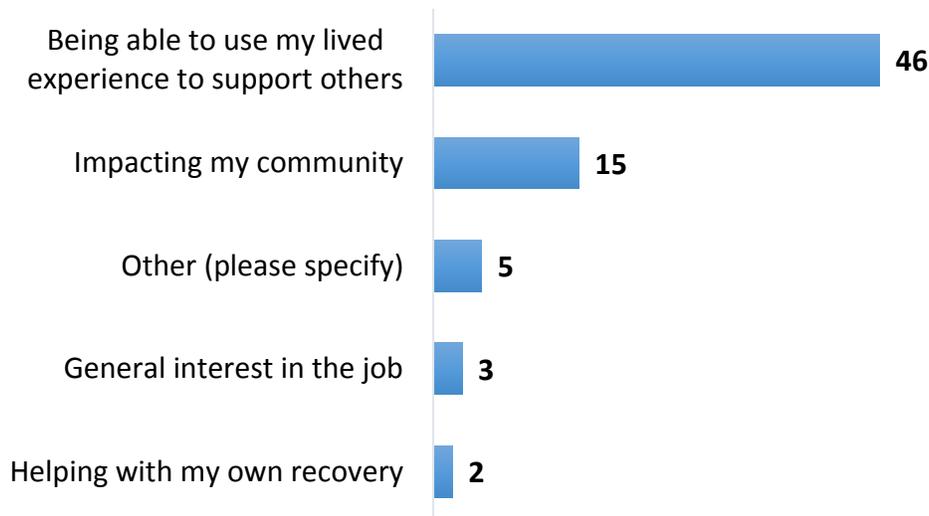
Source: 2016 Nebraska Peer Support Workforce Survey

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### **Motivation (n=71)**

Respondents were asked about their primary motivations for working as a peer support provider. 65% of respondents indicated that their primary motivation is “being able to use my lived experience to support others,” (n=46). About one fifth of respondents indicated that they want to impact their community (21%, n=15). Other selections included “helping with my own recovery,” (3%, n=2) and general interest in the job (n=3, 4%).

Figure 12: What is your **primary** motivation for working as a peer support provider?



Source: 2016 Nebraska Peer Support Workforce Survey

## **BARRIERS TO WORKING**

Both currently employed peer support providers and those who are currently not working in the field or are looking a position in the field were asked about barriers they experience in working additional hours or securing employment as a peer support provider. The results are presented below and then compared.

### **Barriers to Working for the Not Currently Employed Workforce (n=23)**

Responses varied in regards to barriers for those who are currently not working as peer-support providers. The top reason cited for not currently working as a peer support provider was personal concerns (26%, n=6). The second most cited reason was that there are not any full-time positions available (17%, n=4). Other reasons cited include stigma/discrimination (13%, n=3), lack of on the job experience (13%, n=3), low wages (13%, n=3), benefit loss (9%, n=2), lack formal credential/certification (9%, n=2), need more education (9%, n=2) and planning to move out of this field (4%, n=1). About 9% of not currently employed respondents indicated that they wish to only volunteer (n=2). Approximately 35% of respondents who are not currently employed indicated that they do not experience any barriers.

Figure 13: Do you currently experience any barriers to working additional hours or securing employment as a peer support specialist? (Not currently employed workforce)



Source: 2016 Nebraska Peer Support Workforce Survey

**Barriers to Working for the Currently Employed Workforce (n=75)**

Responses varied in regards to barriers for those who are currently working as peer-support providers. The top reason cited barrier for working more hours was personal concerns (15%, n=11). The second most cited reason was low wages (13%, n=10). The third most cited reason was there are not any full-time positions available (9%, n=7). Other reasons cited include stigma/discrimination (5%, n=4), lack of on the job experience (5%, n=4), I wish only to volunteer (5%, n=4), lack of formal credential/certification (5%, n=4), need more education (3%, n=2) and benefit loss (3%, n=2). About a fifth of respondents indicated that they do not wish to work more hours (20%, n=15) and 43% indicated that they do not experience any barriers (43%, n=32).

Figure 14: Do you currently experience any barriers to working additional hours or securing employment as a peer support specialist? (Currently employed workforce)

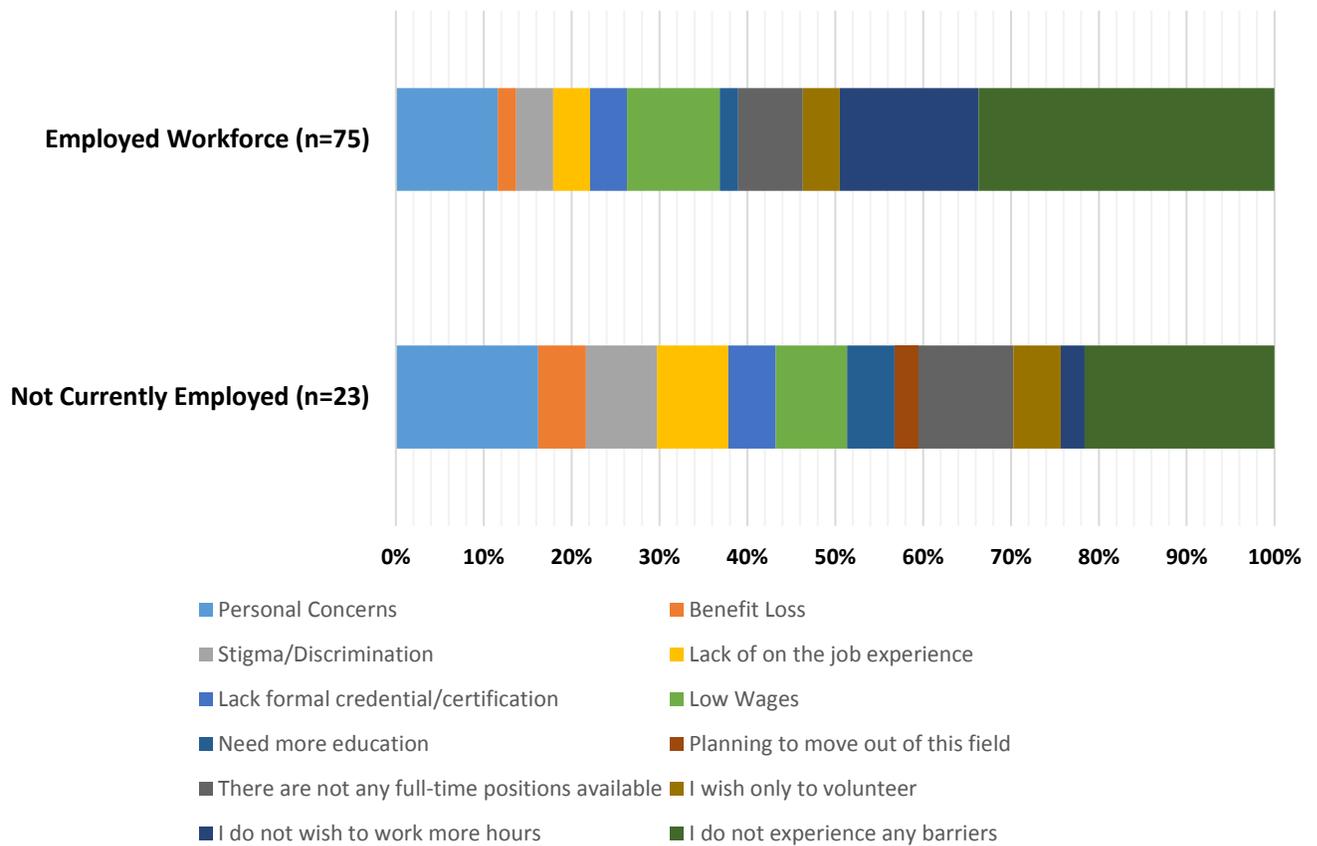


Source: 2016 Nebraska Peer Support Workforce Survey

**Comparison**

The responses indicate that for both those who are not currently employed in the peer-support workforce and those who are, personal concerns is the top reason for not working more hours or working at all. Low wages are a concern for both those who are working and those who are not as well as the lack of availability of full time positions. These results may indicate that there are individuals who are interested in working in the peer-support workforce, but wages and the lack of enough working hours is causing them to consider other employment. A small number of individuals indicated that they only wish to volunteer, which may indicate that an increase in available volunteer positions may be a beneficial. On a positive note, a fair proportion of individuals indicated that they do not experience any barriers.

*Figure 15: Do you currently experience any barriers to working additional hours or securing employment as a peer support specialist?*



*Source: 2016 Nebraska Peer Support Workforce Survey*

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## LOOKING FORWARD

### *Educational Opportunities (n=106)*

Both currently employed and not currently employed survey respondents indicated that they would be interested in more educational opportunities. The results were fairly consistent among opportunities; they are listed below:

*Figure 16: Please select which additional educational opportunities would be beneficial to help you increase the quality of the peer support services you provide.*



*Source: 2016 Nebraska Peer Support Workforce Survey*

## RESPONDENT DEMOGRAPHICS (EMPLOYED PEER SUPPORT WORKFORCE)

The following descriptions and graphs below pertain to individuals who are currently employed as paid or volunteer peer support providers.

### *Behavioral Health Region*

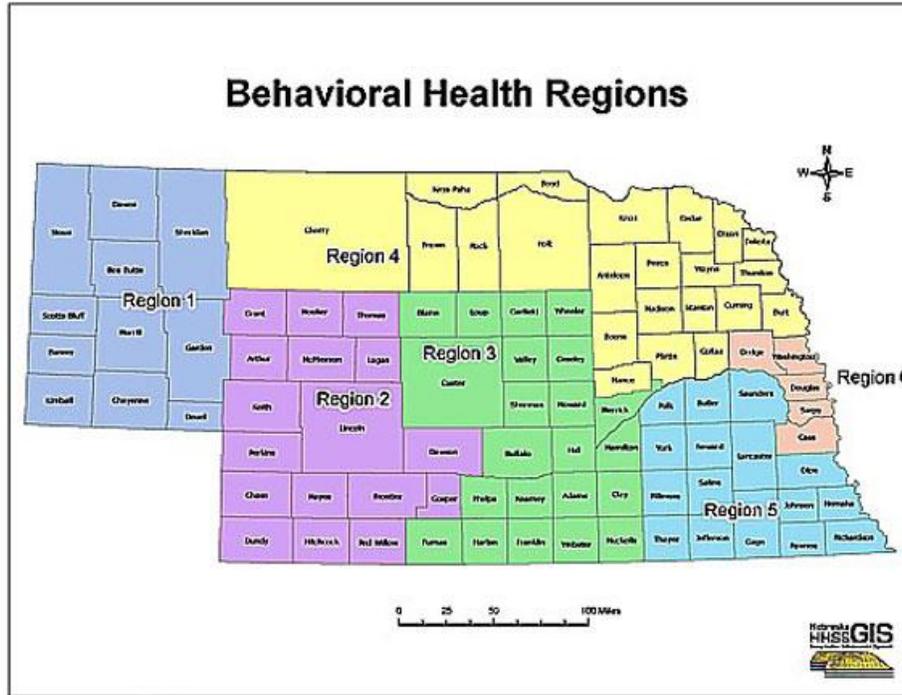


Figure 17: In which Behavioral Health Region do you reside?

Region	Currently Employed/Volunteering (n=71)		All Respondents (n=91)	
	%	n	%	n
1	1%	1	2%	2
2	3%	2	2%	2
3	13%	9	12%	11
4	9%	6	9%	8
5	46%	33	46%	42
6	28%	20	29%	26

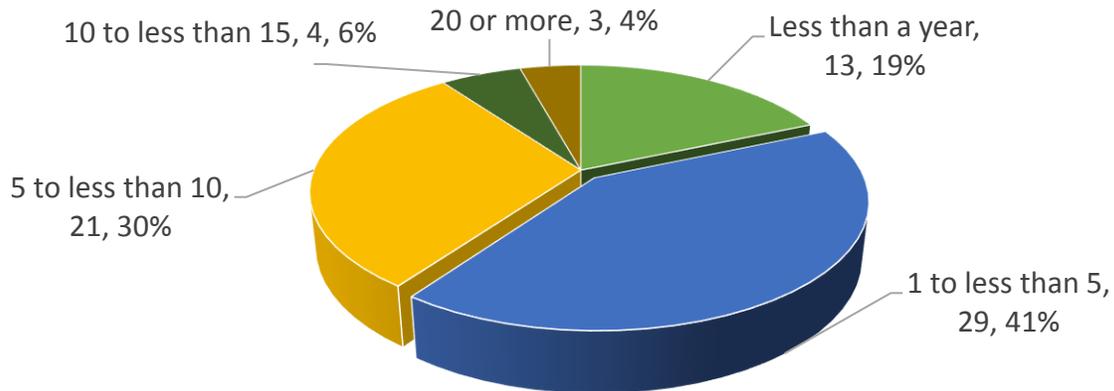
Source: 2016 Nebraska Peer Support Workforce Survey

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### ***Amount of Time in the Field (n=75)***

Respondents were asked how long they have been working in the field of peer support. When removing cases where individuals reported working less than 1 year, the average length reported was 5.3 years. 17% of respondents indicated that they have worked in the field for less than year (n=13).

Figure 18: ***In total***, how many years have you worked or volunteered as a peer support provider?

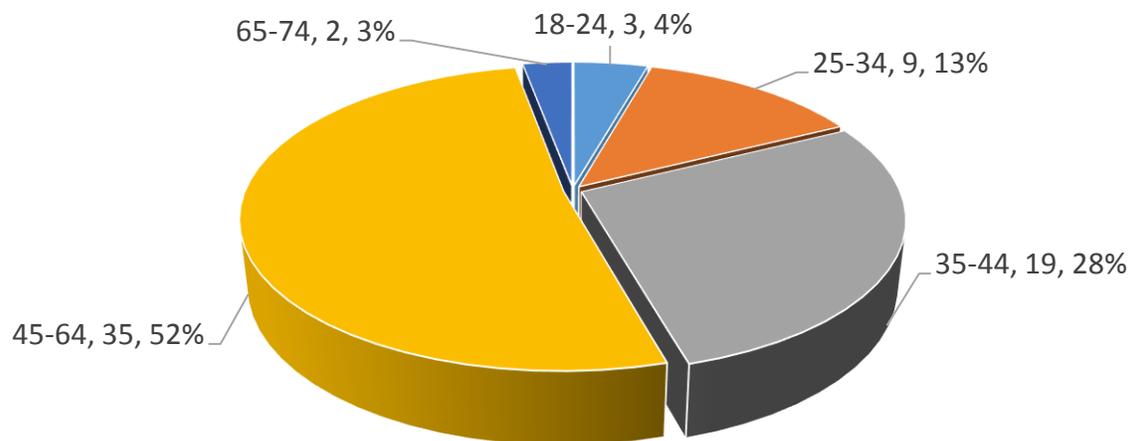


Source: 2016 Nebraska Peer Support Workforce Survey

### ***Age (n=68)***

The average age of employed respondents was 46 years old. Over half of survey respondents were aged 45-64 (52%, n=35) and about a fifth were aged 35-44 (28%, n=19). 13% were aged 25-34 (n=9), 4% were aged 18-24 (n=3) and 3% were aged 65-74 (n=2).

Figure 19: What is your age?



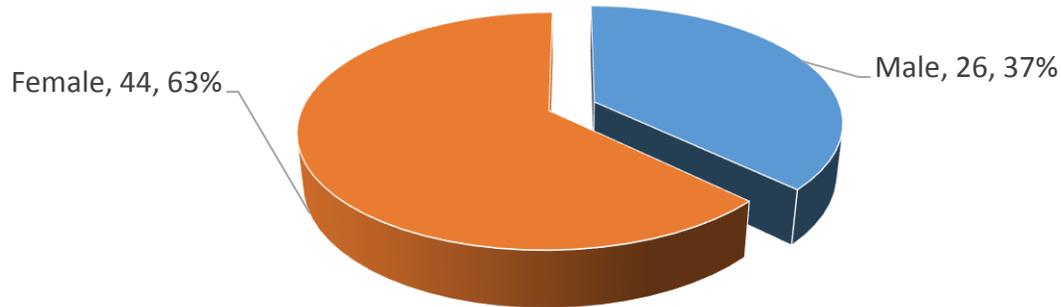
Source: 2016 Nebraska Peer Support Workforce Survey

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**Gender (n =70)**

The majority of employed survey respondents were female (63% n=44). Thirty seven percent, 37%, of survey respondents were male (n=26).

Figure 20: What is your gender?

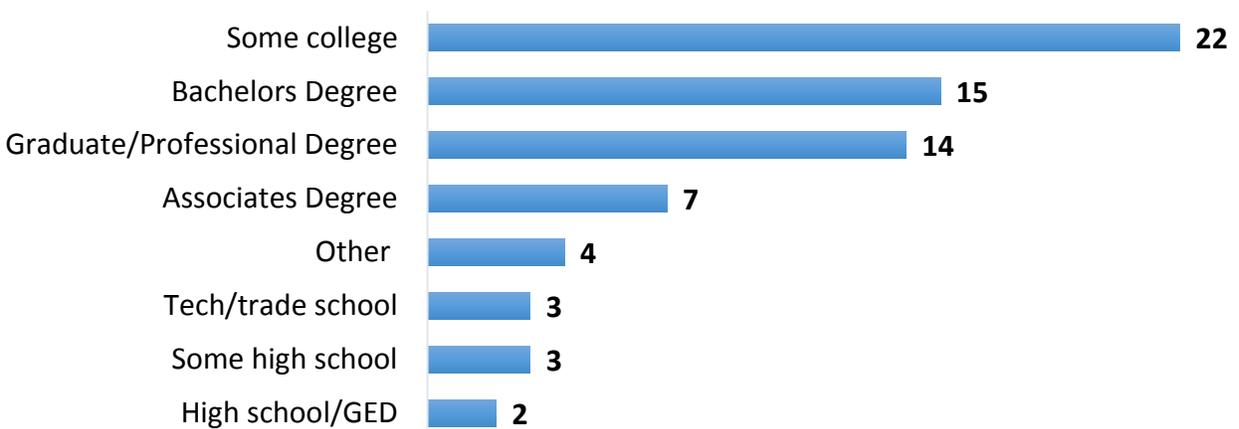


Source: 2016 Nebraska Peer Support Workforce Survey

**Highest Level of Education (n =70)**

Of the employed respondents to the survey, 41% of sample respondents indicated having completed at least an associate's degree. Just over a fifth of respondents responded that their highest level of education was a bachelor's degree (21%, n=15). A fifth responded that their highest level of education was a graduate or professional degree (20%, n=14). 31% of survey respondents responded that their highest level of education was some college (n=22), 3% reported high school (n=2) and 4% reported some high school (n=3).

Figure 21: What is your highest level of formal education?



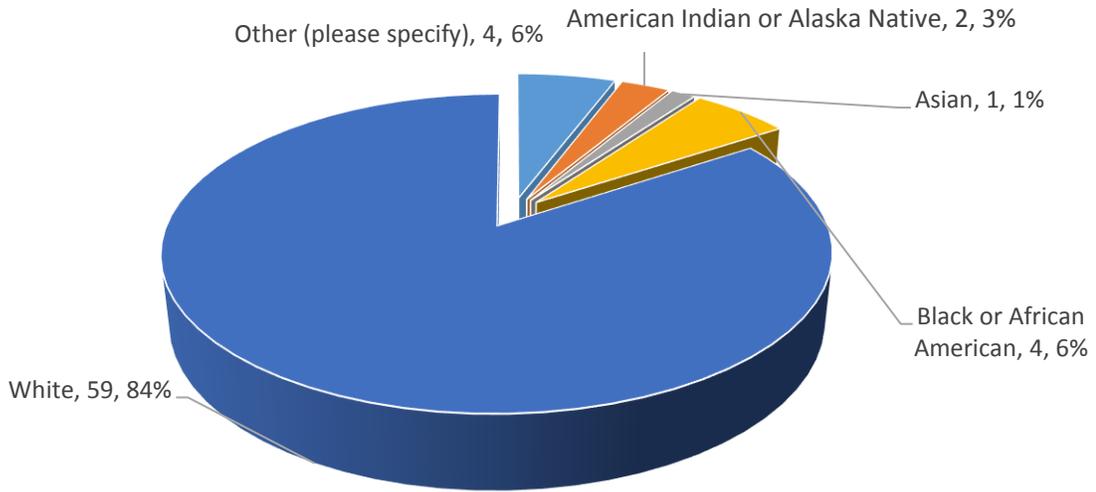
Source: 2016 Nebraska Peer Support Workforce Survey

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**Race/Ethnicity/Hispanic Origin (n =70)**

The vast majority of employed survey respondents identified as white (84%, n=59). 6% of respondents identified as Black or African American (n=4), 3% identified as American Indian or Alaska Native (n=2), 1% identified as Asian (n=1) and 6% identified as other (n=4). When asked about Hispanic origin, about 6% of respondents indicated that they were or Hispanic origin or descent (n=4).

Figure 22: What is your race/ethnicity?

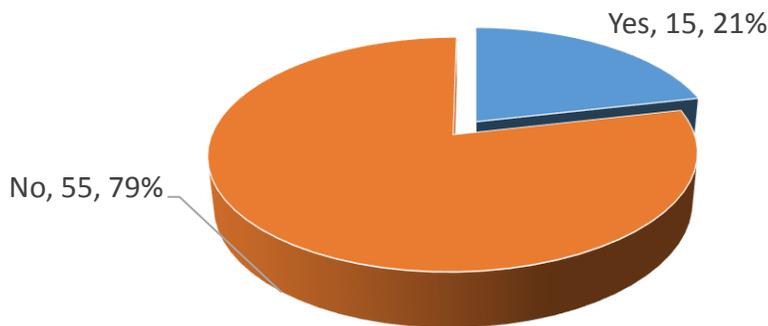


Source: 2016 Nebraska Peer Support Workforce Survey

**Military Service (n =70)**

Just over one-fifth of employed survey respondents have served on active duty in the US Armed Forces or the Armed Forces of another country (21%, n=15).

Figure 23: Have you ever served on active duty in the US Armed Forces or the Armed Forces of another country?



Source: 2016 Nebraska Peer Support Workforce Survey

## COMPARISONS BETWEEN iNAPS AND DBH OCA FINDINGS

Below are comparisons between the 2014 iNAPS U.S. Peer Support Provider Education, Compensation, and Satisfaction Survey and the 2016 Nebraska Peer Support Workforce Survey.

### *Job Characteristics*

Survey	Average hourly wage	Average weekly hours	Average years on the job	Average # peers per week
iNAPS, 2014	\$13.53 (n=288)	32.2 (n=570)	3.8 (n=515)	19.75 (n=523)
DHHS, 2016	\$16.72 (n=52)	34.2 (n=72)	5.2 (n=72)	17 (n=75)

### *Overall Job Satisfaction*

Survey	Very satisfied/mostly satisfied	Neither satisfied nor dissatisfied	Mostly dissatisfied/Very dissatisfied
iNAPS, 2014, n=516	88.6% (n=457)	3.6% (n=19)	7.75% (n=40)
DHHS, 2016 n=70	85.7% (n=60)	13.0% (n=9)	2.9% (n=2)

*Peer Support Providers reported feeling respected by their supervisor and colleagues at work (as an equal member of the team and not a patient or client.)*

Survey	Strongly agree	Somewhat agree (iNAPS – agree)*	Neither Agree nor Disagree	Somewhat disagree (iNAPS-disagree)*	Strongly disagree
iNAPS, 2014, n=512	44.3% (n=226)	35% (n=180)	10.1 (n=52)	7.4% (n=38)	2.8% (n=14)
DHHS, 2016 n=70	64.0% (n=45)	14.0% (n=10)	11.0% (n=8)	7.0% (n=5)	3.0% (n=2)

\*Likert scales did not match up perfectly, iNAPS scale in parentheses.

### *Gender*

Survey	Female	Male	Other
iNAPS, 2014, n=588	64.3% (n=378)	35.2% (n=207)	0.5% (n=3)
DHHS, 2016, n=70	62.9% (n=58.7%)	37.1% (n=26)	0.0% (n=0)

**Age**

Survey	18-24	25-34	35-44	45-64	65+
iNAPS, 2014, n=581	2.2% (n=13)	12.2% (n=71)	19.2% (n=112)	60.8% (n=353)	5.5% (n=32)
DHHS, 2016, n=68	4.4% (n=3)	13.2% (n=9)	27.9% (n=19)	51.5% (n=35)	2.9% (n=2)

**Highest Level of Formal Education**

Survey	Some High School	High School/GED	Tech/Trade School	Some College	Associates	Bachelors	Graduate Degree or Higher
iNAPS, 2014, n=585	0.5% (n=3)	10.3% (n=60)	3.8% (n=22)	30.0% (n=175)	16.1% (n=94)	23.8% (n=139)	10.9% (n=64)
DHHS, 2016, n=70	4.3% (n=3)	2.9% (12.9%)	4.3% (n=3)	31.4% (n=22)	10.0% (n=7)	21.4% (n=15)	20.0% (n=14)*

\*Asked as Graduate Degree/Professional Degree

**Race/Ethnicity\***

Survey	White	Black	Hispanic	Asian	Native American	Pacific Islander
iNAPS, 2014, n=577	75.4% (n=435)	15.4% (n=89)	9.4% (n=54)	0.5% (n=3)	4.5% (n=26)	0% (n=0)

Survey	White	Black/African American	Asian	American Indian or Alaska Native	Native Hawaiian or Other Pacific Islander	Other
DHHS, 2016, n=70	84.3% (n=59)	5.7% (n=4)	1.4% (n=1)	2.9% (n=2)	0% (n=0)	5.7% (n=4)

**Hispanic**

Survey	Yes	No
DHHS, 2016, n=70	5.7% (n=4)	94.3% (n=66)

\*This question was asked differently on each survey. For iNAPS, the Hispanic category was combined into the Race question. For the DHHS survey, Hispanic ethnicity was asked as a separate question.

**I have served in the military.**

Survey	Yes	No
iNAPS 2014, n=587	17.2% (n=101)	82.8% (n=486)
DHHS, 2016, n=70	21.4% (n=15)	78.6% (n=55)

The following descriptions and graphs below pertain to all respondents, n=106.

**Barriers**

Survey	Against Medical Advice	Benefit Loss	Past Issues	Stigma and Discrimination	Lack on the job experience
iNAPS, 2014, n=153	22.2% (n=34)	60.1% (n=92)	5.8% (n=9)	8.5% (n=13)	7.2% (n=11)
DHHS, 2016, n = 106	-	3.8% (n=4)	16.0% (n=17) †	6.6% (n=7)	5.7% (n=6)

† Asked as “Personal issues”

- Was not asked

Survey	Need more education	There are no paid/full-time positions	Enjoy working part-time	Volunteering is rewarding	I do not experience any barriers
iNAPS, 2014, n=153	8.5% (n=13)	47.7% (n=73)	41.8% (n=64)	15.7% (n=24)	-
DHHS, 2016, n = 106	3.8% (n=4)	10.4% (n=11)	15.1% (n=16) †	5.7% (n=6)*	37.7% (n=40)

† Asked as “I do not wish to work more hours”

\*Asked as “I wish only to volunteer”

- Was not asked

Survey	Lack Formal Credential	Trying it before making a commitment	Planning to move out of this field	Low Wages
iNAPS, 2014, n=153	9.8% (n=15)	9.1% (n=14)	2.6% (n=4)	-
DHHS, 2016, n = 106	5.7% (n=6)	-	-	12.3% (n=13)

- Was not asked

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## **Participant comments**

- ✚ “I found the 40-hour training to become a Certified Peer Support and Wellness Specialist to be very thorough and informative. The presenters were outstanding, the group interaction and "projects" taught us a lot, and I made some great friends! I've also really appreciated the continuing ed opportunities and excellent communication that peers receive through the state peer conference.”
- ✚ “I currently have a non-profit that works with ex-offenders and want to move peer support with that population what we have is peer support mentoring and my peer support skills will be very useful working with this population.”
- ✚ “I have experienced various childhood, and adolescent traumas, as well as struggling with mental illness issues as far back as junior high school. I have been in and out of psychiatric hospitals over the course of my life, including outpatient care. But, since becoming a peer support specialist..... I have experienced healing in so many ways. Becoming a certified peer support and wellness specialist has given meaning to all my experiences of mental illness and trauma. I live a truly happy life. God has blessed me in so many ways.”
- ✚ “I believe Peer Support is a fantastic service to others that impacts the consumer and the peer. If done correctly, efficiently, and supported by others in the treatment process will prevent hospitalizations that are not necessary. In order to have this credible we need to have a more organized peer support program that will bring respect and credibility to the whole program. Let's work toward identify the foundation of peer support and making strides toward that.”
- ✚ “A majority of people working in this organization and other organizations providing similar services all deserve more praise as well as financial support. This job is rewarding but it also takes its toll the workers. The turnover rate is high. It's difficult to predict the solution to reducing turnover, but making the effort visible to the workers of an agency should be imperative.”
- ✚ “The Trauma Informed Care culture and trauma treatment that is building as a result of the TIC efforts have had an amazing paradigm. Promoting more of focusing on helping the person understand and put their story to rest, reconcile it or resolve a past that has such a grip on them can continue to grow as peers have relief from targeted treatments, like EMDR, that focus on the source of the struggle instead of battling symptoms while maintaining illness. There has been great progress made it taking the focus off of what is wrong with me and more focus on what has happened to me or what have I experienced that has led up to my past having such a grip on me and dictating my behavior and worldview. I can see movement in myself and the peers I work with in moving from a fear based worldview to one of true deep felt HOPE! I have heard and been told, by providers, not trained in how to work with the sub-conscious, like EMDR, that this trauma thing will be a passing fad, but I do not think it will as people are moving into healing and word of mouth from peers will help build the courage to venture into those dark buried places of our souls. The workforce is increasing in knowledge and skills of working from this mind body approach and I would encourage us to continue to build this capacity for peers to be educated and intrigued while providers continue to educate and receive certification in body mind centered treatments. Thank you for all you do at the OCA.”

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## **Special Acknowledgements**

The iNAPS used an agency version of the survey, which was adapted from a statewide survey of New Jersey peer/consumer providers developed by Peggy Swarbrick of the Collaborative Support Programs of New Jersey (CSPNJ) Wellness Institute for the Mental Health Association in New Jersey (MHANJ) and CSPNJ. For copies of the original survey contact: [pswarbrick@cspnj.org](mailto:pswarbrick@cspnj.org) . To view the results, visit: New Jersey Statewide Provider Agency Survey Results

In addition, the 2014 surveys conducted by iNAPS were approved by the iNAPS Board of Directors: Andy Bernstein, Anthony Stratford, Lisa Goodale, Diann Schutter, Dwayne Mayes, Gladys Christian, Gayle Bluebird, Lisa St. George, Matthew Federici, Mike Roaleen, Mike Weaver, Peter Ashenden, and Kasey Moyer. We also thank Larry Davidson of Yale University, Andy Bernstein of University of Arizona (UA) Camp Wellness, Matthew Federici of the Copeland Center for Wellness and Recovery, Lisa Goodale of the Depression Bipolar Support Alliance, Lori Ashcraft of Recovery Opportunity Center, and Rita Cronis of iNAPS and Rutgers University for contributions during the development and review of this survey. ([https://na4ps.files.wordpress.com/2014/07/2007-2014\\_comparisonreport1.pdf](https://na4ps.files.wordpress.com/2014/07/2007-2014_comparisonreport1.pdf))

The Nebraska Office of Consumer Affairs would like to acknowledge the work of iNAPS and their partners in conducting a national survey to assess to the peer support workforce. In addition, the Nebraska peer support workforce continues to go above and beyond. Their involvement in meaningful initiatives to move the system forward is evident through the survey response compared nationally. The national survey conducted in 2014 collected 605 responses from 43 states between July and October 2014. The Nebraska survey collected 106 responses between December 2015 and January 2016.

Thank you to community partners, peers, youth advocates, family advocates, and others who helped spread the work of the importance of this survey. Special thanks to Speak out, Families Care, Parent to Parent, Families Inspiring Families, Healthy Families Project, Nebraska Family Support Network, the Regional Behavioral Health Authorities, Mental Health Association of NE, NAMI-NE, Partners in Recovery, Women's Center for Advancement, Peer Run organizations in Nebraska, the Veterans Administration, Nebraska Children and Families Foundation, OCA People's Council, and the Mental Health and Substance Abuse Advisory Committees

Lastly, a special acknowledgment to Mazen Sarwar for his leadership in this project. Mazen served as the lead data analyst and author of the data narrative. Additional DBH analysts that supported this project were as follows.

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Department of Health & Human Services



December 2015

Dear Peer Support Providers,

The DHHS Division of Behavioral Health Office of Consumer Affairs is interested in learning more about the current workforce environment for employed/volunteer peer support providers, those who have worked in the past as a peer support provider, and those who are currently seeking a position as a peer support provider. For purposes of this survey, peer support providers are inclusive of those who serve children, family, youth, adults, or veterans in the State of Nebraska while utilizing their personal lived experience with a behavioral health condition and/or trauma to support others.

As peer support continues to grow all across Nebraska, it is important to collect meaningful data that can support the field as it moves forward. We would like your assistance in gathering Nebraska specific workforce data as it relates to some of the following areas: training, hours worked per week, number of people you support, job satisfaction, service provision, organization type, demographics, and more.

This survey should take approximately ten minutes to complete. As a valued partner to the work we do, your participation in this survey is highly encouraged!

Please complete the survey by **January 15, 2016**. Your responses will remain confidential and no personal information will be identified. Please feel free to reach out to me if you have any questions about this survey request.

Thank you for your courage to serve and commitment to helping people live better lives.

Sincerely,

Cynthia Harris, M.S., CPSWS  
Nebraska Department of Health and Human Services  
Division of Behavioral Health  
Network Operations Cross Systems Specialist &  
Interim Manager of Office of Consumer Affairs  
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1. Have you received 40 hours of specialized peer support training?

- Yes
- No, but I plan to pursue this training in the future
- No and I do not wish to pursue specialized training at this time

2. Did you obtain any of the following certifications? Please select all that apply.

- Certified peer support and wellness specialist (CPSWS) through the NE Office of Consumer Affairs
- Certification for Parent Support Providers (CPSP®) through the National Federation of Families
- No, but I plan to obtain certification in the future.
- I have not received any certifications.
- Other (please specify)



\* 3. As a peer support provider, are you currently...

- Employed in a paid position
- Employed in a volunteer position (for the purpose of this survey, please consider a volunteer position as a position where you are NOT paid for your services)
- Not currently employed in an unpaid volunteer position or paid position, but I have worked as a peer support provider in the past.
- Not currently employed in an unpaid volunteer position or paid position, but I am currently seeking a position as a peer support provider.
- I have never volunteered or been employed as a peer support provider.



\* 4. Do you currently experience any barriers to working additional hours or securing employment as a peer support specialist?

- Personal concerns
- Benefit loss
- Stigma/Discrimination
- Lack of on the job experience
- Lack formal credential/certification
- Low wages
- Need more education
- Planning to move out of this field
- There are not any full-time positions available
- I wish to only volunteer
- I do not wish to work more hours
- I do not experience any barriers.

5. Within your current volunteer/paid position as a peer support provider, how many years have you been with the organization? If less than a year, please enter "Less than a year."

6. How long do you expect to remain in your current volunteer/paid position?

- Indefinitely
- At least 3 years
- For another year
- Until something else comes along
- Other (please specify)

7. Within your current volunteer/paid position as a peer support provider, what is your **primary** role? Please select one.

- Direct Service Provider
- Program Manager
- Agency Director
- Administrative Support
- Education/Training Provider
- Systems Transformation Advocate
- Other (please specify)

8. What is your current title?

9. What is your hourly wage in dollars?

10. Within your current volunteer/paid position as a peer support provider, on average, how many hours per week do you work?

11. Within your current volunteer/paid position as a peer support provider, on average, how many people do you support per week?

12. Within your current volunteer/paid position as a peer support provider, what type of support services do you provide? Please select all that apply. (If needed, definitions are below).

- Advocacy
- Mentoring
- Support Groups
- Crisis Intervention
- Recovery Support
- Supportive Services
- Health/Behavioral Health Education
- Other (please specify)

**Definitions:**

Advocacy: A peer empowering a peer/family to learn self and system advocacy.

Mentoring: A peer to peer/family in a supportive relationship to improve self-help skills.

Support Groups: A group of peers/families in a supportive meeting environment.

Crisis Intervention: A peer providing timely support to a peer/family to help stabilize, reduce risk of system involvement and promote resiliency such as loss teams, family navigators, warmlines, crisis response teams, etc...

Recovery Support: A peer supporting a peer/family to promote resiliency, relapse prevention support plus long term safety and wellbeing; such as Clubhouse, WRAP, respite, transition planning, etc...

Supportive Services: A peer supporting a peer/family to connect to community resources that support recovery and whole health; such as accessing benefits, housing, job training, etc...

Health/Behavioral Health Education: A peer empowering a peer/family with education that supports healthy living; such as parenting courses, smoke-free living, etc...

Other Supports: Aid that benefits peers such as transportation or case management but also provided by a peer.

13. Do you currently experience any barriers that prevent you from working more hours as a peer support provider? Please select all that apply.

- Personal concerns
- Benefit loss
- Stigma/Discrimination
- Lack of on the job experience
- Lack formal credential/certification
- Low wages
- Need more education
- Planning to move out of this field
- There are not any full-time positions available
- I wish to only volunteer
- I do not wish to work more hours
- I do not experience any barriers.

14. Within your current volunteer/paid position as a peer support provider, which **best describes** the type of organization you work for?

- Peer Run organization
- Non-Profit
- For-Profit
- Local/State Government agency
- Federal Government agency
- Independent Contractor
- Law Enforcement
- Hospital
- Faith-based organization
- Other (please specify)

15. Within your current volunteer/paid position as a peer support provider, how would you rate your job satisfaction?

- Very Satisfied
- Mostly Satisfied
- Neither Satisfied nor Dissatisfied
- Mostly Dissatisfied
- Very Dissatisfied

16. What is your **primary** motivation for working as a peer support provider?

- Financial gain
- Impacting my community
- Being able to use my lived experience to support others
- Having something to do
- Helping with my own recovery
- General interest in the job
- Other (please specify)

17. How much do you agree or disagree with the following statement: I am respected by my supervisor and colleagues when I am working as a peer support provider.

- Strongly Agree
- Somewhat Agree
- Neither Agree nor Disagree
- Somewhat Disagree
- Strongly Disagree

18. How much do you agree or disagree with the following statement: I am treated as an equal member of the team when I am working as a peer support provider.

- Strongly Agree
- Somewhat Agree
- Neither Agree nor Disagree
- Somewhat Disagree
- Strongly Disagree

19. Lastly, we have some demographic questions.

In which behavioral region to you reside?

- Region 1
- Region 2
- Region 3
- Region 4
- Region 5
- Region 6

20. **In total**, how many years have you worked or volunteered as a peer support provider? If less than a year, please enter "Less than a year."

21. What is your age?

22. What is your gender?

- Male
- Female
- Other

23. What is your highest level of formal education?

- Some high school
- High school/GED
- Some college
- Tech/trade school
- Associates Degree
- Bachelors Degree
- Graduate/Professional Degree
- Other (please specify)

24. Are you of Hispanic origin or descent?

- Yes
- No

25. What is your race/ethnicity?

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Other (please specify)

26. Have you ever served on active duty in the US Armed Forces or the Armed Forces of another country?

- Yes
- No

27. Please select which additional educational opportunities would be beneficial to help you increase the quality of the peer support services that you provide.

- Wellness and Recovery Action Planning
- Prevention Education
- Public Speaking/Giving Effective Testimony
- Crisis Support
- Peer Rights
- Personal and Professional Development
- Boundaries and Ethics
- Behavioral Health Promotion
- Trauma Informed Care
- Cultural Sensitivity Training
- System Navigation and Accessing Benefits
- Building Capacity of Peer Organizations
- Other (please specify)

28. Please use this box to provide any feedback, comments, or concerns. Thank you for completing this survey!

# Peer Support Services Survey

Division of Behavioral Health

April 2014

# Peer support survey

- ❖ Purpose: To learn more about what Peer Support Services may exist in Nebraska, what opportunities and barriers may exist to providing them and perspectives about the ongoing development and growth of peer support.
- ❖ Method: Survey Monkey online survey tool
- ❖ Distribution: Sent via email invitation and posted to DHHS website
- ❖ Target Audience: Consumers/Stakeholders, Behavioral Health Providers and Peer Support Providers
- ❖ Total Participation:
  - ❖ Consumer/Stakeholder Survey – 25
  - ❖ Behavioral Health Provider/Peer Support Provider - 137

# Disclaimers

- ❖ This is a preliminary preview of the survey data.
- ❖ This presentation includes ONLY Provider response data, not Consumer/Stakeholder response data.
- ❖ Numbers (and Percentages) represent the number of survey respondents, not the number of agencies.
- ❖ Limited understanding of peer support services may have resulted in variance in responses.
- ❖ Most respondents indicated also providing peer support services, which may suggest bias in interest and support.

Total Provider Survey response rate =137

Region	Peer Agency	BH Agency
1	1	5
2	3	1
3	6	13
4	6	9
5	25	13
6	19	36
<b>Sub-Total:</b>	60	77
<b>Total:</b>	<b>137</b>	

# Provider (BH and Peer) demographics

Population Served	Peer Agency*	BH Agency*
Mental Health	51	63
Substance Abuse	38	50
Co-Occurring Disorders	48	64
Adults (19+)	49	68
Children (0-18)	22	21
Adolescents (19-24)	24	28
Families with Children	38	29

*\* Total number of survey respondents for each response choice*

# Questions about barriers or incentives for the capacity to provide peer support services

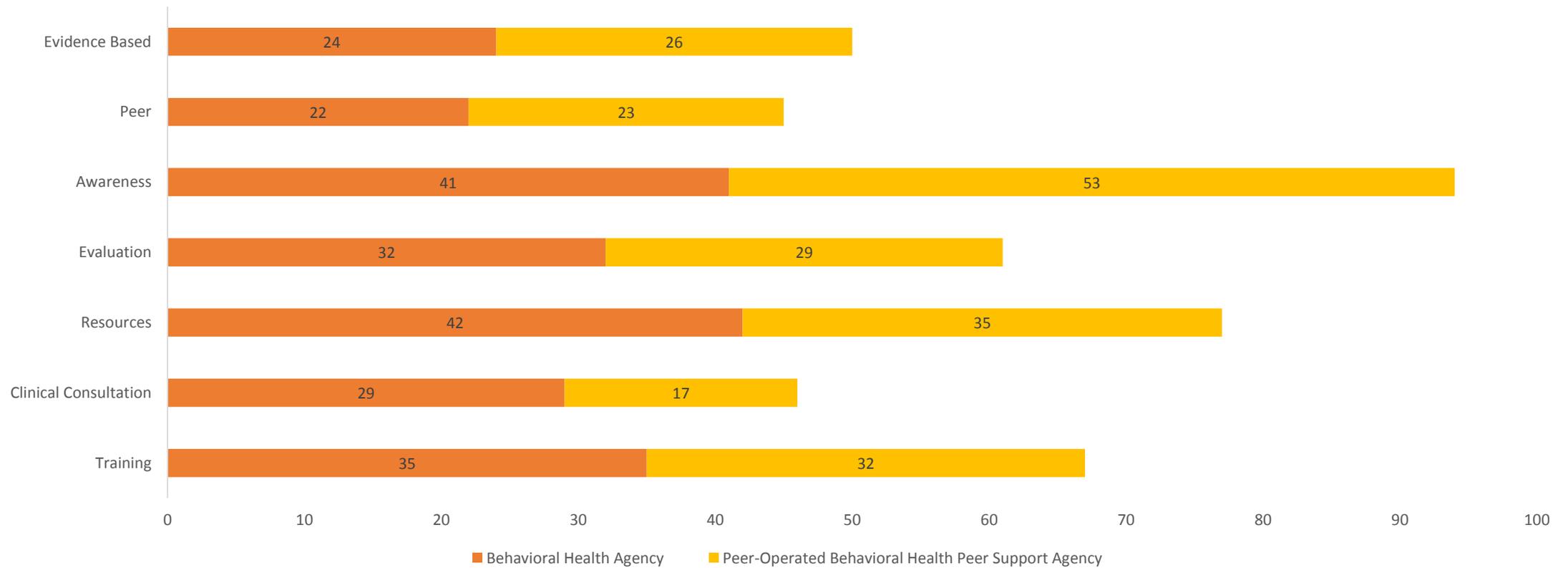
- Question: Please indicate what barriers or challenges might agencies encounter related to providing peer support services. Please choose all that apply:
- Question: Please indicate what resources or incentives might you suggest as potentially beneficial to increase the capacity of agencies to provide peer support services. Please choose all that apply:
  - *Response options (check all that apply) were broadly defined categories of peer support services.*

# Barriers or challenges to providing peer support services

Category	Barrier/Challenge Definition
Evidence-Based	Lack of capacity to implement evidence based peer support programs
Peer	Limited availability of certified and/or sufficiently trained peer support specialists
Awareness	Lack of awareness among behavioral health providers to integrate peer support services in the behavioral health system
Evaluation	Non-availability of resources to ensure program evaluation and quality improvement activities for peer support services
Resources	Non-availability of resources to hire qualified peer support specialists
Clinical Consultation	Cost of providing clinical consultation for peer support specialists
Training	Limited availability of training and ongoing education for peer support specialists

# What barriers/challenges might agencies encounter in providing peer support services?

Barriers related to providing Peer Support Services

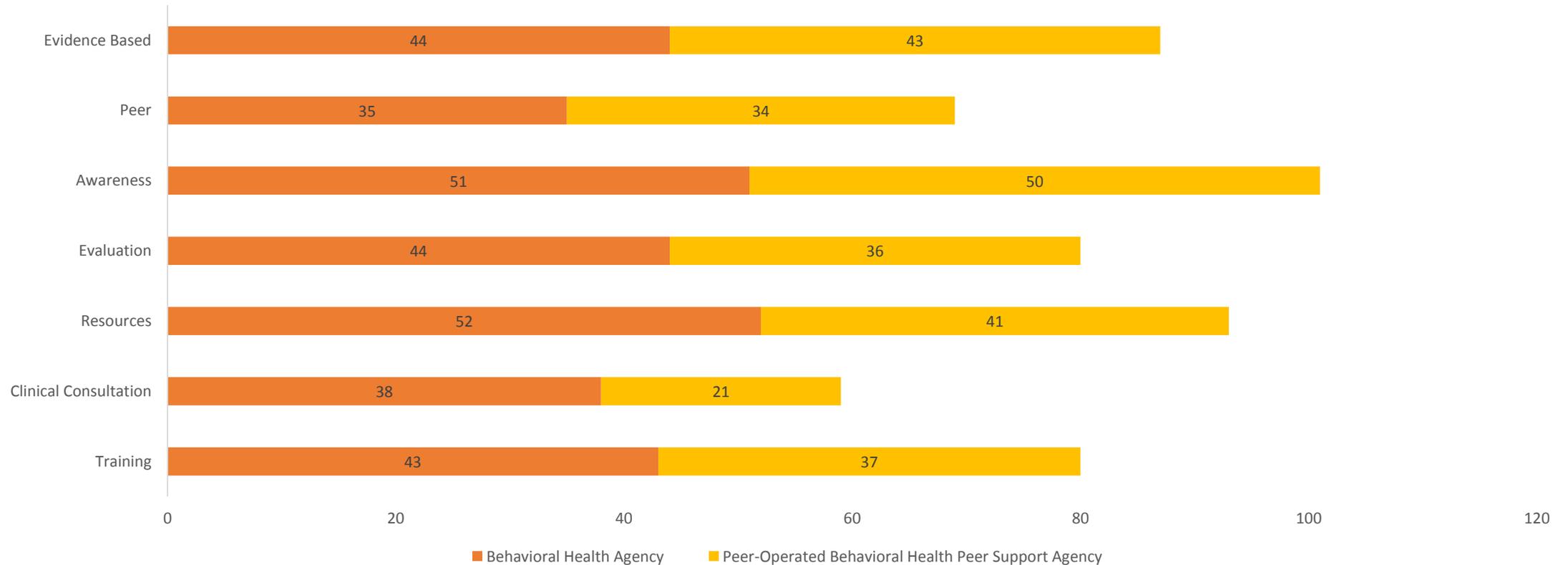


# Resources or incentives to providing peer support services

Category	Resources/Incentives Definition
Evidence-Based	Providing resources to implement evidence based peer support programs
Peer	Increasing the availability of certified and/or sufficiently trained peer support specialists
Awareness	Providing education to behavioral health providers to integrate peer support services in the behavioral health system
Evaluation	Providing resources to ensure program evaluation and quality improvement activities for peer support services
Resources	Providing resources for employment of qualified peer support specialists
Clinical Consultation	Providing resources for clinical consultation for peer support specialists
Training	Increase access to training and ongoing education for peer support specialists

# What resources or incentives might benefit the capacity to provide peer support services?

Incentives that could be potentially beneficial to providing Peer Support Services



# Questions about peer support specialist training and credentialing

**Do you believe that Peer Support Specialists should have some type of training prior to providing peer support services?**

	Response #	Percent
Yes	120	97.6%
No	1	.8%
Don't Know	2	1.6%
<b>Total:</b>	<b>123</b>	<b>100%</b>

**Do you believe that Peer Support Specialists should earn a certificate through a training entity prior to providing peer support services?**

	Response #	Percent
Yes	90	73.2%
No	22	17.9%
Don't Know	11	8.9%
<b>Total:</b>	<b>123</b>	<b>100%</b>

# Questions about peer support specialist training and credentialing

**Do you believe that Peer Support Specialists should be credentialed professionals, recognized and regulated by the State?**

	Response #	Percent
Yes	60	48.8%
No	39	31.7%
Don't Know	24	19.5%
<b>Total:</b>	<b>123</b>	<b>100</b>

**If a formal, regulated credential existed in Nebraska, would you employ a credentialed Peer Support Specialist?**

	Response #	Percent
Yes	81	65.9
No	7	5.7
Don't Know	35	28.5
<b>Total:</b>	<b>123</b>	<b>100</b>

# Administrative information about providing peer support services

Does your agency provide peer support services through a subcontract with an external agency to provide the services directly?

	Response #	Percent
Yes	31	25.8%
No	89	74.2%
<b>Total:</b>	<b>120</b>	<b>100%</b>

Does your agency provide peer support services through paid, employed staff?

	Response #	Percent
Yes	107	89.2%
No	13	10.8%
<b>Total:</b>	<b>120</b>	<b>100%</b>

# 108 respondents said their agency provides peer support services

Category	Definition
<b>Advocacy:</b>	A peer empowering a peer/family to learn self and system advocacy.
<b>Mentoring:</b>	A peer to peer/family in a supportive relationship to improve self-help skills.
<b>Support Groups:</b>	A group of peers/families in a supportive meeting environment.
<b>Crisis Intervention:</b>	A peer providing timely support to a peer/family to help stabilize, reduce risk of system involvement and promote resiliency such as loss teams, family navigators, warmlines, crisis response teams, etc...
<b>Recovery Support:</b>	A peer supporting a peer/family to promote resiliency, relapse prevention support plus long term safety and well being; such as Clubhouse, WRAP, respite, transition planning, etc...
<b>Supportive Services:</b>	A peer supporting a peer/family to connect to community resources that support recovery and whole health; such as accessing benefits, housing, job training, etc...
<b>Health/Behavioral Health Education:</b>	A peer empowering a peer/family with education that supports healthy living; such as parenting courses, smoke-free living, etc...
<b>Other Supports:</b>	Aid that benefits peers such as transportation or case management but also provided by a peer.

# Types of peer support services provided

Peer Support Service Category	BH Agency*	Peer Agency*	Category Total*:
Advocacy	53	51	<b>104</b>
Mentoring	49	47	<b>96</b>
Support Groups	40	47	<b>87</b>
Crisis Intervention	41	39	<b>80</b>
Recovery Support	51	45	<b>96</b>
Health/Behavioral Health Education	35	37	<b>72</b>
Other Supports	36	26	<b>62</b>

*\* Total number of survey respondents for each response choice*

# Administrative information about providing peer support services

Does your agency provide continuing education opportunities for Peer Support Specialist staff?

	Response #	Percent
Yes	92	76.7%
No	28	23.3%
<b>Total:</b>	<b>120</b>	<b>100%</b>

Does your agency provide clinical consultation for Peer Support Specialists to utilize, related to providing peer support services?

	Response #	Percent
Yes	67	55.8%
No	53	44.2%
<b>Total:</b>	<b>120</b>	<b>100%</b>

# Administrative information about providing peer support services

## Are Peer Support Specialists on staff paid via an hourly rate?

	Response #	Percent
Yes	91	85%
No	16	15%
<b>Total:</b>	<b>120</b>	<b>100%</b>

## Are Peer Support Specialists on staff paid an annual salary?

	Response #	Percent
Yes	37	34.6%
No	70	65.4%
<b>Total:</b>	<b>120</b>	<b>100%</b>

# Administrative information about providing peer support services

Does your agency provide Peer Support Specialists on staff with the same level of employment fringe benefits as other staff?

	Response #	Percent
Yes	96	80%
No	24	20%
<b>Total:</b>	<b>120</b>	<b>100%</b>

Does your agency utilize volunteers to provide peer support services?

	Response #	Percent
Yes	40	33.3%
No	80	66.7%
<b>Total:</b>	<b>120</b>	<b>100%</b>

# A few key highlights

- Top 3 identified barriers to providing peer support services:
  1. Lack of awareness among behavioral health providers to integrate peer support services in the behavioral health system
  2. Non-availability of resources to hire qualified Peer Support Specialists
  3. Limited availability of training and ongoing education for Peer Support Specialists
  
- Top 3 identified incentives to providing peer support services:
  1. Providing education to behavioral health providers to integrate peer support services in the behavioral health system
  2. Providing resources for employment of Peer Support Specialists
  3. Providing resources to implement evidence based peer support programs

# A few key highlights

- ❖ Overwhelming agreement that Peer Support Specialists should have some training prior to providing peer support services, and strong support for an earned certification.
- ❖ Mixed response on credentialing but strong support for hiring credentialed Peer Support Specialists.
- ❖ Most respondents indicated providing initial and ongoing training to Peer Support Specialists to equip staff to perform peer support services.

# Real Improvements Sustainable Progress Better Lives For Nebraskans

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A DHHS BUSINESS PLAN

*"Helping People Live Better Lives"*

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COURTNEY N. PHILLIPS, CEO

“Helping people live better lives.” Those five words guide the work of our DHHS team every day along with the attributes outlined in our values and core competencies. All Nebraskans can expect a commitment to excellence, integrity, fiscal responsibility, positivity, professionalism, transparency and accountability.

These behaviors and attitudes are the foundation of our can-do culture that is transforming DHHS. We’ve already seen significant advances in providing Nebraskans with the responsive, high-quality and efficient services they deserve.

I’m pleased to present the Department’s first business plan. The business plan will serve as a road map through June 2017. It outlines 25 agency priorities and goals. The plan follows the lead and support of Governor Pete Ricketts to improve the performance of state government through strategic actions and measurable outcomes.

As we move forward, we’ll share our successes and look for opportunities as we face our challenges.

We’re making great strides and I’m proud of the DHHS team. We’re here because we believe in what we do and we’re dedicated to helping Nebraskans live better lives.

A handwritten signature in black ink, appearing to read "Courtney N. Phillips", with a long horizontal line extending to the right.

## Executive Summary

History shows Nebraska has been caring for its citizens even prior to achieving statehood in 1867. Over time, state government has changed but our commitment to the people we serve remains steadfast.

The Nebraska Department of Health and Human Services touches the lives of Nebraskans every day, and when people interact with the Department, the goal is to make the experience a positive one.

Our team has worked diligently to improve our responsiveness and service to our state's most vulnerable citizens.

Governor Pete Ricketts assembled a dynamic team of DHHS directors who share their experience and insight to move the Department forward and continue to develop high-quality, efficient, and customer-friendly services to help Nebraskans live better lives.

Governor Ricketts has identified five priorities for his administration and this business plan strategically aligns DHHS with them. The Governor's priorities are:

- ▶ A more efficient and effective state government
- ▶ A more customer-focused state government
- ▶ Grow Nebraska
- ▶ Improve public safety
- ▶ Reduce regulation and regulatory complexity



This business plan will guide the current and future work of the Department through June 2017. Its focus is to outline DHHS priorities, define goals, and chart progress as we continue our efforts to improve services and effectively manage resources.

The plan will also ensure a new level of transparency and accountability for the benefit of taxpayers.

The Department has identified 25 priorities that will result in real improvements, sustain current progress, and help Nebraskans live better lives. They are grouped under five categories that span the work of the Department:

- ▶ Integrating Services and Partnerships
- ▶ Promoting Independence through Community-Based Services
- ▶ Focusing on Prevention to Change Lives
- ▶ Leveraging Technology to Increase Effectiveness
- ▶ Increasing Operating Efficiencies and Improvements

### Integrating Services and Partnerships

Integrating services across our Department into a more effective, efficient, comprehensive, and coordinated system helps state government, through the Department, deliver better outcomes to the people we serve with greater value for taxpayers. Working across divisions, disciplines, and programs, together with our partners, simplifies processes for consumers, increases quality of care and is more efficient and effective.

There are four DHHS priorities in this category:

- ▶ Heritage Health (Medicaid Managed Care)
- ▶ Behavioral Health System of Care for Children, Youth and Families
- ▶ Family-Focused Case Management in Economic Assistance
- ▶ Cross-Division Solutions Team

### Promoting Independence through Community-Based Services

DHHS continues its work to ensure people are being served in supportive and safe environments, including within their own communities. In recent years, state-implemented reforms have transformed its service delivery system for people and greatly expanded and enhanced community capacity, and minimized reliance on institutional services.

Community-based services that are built on the needs of our varied customers provide needed support to help them maintain independence and flourish in their respective communities. Engaging with

stakeholders through a focus on customer service will guide our work.

There are four priorities in this category:

- ▶ Developmental Disabilities Home and Community-Based Waivers, and Community-Based Transition Plan
- ▶ Developmental Disabilities Registry of Unmet Needs
- ▶ Long-Term Services and Supports (LTSS) Redesign Project
- ▶ Increasing Access to Evidence-Based Community Treatment Services for At-Risk Youth

### **Focusing on Prevention to Change Lives**

Prevention is key to a healthy life and longevity. Prevention can take many forms, whether it is preventing disease or providing support to families and improving public safety to prevent child abuse or neglect. DHHS is investing in healthy behaviors and growing Nebraska by working with Nebraskans to achieve lifelong success and potentially save lives.

There are three priorities in this category:

- ▶ Prescription Drug Overdose Prevention and Prescription Drug Monitoring Program
- ▶ Expansion of Alternative Response
- ▶ Reduction in Out-of-Home Placement of State Wards by Safely Expediting Reunifications

### **Leveraging Technology to Increase Effectiveness**

Technology is a valuable tool and resource in state government. Different electronic systems streamline and automate processes, provide real-time data, and make DHHS information and many of the services the agency offers more accessible, timely, and customer focused. The landscape of how we move, receive and exchange information is constantly changing and DHHS must keep pace. It is critical that different kinds of data work together effectively across the board to produce real results. DHHS is looking toward the future of how our data systems will change and what can be done now to put new technology in place that will serve Nebraskans well today, tomorrow and in the years to come.

There are seven priorities in this category:

- ▶ Improve Utilization of THERAP
- ▶ Developmental Disabilities Eligibility Determinations
- ▶ Medicaid Client Eligibility and Enrollment Solution
- ▶ Medicaid Management Information System Replacement Project
- ▶ Veterans' Homes Electronic Health Record and Pharmacy Management Software
- ▶ Behavioral Health Centralized Data System
- ▶ Enterprise Technology Delivery

### **Increasing Operating Efficiencies and Improvements**

The existence of a solid Department foundation is a determinant of future success. A focus on additional improvements, efficiencies, and reduction in regulatory complexities will strengthen the agency's culture, enhance quality and performance, and help make the agency even better positioned to serve Nebraskans.

There are seven priorities in this category:

- ▶ Public Health Accreditation
- ▶ LPN/RN Licensure Application Improvements
- ▶ Central Nebraska Veterans' Home
- ▶ Employee Recruitment and Retention
- ▶ Improve Flow and Decrease Wait List at Lincoln Regional Center
- ▶ Maintain and Improve ACCESSNebraska Performance for Economic Assistance Programs
- ▶ Single Audit Corrective Action Plans

DHHS will work toward and show progress on these 25 priority initiatives. Nebraskans can be proud of the improvements made by the DHHS team so far, and can be confident that this Agency continues its commitment to helping people live better lives.

## Introduction

This business plan will guide the current and future work of the Department of Health and Human Services through June 2017. The focus is on real improvements and sustainable progress, resulting in better lives for Nebraskans. While this does not represent the full work of the Department, its purpose is to present the Department's top priorities as they appear today, aware that others may emerge as we move forward. This plan outlines 25 priority initiatives, defines goals, and charts progress as we continue our efforts to improve services and effectively manage resources.



## DHHS Overview

### Organizational Review

The Department of Health and Human Services provides important and oftentimes life-sustaining services to Nebraskans. Our mission, *"Helping people live better lives,"* provides the motivation to effectively provide these services and make a difference in the lives of hundreds of thousands of people.

DHHS is Nebraska's largest state agency, responsible for nearly one-third of state government in terms of employees and budget.

Agency-wide values guide employees in achieving this mission and effectively implementing the state- and federally-mandated programs and services that

assist Nebraskans. These values include: constant commitment to excellence, high personal standard of integrity, positive and constructive attitude and actions, openness to new learning, and dedication to the success of others.

### Leadership and Management

The Chief Executive Officer, who is appointed by the Governor and confirmed by the Legislature, directs the responsibilities and work of the Department with direct oversight of six divisions and eight operational areas.

The six Division Directors, who are appointed by the Governor and confirmed by the Legislature, report to the CEO. The divisions are Behavioral Health, Children and Family Services, Developmental Disabilities, Medicaid and Long-Term Care, Public Health, and Veterans' Homes.

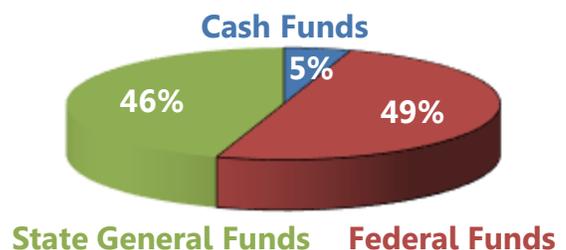
Operational areas include Communications and Legislative Services, Information Systems and Technology, Legal Services, Human Resources and Development, Support Services, Internal Audit and Operations Consulting.

In addition, a Chief Financial Officer reports to the CEO and oversees Financial Services.

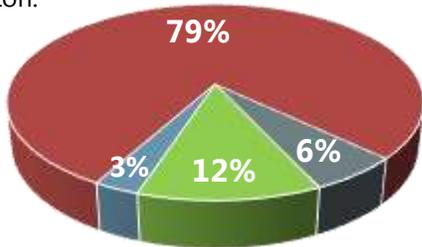
The 2015 State of Nebraska Personnel Almanac reported 5,469 full-time equivalent employees for DHHS at the end of December 2014. This includes staff in all offices and the 10, 24-hour facilities located across the state.

Expenditures to support programs and services for Fiscal Year 2015 totaled \$3,074,734,159.

The funds came from three sources: federal funds (49 percent), state general funds (46 percent), and cash funds (5 percent).



In Fiscal Year 2015, more than three-fourths (79 percent) of DHHS expenditures were for cash benefits and services to Nebraskans. Six percent was for state-operated services, such as the Beatrice State Developmental Center, three Regional Centers, four Veterans' Homes and two Youth Rehabilitation and Treatment Centers. Three percent was to provide population-based services, including public health prevention and promotion activities. Twelve percent went for administrative services, including the functions of determining eligibility for agency programs, the protection and safety of children, and service coordination.



- Client Benefits and Services
- State Operated Services
- Administrative Services
- Population Based Services

The two guiding principles for managing the Department's budget are transparency and accountability. As a public agency, DHHS has a responsibility to use citizens' tax dollars wisely and to uphold the highest standards of fiscal integrity.

### Division of Behavioral Health

SHERI DAWSON, DIRECTOR

The Division of Behavioral Health is the behavioral health authority for the state and directs the administration and coordination of the public behavioral health system to address prevention and treatment of mental health and substance use disorders. The Division's mission is to provide leadership and resources for systems of care that promote and facilitate resilience and recovery for Nebraskans.

The Division provides funding and contract management to six behavioral health regions and a variety of providers to ensure community-based mental health and substance abuse prevention and treatment services are available.

The Division operates three Regional Centers in Lincoln (LRC), Norfolk (NRC), and Hastings (HRC). Combined, they serve about 400 people. Services include general psychiatric services for those committed by a board of mental health or ordered there by a court (LRC), as well as treatment to sex offenders (NRC, LRC). Services also include Psychiatric Residential Treatment Facility treatment for substance use disorders for young men (HRC) and for young men who have sexually harmed (LRC/Whitehall). Most of the young men served have been involved in the criminal justice system.

An Office of Consumer Affairs focuses on recovery initiatives, planning, research, and advocacy for behavioral health consumers.

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



### Division of Children and Family Services

DOUG WEINBERG, DIRECTOR

The Division of Children and Family Services provides child and adult protective services, economic assistance services, and juvenile rehabilitation and treatment services.

Child protective services include prevention activities, investigations of child abuse and neglect, in-home services to keep children at risk of abuse and

neglect safely with their parents, domestic violence services, foster care and adoption services for children who cannot safely live at home, and transitional services designed to assist and promote self-sufficiency for youth preparing for adulthood. Services are organized into five service areas geographically aligned with judicial districts. Adult protective services investigate reports of vulnerable adults who have been abused, neglected or exploited, intervene when maltreatment is confirmed, and connect individuals with the supports and services needed.

Economic assistance programs are a safety net for more than 242,000 Nebraskans and include programs such as Supplemental Nutrition Assistance Program (SNAP); Employment First education and job training; Aid to Dependent Children; Aid to the Aged, Blind and Disabled; refugee resettlement; energy assistance; child care subsidy; as well as child support enforcement.

The DHHS Office of Juvenile Services serves about 140 youth in two Youth Rehabilitation and Treatment Centers in Kearney and Geneva, which are accredited by the American Correctional Association. With the addition of a new administrator at the YRTC-Kearney, processes and structure are being reviewed and could lead to an additional initiative.

### Division of Developmental Disabilities

COURTNEY MILLER, DIRECTOR

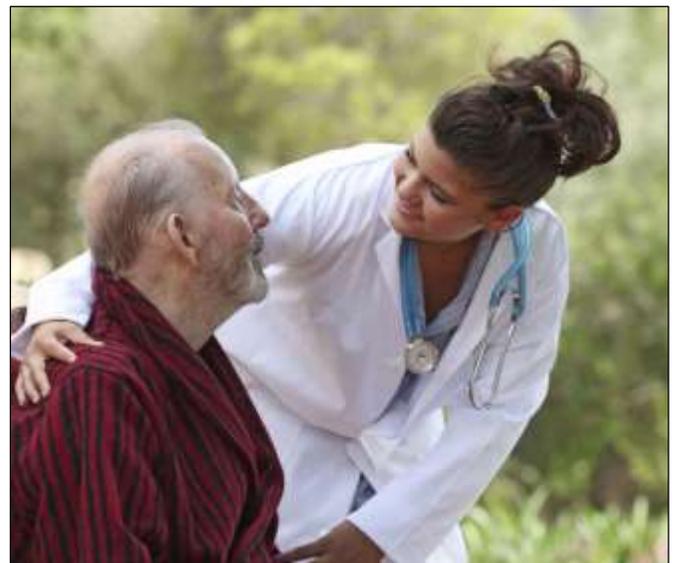
The Division of Developmental Disabilities administers publicly-funded developmental disability services to approximately 5,000 individuals within a community-based setting. An additional 4,000 individuals are waiting on the registry of unmet need for a service. An added 115 people live in five DHHS intermediate care facilities for persons with developmental disabilities (ICF/DD) in Beatrice.

The Division of Developmental Disabilities strives to support the choices of individuals with disabilities and their families by promoting and providing flexible, quality, member-driven services and supports within communities, and valuing our community connections with an emphasis on looking at a person's strengths and gifts.

The Division administers three home and community-based services (HCBS) Medicaid waivers

as well as state-funded services. Services are provided based on each person's identified needs, state and/or federal guidelines and, when applicable, the availability of funds. While some services are delivered directly by DHHS, most services are delivered through a large network of individual and agency contracted providers. The Division collaborates with other agencies, providers, families and self-advocates, increasing opportunities for individuals with developmental disabilities to access the most integrated, least restrictive services and supports.

A clinical team is available to provide dental, nutritional, medical and psychiatric consultations, and support to eligible individuals in the community at large. Additional specialized staff provide training across the state in functional behavioral assessment, physical and nutritional management, and other topics relevant to supporting people with developmental disabilities.



### Medicaid and Long-Term Care

CALDER LYNCH, DIRECTOR

The Division of Medicaid and Long-Term Care (MLTC) includes Medicaid and the Children's Health Insurance Program, Home and Community Services for Aging and Persons with Disabilities, and the State Unit on Aging.

Medicaid pays for health care services to eligible elderly, persons with disabilities, low-income pregnant

women, and children and their parents, covering more than one in every 10 Nebraskans.

The Division also administers non-institutional home and community-based waivers including the aged, adults and children with disabilities, and infants and toddlers with special needs.

The State Unit on Aging collaborates with public and private service providers to ensure a comprehensive and coordinated community-based services system that assists people to live in a setting they choose and continue to be contributing members of their community. The Unit partners with Nebraska's aging network that includes eight Area Agencies on Aging.

The Division also includes Medicaid eligibility determination, policy, provider enrollment, rate setting and reimbursement activities, claims processing, and program integrity activities.



## Division of Public Health

COURTNEY PHILLIPS, ACTING DIRECTOR

The Division of Public Health brings together all the elements of public health within the Department of Health and Human Services. It's committed to ensuring Nebraskans receive safe, effective, quality care as well as helping them live a healthy lifestyle throughout their entire lives.

The Division has two sections. One is Health Licensure and Health Data and the other is Community and Environmental Health. Health Licensure and Health Data is responsible for epidemiology and informatics; licensure, regulation and investigations of health-related professions, occupations, facilities and services; public health preparedness and emergency response;

and vital records. Community and Environmental Health is responsible for community and rural health planning, environmental health, health promotion and lifespan health services.



## Division of Veterans' Homes

JOHN HILGERT, DIRECTOR

Providing outstanding care and service to Nebraska veterans is the top priority for the Division of Veterans' Homes. The Division operates four state veterans' homes located in Bellevue, Grand Island, Norfolk, and Scottsbluff. Construction will soon begin on a home to replace the Grand Island facility to be located in Kearney.

Employees at all four Nebraska's Veterans' Homes provide a helping hand to our member veterans every day, and treat the men and women who have served in the U.S. Armed Forces with the respect they deserve.

With a total capacity of 637 beds, the four Veterans' Homes provide a variety of medical, nursing and rehabilitative services tailored to the needs of their members. Services range from assisted living care for members able to care for themselves to skilled nursing care. Members' health care services are administered by dedicated nurses, physicians, dietitians, occupational therapists, speech therapists, physical therapists and other professionally trained personnel.

All four homes have a proud history of serving veterans.

## General Operations

DHHS has eight operational sections that provide specialized expertise and support to all divisions. The daily work of these areas impacts the success of every

employee in carrying out the DHHS mission of helping people live better lives.

Communications and Legislative Services manages public, internal and stakeholder communications including media relations, outreach and publicity/promotion efforts, the DHHS website, social media, newsletters, video productions and graphic design; legislative activities; and the DHHS Helpline which responds to questions and concerns related to DHHS programs and services.



Financial Services provides support through budget development and monitoring, state and federal report preparation, program evaluation, accounting transactions, revenue collections and monitoring, grant and contract support, claims processing, research, financial and program analysis, and cost allocation.

Human Resources and Development (HRD) provides personnel support to Department employees and managers across the state, including staffing requests for position reclassification and salary grade adjustments; analysis of staffing plans; payroll, workers' compensation and benefits; employee and labor relations; employee recognition, recruitment, selection, placement, retention and succession planning; and the Employee Assistance Program. In addition, HRD is responsible for training coordination, staff development, leadership and supervisory training, and meeting and team facilitation.

Internal Audit evaluates, identifies, and assists areas in need of improvements with their current

processes and procedures, and provides guidance and information to DHHS staff regarding procedures, operational controls, regulations, internal controls, and best practices. Internal Audit also maintains audit records and provides a DHHS point of contact for the coordination of all audits, reviews, attestations, or site visits in which a federal or state official is reviewing one or more DHHS programs or grants.

Information Systems and Technology provides planning and project management, implementation and ongoing support of information systems, network and hardware support including procurement and installation, local area network management and maintenance, and internal help desk support for both system-specific and agency-wide questions and concerns.

Legal Services provides legal advice to DHHS divisions; represents DHHS in administrative hearings and court cases; interprets state and federal laws and regulations; drafts and reviews legislation, rules and regulations, contracts and other documents.

Operations Consulting is an internal consulting team that identifies, develops, implements, and evaluates business practices throughout DHHS for efficiency and effectiveness with a concentration on improved services, reduced costs and streamlined processes. Work may also impact other state agencies and external stakeholders. Operations Consulting provides additional assistance to DHHS program staff to implement corrective action plans.

Support Services provides technical assistance and support in purchasing; equipment inventory; surplus property; vehicle management; risk management; land-based telecommunications; language line; Spanish translation; office space planning, leasing, space management, office set-up, and facility engineering; Americans with Disabilities Act (ADA) compliance review and design; records management; security and emergency planning; building access control, word processing, centralized scanning, property insurance administration, distribution of mail; forms and supply management, contractual services and sub-awards, and security administration for EnterpriseOne, the state's accounting, procurement and payroll system.

## DHHS Priorities

The Department has identified 25 priorities that will result in real improvements, sustain current progress, and help Nebraskans live better lives. They are grouped under five categories that span the work of the agency:

- ▶ Integrating Services and Partnerships
- ▶ Promoting Independence through Community-Based Services
- ▶ Focusing on Prevention to Change Lives
- ▶ Leveraging Technology to Increase Effectiveness
- ▶ Increasing Operating Efficiencies and Improvements

### Integrating Services and Partnerships

#### Heritage Health (Medicaid Managed Care)

##### BACKGROUND

Nebraska Medicaid currently provides health care coverage for approximately 231,000 individuals each month at an annual cost of approximately \$2 billion. The Nebraska Medicaid Managed Care Program, which was first implemented in Nebraska in July 1995, initially provided physical health benefits to Medicaid members in three counties. Today, approximately 80 percent of individuals who qualify for Medicaid receive their physical health benefits through managed care and almost all Medicaid members receive their behavioral health benefits through managed care. Physical health services are provided by three managed care organizations (MCOs) and behavioral health services are provided by a separate contractor.

In October 2015, the Department released a request for proposal (RFP) to select qualified MCOs to provide statewide integrated medical, behavioral health, and pharmacy services to almost all Medicaid members. This program will be called Heritage Health. DHHS awarded three MCO contracts in April 2016 and the program will begin operations on January 1, 2017.

In a risk-based managed care delivery system, MCOs are responsible for the management and provision of specific covered services. For this responsibility, they receive a set amount per member each month as payment from DHHS. Having one health plan responsible for the full range of

services for a member encourages investment in more cost-effective services to better address the health care needs of the whole person.

Heritage Health will integrate the health care for groups of enrollees who were previously excluded from participation in the Department's physical health managed care program, but who received their behavioral health services through the Department's behavioral health managed care contractor. These groups include individuals with Medicare as their primary insurance, individuals who are enrolled in one of DHHS' home and community-based waiver programs for individuals with physical disabilities or developmental disabilities, as well as individuals who live in long-term care institutional settings such as nursing homes or intermediate care facilities for people with developmental disabilities.

While these individuals will have their physical, behavioral, and pharmacy health services coordinated by their Heritage Health plan, the administration of their long-term supports and services (such as their institutional care or in-home care) will continue to be administered as it is today while DHHS works with stakeholders to study reform for that system.



The Heritage Health RFP requires contracted MCOs to report comprehensively on a wide variety of nationally recognized health measures. Nebraska Medicaid will partner with its sister Divisions to use this reporting to design and implement quality improvement programs, with the aim of establishing Nebraska as a performance leader in a broad range of health measures for children and adults. Furthermore, quality measure reporting will lead to the establishment of performance goals tied to financial incentives for measures specific to the needs of Nebraska's Medicaid members.

Heritage Health will also require a significantly more robust care management strategy focused on the early identification of members who require active care management. Once a member is identified for active

care management, the goal of the program is to ensure that the member receives the appropriate combination of services and that costly episodes of care, like emergency room visits or hospital admissions or readmissions, are prevented.

The RFP also requires that Heritage Health MCOs address the social determinants of health in their health risk assessment and care management strategy. There are clear connections between social factors like housing, food security, and education with health outcomes. All MCO staff must be trained on how social determinates affect members' health and wellness, including issues related to housing, education, food, and trauma. Staff must also be trained on, and have access to, information regarding Nebraska's community resources and making referrals to these agencies and other programs that are helpful to members.

Heritage Health MCOs will be required to maintain robust provider networks which include hospitals, physicians, specialists, pharmacies, mental health and substance use disorder providers, federally qualified health centers and rural health clinics, and allied health providers. The development of these provider networks in the state will increase access to services, including behavioral health services to at-risk youth. The MCOs' network of providers must offer an appropriate range of preventive, primary care, specialty, and recovery-oriented services that meet specific provider access standards. Heritage Health MCOs will also support and promote patient-centered medical homes that provide comprehensive, coordinated health care through consistent, ongoing contact with members.

## GOALS

Managed care was implemented in Nebraska to improve the health and wellness of Medicaid members by increasing their access to comprehensive health services in a cost-effective manner. As behavioral health services are added to the physical health delivery system, additional goals for all members include decreased reliance on emergency and inpatient levels of care by providing clients with evidence-based care options that emphasize early intervention and community-based treatment. MLTC also anticipates

that integrated physical and behavioral health managed care will achieve the following outcomes:

- ▶ Improved health outcomes
- ▶ Enhanced integration of services and quality of care
- ▶ Emphasis on person-centered care, including enhanced preventive and care management services
- ▶ Increased access to evidence-based behavioral health services to at-risk youth
- ▶ Reduced rate of costly and avoidable care
- ▶ Improved financially sustainable system

## PROGRAM STRATEGY

Developing and implementing Heritage Health involves the following strategies and activities:

**Complete the procurement process.** DHHS released the Heritage Health RFP in October 2015. The Department determined the proposal teams, and developed the criteria and training materials for the evaluators. DHHS staff evaluated proposals and recommended to leadership the bidders that should receive a contract. The final step in this process is contract negotiation with the MCOs.

**Contract with enrollment broker.** DHHS released an RFP in late December 2015 to procure an enrollment broker (EB). Starting in September 2016, the successful EB will assist Medicaid enrollees with Heritage Health MCO and primary care provider selection. On or before January 2018, the EB will also work with DHHS to determine the monthly capitation payment each MCO should receive and calculate any needed payment recoupments.

**Ensure operational readiness.** Once DHHS has awarded contracts with the MCOs, it must ensure that each MCO is operationally ready. A readiness review will be completed before the MCOs can begin operations. If any issues are discovered during the readiness review process, the MCOs must implement corrective measures to resolve the issues before operations can begin.

**Implement program enhancement initiatives.** DHHS has described several program enhancements that it will work with the MCOs to implement. These will include, but are not limited to:

- ▶ Establishing a Behavioral Health Integration Advisory Committee to facilitate the integration of physical and behavioral health services and promote the successful transition for members and providers
- ▶ Involving community organizations in outreach, education and service delivery to ensure that members' health and social needs are met
- ▶ Working with the MCOs to design and implement robust reporting of performance metrics, including quality of care and member and provider satisfaction
- ▶ Establishing a quality committee to include providers, MCO quality experts and DHHS clinical leadership to enhance the MCOs' quality initiatives and determine performance incentives
- ▶ Working with the MCOs to advance patient-centered medical home strategies
- ▶ Completing annual operational reviews of the MCOs
- ▶ Increasing access to behavioral health services to at-risk youth
- ▶ Designing financial incentives and penalties to ensure compliance with key operational provisions and incentivize strong performance on program goals
- ▶ Establishing an Administrative Simplification Committee with state, provider, and MCO representation to identify and implement common practices and forms to streamline providers' administrative experience
- ▶ Working with the MCOs to establish and expand value-based purchasing arrangement

**DELIVERABLES**

<b>Deliverable</b>	<b>Target Completion</b>
RFP release	<b>October 21, 2015</b>
Proposals due	<b>January 5, 2016</b>
Evaluation period	<b>January 12 – 29, 2016</b>
Intent to award announcement	<b>February 5, 2016</b>
MCO contract award	<b>April 2016</b>
EB contract award	<b>April 2016</b>
MCO readiness reviews	<b>July 2016</b>
MCO selection and enrollment	<b>September – December 2016</b>
Heritage Health start date	<b>January 2017</b>

**Behavioral Health System of Care for Children, Youth and Families**

**BACKGROUND**

System of Care is a framework for integrating mental health services and supports for children and youth who have a serious emotional disturbance, and their families, through a collaboration across and involving public and private partners, families and youth.



A System of Care improves access to a full array of coordinated community-based services and builds on the strengths of individuals. It addresses each person's cultural and linguistic needs. It helps children, youth, and families function better at home, in school, in the community, and throughout life.

This approach has gained wide acceptance particularly for children with serious and complex mental health needs, and who may be involved in multiple systems.

States and communities that have implemented the System of Care approach have reported changes, including:

- ▶ Increase in school attendance and school performance
- ▶ Decrease in average age of first system contact
- ▶ Decrease in cost per youth receiving services
- ▶ Increase in percent of youth and young adults living in home settings

## GOALS

Access to appropriate and effective behavioral health services will increase, particularly for individuals with complex needs, by integrating the System of Care across DHHS divisions and programs. The program will partner to develop a common language for care, unify policies and practices including family-centered care, and avoid duplication of services for children and their families.

## PROGRAM STRATEGY

Behavioral Health will initiate the first phase of Children’s System of Care, and implement an action plan through developed partnerships to include formation of the system structure, initiation of standing work teams, and development of regional System of Care leadership groups.

## DELIVERABLES

Deliverable	Target Completion
Staff assembled, Leadership Board, Implementation Committee and Standing Work Teams convened	September 2016
Cross-system map of services/supports, eligibility, funding sources, policies, practices and regulations completed	September 2016
Mechanism for public/private partnerships in carrying out implementation action steps (contractual/MOUs) established	June 2017
Mechanism established for cross-system monitoring of SOC services and supports	June 2017

## Family-Focused Case Management in Economic Assistance

### BACKGROUND

A long-standing criticism of government at both the state and federal levels has been the nature of public financial support. Too many funding silos across too many seemingly independent agencies make success in social services a difficult challenge. This is especially true in the area of intergenerational poverty and self-sufficiency. Compounding the problem is the fact that the barriers to sustainable employment often extend far



beyond education and job training. To successfully support children and families, break the cycle of intergenerational poverty, and reduce the potential for subsequent child abuse and neglect, policy makers must leverage funding and programming across a number of state, local, federal, and private agencies in line with the Governor’s priorities for efficient and effective government that improves public safety and well-being.

In Nebraska, opportunities for closer collaboration between child welfare, Aid to Dependent Children through the Temporary Assistance to Needy Families (TANF) block grant, Supplemental Nutritional Assistance Program (SNAP), child care subsidies, child support enforcement, and the private sector exist within the Division of Children and Family Services. Opportunities also exist to leverage resources across other federal, state, and private funding streams.

Introducing family-focused case management to families involved in Nebraska’s public assistance programs represents a bold step in this direction. One possible approach would be to provide family-focused case management to recipients of Nebraska’s Aid to Dependent Children’s (ADC) program through the state’s Employment First Program. The goal of this program is to promote sustainable employment at a reasonable wage that leads families to self-sufficiency.

Family-focused case management emphasizes the family unit as a whole, not just increasing the job readiness of potential wage earners through job skills training and education. The goal is to eliminate the barriers to long-term, sustainable employment that many families face.

Barriers to sustainable employment can include any one or combination of the following:

- Substance use and/or addiction
- Adult or child mental health issues
- Adult or child physical health issues
- The need to care for younger siblings or children
- The need to care for older adults
- Potential incarceration for past due child support
- Homelessness
- Child care issues
- Lack of extended family supports
- Lack of community supports
- Lack of social capital and positive peer support
- Insufficient education
- Lack of job training

## GOALS

The Division of Children and Family Services (CFS) introduces family-focused case management to Economic Assistance programs to promote self-sufficiency and sustainable employment to reduce the number of individuals and families re-entering public assistance programs.

This intensive family-focused case management can provide long-term positive results for the family including, but not limited to, sustainable employment and improved parenting.

## PROGRAM STRATEGY

CFS will incorporate family-focused case management in its new Employment First contract by creating partnerships with contractors, case managers, and clients to integrate services. Employment First is the Division's workforce services program that provides ADC (TANF) recipients in Nebraska with education, training, and other services to assist them in achieving sustainable employment.

The practice of family-focused case management builds connections throughout the community in an effort to address one or more of these barriers. Connections can include other economic assistance programs, one-stop job centers, physical and mental

health programs and providers, other state agencies, non-profit community resources and agencies, faith-based organizations, extended family members, and positive peer influences such as local support groups.

The key to success is the careful coordination of all potential sources of support, and a comprehensive inventory of all available supports at the case manager's fingertips, regardless of funding stream or responsible governmental entity.



A family-focused case management pilot or program in Nebraska would involve embedding economic assistance as well as protection and safety case workers in the Employment First office to enhance communication and coordination of an array of services to help clients reach self-sufficiency. The initial goal of the family-focused case management is triage. A multi-disciplined team would staff the case. Once the most significant barriers are identified, the case management team can prioritize potential interventions and supports in a comprehensive case plan and subsequently reach out to community resources and supports to make appropriate referrals and contacts. The case management team will also work with the family to identify activities and/or support groups that will provide positive peer influence and social capital.

At the same time, family-focused case managers work closely with all family members to build a level of trust and confidence with the family.

Finally, case managers work with families to ensure appropriate connections are made in a timely and consistent manner. Case managers also frequently follow up in team meetings with the family and community agencies to develop assistance and interventions aimed at moving clients to self-sufficiency.

Benefits to the state include reduction in TANF, SNAP, child care assistance, and Low-Income Home Energy Assistance Program (LIHEAP) recipients, reduced arrearages in child support payments, and reduced instances of child abuse and neglect.

### DELIVERABLES

Deliverable	Target Completion
Development of pilot program	<b>May 2016</b>
Commencement of new statewide Employment First contract with Family Focused Case Management pilot	<b>July 1, 2016</b>
Review progress of pilot program	<b>December 2016</b>
Evaluate pilot program to assess expansion to other areas of the state	<b>June 2017</b>

### Cross-Division Solutions Team

#### BACKGROUND

Department of Health and Human Services Chief Executive Officer developed the Cross-Division Solutions Team (CDST) to find solutions for individuals and/or families who have complex issues and who may need services or supports from multiple Divisions within DHHS. Prior to this team, Divisions did not have a direct venue to work together on cases. The Divisions of Behavioral Health, Children and Family Services, Developmental Disabilities, and Medicaid and Long-Term Care, as well as Legal Services and Internal Audit meet weekly to review these cases. The Division of Public Health is involved as needed. Referrals for the CDST come from the DHHS CEO, the Division Directors, Ombudsman’s office, senators’ offices, and other system partners.

#### GOALS

- ▶ Evaluate each individual’s and/or family’s complex needs to determine how the Divisions can work together to increase accessibility
- ▶ Identify system gaps and make recommendations resulting in better outcomes
- ▶ Increase participant knowledge on available services provided within the Department

### PROGRAM STRATEGY

Key individuals from each Division have been chosen by the various Division Directors to be members of the Cross-Division Solution Team (CDST). The members of the CDST meet weekly to review the case referrals, and as a whole, develop solutions to meet the needs of individuals and families. The members take a “can do” approach and think out of the box without going outside of the Department rules and regulations.

### DELIVERABLES

Deliverable	Target Completion
Consistent Division participant representation	<b>January 2016</b>
Program representatives including Magellan presented on eligibility and benefits	<b>January 2016</b>
Engagement and cross-divisional collaboration	<b>Ongoing</b>
Broader analysis of issues and how they can be addressed with agency resources as a whole	<b>Ongoing</b>
Identify gaps in the system	<b>Ongoing</b>
Individual and Family outcomes	<b>Ongoing</b>
Standardized referral process	<b>March 2016</b>
Memo to internal employees	<b>March 2016</b>
Data collected on program eligibility status of each individual referred	<b>Ongoing</b>

### Promoting Independence through Community-Based Services

#### Developmental Disabilities Home and Community-Based Waivers, and Community-Based Transition Plan

#### BACKGROUND

Two of the Division of Developmental Disabilities’ (DD) Medicaid adult waivers are in the renewal process and negotiations are underway with the Centers for Medicare and Medicaid Services (CMS) to ensure that the waivers comply with all federal regulations, and afford optimal services for Nebraskans with developmental disabilities. DD has requested an extension to respond to questions and address the gaps in the

waiver applications, and will resubmit these waiver applications as well as the DD children's waiver application to ensure consistency in administration of the waiver programs.

The federal mandate is that the state Medicaid agency retain ultimate administrative and financial authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

The waivers lack adequate Division of Medicaid and Long-Term Care (MLTC) oversight and Developmental Disabilities (DD) will be correcting this critical administrative and structural gap through the waiver renewal process. One critical example of the lack of oversight is that DD has closely managed the utilization and corresponding financial performance of its waivers with little-to-no oversight by MLTC. Waiver budget cycles are not aligned with the state's fiscal year and waiver services are underutilized.

We will be working closely with Medicaid leadership to tighten our fiscal management of the waivers and ensure that we maximize our Medicaid program to benefit Nebraskans with developmental disabilities

An important federal rule took effect on March 17, 2014. There are three parts to the new Rule, 42 CFR 441.301: The person-centered planning process, which increases the person's input in how services are planned and what is included in the plan of care; conflict-free case management; and home and community-based services settings which increase protections related to where people receive Home and Community-Based Services (HCBS).

## GOALS

The goal is to develop and implement DD HCBS waivers focused on person-centered, customer-focused planning, indicate the priority system in Nebraska for waiver funding, indicate the appropriate number of waiver slots available and utilized, and provide CMS accurate information on the waiting list in Nebraska. Regarding the new rule regarding person-centered planning, we will develop and implement a transition

plan that complies with CMS requirements while maintaining our service array and provider network.

## PROGRAM STRATEGY

The Division of Developmental Disabilities will ensure compliance of CMS regulations on the waiver process to accurately identify and articulate the service delivery for people with developmental disabilities in Nebraska, and build on best practices in the nation to serve people in the least restrictive community setting. We will meet with internal and external stakeholders for ideas and strategy development to build the best transition plan possible for Nebraska, and draft an amended transition plan and publish it for public comment.



**DELIVERABLES**

<b>Deliverable</b>	<b>Target Completion</b>
Submitted DD HCBS waivers to CMS	<b>September 30, 2015</b>
Self-assessment by CDD providers only for Transition Plan	<b>November 2015</b>
Statewide meetings with staff and providers for Transition Plan	<b>December 2015</b>
Received questions about the waiver submissions	<b>December 2, 2015</b>
Submitted temporary extensions on adult waivers	<b>December 4, 2015</b>
Provide responses to questions from CMS	<b>Ongoing</b>
Engage in a corrective action plan as needed	<b>Ongoing</b>
Simplify Personal Focus Worksheet for Transition Plan to ensure people a voice by utilizing best practices and input from pilot project	<b>January 2016</b>
Implement a new level of care instrument that is best practice	<b>January 2016</b>
Stakeholder engagement	<b>February 2016/ongoing</b>
Add valid statistical sample for QI measure	<b>March 2016</b>
Assessment of statistical stratified sample of residential and day service programs by service coordination with providers for Transition Plan	<b>March 2016</b>
Post final Transition Plan assessment findings	<b>April 2016</b>
Schedule/hold public comment on Transition Plan	<b>April 2016</b>
Rewrite our waivers utilizing best practice and a national expert in the field of DD waivers	<b>October 1, 2016</b>

**Developmental Disabilities Registry of Unmet Needs**

**BACKGROUND**

All individuals determined eligible for developmental disabilities services are entered into this Registry database through the completion of a comprehensive demographic and risk assessment instrument. The purpose of the Registry is to identify the service needs of individuals deemed eligible for Division of Developmental Disabilities services. This includes a risk assessment to prioritize those in need of residential placement or identify the need for other critical

services, whether they are eligible for services under the Medicaid DD waivers or the DD Service Authorization entitlement program.

**GOAL**

The purpose of the Registry is to identify the service needs of individuals deemed eligible for Division of Developmental Disabilities services, and, through the Registry, track those services by funding source.

**PROGRAM STRATEGY**

The Division of Developmental Disabilities will review all individuals on the Registry of Unmet Need to ensure that the individuals meet residence requirements and still desire services, encourage all individuals over 18 years of age to apply for Medicaid since they may no longer have an ability to pay, offer service coordination to individuals listed on the Registry, and work with individuals receiving service coordination to access other services inside and outside DHHS including programs such as the Program of All-Inclusive Care for the Elderly (PACE), Personal Assistance Service (PAS), and Aged and Disabled (AD Waiver).

**DELIVERABLES:**

<b>Deliverable</b>	<b>Target Completion</b>
Improved number of people getting the correct services from the correct agency at the correct time in their lives	<b>June 2016</b>
Better identification of service needs of individuals deemed eligible for DD services	<b>June 2016</b>
Track services by funding source and utilize data for future budget considerations	<b>January 2017</b>
Improvement in identifying individuals in need of residential placement and other critical services	<b>June 2017</b>
More complete and useful Registry	<b>June 2017</b>

**Long-Term Services and Supports (LTSS) Redesign Project**

**BACKGROUND**

Over the past several years, the Division of Medicaid and Long-Term Care (MLTC) has engaged stakeholders in conversations regarding the delivery of long-term services and supports (LTSS). Those initial conversations

resulted in a plan to implement managed LTSS by integrating the services into risk-based contracts with managed care organizations. MLTC has revisited those plans and is opening a broader dialogue with stakeholders regarding a more comprehensive redesign of LTSS services in Nebraska. The LTSS redesign project will be a collaborative initiative between MLTC and LTSS stakeholders to evaluate the current LTSS landscape, identify key opportunities for improvement, and redesign the system to meet the future challenges and growing demand for LTSS.

## GOALS

The LTSS redesign effort is focused on opportunities for improvement in Medicaid LTSS services, specifically the following goals:

- ▶ Improve the quality of services and health outcomes of recipients.
- ▶ Promote independent living in the least restrictive setting through the use of consumer focused and individualized services and living options.
- ▶ Strengthen access, coordination and integration of care through streamlined LTSS eligibility processes and collaborative care management models.
- ▶ Improve the capacity to match available resources with individual needs through innovative benefit structures.
- ▶ Streamline and better align the programmatic and administrative framework to decrease fragmentation for clients and providers.
- ▶ Refocus and rebalance the system in order to match growing demand for supports in a sustainable manner.

## PROGRAM STRATEGY

Developing and implementing the LTSS redesign project involves the following strategies and activities:

**Releasing the LTSS redesign concept paper.** In January 2016, MLTC released a concept paper with the general principles to guide the LTSS redesign project. MLTC has identified several current components of the Medicaid LTSS system that present opportunities for focused effort and improvement that are highlighted

in the concept paper. These areas are interrelated and, when addressed together, have great potential to offer improvement in long-term care and choice for the Nebraska LTSS population, help achieve compliance with federal requirements, promote administrative efficiencies, and maximize program resources.

### **Engage LTSS Redesign Technical Assistance**

**Consultant.** MLTC will complete a competitive procurement to select and engage a technical assistance consultant to work with the Division to gather stakeholder input, study best practices, and develop recommendations and work plans for the redesign effort.

### **Engage with stakeholders on the LTSS redesign.**

MLTC and the contractor will solicit input and feedback from individuals receiving LTSS, advocacy organizations, providers, managed care organizations, care coordination agencies, legislators, and any other interested members of the public. This feedback will be reflected in the final LTSS redesign plan.

**Develop LTSS redesign plan.** From the concept paper feedback and the work of the LTSS consultant, MLTC will release a substantive LTSS redesign proposal by the end of 2016. This redesign proposal will outline a concrete plan for improving LTSS in Nebraska for the state's Medicaid clients and providers.

### **Begin implementation of program improvements.**

After MLTC receives feedback from its stakeholders on the LTSS redesign plan, the opportunities for improvement identified will begin to be implemented in 2017.

## DELIVERABLES

Deliverable	Target Completion
Initial concept paper	December 2015
RFP release for consulting contractor	March 2016
Contract award	May 2016
Stakeholder meetings	July 2016
Release of LTSS redesign plan	Late 2016
Implementation of changes	Beginning 2017

## Increasing Access to Evidence-Based Community Treatment Services for At-Risk Youth

### BACKGROUND

Nebraska Medicaid will be growing its behavioral health service array over the next year to provide access to evidence-based services directed toward at-risk youth. In 2015, the Nebraska Legislature passed LB 500. This bill requires the Department to submit a Medicaid State Plan Amendment (SPA) to cover multisystemic therapy (MST). MST is an intensive family- and community-based treatment program designed to enhance parental skills and provide intensive family therapy to troubled and delinquent teens which empowers youth to cope with the family, peer, school, and neighborhood problems that they encounter in order to prevent recidivism in the juvenile criminal justice system.

Medicaid is collaborating with the Divisions of Behavioral Health and Children and Family Services, as well as Probation, on the service array.



Nebraska Medicaid has spent the last year researching and will be prepared to submit this SPA. In addition, the Department will also be including coverage for functional family therapy (FFT) in this state plan. Through its research, Medicaid recognized that coverage for FFT is an important component of a comprehensive evidence-based strategy to improve outcomes for these youth.

For FFT, therapists work with all family members to create specific interventions looking at each individual's unique challenges and strengths. The combination of these two services is projected to lead to improvement in outcomes for at-risk youth, reducing out-of-home placements and preventing recidivism in juvenile offenders.

### GOALS

The goals of expanding services to at-risk youth are the following:

- ▶ Reducing out-of-home placements
- ▶ Preventing recidivism in juvenile offenders
- ▶ Improving family relationships

### PROGRAM STRATEGY

The strategies are:

- ▶ Submit State Plan Amendment. LB 500 requires the Department to submit a State Plan Amendment by May 1, 2016. The Department will work with the Centers for Medicare and Medicaid Services for its approval.
- ▶ Work with the Office of Probation to expand access to these services.
- ▶ Educate the public about service availability.

### DELIVERABLES

Deliverable	Target Completion
Tribal notice for SPA sent	<b>January 22, 2016</b>
Draft SPA sent to stakeholders for comment	<b>February 29, 2016</b>
SPA submitted to CMS for approval	<b>April 1, 2016</b>
Implement after CMS approval	<b>Ongoing</b>

## Focusing on Prevention to Change Lives

### Prescription Drug Overdose Prevention and Prescription Drug Monitoring

#### BACKGROUND

The Nebraska Department of Health and Human Services' Division of Public Health identified preventing unintentional drug overdose as a priority area. Recently, DHHS has received two grants to provide more concentrated and coordinated efforts on this issue. The rate of drug overdose deaths in Nebraska has increased, as well as the rate of neonatal abstinence syndrome, and the rate of drug abuse/withdrawal related emergency department visits. The trend is corresponding with the national trend driven by the alarming increase in prescription opioid addiction.

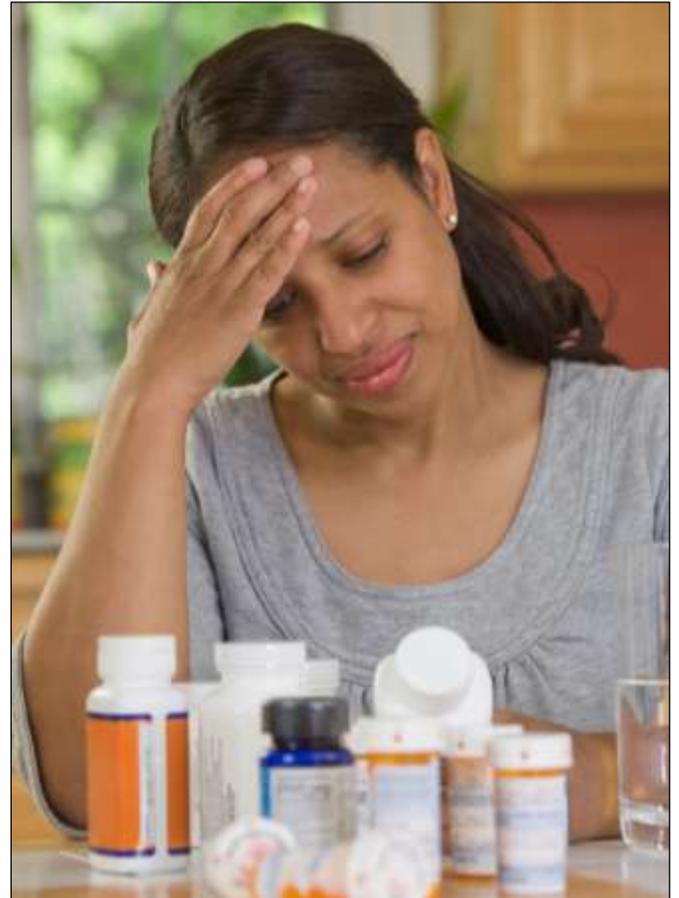
#### GOAL

The overall goal is to reduce drug abuse/misuse in Nebraska, which can result in death, hospitalization, addiction, and neonatal abstinence syndrome.

#### PROGRAM STRATEGY

The following strategies are based on the best available evidence from the Centers for Disease Control and Prevention on addressing the prescription drug overdose epidemic by states. Specific measures were examined from the Injury Surveillance system, to assess the health burden of drug abuse/misuse. Items listed below are identified as promising strategies that states can advance to ensure the health and well-being of their residents.

- ▶ Identify and implement ways to increase use of Prescription Drug Monitoring Programs (PDMP), which are state-run databases that track prescriptions for controlled substances and can help improve painkiller prescribing, inform clinical practice, and protect patients at risk
- ▶ Implement and promote evidence-based opioid prescribing standards
- ▶ Expand use of Naloxone, the opioid overdose antidote through expanded access



- ▶ Identify opportunities to increase access to substance abuse treatment

Specific tasks over the coming months for developing and implementing these strategies include the following:

- ▶ **Make the PDMP easier to use and access.** Convene a group of key partners to review and identify barriers to PDMP access and use. Develop and implement a plan to rectify barriers to PDMP access and use. Expand a pool of healthcare professionals permitted to access PDMP data. Support PDMP training efforts in high-burden regions.
- ▶ **Collaborate with the Nebraska Health Information Initiative (NeHII) on the state PDMP.** DHHS will contract with NeHII to hire a trainer to provide those medical professionals authorized to access the system training on how to use the system to improve patient care. NeHII will

also provide DHHS with PDMP data to use for public health surveillance purposes. NeHII will implement enhancements to the PDMP system to expand access to authorized medical professionals.

- ▶ **Conduct public health surveillance with PDMP data and publicly disseminate reports on a regular basis.** Through collaboration with NeHII, DHHS will support improvement to the PDMP infrastructure for its use as a public health surveillance system. Indicators to be calculated from the PDMP data are: increased registration for and use of PDMP, the percent of patients receiving more than an average daily dose of >100 morphine milligram equivalents (across all opioid prescriptions), rates of multiple provider episodes for prescription opioids (five or more prescribers and five or more pharmacies in a six-month period) per 100,000 residents, percent of patients prescribed long-acting/extended-release opioids who were opioid-naïve (i.e., have not taken prescription opioids in 60 days), percent of prescribed days overlap between opioid prescriptions, and percent of prescribed opioid days that overlap with benzodiazepine prescriptions.
- ▶ **Provide education and awareness on expanded access and appropriate use of Naloxone.** Collaborate with medical professional associations to help educate and raise awareness. Communicate new policy with DHHS programs, such as Emergency Medical Services program, DHHS licensure, and other state agencies who can help raise awareness. Discuss with groups effective ways to educate their members and the general public.
- ▶ **Collaborate with the Division of Behavioral Health and the Division of Medicaid and Long-Term Care.** Invite representatives from both Divisions to stakeholder meetings. Identify ways to collaborate on the issue of drug misuse/abuse. Share information with other Divisions on health burden, recent efforts, funding, and other issues.
- ▶ **Develop and adopt opioid prescribing guidelines.** Convene a 'Prescribing Guidelines Committee' of key external stakeholders, including members of relevant professional boards to establish prescrib-

ing guidelines specific to pain management and opioids. Prescribing guidelines specific to pain management will be disseminated to health care professionals.

- ▶ **Pursue capability of utilizing syndromic surveillance data to rapidly identify "hotspots."** Continue collaboration with the syndromic surveillance coordinator to utilize syndromic surveillance data to rapidly identify areas in the state that are experiencing a high rate of drug-related emergency department visits.

### DELIVERABLES

Deliverable	Target Completion
Recruit, hire and train two full-time staff positions	January 2016
Review CDC proposed prescribing guidelines	January 2016
Convene prescribing guidelines workgroup	February 2016
Access PDMP data for public health surveillance	November 2016
Begin training physicians and prescribers on access and use of PDMP system	November 2016
Pilot test using syndromic surveillance data to identify "hotspots"	January 2017
Support efforts to train prescribers/dispensers in high burden areas	January 2017
Coordinate efforts to propose opioid prescribing guidelines to professional boards	March 2017
Convene stakeholder workgroup on regular basis	Ongoing
Convene PDMP workgroup to address barriers and improve access	Ongoing
Support Naloxone education efforts	Ongoing

### Expansion of Alternative Response

#### BACKGROUND

The Division of Children and Family Services (CFS) implemented an Alternative Response (AR) pilot project on October 1, 2014, in five counties (Scotts Bluff, Hall, Lancaster, Dodge, and Sarpy). Alternative Response is designed to connect families with less severe reports of

child abuse and/or neglect to the supports and services they need in order to strengthen the protective factors that support parents with keeping their children safe and healthy.

AR is one intervention CFS implemented as part of the Title IV-E Waiver Demonstration Project awarded in 2013 by the U.S. Department of Health and Human



Services, Administration on Children Youth and Families (ACYF). As part of the terms and conditions of the demonstration project, the state was required to secure a third-party, independent evaluator to assess the

process, outcomes and costs of the project. The University of Nebraska-Lincoln Center on Children, Families, and the Law (CCFL) was awarded the contract for the program evaluation.

The development of the AR program was a collaborative project with internal and external stakeholders. To obtain feedback from the numerous entities, various AR committees were created:

- ▶ The AR Internal Workgroup is comprised of CFS field staff and administrators who researched AR and drafted the program and practice model. Recommendations from this workgroup were shared with the Director’s Steering Committee and the AR Statewide Advisory Committee.
- ▶ The AR Director’s Steering Committee representatives include the Foster Care Review Office, Office of Inspector General, Region V Behavioral Health, Lancaster County Attorney, Court Improvement Project, Nebraska Children and Families Foundation, a Child Advocacy Center, Voices for Children, and internal CFS Administrators.
- ▶ The AR Statewide Advisory Committee is comprised of the Director’s Steering Committee along with community and family partnering organizations.

CFS utilized the expertise of the members within each workgroup to obtain feedback and generate ideas about how best to develop an AR model for Nebraska

that is even more customer focused. Their participation was vital to the development and implementation of AR. CFS continues to meet regularly with each of these committees to share implementation and program progress.

A family’s ability to access timely services within their community is a vital component of AR. In an effort to expand service capacity, CFS continues to collaborate with the Nebraska Children and Families Foundation (NCF) which leads local efforts aimed at minimizing poverty, homelessness, and child abuse/neglect within communities. Developing and implementing Child Well-Being Communities is one strategy designed to achieve this goal. Child Well-Being Communities utilize the parental protective factor framework to link families to evidence-based, evidence-informed, and promising practice services available in their community to enhance protective factors, and promote family stability and sustainability. Integrating AR efforts with Child Well-Being Community efforts enhances the likelihood of family success and reduces the likelihood a family will need future CFS intervention.



Building service capacity is only one aspect of the overall service array component. Access to flexible funding is another critical component. Purchase cards are available in each pilot site to buy the concrete supports that are often needed by families. As of July 2015, the most prevalent services utilized include Intensive Family Preservation, Family Support, housing-related assistance (rent, cleaning, utilities, and deposits), transportation (motor vehicle repairs, gas, tires, and windshield), food and clothing. Expenditures for

services and concrete supports through December 31, 2015, total about \$86,000. While the utilization of flexible funds for concrete services is less than expected, field staff report tremendous support from community agencies that have delivered supports and services at no cost.

**GOALS**

The Division of Children and Family Services will expand the delivery of the AR program to assist families with less severe reports of child abuse and/or neglect, and connect to the supports and services they need in order to prevent children from being placed outside the family home due to safety threats.

**PROGRAM STRATEGY**

CFS will work with the AR Director’s Steering Committee, the AR Internal Workgroup and the AR Statewide Advisory Committee to develop recommendations for the phased expansion of AR. Through the partnership with NCFE, CFS will continue to support the development of Well-Being Communities in order to connect families to the sustainable community services and supports needed.

**DELIVERABLES**

Deliverable	Target Completion
Implementation of AR occurs in Banner, Cheyenne, Deuel, Garden, Kimball and Morrill counties	<b>January 2016</b>
Finalize Phase II Expansion Plan	<b>February 2016</b>
Implementation of AR occurs in Arthur, Frontier, Chase, Dundy, Grant, Hayes, Hitchcock, Keith, Perkins, Colfax, Red Willow, Stanton, Platte, Madison, Nance, Boone, Howard, Sherman, Greeley, and Valley counties	<b>March 2016</b>
Implementation of AR occurs in Sioux, Dawes, Box Butte, and Sheridan counties	<b>April 2016</b>
Implement Phase II	<b>July-October 2016</b>
Finalize Phase III Expansion Plan	<b>October 2016</b>
Implement Phase III	<b>January 2017</b>
Finalize Phase IV Expansion Plan	<b>April 2017</b>
Implement Phase IV	<b>July 2017</b>

**Reduction in Out-of-Home Placements of State Wards by Safely Expediting Reunifications**

**BACKGROUND**

Sixty percent of all children served by the Division of Children and Family Services’ (CFS) Protection and Safety unit are in out-of-home placements. These include congregate care facilities (7 percent of all out-of-home placements), relative or kinship homes (49 percent), traditional non-relative foster homes (36 percent), and other out-of-home placements such as hospitals, detention centers, and youth rehabilitation treatment facilities (8 percent). While the increase in the proportion of children placed with relative and kinship homes is commendable, the overall percentage of children placed in out-of-home settings is well above national averages.

	In-Home	Out-of-Home
<b>Nebraska</b>	40%	60%
<b>United States*</b>	64%	36%

\* Child Maltreatment Report 2013, U.S. Department of Health and Human Services.

	Congregate Placement	Non-Relative Foster Home	Relative Foster Home	Other Placement
<b>Nebraska</b>	7%	36%	49%	8%
<b>United States*</b>	14%	46%	29%	11%

\* Child Trends analysis of data from the Adoption and Foster Care Analysis and Reporting System (AFCARS), made available through the National Data Archive on Child Abuse and Neglect (2013).

A great deal of research has been completed assessing the long-term impact of trauma experienced by children when they are removed from their parents. Across the country, child welfare agencies are introducing interventions with evidence of effectiveness designed to allow children to safely remain home. These interventions include: Alternative Response, family-based services such as parent-child interaction therapy (PCIT), intensive family preservation (IFP), and Triple P Positive Parenting Program, as well as early childhood home visiting service models. As a result of these new child welfare practices, jurisdictions across the country have reported significant reductions in

the number of child removals with positive outcomes related to child well-being and repeat maltreatment.

In 2008, Nebraska commenced the process of privatizing child welfare. Over the next several years, all but one of the original lead agencies declared bankruptcy or cancelled their contract. As a result, only one service area, the Eastern Service Area (ESA) serving Douglas and Sarpy Counties, has a lead agency – Nebraska Families Collaborative (NFC). The original five-year contract with NFC has received several one-year extensions. The current emergency extension expires June 30, 2016.

**GOAL**

The Division of Children and Family Services will implement best-practice interventions designed to safely prevent and reduce the number of children in out-of-home placements resulting in improvement of public safety, as well.

**PROGRAM STRATEGY**

CFS intends to enter into a new sole-source pilot with NFC, which will include a performance-based lead agency program in the ESA with a sub-pilot focused on reducing out-of-home placements.

The new contract will be established as a risk-based or performance-based contract, which clearly aligns the objectives of both parties in that the provider has capital at risk and financially benefits from improved outcomes.

The contract will include a sub-pilot which incorporates a cross-system of care model, focused on providing families with the services and supports they need to safely prevent removals and expedite the reunification process. The sub-pilot will focus on a specific population of children who are either at risk of removal or who are currently in out-of-home care.

Interventions will include coordinated response teams jointly staffed by DHHS and NFC, the development of new 72-hour placement alternatives for short-term, out-of-home placements to provide time for family stabilization, and readily available in-home safety services and interventions. The sub-pilot will be developed and implemented with input from the courts, county attorneys, juvenile probation, and key community stakeholders.

CFS also is exploring the feasibility of implementing other evidence-based programs for the remainder of the state to prevent unnecessary out-of-home placements. This includes a capacity building project with our federal partners to redesign the IFP model in order to improve family functioning and promote child safety. CFS will be engaged in service area-specific assessments to identify the availability of in-home safety interventions and services required to mitigate identified safety threats that, when not addressed, result in out-of-home placements.

**DELIVERABLES**

<b>Deliverable</b>	<b>Target Completion</b>
Involve IFP Partners for IFP model redesign	<b>February 2016</b>
Service Area-specific assessment (in-home safety services) template developed	<b>February 2016</b>
Service Areas complete assessment	<b>March 2016</b>
Sub-pilot developed and approved	<b>March 1, 2016</b>
Contract negotiations with NFC finalized	<b>March 31, 2016</b>
Aggregate assessments to identify gaps/capacity needs	<b>April 2016</b>
Conduct financial analysis on identified service needs	<b>May 2016</b>
Signed contract with NFC	<b>June 15, 2016</b>
Finalize IFP model/modify contracts to include new service description	<b>June 2016</b>
Pilot implementation begins (NFC)	<b>July 1, 2016</b>
Execute new IFP contracts	<b>July 1, 2016</b>
Modify/execute contracts	<b>July 1, 2016</b>

**Leveraging Technology to Increase Effectiveness**

**Improve Utilization of THERAP**

**BACKGROUND**

The Division of Developmental Disabilities entered into a contract with THERAP in 2010, mandating the use of general event record reporting by all specialized DD providers. THERAP is an electronic records and

documentation system used for the planning, documentation, and reporting needs of organizations that support people with intellectual and developmental disabilities in home and community-based services and other settings.



The state procurement process was completed in March 2012, which included the purchase of and access to all THERAP modules for every provider on a per person/per month basis, funded by DHHS. The initial contract is for a four-year period ending in March 2016. The contract provides for two, three-year extensions. The initial procurement indicated that THERAP is a comprehensive online and web enabled Application Service Provider (ASP) model solution designed to meet the needs, business practices, security requirements, and reporting requirements of the Division and supporting agencies, including providers, Division program management-related functions, and federal agencies. DD service coordinators were trained on the Individual Support Plan components in January 2015. The Registry of Unmet Needs, monthly billing caps, and monthly allocations to non-specialized service authorizations were implemented in 2015.

## GOAL

The goal is to utilize THERAP to its greatest functionality while evaluating its effectiveness for continued utilization.

## PROGRAM STRATEGY

There will be work with the THERAP team to identify areas of success and areas of improvement. This will include engaging internal and external stakeholders while focusing on the needs of the individuals we serve and having access to information in real time to ensure that person-centered planning and informed consent are present in our delivery system.

## DELIVERABLES

Deliverable	Target Completion
Edit claims not submitted as payable within 180 days	February 2016
Stop claims outside 180 days for review by DD	February 2016
THERAP will utilize the best practices in the Nebraska Resource Library identified from the Department of Justice Independent expert in the areas of nursing care plans, behavioral support plans, and protocols for risk such as choking, falls, seizures, etc.	March 2016
Provide billing reconciliation in THERAP via 835 files	March 2016
Simplify the service authorization approval process	March 2016
Transition of all Individual Program Plans (IPP) from InfoPath to the Individual Service Plan (ISP) module in THERAP during annual or semiannual review	July 2016
Modify risk contracts to require all risk providers to utilize the health modules in THERAP	July 2016
All agencies approved for exception funding required to utilize the health modules in THERAP	July 2016
Non-specialized providers allowed to bill in THERAP	July 2016
Implement individual and family access for THERAP	September 2016
Waiver eligibility components automated checklist	December 2016

## Developmental Disabilities Eligibility Determinations

### BACKGROUND

Applicants for Developmental Disabilities (DD) services have indicated a lack of understanding about the eligibility process in general, including how to fill out an application, and what documents are needed in order to determine eligibility for DD Services. As a result, applicants gather many documents in excess of what may be needed in order to determine DD eligibility. In addition, DHHS staff have also learned that individuals and families do not have working knowledge of the wide variety of other DHHS or community services that may be available to them and are unaware of how the various programs function and relate to each other. For example, families often assume that DD and Social Security are a single program, and that ineligibility for DD services also affects their eligibility for other programs such as Medicaid and Social Security. By providing information upfront about the eligibility process, requirements, and other resources and services that the individual may be eligible or qualify for, individuals and their families have some assurance relative to other choices about services that might best meet the individuals needs.

### GOAL

The goal is to create a more user-friendly application process and ensure an accurate and timely eligibility determination.

### PROGRAM STRATEGY

We are striving to create a user-friendly access point to DD to expedite the application handling process and tighten the timeline for DD responsiveness to eligibility determination requests. Staff have been instructed to work closely with applicants to ensure that the most relevant and current information is available to make sound eligibility determinations.

## DELIVERABLES

Deliverable	Target Completion
New application template utilizing community experts	January 2016
Notice of Decision with specific reason for denial	January 2016
Get approval for new application and Notice of Decision	January 2016
Streamlined process for eligibility determinations	January 2016
Issue policy for application processing and determinations with timelines	January 2016
Training for eligibility determination processes	January 2016
Monitoring process for application processing	January 2016
Survey for customer satisfaction and issue survey periodically	January 2016/ongoing
Fillable online PDF application	February 2016
Publish timeliness of eligibility determinations to CEO	February 2016
Application management process guide for NFOCUS	June 2016
Application management process guide training for NFOCUS	June 2016
Electronic data and tracking system for application process	June 2016
Application in NFOCUS with major release	July 2016
Online application process in ACCESSNebraska	July 2016
System reports to monitor data and processing timelines	July 2016
Evaluate process for continuous quality improvement	June 2017

## Medicaid Client Eligibility and Enrollment Solution

### BACKGROUND

Implementation of the Affordable Care Act (ACA) required significant changes to states' Medicaid eligibility and enrollment systems. Nebraska's current system, Nebraska Family Online Client User System (NFOCUS), has been in use since the 1990s. After considering alternatives, DHHS determined the best way for Nebraska to meet federal eligibility system

requirements was to implement a new Medicaid eligibility and enrollment solution (EES).

In the latter part of 2013, a Request for Proposals (RFP) was issued and evaluated for a system integrator (SI) to implement a commercial off-the-shelf (COTS) based EES. In addition to the Medicaid eligibility system, the RFP also requested services for business process reengineering, communications, organizational change management, systems hosting, maintenance, and operations. In mid-2014 a contract was awarded to Wipro, LLC. Implementation of the new solution is underway with a target go-live date of March 31, 2017. To date, project initiation and project management fundamentals are complete. The project is entering the latter part of the requirements verification phase.

### GOALS

Key goals of the EES project include increased automation for eligibility processing, compliance with federal requirements for Medicaid eligibility systems, implementing an efficient, consumer-friendly solution, and utilizing technology that can be further leveraged by DHHS in the future.

### PROGRAM STRATEGY

During the planning phase, project fundamentals, such as project governance and project management tools/processes, were established to build a solid foundation suitable for a large-scale project.

The requirements phase consists of three significant activities: requirements verification, business process modeling, and fit-gap analysis.

This phase is crucial as the expected outcome is a clear definition of the solution to be implemented. The goal of the architecture phase is to design not only a cohesive, integrated solution for Medicaid eligibility and enrollment, but also to ensure the solution fits into a broader enterprise architecture vision.

The design phase details how project requirements will be implemented. The development phase implements the solution utilizing output from all prior phases.

When the complete solution is ready, the project will enter its final phase and be deployed for use. Contingency plans will be developed, user training conducted, client and user support systems put in place, and finally, the solution will be deployed for use by clients and eligibility workers.

Following go-live, the system will be monitored and adjusted as required to ensure a quality user experience.

Specific strategies for developing and implementing EES will involve the following:

- ▶ **Utilize a classic system implementation model.** The EES project follows best practices for system implementations with project initiation/planning, requirements analysis, architecture, design, development, test, and deployment phases. The phased model allows for a structured approach while minimizing project risks.
- ▶ **Re-engineer business processes.** Medicaid eligibility and enrollment processes are examined end-to-end and re-engineered to be automated, where practical, consumer friendly, and efficient.
- ▶ **Leverage COTS to build a modern, flexible platform that can be enhanced for future DHHS initiatives.** The COTS procurement allows for compliance with federal requirements, flexibility for other programs, technology that meets industry standards, collaboration with other states, adoption of best practices, and opportunities to find resources skilled in the technology.
- ▶ **Utilize effective project resource model.** The EES project uses a mixed staffing model including state staff, a system integrator (SI), staff augmentation, and independent verification and validation (IV&V) staff to implement the solution. The multiple disciplines provide a diverse set of resources from which to draw expertise and increase the opportunity for success.

### DELIVERABLES

Deliverable	Target Completion
Project kickoff	September 2014
Project initiation and initial planning completed	June 2015
Requirements analysis completed	March 2016
Architecture completed	June 2016
Design completed	June 2016
Development completed	December 2016
Test and training completed	March 2017
Go live	March 2017
Post go live stabilization period completed	June 2017

## Medicaid Management Information System (MMIS) Replacement Project

### BACKGROUND

The Medicaid Management Information System (MMIS) is the mechanized claims processing and information retrieval system that the federal government has historically required states to operate as part of their Medicaid program. Nebraska's MMIS was created in 1977 and can no longer meet the demands of a rapidly changing Medicaid environment. The need for expedient programmatic changes and the ability to readily produce actionable information from data are just two of the many improvements necessary to efficiently manage today's Medicaid program.

During 2015, Nebraska Medicaid completed a strategic analysis, which is comprised of alternative, procurement and market analyses. Seven alternatives were initially analyzed, with a mixture of traditional and innovative solutions. Three additional alternatives were then analyzed and a recommended solution was developed.

The market analysis indicated the vast majority of state Medicaid agencies have traditionally utilized one of two solutions by which to operate their MMIS – either as a self-administered system with in-house operations (as is currently done in Nebraska) or by contracting with an entity to provide and maintain a system and conduct operations, often referred to as a fiscal-agent arrangement. While these approaches are traditional, the Centers for Medicare and Medicaid Services (CMS) has been strongly encouraging states to move to more innovative and flexible approaches. An innovative alternative being considered by some states is contracting for claims processing as a service rather than implementing a new system.

Based on the alternatives assessment and a planned potential future state in which Nebraska Medicaid will pay few, if any, claims directly, the Medicaid and Long-Term Care Division (MLTC) has chosen to pursue claims processing as a service through a claims broker services (CBS) agreement. The CBS model seeks to partner with one or more of the managed care organizations (MCOs) in Nebraska that participate in risk-based Medicaid to also process fee-for-service (FFS) claims for clients and

services not in managed care. DHHS would not own the processing system or be responsible for its maintenance, but would set the policy and reimbursement rates and pass through the actual cost of the services. Operational functions would also be performed by the CBS.

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*Managing the data, producing accurate and timely reports, and utilizing the data to make informed business decisions has become more critical with the growth of the Medicaid program.*

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Moving to the CBS model provides an opportunity to implement a cost-effective solution to replace the remaining MMIS functionality. The CBS model will allow MLTC to avoid the high costs of replacing a full legacy MMIS. Procuring the necessary functionality using a best-of-breed, modular approach will not only meet future state requirements but also satisfy CMS requirements for innovative solutions. Modularity is one of the foundations necessary to secure federal matching funds for project planning and implementation.

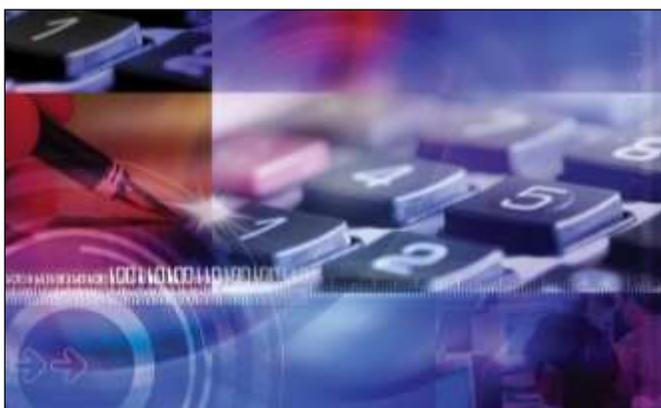
MLTC will separately procure data management and analytics capabilities, which is considered by most experts as foundational to the future of health care. The data management and analytics (DMA) planning project will produce an RFP to provide MLTC with an enterprise data platform that will encompass MLTC/vendor systems and data in a holistic data solution. This will serve as the data management module for MLTC and be designed to “fit” within the overall architecture. Additional functionality such as financial management, eligibility and enrollment, etc. will be secured via existing or planned procurements with the same overarching modular approach.

### GOALS

After considerable review of the programmatic goals of Nebraska Medicaid, the top priority for the project is providing Nebraska Medicaid with improved capability to manage the vast amounts of data received by the agency. Managing the data, producing accurate and timely reports, and utilizing the data to make informed business decisions has become more critical with the

growth of the Medicaid program. Over the next few years, Nebraska Medicaid will procure and implement a new data management and analytics solution to support and meet this priority.

Additionally, as Nebraska Medicaid integrates services under MCOs, the volume of FFS claims and the need for a separate and distinct infrastructure to support their processing will diminish. Therefore, over the next few years Nebraska Medicaid will also establish CBS with one of the Heritage Health MCOs to process FFS claims. This approach will capitalize on capacity and technological infrastructure already developed by the MCO and in place to pay claims through their at-risk business.



### PROGRAM STRATEGY

As indicated above, achieving the goals to meet Nebraska Medicaid’s business needs will require several years. The following strategic activities will be undertaken to progress toward those goals:

- Finalize the DMA RFP incorporating comments from draft
- Procure the DMA solution vendor that best meets the outlined requirements
- Continue outreach and communication with CMS to maintain ongoing federal funding for the project
- Finalize contract with the Heritage Health MCO that will perform as the CBS
- Prepare and execute a plan to support the implementation activities and align organizational resources to the new model
- Start implementing the DMA solution

### DELIVERABLES

Deliverable	Target Completion
Release DMA RFP to vendors for comment	January 2016
Submit DMA RFP to CMS for approval	March 2016
Release DMA RFP solicitation for vendor bids	May 2016
Vendor DMA proposals submitted	July 2016
Publish DMA intent to contract	October 2016
Submit DMA contract to CMS for approval	November 2016
Finalize contract and start DMA implementation	February 2017
Prepare plan to support implementation activities	February 2016
Select Heritage Health Plan to perform as the CBS	April 2016
Prepare organization to support implementation activities	January 2017
Start joint planning and implementation preparations with CBS	February 2017

### Veterans’ Homes Electronic Health Record and Pharmacy Management Software

#### BACKGROUND

The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, was signed into law on February 17, 2009 to promote the adoption and meaningful use of health information technology. The Division of Veterans’ Homes realized the importance of procuring a new electronic health record system and issued an RFP. The only bidder and subsequent award winner was eventually unable to fulfill the terms of the contract and it was terminated.

A decision was made to amend an existing contract with NETSMART and AVATAR, held by the Division of Behavioral Health, to serve as the electronic health record (EHR) system for the Veterans’ Homes. AVATAR is designed as an acute care, mental and behavioral health medical record and does not specifically fit the needs of a geriatric, long-term care population. It was modified but is cumbersome and requires duplicate entry by multiple users to maintain duplicate data in a parallel system. Ideally, all patient information should

be maintained in an easily accessible system to avoid potential serious user errors.

In Fiscal Year 2015, the Division was re-appropriated funds to obtain a new congruent EHR, and a request for proposals was issued for an integrated, streamlined, robust long-term care EHR that has an integrated approach to clinical, long-term care minimum data set, care plans, assessments, progress notes, physician orders, electronic medication and treatment administration, physician/provider electronic billing, member billing, and member trust banking.

The Division of Veterans’ Homes also issued a request for proposals for a new long-term care pharmacy management software and automated pharmacy packaging/dispensing machines. These systems must be able to provide a seamless real time interface with each other.

**GOALS**

The Division of Veterans’ Homes is planning to select, purchase, and implement a new integrated EHR system. The requirements include converting data from our current (legacy) systems as soon as possible. Depending on the selection dates and contract negotiations, the new system is estimated to be live by the third quarter of Fiscal Year 2017.

**PROGRAM STRATEGY**

The Division of Veterans’ Homes proposes a staggered approach to implementing the new system. The Grand Island Veterans’ Home (GIVH) and the Western Nebraska Veterans’ Home (WNVH) are using the legacy electronic medical record and pharmacy modules, making them the best candidates for initial implementation. GIVH will be the first facility to go-live with the new EMR, pharmacy software, and medication dispensing machines.

The second facility to go-live with all three components would be WNVH. The Eastern Nebraska Veterans’ Home and Norfolk Veterans’ Home will follow. Each facility’s go-live would be at the end of month with patient records closing on the last day of the month, data converted and then on the first day of the month the new system would be live. Member statements will be produced out of the legacy system.

Both systems would run simultaneously, with the new system being the system of record but ensuring accuracy until the systems are audited and found to be in sync.

The implementation of all systems will require coordination so they occur at the same time since there is a dependency on each other. The following timeline will be adjusted if an additional Request for Proposal (RFP) process is necessary, and would be extended to February 2017.

**DELIVERABLES**

<b>Deliverable</b>	<b>Target Completion</b>
Electronic health record – RFP Scoring	<b>December 2015</b>
Pharmacy management RFP – Scoring	<b>December 2015</b>
Oral interview’s/presentations	<b>December 2015</b>
Intent to award posted	<b>January 2016</b>
Final evaluation document	<b>January 2016</b>
Contract finalization and award	<b>March 2016</b>
Contractor start date	<b>March 2016</b>
Project schedule due	<b>March 2016</b>
Project management plan due	<b>April 2016</b>
Project work plan due	<b>May 2016</b>
Project kickoff meeting	<b>May 2016</b>
Detailed system design document due	<b>June 30, 2016</b>
Data migration plan due	<b>June 30, 2016</b>
Testing plan due	<b>June 30, 2016</b>
User acceptance testing plan due	<b>June 30, 2016</b>
System implementation plan due	<b>June 30, 2016</b>
Training plan due	<b>June 30, 2016</b>
GIVH go live	<b>August 1, 2016</b>
WNVH go live	<b>September 1, 2016</b>
ENVH go live	<b>October 1, 2016</b>
NVH go live	<b>November 1, 2016</b>

**Behavioral Health Centralized Data System**

**BACKGROUND**

The Division of Behavioral Health’s reporting responsibilities stem from its designation as the state behavioral health authority. This authority is for mental health and substance abuse. As the state authority,



there is a responsibility for transparency in reporting and managing processes designed to provide prevention and treatment services to the consumers of behavioral health services in Nebraska.

The Division must provide reliable, accurate and current data to a variety of funding sources and system partners. These reporting requirements include monthly and annual Utilization and Financial Reports, National Outcome Measures (NOMs), and the Nebraska Uniform Reporting System (URS). In addition to planned reporting, a wide variety of requirements and report breakdowns for various funders and stakeholders are often requested on an ad hoc basis.

### GOAL

The goal is to improve the data that informs service planning for the public behavioral health services for children and adults.

### PROGRAM STRATEGY

A Centralized Data System (CDS) addresses the need for access to timely, reliable and accurate data essential for managing processes and serves as a foundational business practice that drives the Division's operational efficiency. The strategy is to develop a system that:

- ▶ Eliminates time consuming manual data collection and aggregation processes
- ▶ Provides updated technological tools for data analysis, data sharing, decision-making and quality improvement

- ▶ Standardizes data across the Division
- ▶ Increases access to underlying data
- ▶ Provides up-to-date data analysis necessary for reports and ongoing decision making

### DELIVERABLES

Deliverable	Target Completion
Train regional center staff to include Results-Based Accountability (RBA) and CDS	<b>March 1, 2016</b>
CDS implementation	<b>April 15, 2016</b>
Onsite visits with Regions and ongoing CDS training	<b>May 2016</b>
Develop reporting and timeframe mechanics of Memorandum of Understanding (MOU) currently in place with DHHS Medicaid that will provide for comprehensive examination of behavioral health services	<b>June 30, 2016</b>
Work to initiate development of MOUs with other behavioral health system partners will be ongoing	<b>December 31, 2016</b>

### Enterprise Technology Delivery

#### BACKGROUND

The DHHS Information Systems and Technology (IS&T) section is responsible for the development, delivery, security and management of technology platforms and solutions supporting Nebraska's most vulnerable citizens. The three major systems utilized by DHHS include:

- ▶ **NFOCUS** – an integrated system that automates benefit/service delivery and case management for more than 30 DHHS programs, including Child Welfare, Aid to Dependent Children, Supplemental Nutrition Assistance Program, and Medicaid
- ▶ **MMIS** – primary functions include fee-for-service claims processing and support for Medicaid managed care service delivery
- ▶ **CHARTS** – statewide Child Support Enforcement system, which includes case management, enforcement, financial management, and extensive integration with other state and federal agencies

In the past, many of the IT systems and supporting technologies were delivered within Division silos which limited reusability, increased IT costs, and in some instances, limited information technology expertise within the agency. Additionally, key systems (NFOCUS and MMIS) are scheduled for replacement as part of broader DHHS program initiatives in the 2016-2018 time frame, thus creating the need for the development of additional/new skillsets to successfully deliver, design, implement, and maintain the solutions going forward.

**GOAL**

The goal is to create an enterprise IT strategy within DHHS that provides a long-term foundation for cost effective innovation, consolidation, technological leadership, and sustainability.



**PROGRAM STRATEGY**

- ▶ New Medicaid solution for a Document Management Portal
- ▶ Establish an enterprise architecture and governance model for DHHS
- ▶ Look for intra-agency and inter-agency opportunities to consolidate IT platforms
- ▶ Include architectural components in RFP requests to introduce rigor with technological solutions and vendor management
- ▶ Continue to engage and build relationships within the program areas to facilitate IT vision
- ▶ Modernize skills within IS&T to support new technologies and program directives

**DELIVERABLES**

Deliverable	Target Completion
Develop project plan for DHHS IT Infrastructure centralization with OCIO and complete Phase 1 of plan	March 2016 – December 2016
Provide updated IS&T positions and current job descriptions for review by OCIO and HR	March 2016
Identify necessary components for an Enterprise Architecture	June 2016
Define project charter and project plan to make UNL Design Studio ACCESSNebraska mobile application prototype production-ready	June 2016
Develop an initial Enterprise Architecture model and governance structure	September 2016
Initiate product design to make UNL design studio ACCESS-Nebraska mobile application prototype production-ready	September 2016
DHHS IT to centralize service desk software into OCIO platform, allowing the routing of tickets between Agencies and Teams	December 2016
Develop position/staffing/training plans for IS&T in support of Curam product	December 2016

**Increasing Operating Efficiencies and Improvements**

**Public Health Accreditation**

**BACKGROUND**

In 2009, the Department of Health and Human Services received a National Public Health Improvement Initiative grant from the Centers for Disease Control and Prevention to accelerate public health accreditation readiness activities, implement performance and improvement management practices and systems, and implement and share practice-based evidence. Through this grant, the Division of Public Health began to prepare for national accreditation (meeting national standards and measures for public health departments) by developing and implementing the following plans and systems:

- ▶ Comprehensive statewide health assessment
- ▶ State Health Improvement Plan
- ▶ Division of Public Health Strategic Plan
- ▶ Quality Improvement Plan
- ▶ Workforce Development Plan
- ▶ Performance Management System

Through this work, the Division has made and continues to make improvements in the way it does business. The public health accreditation process involves submitting documentation to the Public Health Accreditation Board for review by a site visit team to determine if the Division is meeting national standards and measures and to what extent. After the site visit team reviews the documentation, they conduct a site visit and then provide a report to the Division outlining strengths and opportunities for improvement. The Public Health Accreditation Board makes a decision about accreditation status, either accredited for five years or development of a 12-month action plan and opportunity for resubmission.

In October 2014, the Division of Public Health submitted its application for accreditation through the Public Health Accreditation Board. Public health accreditation focuses on performance and quality improvement centered on the 10 Essential Public Health Services. In June 2015, staff submitted documentation to show how the Division is meeting national standards and measures. The Division's site visit is scheduled for January 2016.

## GOALS

Key goals of public health accreditation include improved quality and performance of programs and systems to meet national public health standards, increased accountability and credibility, and continuous quality improvement.

## PROGRAM STRATEGY

When the Division of Public Health accreditation site visit is complete in January 2016, the Public Health Accreditation Board will submit a report that includes



strengths and opportunities for improvement. We anticipate that by late spring 2016, the Public Health Accreditation Board will notify the Division about accreditation status, either accredited or development of a 12-month corrective action plan. If the Division receives an action plan, staff led by the Office of Community Health and Performance Management, with involvement from all units within the Division, will make required improvements and resubmit documentation within 12 months. When the Division receives full accreditation status, it will cover a period of five years.

Specific strategies for developing and implementing accreditation efforts will involve the following:

- ▶ Update statewide health assessment, state health improvement plan, and Division strategic plan. These are the required prerequisites for accreditation and must be updated every five years.
- ▶ Expand and maintain a performance management system including continuous quality improvement. Maintaining a performance management system which includes continuous quality improvement is a requirement of public health accreditation. The Division recognizes the need to expand the current performance management system and continue quality improvement efforts.

- ▶ Prepare action plan for responding to accreditation results. Based on the results of the accreditation process, the Division will create an action plan to respond to the opportunities for improvement noted by the site visit team.
- ▶ Implement performance and quality improvement efforts. The Division will begin to implement performance and quality improvement efforts based on accreditation results.

**DELIVERABLES**

Deliverable	Target Completion
Accreditation site visit	January 2016
Update statewide health assessment	January-March 2016
Action plan for responding to accreditation results	April-June 2016
Complete state health improvement plan and Division strategic plan	October-December 2016
Expand performance dashboards covering all Division Units	April-June 2017
Have at least four performance and quality improvements based on action plan	April-June 2017

**LPN/RN Licensure Application Improvements**

**BACKGROUND**

The Department of Health and Human Services (DHHS) Operations Consulting team reviewed the processes and procedures for the initial Licensed Practical Nurse/Registered Nurse (LPN/RN) applications to provide recommendations for improving turnaround time. During September 2015, operations consultants job shadowed each of four nursing licensure specialists to document the current process.

**GOAL**

The overall goal is to improve the length of time required to process an application for initial licensure as an RN or LPN.

**PROGRAM STRATEGY**

The following findings are based on job shadowing of the nursing licensure staff, meetings with program staff, surveying of recently licensed nurses, and

reviewing of other states’ processes and applications. Data was also taken from the Licensure Information System (LIS) to find trends, areas of improvement, and strengths. The issues below are ordered in priority (1 highest priority, 6 lowest priority) and anticipated to provide the highest return on investment.



1. The current LPN/RN application has over 100 fail points for applicants and contains redundant portions leading to applicant confusion. Approximately 80 percent of applications currently arriving contain deficiencies or do not include all supporting documentation. This results in applications needing to be sent back to the applicant or waiting for supporting documentation to arrive before the application can be fully processed.
2. There is approximately a 30-day backlog for pending applications awaiting additional documentation from applicants.
3. Benchmarks and process expectations are not clearly defined.

4. The work process flow is being interrupted by the amount of phone calls being received. Currently, licensure specialists receive a phone call approximately every 10-20 minutes.
5. The webpages pertaining to the LPN/RN license process can be difficult to find along with the information within each webpage.
6. Currently, only a paper application process exists. This does not allow for applicants to easily submit information. The paper process can also be inefficient due to forms being mailed between the applicant and the licensure staff.

Specific recommendations and strategies over the coming months for developing and implementing improvements to the LPN/RN initial application process include the following:

- ▶ **Revise the LPN/RN licensure application.** Create different applications for examination and endorsement. Review for consistent language and terminology throughout both applications. Have outside resources review the application for feedback. Place licensure unit phone number at end of application. Provide training for nursing licensure specialists on application requirements and expectations. Disperse new application to users via website and stakeholders; for example, colleges, employers, etc.
 

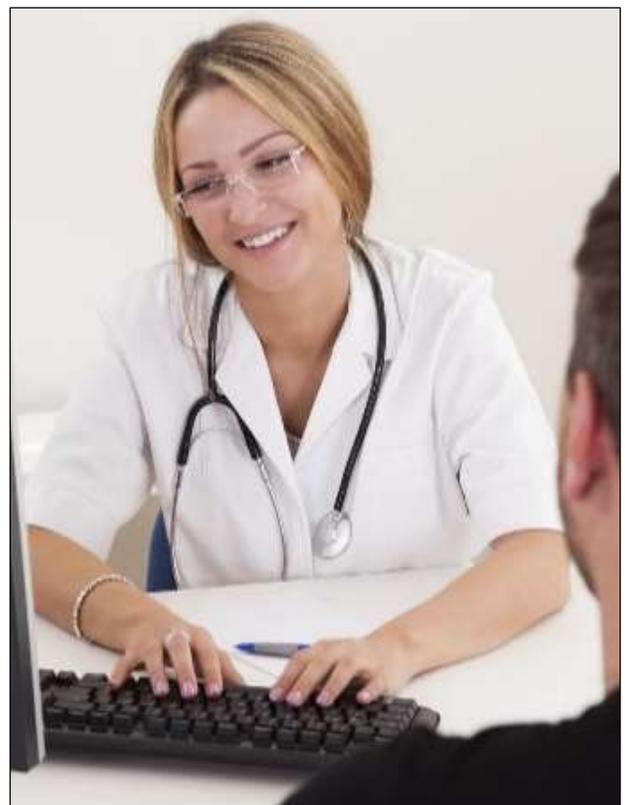
**Continue pilot project.** In October 2015, DHHS staff started to notify applicants who have incomplete applications within three working days of receiving the application. Continue that process and track data. Conduct weekly meetings to discuss the amount of applications processed, common calls, and overcoming obstacles. Hold daily huddles with staff to provide guidance/oversight. Review pilot project for effectiveness and enhancements.

**Provide clear expectations and benchmarks for staff.** Create weekly benchmark expectations for staff. Hold weekly meetings to discuss prior week's production, current week's expectations, staff concerns, etc. Implement reviewing a quarterly sample of each licensure specialist's processed applications to ensure accuracy.

Re-evaluate benchmarks for improvements and increased production.

- ▶ **Reduce the amount of phone calls received.** Further explore the possibility of a voice automated routing system to direct callers to the appropriate licensure specialists. Put contact information for nursing licensure specialists at the end of forms, documents, or webpages. Revise frequently asked questions on website to give clear and direct answers that set realistic expectations.

**Revise the website to provide easy access to LPN/RN applications.** Run analytics on the licensure homepage to determine most frequently visited webpages. Revise frequently asked questions to provide clear direction and realistic expectations for LPN/RN applicants. Create a consistent layout for each licensure webpage. Provide information in drop down menus to organize material/information. Gather feedback from end users. Create document library for forms and applications.



**DELIVERABLES**

<b>Deliverable</b>	<b>Target Completion</b>
Project kickoff	<b>September 2015</b>
Obtain input from stakeholders on revised LPN/RN licensure application	<b>January 2016</b>
Continue customer-focused upgrades to licensure website including streamlining pages, revising FAQs and creating a library of applications for easier access	<b>February 2016</b>
Conduct presentations at nursing schools to orient graduating students to completing the revised application	<b>February 2016</b>
Implement automated phone attendant	<b>March 2016</b>
Continue pilot project of responding to applications within three days	<b>Ongoing</b>
Evaluate data to establish achievable expectations and benchmarks	<b>Ongoing</b>
Continue to work with the Office of the Chief Information Officer and DHHS Information Systems and Technology to provide online submission for initial applications	<b>Ongoing</b>

**Central Nebraska Veterans’ Home**

**BACKGROUND**

The Grand Island Veteran’s Home (GIVH), originally known as the Nebraska Soldiers and Sailors Home, opened in Grand Island in 1887 and was the first veterans’ home in Nebraska. The current total capacity at the facility is 266.

GIVH is being replaced in order to meet the long-term care needs of Nebraska veterans by providing a facility that meets the United States Department of Veterans Affairs (USDVA) standards and guidelines. GIVH has building deficiencies which do not conform to current best practices of the USDVA Community Living Centers.

A major objective of the design is to develop an enhanced living environment for veterans that is more like home and less institutional than the traditionally designed nursing home, which has been historically based on a hospital model with wards. The proposed facility will provide a member-centered environment

that focuses care and resources around the individual members in an effort to improve and enhance their quality of life.

The new facility will be comprised of a series of neighborhood homes that are clustered in groups of three and interconnected in neighborhood groupings of three as well. These clusters connect to hubs and these hubs in turn connect to the Veterans’ Home Center. Provision of individual member bedrooms, large gathering spaces, social activity spaces, therapy centers, views to nature, household gardens, and a fishing pond all serve to enhance the quality of life for veterans while providing privacy, security, and the capacity for interaction.



Features and characteristics of the Central Nebraska Veterans’ Home will include:

- ▶ 225 private bedrooms and private baths
- ▶ 18 individual home environments including dining, activity, living, laundry, and den space
- ▶ 2 physical therapy and large group activity spaces
- ▶ Large group/assembly room for campus events
- ▶ Chapel
- ▶ Wood shop
- ▶ Craft area
- ▶ Specialized dining – Foxhole Pub area providing meal choice options
- ▶ Clinic area and pharmacy support
- ▶ Barber shop and beauty salon

The facility also incorporates adequate support and administrative services. The entire facility will be

335,000 square feet constructed on a 67-acre site located at the intersection of 56th Street and Cherry Avenue in Kearney. Completion and move-in are planned for Fall 2018.

**GOALS**

The goals are to meet the construction timeframes, to prepare and support current employees and members for the transition, and to work with the City of Kearney and others in the recruitment, and referral of new employees and volunteers.

**PROGRAM STRATEGY**

The Division will provide ongoing involvement and support through the construction phases to the Nebraska Department of Administrative Services, the lead state agency for construction of the new Central Nebraska Veterans’ Home. Knowledge of and communication regarding USDVA requirements is paramount. The project falls under the USDVA State Home Construction Grants Program which provides the overall guidance and regulations governing the construction of State Veterans’ Homes. The planning and design process follows USDVA design criteria, the USDVA Community Living Center Design Guide and applicable codes for design and construction.

The Division of Veterans’ Homes is responsible for an extensive transition plan for employees and members. In partnership with DHHS Human Resources and Development, a number of components to support employees have been identified as possible activities, including a recruitment and referral program, holding courses for certified nursing assistants in Kearney, planning transportation options between Grand Island and Kearney, developing a retention incentive, writing necessary new job descriptions, determining the need to contract with a staffing agency, and job placement and retraining opportunities.

Preparing the members for the transition to a new facility will be a priority with a focus on managing the census as completion of the facility nears, developing and recruiting for a buddy program specific for the move, training volunteers in the new community, and familiarizing members with the new facility. The logistics of the move day will be significant with details developed as the move approaches.

The construction target completion dates are contingent on timing of contract awards and federal approval.

**DELIVERABLES**

<b>Deliverable</b>	<b>Target Completion</b>
<b>Construction</b>	
Construction contracts awarded	<b>January 2016</b>
State of Nebraska submits CNVH for USVA final cost approval	<b>January 8, 2016</b>
Grant deadline (180 days from conditional approval letter)	<b>March 25, 2016</b>
Construction begins	<b>April 1, 2016</b>
Construction complete; members move in	<b>Fall 2018</b>
<b>Staff transition</b>	
Staff recruitment and referral program	<b>June 2016 - move in</b>
Kearney CNA class	<b>January 2016 ongoing</b>
Transportation	<b>January 2016 ongoing</b>
Retention incentive	<b>Fall 2018</b>
Develop geriatric Support Specialist job description	<b>Fiscal Year 2017</b>
Contract with staffing agency	<b>July 2016 ongoing</b>
Job placement/retraining	<b>Fiscal Year 2018</b>
Move day	<b>Fall 2018</b>
<b>Member transition</b>	
Moving buddy program	<b>Summer 2018 - move in</b>
Volunteer training	<b>Summer 2018</b>
Facility familiarization	<b>Fiscal Year 2018</b>
Move day	<b>Fall 2018</b>

**Employee Recruitment and Retention**

**BACKGROUND**

Proactive strategic human resources operations are critical for overall agency effectiveness. DHHS employees are the primary component of agency success. Recruiting, developing, and retaining outstanding people is the primary mission of Human Resources and Development.



In alignment with the overall agency goals, Human Resources and Development will establish priorities, streamline and enhance processes to improve operations and enhance customer service.

A number of HR-related issues have been identified that will be included in these activities. The average number of days to post an open

position is 34.6. The average length of time from post to offer is 74.79 days, and the 2015 annual turnover held at 19.1 percent. Thirty-three percent of the DHHS workforce is currently eligible to retire; yet, the Agency does not have a formal succession planning program or process to transfer knowledge.

**GOAL**

The goal is to develop new and enhance existing HRD operations to build a foundation for long-term strategic innovation and proactive program development.

**PROGRAM STRATEGY**

- ▶ Put recruitment model in place which allows for the acquisition of top talent through effective recruitment strategies and efficient recruitment processes
- ▶ Improve employee retention by creating opportunities for workplace resilience, and develop and implement a strategy around “stay interviews”
- ▶ Develop a comprehensive communications and measurement plan that outlines in detail the

partnership between recruitment, DHHS managers and training in the effective on-boarding, training, and development of newly hired and newly promoted employees

- ▶ Identify key performance indicators and develop assessment tools to measure effectiveness of operations and programs
- ▶ Develop internal capacity for program development through continued organizational structure review
- ▶ Establish program development priorities to achieve identified short- and long-term talent acquisition and employee development needs

**DELIVERABLES**

<b>Deliverable</b>	<b>Target Completion</b>
Identify internal metrics, assessment processes, and/or data analysis to assess operational effectiveness and identify opportunities for improvement	<b>January - March 2016</b>
Identify a process and format for regular reporting metrics and assessments to stakeholders and internal customers	<b>January - March 2016</b>
Utilize metrics to identify initial priorities to stabilize workforce and HR operations	<b>April - June 2016</b>
Identify an organizational structure to support program development and enhanced customer service	<b>April - June 2016</b>
Initiate process improvement activities for key operations	<b>April - June 2016</b>
Identify key bargaining proposals for inclusion in contract negotiation and submit to DAS-Employee Relations	<b>April - June 2016</b>
Establish timelines and resources for program development to address priorities identified through analysis of established metrics and assessment processes	<b>June - September 2016</b>
Provide updates and reports of qualitative and quantitative to stakeholders and internal customers and establish ongoing priorities for additional program development	<b>October - December 2016</b>

## Improve Flow and Decrease Wait List at Lincoln Regional Center

### BACKGROUND

The population at the Lincoln Regional Center (LRC) includes individuals who were ordered there by the court, including those incompetent to stand trial, competency evaluations, and not responsible for reasons of insanity; individuals who have been deemed sex offenders; and individuals under mental health board (MHB) commitments.



LRC experiences a waiting list. If at any time it becomes necessary, for lack of capacity or other cause, to establish priorities for the admission of patients into the state hospitals for the mentally ill, the following priorities for admission are recognized: (1) Patients whose care in the state hospital is necessary in order to protect public health and safety; and (2) patients committed by a mental health board under the Nebraska Mental Health Commitment Act, the Sex Offender Commitment Act, or by a district court. A focus is to return consumers to a community setting of their choice through the assistance of partners throughout the system.

### GOAL

Increase access to appropriate and effective integrated behavioral health services, particularly for individuals with complex needs.

### PROGRAM STRATEGY

Improve flow and decrease the wait list at Lincoln Regional Center.

## DELIVERABLES

Deliverable	Target Completion
Identify and develop community-based hospital and emergency system options for Behavioral Health Region V consumers needing inpatient care	<b>December 31, 2016</b>
Identify and develop intermediate service options/plan to reduce admissions to Lincoln Regional Center <ul style="list-style-type: none"> <li>▶ Identify placement and service options for LRC consumers by Cross-Division Solutions Team</li> <li>▶ Develop health information technology and telecommunications options</li> <li>▶ Enhance community-based service options</li> </ul>	<b>December 31, 2016</b>
Explore development of a mechanism for applying population management processes to other Behavioral Health Regions	<b>December 31, 2016</b>
Continue Division Integration and Clinical Improvement/Quality Improvement Project <ul style="list-style-type: none"> <li>▶ Review NRC/LRC Sex Offender Programs – Admission and discharge flow within LRC</li> <li>▶ Develop recommendations that will improve flow</li> <li>▶ Attend quarterly meetings with Administrative Office of the Courts</li> </ul>	<b>December 31, 2016</b>

## Maintain and Improve ACCESSNebraska Performance for Economic Assistance Programs

### BACKGROUND

Economic Assistance delivers services for federal programs including: Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance to Needy Families (TANF), Low-Income Home Energy Assistance Program (LIHEAP), Assistance to Aged Blind and Disabled (AABD), Child Care, and Social Services Block Grant (SSBG). In Nebraska, TANF includes Aid to Dependent Children (ADC) and Employment First.

In November 2015, approximately 9 percent of Nebraska's population received SNAP, or 77,976



households with 174,887 individuals. ADC recipients totaled 5,772 families, and 17,999 children were in the Child Care Subsidy program. Each month approximately 8,000 applications are received for Economic Assistance programs, and over 40,000 telephone calls are made to the Customer Service Centers in Fremont and Scottsbluff.

The Department of Health and Human Services administers and manages eligibility for both Economic Assistance programs and Medicaid and Long-Term Care through a service delivery system known as ACCESS-Nebraska. ACCESSNebraska started in September 2008, with a public website containing an online application for benefits, and was fully implemented in April 2012.

ACCESSNebraska's operations include the following components:

- ▶ ACCESSNebraska.ne.gov website
- ▶ Document management with two imaging centers (Lincoln and Omaha)

- ▶ Customer Service Centers for Economic Assistance (Fremont and Scottsbluff) and Medicaid (Lexington and Lincoln)
- ▶ Local offices (over 50 throughout Nebraska)
- ▶ NFOCUS eligibility system

In May 2015, ACCESSNebraska began operating with a cross-divisional team focused on addressing operational improvements through a series of process initiatives. Operational improvements are driven by the following areas of focus:

- ▶ Document intake and processing
- ▶ Call management
- ▶ Field operations and task management
- ▶ Recruiting and retention
- ▶ Policy reviews and enhancements
- ▶ Workforce management/capacity planning
- ▶ Client/user communications
- ▶ Legislative reporting
- ▶ Change management
- ▶ UNL mobile application project

Significant strides have been made in the past year in the performance and efficiency of ACCESSNebraska for Economic Assistance programs:

- ▶ The average call wait time at the Economic Assistance Customer Service Centers dropped from 21 minutes and 24 seconds in January 2015 to 5 minutes and 34 seconds in December 2015
- ▶ The average days to process economic assistance applications dropped from 18.70 days in January 2015 to 14.32 days in December 2015
- ▶ The SNAP initial expedited application timeliness increased from 94.44 percent in August 2014 to 99.28 percent in December 2015
- ▶ SNAP initial non-expedited application timeliness increased from 70.61 percent in August 2014 to 96.75 percent in December 2015
- ▶ The SNAP recertification timeliness increased from 61 percent in August 2014 to 94.25 percent in December 2015

**GOAL**

The Division of Children and Family Services will continue to evaluate and implement more efficient and effective systems in ACCESSNebraska for Economic Assistance programs to improve customer service and long-term performance in areas such as call wait times and timeliness.

**PROGRAM STRATEGY**

- ▶ Hold daily management huddles to communicate performance and the emphasis of daily work
- ▶ Place performance dashboards on the internal and external websites to communicate progress
- ▶ Increase client accessibility to Economic Assistance programs by adding the ability to apply and recertify/review benefits via the telephone
- ▶ Utilize email and text messaging to increase communication with clients providing increased communication options in addition to relying on U.S. mail
- ▶ Utilize workforce management/capacity planning calculations to assess and assign staffing to meet program targets
- ▶ Increase and improve online/mobile services available for clients
- ▶ Increase the amount of applications processed the same day the application is received utilizing electronic verification sources
- ▶ Increase client communication on review/recertification timelines by utilizing multiple communication methods other than U.S. mail
- ▶ Utilize program policy enhancements to assist staff in the recertification process
- ▶ Allow clients the option to receive electronic notifications only
- ▶ Increase the amount of information available in the online accounts and via Interactive Voice Response (IVR) Self Service
- ▶ Implement quarterly address checks utilizing mail software to keep addresses current
- ▶ Implement the use of Intelligent Mail to track the delivery of mail to ACCESSNebraska

- ▶ Utilize workforce management to forecast the amount of staff needed to handle the phone volume
- ▶ Implement the findings of the LR 33 ACCESSNebraska Special Investigative Committee and other legislative studies

**DELIVERABLES**

Deliverable	Target Completion
Process all Economic Assistance program applications in an average of 10 days	<b>April 2016 and ongoing</b>
Process all Economic Assistance program applications within the federal timelines 95 percent of the time	<b>Ongoing</b>
Decrease by 10 percent the amount of benefit interruptions caused by untimely review/recertification processing	<b>April 2016 and ongoing</b>
Process all Economic Assistance program reviews/recertifications within the federal timelines 95 percent of the time	<b>February 2016 and ongoing</b>
Improve client communication by reducing the amount of returned mail by 25 percent from 2015 levels	<b>October 2016</b>
Improve customer service by answering calls to the Customer Service Centers quickly. ACCESSNebraska will have an average call wait time of 5 minutes	<b>Ongoing</b>

**Single Audit Corrective Action Plans**

**BACKGROUND**

The Nebraska Auditor of Public Accounts audits the State of Nebraska Comprehensive Annual Financial Report (CAFR) as well as conducts the Statewide Single Audit to ensure compliance with state and federal laws and to assess the adequacy of current controls over expenditures by state agencies.

Single Audit findings regarding DHHS programs have been identified as a significant risk for DHHS by both senior management and external stakeholders. DHHS is responsible for promptly responding to the issues noted in the audit reports and taking appropriate

corrective action steps to ensure compliance with applicable criteria and efficient operations.

**GOAL**

The goal is for all corrective action plans to be fully implemented no later than June 30 of the fiscal year immediately following the audit period in which the finding was identified.

**PROGRAM STRATEGY**

Each audit finding is assigned to DHHS staff who are responsible for drafting, approving, and implementing a corrective action plan.

The corrective action plan must also include a detailed implementation plan which outlines specific action steps for achieving the corrective action plan.

All corrective action and implementation plans will be reviewed and tested for compliance by the Internal Audit Section.

**DELIVERABLES**

Deliverable	Target Completion
Internal audit report for each finding to include the opinion of the Internal Audit Section on the completeness and adequacy of the corrective action plan	Ongoing
Tracking matrix for all Single Audit findings available for all DHHS employees, including management, to view the status of corrective action plan implementation	Ongoing
Quarterly meetings with each Division’s Senior Management team to provide status updates	Ongoing



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## DHHS Mission:

**“Helping People Live Better Lives”**

## DHHS Values:

### **Constant Commitment to Excellence:**

Takes timely action in regard to tasks or information; works to eliminate mistakes; looks for, and embraces, opportunities for organizational improvements; actively seeks to provide prompt, efficient, and courteous service; shows initiative.

### **High Personal Standard of Integrity:**

Avoids any impropriety, bias, or conflict of interest; follows through on commitments; is truthful; shows good judgment in decisions made.

### **Positive and Constructive Attitude and Actions:**

Maintains constructive communication with others; supports co-workers, customers, and clients; expresses appreciation for the efforts and work of others; is constructive and helpful.

### **Openness to New Learning:**

Open to new ideas and trying new ways of doing things; open to the idea that a given view or opinion is often made better by the input of others; open to the challenge of unfamiliar tasks and problems.

### **Dedication to the Success of Others:**

Aids in the growth and success of colleagues; treats all people with respect and dignity; views the success of the whole as a personal success; gives the assumption of good intent to others.

## DHHS Core Competencies:

### **Demonstrates Responsibility & Accountability:**

Cares for and maintains equipment/facilities; conserves supplies and funds; takes responsibility and is reliable for completing assigned tasks; acknowledges and corrects mistakes; adheres to the expectations of their supervisor.

### **Demonstrates Professional Composure:**

Demonstrates calm, dignity and self control under pressure; defuses situations with empathy and respect.

### **Demonstrates Effective Interpersonal Relationships:**

Works to gain the trust of others; demonstrates courtesy, and civility; is open and transparent with tact; is sensitive and attentive while doing active listening; promptly and effectively deals with conflict; shares opinions while respecting the differing opinions of others.

### **Demonstrates Productive Communication:**

Demonstrates good oral, written, and listening skills; contributes to effective meetings; clearly and accurately shares information.

### **Demonstrates Support of Their Team:**

Shows respect for team leadership; promotes a friendly climate, good morale, and cooperative team relationships; values all team members.

### **Demonstrates Self-Improvement:**

Participates in training and development opportunities; welcomes new learning and the challenge of unfamiliar tasks; seeks to do the job better.

### **\*Demonstrates Motivating Others:**

Inspires, motivates, and guides others toward accomplishing their work; gives recognition for contributions.

### **\*Demonstrates Developing Others:**

Clearly defines expectations; invests time and effort to improve performance; knows all direct reports, and recognizes unique skills and temperament of each; uses an array of development tools; links individual performance to organizational goals.

*\*for supervisors*



Nebraska's  
New  
Integrated  
Managed  
Care Program

**HERITAGE  
HEALTH**

NE OFFICE OF CONSUMER AFFAIRS  
PEOPLE'S COUNCIL  
AUGUST 2, 2016

Department of Health & Human Services  
**DHHS**  
NEBRASKA

## Current Nebraska Medicaid

- ▶ Nebraska Medicaid provides health care coverage to approximately 230,000 people at an annual cost of approximately \$1.8 billion.
- ▶ 12% of Nebraska's population is Medicaid eligible.



## Current Managed Care

- ▶ Nebraska Medicaid contracts with:
  - ▶ Three regional MCOs for physical health services
  - ▶ A separate managed care entity for behavioral health services
  - ▶ A pharmacy benefit management contractor for pharmacy services
- ▶ An individual receives his or her health care through three separate contractors.
- ▶ 82% of Medicaid clients are enrolled in physical health managed care and more than 99% are enrolled in behavioral health managed care.



## Financing Care

### ➤ Capitated Payments

- A fixed amount, per covered individual, is paid each month to a managed care organization (MCO). In return, the provider or MCO is responsible to pay for (and is "at risk" for) the medical care for its patients or members.
- These rates are developed by actuaries and are based on historical costs and projected trends.



## Comparing Models

### A Comparison

#### "At Risk" Model

- Payment is made to the health plan before services are delivered.
- The MCO has a financial incentive to provide cost effective services.
- Risk is assumed by the managed care organization.

#### Fee for Service (FFS) System

- Payment is made after a service is delivered (retrospectively).
- Providers bill for services delivered and are paid a predetermined rate for each service directly by the State.
- The recipient of the FFS payment (providers) has a financial incentive to deliver more services.
- Risk is assumed by the State.



## Key Health Plan Responsibilities

### ➤ Care Management

- Emphasis on use of primary care providers
- Triage and referral for behavioral health
- Disease management
- Clinical standards and best practices

### ➤ Quality Management

- Formal, structured program
- National standard performance measures (e.g. HEDIS, member experience)
- Focused performance improvement projects



## Key Health Plan Responsibilities

### ➤ Utilization Management

- Prospective review – precertification and preauthorization guidelines (not for emergency services)
- Concurrent review – discharge planning
- Retrospective review – use of claims data to determine areas of opportunity

### ➤ Provider Network Management

- Explicit standards for selecting providers
- Policies for continued access to care when providers change
- Provider education



## New Integrated Managed Care Program: Heritage Health

On April 15, 2016, Nebraska Medicaid announced the signing of contracts for Heritage Health, a new managed care program providing integrated health care services.

- ▶ The three awarded health plans are UnitedHealthCare Community Plan of Nebraska, Nebraska Total Care (Centene), and WellCare of Nebraska.
- ▶ Each health plan will coordinate a full range of services, including physical health, behavioral health, and pharmacy services.

Start Date →



## Uniformity with Credentialing

- ▶ Council for Affordable Quality Healthcare (CAQH)
  - ▶ National non-profit organization dedicated to reducing the administrative burden of provider credentialing.  
[www.caqh.org](http://www.caqh.org)
  - ▶ Ensure profile is up to date and has been attested to within the last six months
  - ▶ Select each Heritage Health plan as an approved payer in order for the plan to access the CAQH profile.



## Heritage Health Goals

- ▶ Improved health outcomes
- ▶ Enhanced integration of services and quality of care
- ▶ Emphasis on person-centered approach, care management, enhanced preventive services, and recovery-oriented care
- ▶ Reduced rate of costly and avoidable care
- ▶ Improved financially-sustainable system



## Behavioral Health Integration

- ▶ Designed to better address co-occurring mental illness and substance use disorders – focus on the whole person
- ▶ Plans are financially and contractually incentivized to invest in preventive and community-based care
- ▶ MLTC established a behavioral health integration advisory committee to guide transition

*"There is no health without behavioral health, and individuals with serious behavioral health conditions often have untreated or undertreated physical health conditions. Bringing together the responsibility for managing these services is an important step toward recognizing the importance of treating the whole person in an integrated setting."*

Sheri Dawson  
Director of the DHHS Division of Behavioral Health



## New Populations

- ▶ Individuals participating in home and community based waivers (Aged and Disabled Waiver, TBI Waiver, and DD Waivers)
- ▶ Individuals who live in long-term care institutional settings, such as nursing facilities and intermediate care facilities for people with developmental disabilities.

These individuals will have their physical health (for example, physician and hospital care), behavioral health, and pharmacy services coordinated by their Heritage Health plan.

***Long-term services and supports will continue to be administered as it is today.***



## Contract Key Features

Focusing on Quality, Care Management, and Social Determinants of Health

- ▶ Enhanced MLTC partnership with sister Divisions
- ▶ Performance measures specific to Nebraska's Medicaid members
- ▶ New MLTC Heritage Health Quality Committee
- ▶ Early Identification of care management need
- ▶ Inclusion of social determinants of health in health risk assessment and care management strategy
- ▶ Referrals to community resources

## Contract Key Features

### Expanding Access

- ▶ Requirements for robust provider networks including hospitals, physicians, specialists, pharmacies, mental health and substance use disorder providers, and allied health providers
- ▶ Preventive, primary care, specialty care, and recovery-oriented services
- ▶ Patient-centered medical homes

Contract Key  
Features

Enhanced  
Accountability

- ▶ MLTC-approved policies and procedures
- ▶ Reporting on numerous operational and performance measurements
- ▶ MLTC staff access to information systems
- ▶ Readiness reviews
- ▶ Periodic operational reviews
- ▶ Financial incentives and penalties



Contract Key  
Features

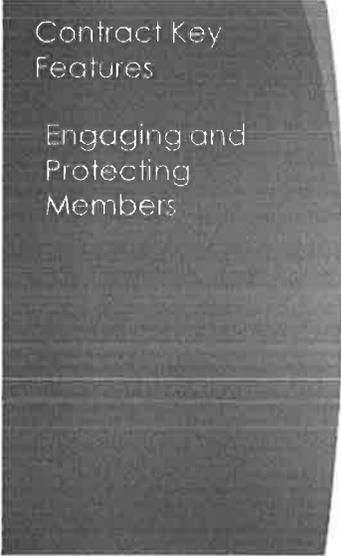
Supporting  
Providers

- ▶ Process simplification and communication
- ▶ Timely payment requirements, shortening the time between filing and receipt of payment
- ▶ Enhanced claim tracking tools
- ▶ Common state preferred drug list
- ▶ Extensive provider training
- ▶ Dedicated provider services staff
- ▶ Provider advisory committees
- ▶ Provider complaint system

## Contract Key Features

### Focusing on Value

- ▶ Moving away from fee for service, and toward more sophisticated strategies for purchasing health care services
- ▶ Plans will be required to meet specific thresholds for "Value-Based Contracts"
  - ▶ Include quality, outcome, or cost metric for providers
  - ▶ Aligns financial incentive of MCO with provider (e.g., shared savings, performance pay)



Contract Key  
Features

Engaging and  
Protecting  
Members

- ▶ Proactive provision of information, accessible formats
- ▶ Availability of toll-free call center
- ▶ Extensive MLTC-approved grievance process
- ▶ Evaluation of member experience, using national survey
- ▶ Member choice – MLTC contracts with Enrollment Broker to provide choice counselling

## Contract Key Features

### Supporting MLTC Partners

Heritage Health plans are required to coordinate with other DHHS and State agency programs, including:

- ▶ Division of Behavioral Health
- ▶ Division of Children and Family Services
- ▶ Division of Developmental Disabilities
- ▶ Department of Education
- ▶ Community Agencies, including and not limited to the Area Agencies on Aging and League of Human Dignity
- ▶ The Office of Probation
- ▶ Other programs and initiatives related to primary care and behavioral health integration/coordination and pharmacy management

## Contract Key Features

### Ensuring a smooth transition

- ▶ MLTC-approved transition and implementation plan
- ▶ Nine-month collaborative implementation period
- ▶ Key staffing requirements
- ▶ Provider network in place 90 days in advance
- ▶ Strong continuity of care protections to ensure no disruption

MLTC and its contracted enrollment broker will coordinate member education and enrollment with the Heritage Health MCOs.

## Heritage Health Enrollment Broker

In April 2016, Nebraska Medicaid signed a contract with Automated Health Systems to act as Medicaid's enrollment broker for the Heritage Health program. The enrollment broker is an independent entity that provides the following services to Medicaid members:

- ▶ Plan selection outreach
  - ▶ Written and phone-based outreach alerting Heritage Health members to the open enrollment period and the timeline for making a voluntary plan selection
- ▶ Comprehensive and unbiased choice counseling
- ▶ Searchable databases of providers that allow members to determine whether his/her current primary care provider or preferred specialist is a part of a specific health plan's network prior to the member selecting his/her health plan



## Communications

- ▶ Heritage Health branding
- ▶ New and redesigned webpages
  - ▶ News releases and program updates
  - ▶ FAQs
  - ▶ Links to procurement site and contracts
- ▶ Public/stakeholder involvement

*"Nebraska has a proud heritage for taking care of ourselves, our families and our neighbors. Heritage Health will be a vehicle for better health for nearly 230,000 Nebraskans, many of whom are among our most vulnerable."*

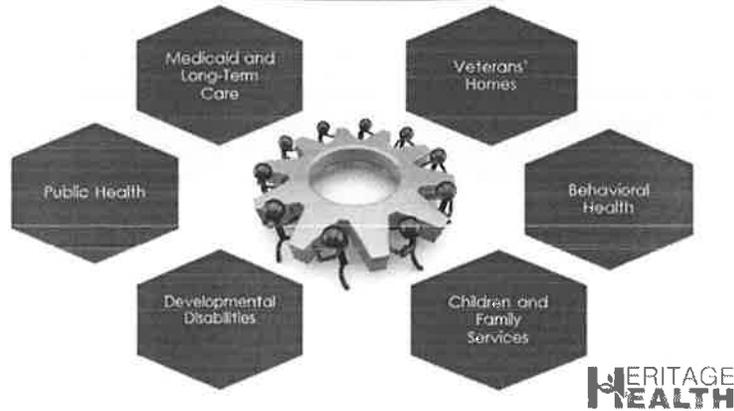
Courtney Phillips, CEO Nebraska DHHS



# Implementation Timeline



Helping People Live Better Lives --  
*Better Together*



## Questions

### Heritage Health Website

<http://dhhs.ne.gov/heritagehealth>

### Email

[dhhs.heritagehealth@nebraska.gov](mailto:dhhs.heritagehealth@nebraska.gov)

*"We are excited about all of the improvements and enhanced accountability that Heritage Health will bring to Nebraska Medicaid. Integration of behavioral and pharmacy services and inclusion of some of our highest need and highest cost populations will help us deliver better outcomes to recipients and greater value for taxpayers."*

Calder Lynch  
Director, Division of Medicaid and Long-Term Care





Nebraska Division of Behavioral Health  
**State Advisory Committee on Mental Health Services (SACMHS)**  
**State Advisory Committee on Substance Abuse Services (SACSAS)**  
 June 23, 2016/ 9:00 am – 4:00 pm Lincoln, NE – Country Inn & Suites

Meeting Minutes

**I. Call to Order/Welcome/Roll Call**

*Renee Faber*

Renee Faber, Division of Behavioral Health (DBH) Advisory Committee Facilitator, welcomed committee members and others present to the meeting. The Open Meetings Law was posted in the meeting room and all presentation handouts were available for public review. Three new members of the State Advisory Committee on Mental Health Services, Vicki Maca, Nancy Rippen and Suzanne Day were introduced and welcomed.

Roll call was conducted and a quorum was determined to exist for the State Advisory Committee on Mental Health Services. At the beginning of the meeting, it was determined that a quorum was not present for the State Advisory Committee on Substance Abuse Services; subsequent late arrivals did meet the quorum threshold.

State Advisory Committee on Mental Health Services Members in Attendance: Adria Bace, Brenda Carlisle, Suzanne Day, Bob Doty; Bev Ferguson, Brad Hoefs; Lisa Jones; Ryan Kaufman, Linda Krutz; Kristin Larsen, Phyllis McCaul; Lisa Neeman, Rachel Pinkerton; Nancy Rippen, Mary Thunker, Diana Waggoner, Stacey Werth-Sweeney. Members Absent: Karla Bennetts, Kathleen Hanson, Patti Jurjevich, Joel Schneider, Mark Schultz.

State Advisory Committee on Substance Abuse Services Members in Attendance: Roger Donovick; Ann Ebsen; Ingrid Ganseboom; Jay Jackson, Michael Phillips; Randy See; Mary Wernke. Members Absent: Janet Johnson; Dusty Lord, Kimberly Mundil.

DHHS Staff in Attendance: Sheri Dawson, Renee Faber, Tamara Gavin; Cynthia Harris, Tiffany Mullison, Nikki Roseberry-Keiser, Deb Sherard, Linda Wittmuss, Cynthia Harris, Debra Sherard, Heather Wood.

**II. Motion to Approve Minutes**

*Chairperson Diana Waggoner*

State Advisory Committee on Mental Health Services (SACMHS) Chairperson Waggoner welcomed members, guests and staff to the meeting and presented the minutes for review. Asking for and receiving no corrections or comments, SACMHS Chairperson Waggoner called for a motion to approve the February 18, 2016 meeting minutes as written. Moved by Doty and seconded by Ferguson, the motion passed on a unanimous voice vote. As there was not a quorum present for the State Advisory Committee on Substance Abuse Services, no vote was called.

**III. Public Comment**

There was no comment offered at the morning Public Comment opportunity.

**IV. Director's Update**

*Sheri Dawson*

- Director Sheri Dawson took the floor and asked all DBH employees to stand. Announcing that it has been a very busy time in the Division, she asked for a round of applause to acknowledge everyone's hard work. Between the SAMHSA Joint Center Federal site audit, development of the strategic bridge plan and various legislative proposals, DBH staff have been "rocking."
- Director Dawson introduced the DHHS Business Plan that was recently announced at a press conference with the governor, stating that this plan, with target dates, assists with the removal of silos between divisions and has us all working together as a team.
- As DHHS formulates action steps to carry out its business plan, DBH is working on a full scale needs assessment that will serve as the foundation of DBH's next strategic plan.
- Director Dawson announced that Cynthia Harris is the new administrator for the Office of Consumer Affairs. The second round of interviews for the Office of Facilitation for Recovery open position, located at the Lincoln Regional Center, are scheduled for the week of June 27<sup>th</sup>. Under the direction of the Office of Consumer Affairs, the Office of Facilitation for Recovery will be the driver of the peer bridge program.
- It was announced that Anthony Walters, CEO of the Nebraska Regional Centers, has resigned. Stacey Werth-Sweeney is serving as interim CEO. The position opening will be posted soon.

- The Federal Site Visit went very well and Renee Faber was recognized for an excellent job coordinating all the logistics for the visit. Director Dawson noted that at the end of the visit, it was suggested that Nebraska is one of the top states in the nation in terms of behavioral health integration and both Dawson and Faber have been invited to speak at the SAMHSA's national block grant meeting in August. A unique addition to the audit included a 'secret shopper' exercise where auditors, posing as consumers, contacted various providers to evaluate their knowledge of service components such as wait lists and admission availability for priority populations. The auditors were overall very impressed with our clinical practices. Director Dawson expressed her pride in our team and our state and stated that even with gaps and needs, we are doing great.
- Director Dawson attended the recent National Association of State Alcohol and Drug Abuse Directors Annual Meeting where Renee Faber presented during a leadership session about prevention efforts. At this meeting, Faber was elected as the Vice President for Internal Affairs for the National Prevention Network, noting everyone was impressed with Nebraska's umbrella approach to prevention and treatment.
- The Annual Behavioral Health Conference, held on May 31 – June 2, 2016 at the Cornhusker Hotel in downtown Lincoln, was very well attended, with over 500 people visiting the booths and attending the break-out sessions. The 2017 conference is slated for April 2017.
- Both the Lincoln Regional Center as well as the Norfolk Regional Center recently had surveyors on site. Their inspections resulted in no deficiencies. A big shout-goes out to both facilities for work well done.
- Nebraska will be holding an Opioid Symposium on October 14 focusing on prevention, treatment, and law enforcement through direct collaboration with the public health, medical and law enforcement communities operating in Nebraska. DHHS has already begun several key initiatives to combat opioid abuse and addiction.
- DBH is collaborating with BHECN on a workforce development plan and it was noted that while the psychiatric nursing shortage at LRC is still a challenge, the vacancy rate has dropped from 48 to 42.1 percent.
- Director Dawson announced an upcoming webinar on June 29 from 10 to noon, which will address the Heritage Health Initiative. Director Dawson explained that the initiative encompasses primary care, pharmacy and behavioral health; serving the whole person. Information to attend the webinar will be sent out tomorrow.
- Director Dawson updated the committees on a series of new contracts with a number of family organizations who deliver family and peer support, adding that there is great impact with family members sharing lived experiences. Dawson explained that the contract with the Federation of Families has ended and DBH is contracting individually with family organizations across the state.
- SAMHSA has indicated they would like to see specific planning in place to serve veterans. To facilitate this project, there will be strategic planning workshops scheduled on September 8 and 9 and we are seeking participants with an interest or background in veterans' affairs. Please let Deb Sherard know if you are interested in serving in this capacity.
- The DBH Centralized Data System is now operational and allowing interface with providers as a built-in authorization system. The system is garnering national attention, with presentations requested at several conferences.
- As noted on page 38 of the DHHS Business Plan, efforts towards improving system flow are underway. DBH will be looking at admissions and discharges as they work to reduce wait time for facilities to improve flow through and that emergency beds are available when needed.
- Jude Dean has been hired to coordinate Preadmission Screening and Resident Review (PASRR) services.
- Leslie Hays of Hays Consulting will be in Lincoln on Monday, June 27 to work with staff on Emergency System Mapping, to identify steps in the Emergency Protective Custody procedures.
- Budget planning for FY18-19 has begun amidst the budget freeze in DHHS, noting that travel, operations such as printing, postage and copying, and open job postings will be limited in lieu of the shortfall.
- Legislative Resolution 413 identifies a mandated task force on "behavioral and mental health," which was proposed as a result of last fall's legislative audit. Senator Bolz is Chair of this committee and they are meeting monthly. Director Dawson noted the task force is primarily interested in policy and funding issues and are especially interested in the results of the comprehensive needs assessment. Anyone seeking more information about the task force and its members may contact Deb Sherard and she will get the information out to you.
- Chairperson Waggoner took the floor and thanked Director Dawson for her and the staff's hard work. She

also inquired as to how the committees may be of service during this time. Director Dawson explained that the committees will be called upon to help prioritize results from the needs assessment and to develop a realistic work plan for the new strategic plan moving forward.

## **V. 2016 SAMHSA Site Visit**

*Renee Faber*

Renee Faber, who coordinated the site visit, reported that after four intensive days of scrutiny, a very preliminary summary of the strengths, opportunities and challenges identified during the visit had been provided in the packets. Faber highlighted the following comments from the site visit team:

- They were very impressed with the new Central Data System and were equally impressed with the Nebraska Prevention Information Reporting System database.
- They appreciated the clear language in the state to region contracts as well with community based providers but noted that the mental health block requirements could be operationalized further.
- They noted DBH's transparency and fiscally accountable relationships with the regions. They did acknowledge that DBH operates primarily as a paper-based system but recognized our movement to EBS.
- They offered a very favorable review of the whole prevention system program, highlighting the coordinated process for administering high school surveys and that responses rate were high.
- Several tobacco retailer compliance checks were observed as part of their review of compliance with the Synar Regulation. They commended the use of mics (for both safety and to uphold convictions) with the undercover teens who law enforcement work with to attempt the purchase of tobacco products. They also said we did a good job being culturally responsive in these processes.
- The team of auditors liked the Kognito online training offered through the Suicide Prevention Program.
- The team favorably reviewed partnership efforts in the areas of federally qualified health centers, criminal justice and suggested work groups to include all modalities.
- They agreed that while we are meeting standards for the provision of interim services, they would like to see more evidence of training and understanding of this requirement among substance use providers.
- Team noted that legislatively, Nebraska laws pertaining to Synar are rather weak, with a lack of central authority over tobacco licensing, making accountability of retail owners difficult. They suggested changes to existing laws as well as more training for the clerks selling tobacco products.

Faber said a draft report will be issued 70 days after the site visit, with a final report coming after DBH reviews.

The Chairs and Vice Chairs for the Mental Health and Substance Abuse Advisory Committees met with the Federal Audit Team. Randy See said although he wasn't sure what to expect, he felt the committee members came through as a voice from the community. Chairperson Ann Ebsen spoke about the challenge of service delivery to rural and western Nebraska wherein the federal auditors offered technical assistance. Overall, the consensus was that committee members did an excellent job of representing DBH and the State of Nebraska.

## **VI. Prevention Activities Update**

*Nikki Roseberry-Keiser, Tiffany Mullison*

*Nikki Roseberry-Keiser, Grant Coordinator for the Partnership for Success program*, reported out for the Prevention Advisory Council, a subcommittee to the Joint Advisory Committee, and provided an update on recent prevention activities.

The Partnership for Success (PFS) subaward is designed to reduce underage drinking. Recently, carry-over funds were approved to be used to provide staff training, continue culturally and linguistically appropriate services (CLAS) training and expand the statewide media campaign. CLAS standards have been integrated into all PFS work plans and training continues on sustainability and fidelity as well as substance abuse prevention skills.

While Nebraska ranks as the 10<sup>th</sup> healthiest state, we also rank #47 for binge drinking. A Collective Impact Workgroup, comprised of a partnership with UNMC and other stakeholder institutions, have started several pilot sites for Screening and Brief Intervention and Referral to Treatment (SBIRT) and are now working to see how the model integration is going. The Division of Behavioral Health, along with Public Health, acknowledge that the numbers for binge drinking in Nebraska are high and CEO Courtney Phillips wants to make an impact on those numbers. Linda Krutz commented that binge drinking is cultural for our state and has a huge parental component. Roseberry added that while the SBIRT model is focused on who is doing the drinking, they hope to expand the

scope to address issues like parental influence. Additionally, a website offered by Region 5 was designed to help parents talk to their children about alcohol use and coalitions implementing the Strengthening Families program aid in this effort.

Roseberry also expounded on data collection, where they have expanded surveys, looking specifically at parental data. Questions were also added about domestic violence and the use of alcohol.

*Tiffany Mullison, Suicide Prevention Outreach Specialist*, presented data that indicated the top nine causes of death in the U.S. have all been declining since 2005 except for suicide, which continues to rise, noting that about half of youth surveyed said they had seriously planned to commit suicide at least once. As part of a three-year award, the Youth Suicide Prevention Grant focuses primarily on youth 10 to 24 years old.

Efforts have proved effective with the passage of LB923, which requires educators to receive at least one hour of suicide awareness and prevention training each year. The numbers of those completing the online Kognito training course were much higher than expected. Also being utilized is a National Hotline and public awareness campaign as well as Local Outreach to Suicide Survivors (LOSS) teams, which are comprised of local advocates who respond to help suicide survivors. While three active teams are covering 29 percent of the state, this program is expanding, in part due to the training provided by this grant.

Discussion following surrounding the idea that suicide prevention training has to encompass kids helping kids. Youth surveys reveal that when asked, kids will go to their peers for help so messaging that empowers young people to respond to someone in crisis is vital.

Mary Thunker suggested that curriculum for a class on mental health issues be required and added that there is a lot of community interest in this idea.

Kristin Larsen said youth suicide prevention is a priority in Public Health and that collaboration with the Division of Behavioral Health through the State Health Improvement Process is a positive step.

*Nikki Roseberry-Keiser* solicited feedback on the Prevention Advisory Council's functions and responsibilities. This group meets quarterly and explores a wide range of prevention topics as well as emerging trends. The PAC started with 13 people appointed by the Governor and had a structure similar to the Joint Advisory Committee but has since evolved into a different format where voting became less significant and everyone has an equal voice. The PAC is asking for guidance relating to the following questions:

1. Should the PAC continue with its current format or should they retain membership appointed by the Director?
2. What does the Joint Advisory Committee see as the PAC objectives?
3. Perhaps the most important, what would the Joint Advisory Committee like to see brought back to the table by the PAC?

Ryan Kaufman added that if PAC is not maximizing the passion among appointed members to do something, people could sign up and volunteer for different areas of interest, echoing what the Joint Advisory Committee has voiced in the past – they would like to be more useful, to be utilized more fully with definable action steps.

## **VII. Nebraska Association of Behavioral Health Organizations**

*Annette Dubas*

Annette Dubas, former Nebraska State Senator, spoke to the Joint Advisory Committee about her role as the first Executive Director for the Nebraska Association of Behavioral health Organizations (NABHO). NABHO is Nebraska's largest behavioral health organization and they advocate on behalf of providers and consumers for a strong, effective and stable behavioral health system of care. Ms. Dubas indicated that NABHO is interested in how DBH, as well as this Committee, could work together more.

## **VIII. Access Measures**

*Tamara Gavin*

*Tamara Gavin, Deputy Director of Community Based Services*, reported on proposed access measures that are purposed to ensure consumers receive the services they need at the time they need them, starting with four services: supported housing, supported employment, short-term residential, and medication management. In choosing which services to address, Gavin explained that supported housing and supported employment underscores our investment not only in treatment services but recovery services as well.

Faber asked for a motion to approve all four access measures as presented by Deputy Director Gavin. It was noted that a quorum was not present for the Substance Abuse Advisory Committee so no vote could be recorded.

Additionally, Committee members indicated they want more baseline data before voting.

Chairperson Waggoner voiced several questions regarding budgeting for supported housing, specifically asking for a dollar amount per family. Gavin said that annual report information will be available by the next meeting, from which a figure could be derived.

After considerable discussion about medication management, it was noted that the specialty population – those discharging from inpatient acute settings – were targeted for this specific access measure as they were felt to be very vulnerable post-discharge from services and allowed the access measures to be tested on a smaller population.

The general consensus was that a larger conversation was necessary before these access measures are approved; specifically there were concerns noted that the access measures, as currently drafted, would not measure provider acceptance rates but would only account for consumers who were admitted into care. Discussion continued without a formal vote. The following questions were posed:

1. Is 95 percent a realistic target, given historic performance?
2. Regarding 21-day access for medication management, is that for an appointment to be set or is the consumer seen within that 21-day window? Wording will be updated to clarify.
3. Were consumers surveyed to obtain data for the proposed measures or was the information obtained from providers?

Gavin agreed to work toward revision of measure language, looking closer at work flow and identifying vulnerabilities, adding this will not move forward without an approval vote. However, a voice vote gave support to moving forward with changes in the CDS to gather more data relevant to access measures.

## **IX. Strategic Planning**

*Linda Wittmuss*

*Linda Wittmuss, Deputy Director for System Integration*, presented an update on the DBH Bridger document, which serves as the 2016 strategic plan and announced plans for developing a framework for the new strategic plan. Wittmuss solicited input from the Committee regarding the general layout of the document as well as content related to the five key areas of the work plan.

It was suggested that accountable relationships appear under each measure and to use “Support” as the actual performance measure. Wittmuss clarified that these are the key activities identified under the current work plan but several of them will continue into the next plan. She would like to hear suggestions on other areas to retain in the new strategic plan.

Wittmuss verified that final results of the needs assessment will be available by the end of July. She has prepared a timeline with a formal draft slated to be ready for review by December 31. After results of the needs assessment are made available, a strategic planning committee will be established to help set the framework for the next plan.

It was suggested that one member of the Advisory Committee be appointed to the strategic planning committee, who will meet three or four times to work with DBH to review the needs assessment results, lay out the framework for the new strategic plan, identify priority areas and then disseminate out for further discussion.

Wittmuss stated initial plans were to have about 20 serve on this committee beginning in August. Suggestions as to who to include on this planning committee were as follows:

- Both mental health and substance abuse providers – and specialized providers
- Representatives from the regions
- Developmental disabilities to address dual diagnosis services
- Specifically Senator Kate Bolz and Annette Dubas for NABHO
- Consumers, a family voice and other advocacy groups
- Law enforcement to address emergency mapping
- EMS and/or first responders
- Geographical representation – urban and rural
- Lincoln Regional Center and/or other hospitals providing behavioral health services
- Adult and juvenile probation, prison system, corrections.

It was also suggested to retain a strategic planning specialist. Mary Wernke offered to recommend a consultant. A strong facilitator as well as writers would be useful as well. Deputy Director Wittmuss then solicited member interest to serve on the strategic planning committee. Michael Philips agreed to serve.

## **X. Legislative Update**

*Linda Wittmuss*

*Linda Wittmuss, Deputy Director of System Integration*, provided a legislative update to the committees, identifying the passage of LB816 and improving our ability to share information with providers and expedite the continuity of care.

LB998 proposed to address the EPC system and it was noted that the needs assessment should help identify areas of concern and ways to improve the behavioral health emergency systems.

Starting now, up until the middle of July, is the time to bring forth proposed legislation in order to start research and writing. In the division, areas we are looking at include:

1. Data sharing – improved processes to exchange this information
2. Clarity – cleaning up process and language re competency restoration
3. Sharing of information for continuity of care, corrections and the regional centers

Wittmuss identified the potential for cleaning up some statutory language, in particular, outpatient treatment for convicted sex offenders. The current law requires utilization of the least restrictive treatment and there is not a lower level option of treatment beyond inpatient. Justice and behavioral health will need to work together to look at developing training and skill sets to address these issues as well as identifying resources and funding to support these activities.

Renee Faber commented briefly that LB1058, which was purposed to offer protection for minors used in tobacco compliance inspections, did not move forward but would be helpful to revisit again. Faber also recognized the need for a centralized licensing process for tobacco at the state level.

While the lead agency for LB1033 is Developmental Disabilities, a representative of each division will be involved to lay out a process for the Olmstead Plan. A broad advisory committee will be formed including one member of this committee and plan on meeting in August or September. Rachel Pinkerton volunteered to serve and there was general consensus approval of her appointment.

## **XI. Committee General Comments and Observations**

*All*

- Director Dawson set a positive tone and it continued throughout the meeting. The agenda was less crowded and better paced.
- Committee members commented that this was a very productive meeting and appreciated having their voices heard. Good energy, good input and enthusiasm for making things better were all comments made.
- Congrats were offered on a successful federal audit.
- Ann Ebsen suggested arranging future agendas to have voting matters addressed early so that quorums are maintained.
- A suggestion was made to have a designated committee member speak about their areas of expertise and interest as a standing agenda item for each meeting. There was also a suggestion to have committee members share announcements about their respective organizations as a standing agenda item as well.

## **XII. Adjournment and Next Meeting**

The meeting was adjourned at 4:03 p.m. The next Joint meeting of the State Advisory Committee on Mental Health Services and the State Advisory Committee on Substance Abuse Services is scheduled on Thursday, August 18, 2016.

Minutes prepared by the Division of Behavioral Health, Nebraska Department of Human Services. Minutes are intended to provide a general summary of the proceedings.

6-23-16 Meeting Minutes

Preliminary identified block grant implementation strengths and opportunities as identified by the SAMHSA site monitoring teams during the Exit Conference on May 13, 2016.

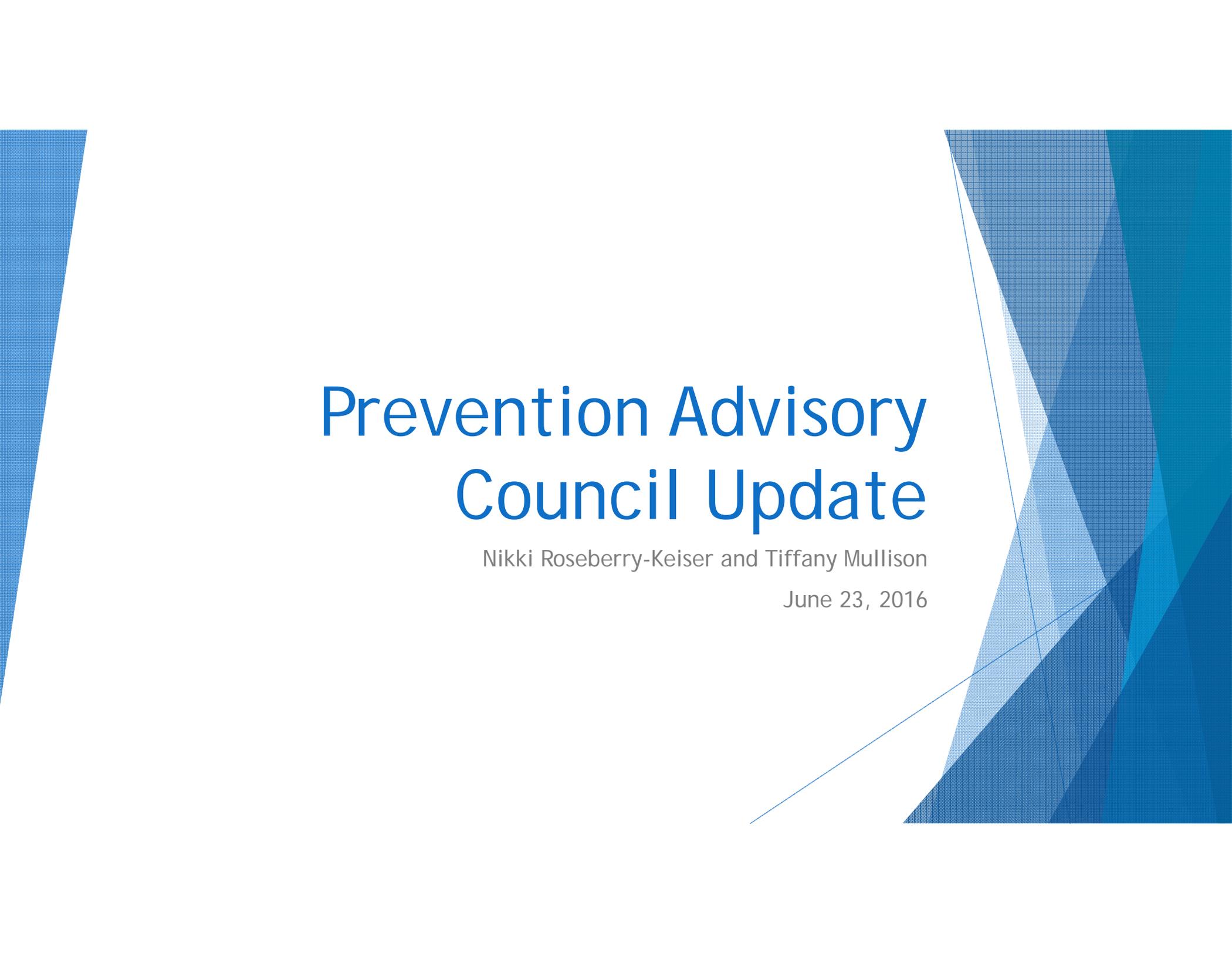
### Major Strengths

- Outstanding supportive documents assembled for the pre-site visit materials
- Strong Trauma-Informed Care system
- Strong Quality Assurance & Quality Improvement processes at all levels, state, intermediary and local – holistic and 360 view ensures accountability
- DBH services are data driven based on metrics and standards
- Excellent Children’s System of Care Implementation – lots of strengths
- Fully engaged behavioral health planning council (State Advisory Committees) and transparency in process
- First Episode Psychosis Pilot Program teams are strong multi-agency collaborations
- Transparency in DBH processes engender a partnership with intermediaries and providers
- RHBA intermediaries have good fiscal-related processes with providers
- Prevention System supports a strong collaboration among state, regions and local partners – the Strategic Prevention Framework is present in this integration and focus is on QI
- Strong Regional Prevention Coordinator role across the state
- Prevention staff supports continuous, ongoing monitoring
- Prevention System development of NPIRS and SHARP supports both reporting needs and prevention programmatic and strategy quality assurance activities
- Synar Program has developed strong interagency partnerships supporting collaborative activities
- Synar inspection process is implemented and operationalized with fidelity
- Synar reporting system provides for real time access and reporting and incorporates quality control measures
- Synar inspection protocol provides for culturally appropriate selection of products
- Nebraska youth tobacco access law has been revised to include Vapor delivery mechanisms
- Innovative use in Suicide Prevention of Kognito’s online role-playing simulation gatekeeper training program

### Opportunities

- Safeguard against SUDs being lost or minimized in mental health and substance abuse integration
- Develop a formal policy for MHBG requirements and responsibilities (similar to SABG policy)
- Review and update DBH practice of using spreadsheets in recording of billings/invoices
- Revise existing DBH reporting inconsistencies in WebBGAS
- Employ Best Practices to improve the mechanisms of transmitting provider invoices to RBHAs
- Expand prevention system collaboration with School Resource Officers
- Develop the youth crisis response system to incorporate school counselors statewide and mobile crisis teams
- Develop additional coordination of criminal justice involved youth within the Children’s System of Care
- Continue collaborations (e.g., BHECN) to address workforce challenges, especially in frontier and rural areas
- Develop a Peer Career Ladder track to increase peer employment in services

- Utilize and expand the number of FQHCs to integrate BH services, explore HRSA grant opportunities
- Increase NBHS partnerships among private and public entities
- Increase use of telehealth to improve access and availability of services
- Support the use of patient centered medical Behavioral Health Homes
- Develop resources to support First Episode Psychosis Pilot Program recruitment, case management and social media activities
- Support additional training on Substance Abuse Block Grant clinical requirements, such as Learning Collaboratives and expanding representation on existing workgroups to include not only intermediaries but also local providers
- Expand workgroups to include all modalities, such as MAT
- Expand criminal justice workgroups to include judges to encourage peer-to-peer learning
- Support the operationalization of Trauma-Informed Care through a Learning Collaborative engaging both treatment providers and RBHAs
- Enhance data utilization to inform practices for SA services and support core Evidence-Based Practices
- Develop strategies to increase the state's flexibility/agility to respond to identified needs affected by limitations due to Service Definitions being tied to legislation and/or regulations
- Increase QI activities and use of Population Management Strategies to identify gaps in system
- Develop a Heritage Health-focused workgroup – engaging the entire treatment spectrum – to share information about processes and changes created by the three MCO configuration and increase the BH voice
- Develop a Learning Management System to improve the availability and accessibility of training and to preserve training in one place overtime
- Enhance training for gender specific services (e.g., relational model), including training focused on the growing number of older clients accessing services
- Develop a BH Health Disparity strategic plan within a BH-oriented framework supporting cultural competency/CLAS
- Develop a more integrated SA Prevention System across the RBHAs to create common and consistent protocols
- Develop funding resources for the SA Prevention System to support community level planning and data collection
- Develop funding resources for the SA Prevention System to support necessary activities from planning to education to coordination, including a dedicated FTE Synar Coordinator position
- Enhance Synar program data capability to measure tobacco retailers' knowledge about the law
- Develop strategies to address environmental challenges such as limitations in the laws (e.g., non-stipulation of fine amount, compliance burden is on sales staff not the retail outlet owner, tobacco retailer license doesn't specify OTC or vending machine)
- Improve community awareness of admission preferences to services for priority populations
- Expand knowledge and training regarding federal requirements for Interim Services

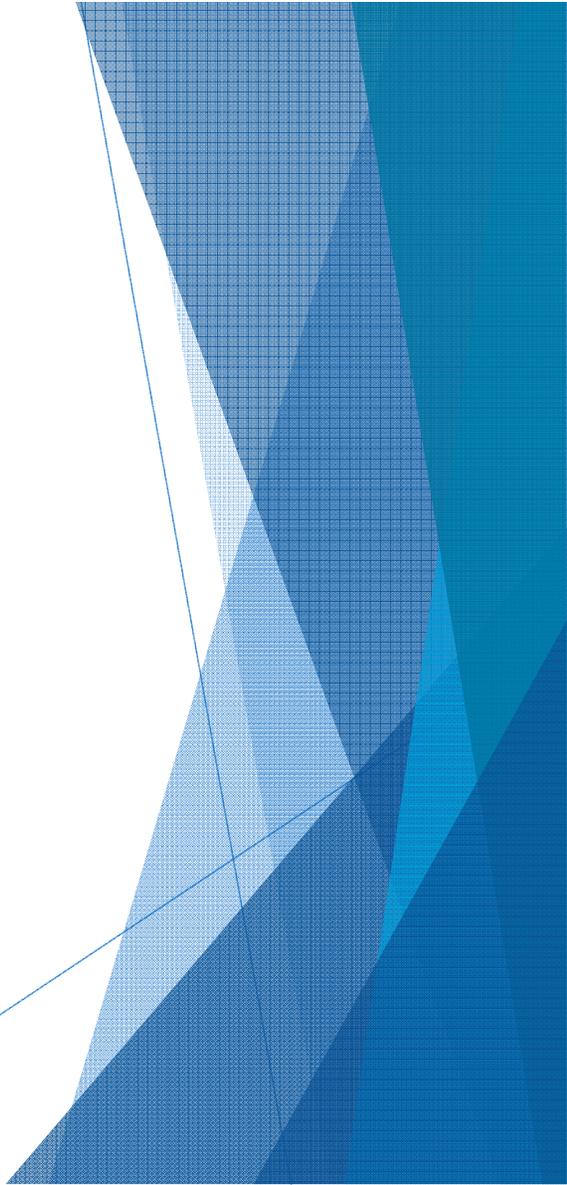
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# Prevention Advisory Council Update

Nikki Roseberry-Keiser and Tiffany Mullison

June 23, 2016

# Partnerships for Success Update

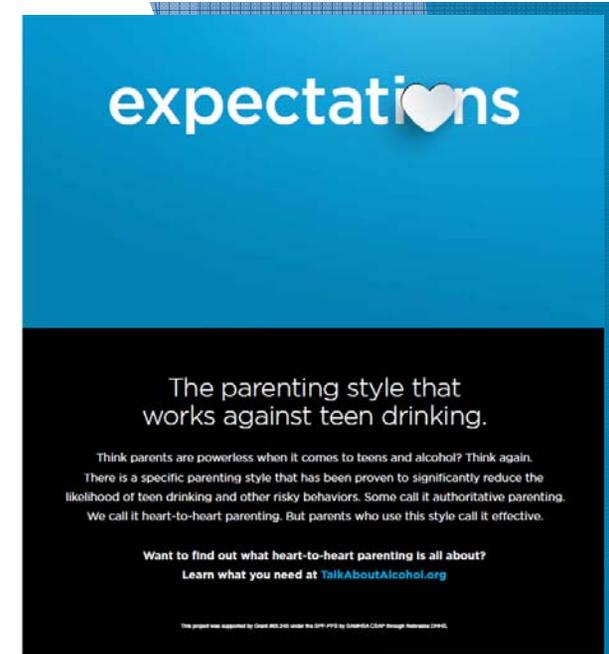
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# Carryover Funding

- ▶ Sending state staff to conferences for training
- ▶ Workforce Survey and Development Plan
- ▶ Culturally and Linguistically Appropriate Services training
- ▶ Expansion of statewide media campaign
  - ▶ Spring event, tips for parents
- ▶ Region and subrecipient requests
  - ▶ Increase capacity through training
  - ▶ Expansion of existing curriculum and media campaigns

# Year 3 Initiatives

- ▶ Media Campaign #taketimeout to talk about alcohol
  - ▶ Huskers.com social media campaign
  - ▶ Directing folks to talkaboutalcohol.org
- ▶ Integration of Culturally and Linguistically Appropriate Standards into Partnerships for Success work plans
- ▶ Training on Sustainability and Fidelity, continuing Substance Abuse Prevention Skills Training
- ▶ Workforce Development Technical Assistance
- ▶ Binge Drinking Collective Impact Workgroup
- ▶ Healthy Youth Nebraska Conference



SAVE THE DATE

**Healthy Youth Nebraska:  
Addressing Risks, Resiliency, and Barriers to Success**

Monday, September 19, 2016 • 7:45am - 5:00pm  
Holiday Inn, 110 S 2nd Ave, Kearney, NE 68847  
\$40 Registration Fee • CEUs Available • Continental Breakfast and Lunch Provided  
Registration information to follow in July

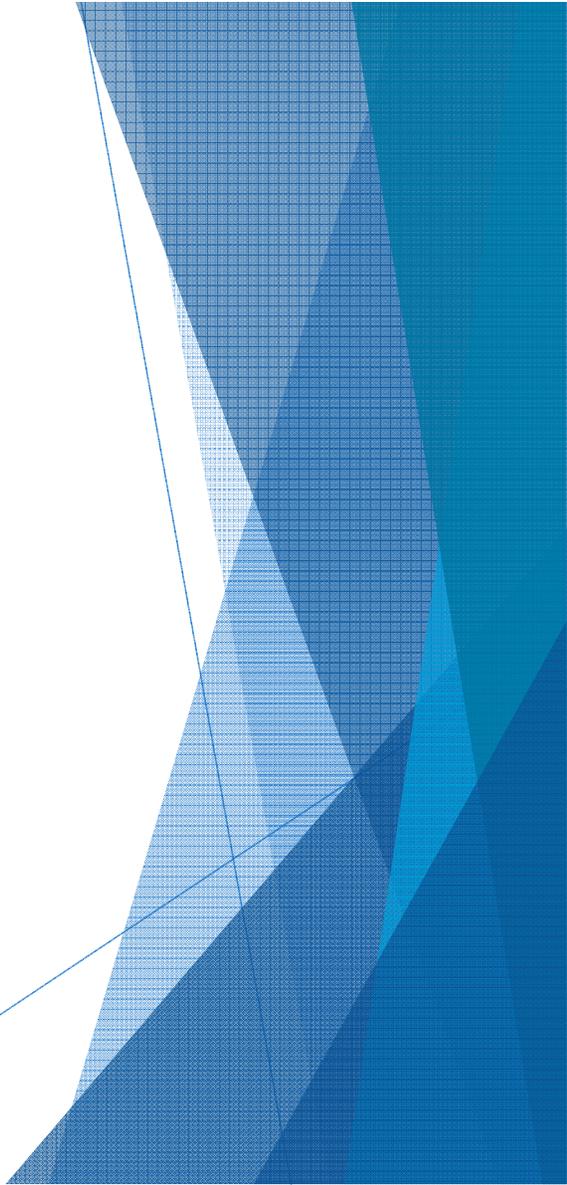
Featuring Keynote Speakers:	Breakout Topics Include:								
<p><b>Kirsten de Fur, MPH</b> Ms. deFur is the assistant director of training and prevention at Columbia University's Sexual Violence Response &amp; Rape Crisis/Anti-Violence Support Center.</p> <p><b>Karen Haase, JD</b> Ms. Haase is a principal in the law firm of KSB School Law, where she focuses her practice exclusively on representing public school districts and related entities.</p> <p><b>Dr. Ken Zoucha, MD</b> Dr. Zoucha is the supervising physician at the Hastings Juvenile Chemical Dependency Program, serving youth from across Nebraska who are diagnosed with substance use disorders.</p>	<table style="width: 100%; border: none;"> <tr> <td style="padding: 2px 5px;">Bullying</td> <td style="padding: 2px 5px;">School Safety</td> </tr> <tr> <td style="padding: 2px 5px;">Youth Engagement in Health Care</td> <td style="padding: 2px 5px;">Social Media</td> </tr> <tr> <td style="padding: 2px 5px;">Omaha's Adolescent Health Project</td> <td style="padding: 2px 5px;">Engagement in Sexual Health Education</td> </tr> <tr> <td style="padding: 2px 5px;">Intimate Partner Violence</td> <td style="padding: 2px 5px;">Sexual Health in Special Education</td> </tr> </table>	Bullying	School Safety	Youth Engagement in Health Care	Social Media	Omaha's Adolescent Health Project	Engagement in Sexual Health Education	Intimate Partner Violence	Sexual Health in Special Education
Bullying	School Safety								
Youth Engagement in Health Care	Social Media								
Omaha's Adolescent Health Project	Engagement in Sexual Health Education								
Intimate Partner Violence	Sexual Health in Special Education								

Sponsored by: NE Department of Health and Human Services, Divisions of Public Health and Behavioral Health, NE Department of Education  
This event is an Equal Opportunity/Affirmative Action Program. The organizers do not discriminate on the basis of race, sex, age, religion, or ethnicity. For more information, contact the organizers at [info@talkaboutalcohol.org](mailto:info@talkaboutalcohol.org).

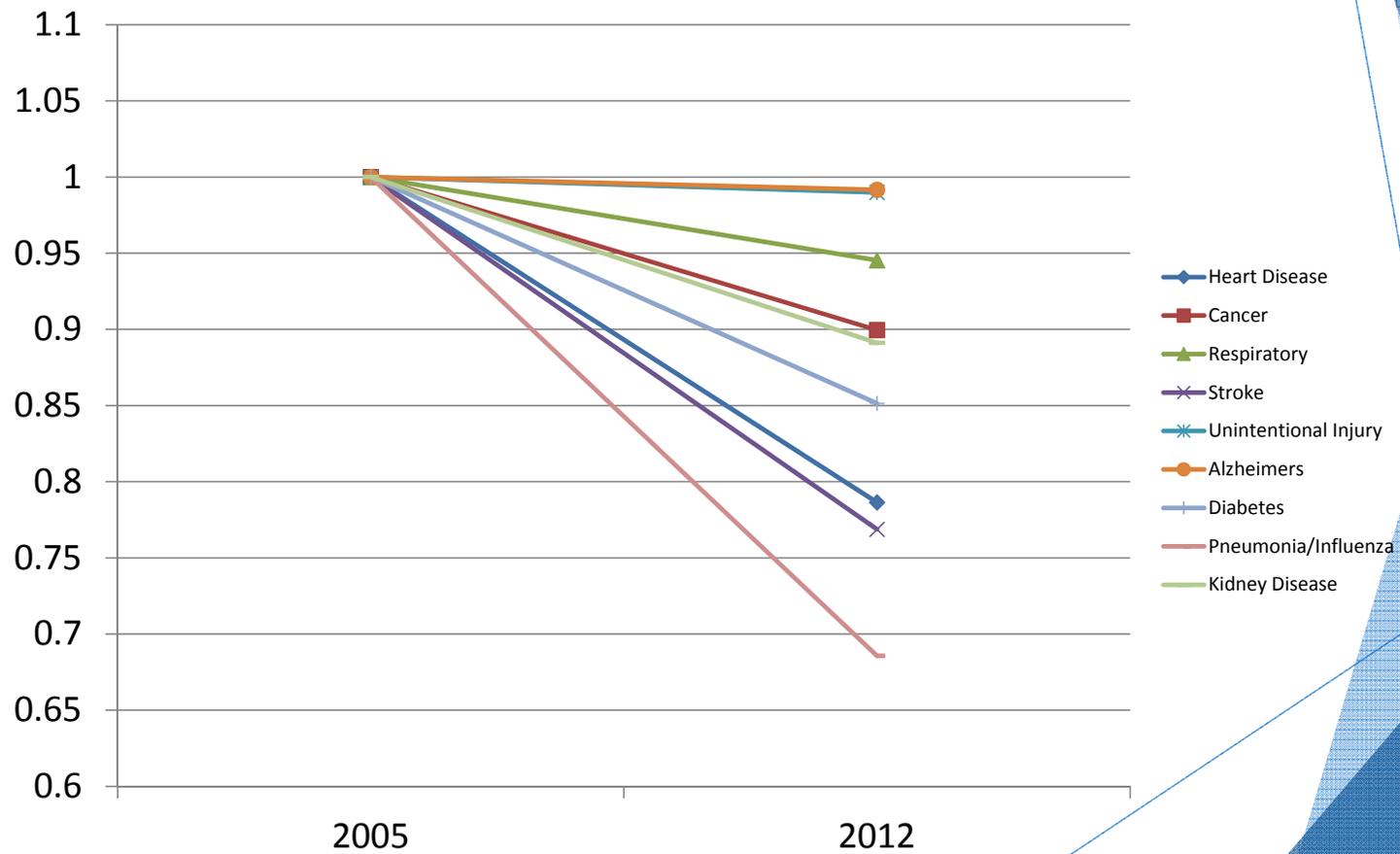
# Collective Impact Workgroup

- ▶ America's Health Rankings place Nebraska as the 10<sup>th</sup> Healthiest State, but we rank #47 for binge-drinking
- ▶ Partnership between DBH and UNMC to bring together members of stakeholder institutions to work toward lowering the binge drinking rate statewide.
  - ▶ Some of the partners include: Project Extra Mile, Omaha Collegiate Consortium, CHI Health, Nebraska Medicine, Blue Cross, Blue Shield, among others.
- ▶ Several pilot sites have begun Screening and Brief Intervention and Referral to Treatment (SBIRT), including clinics and college health centers

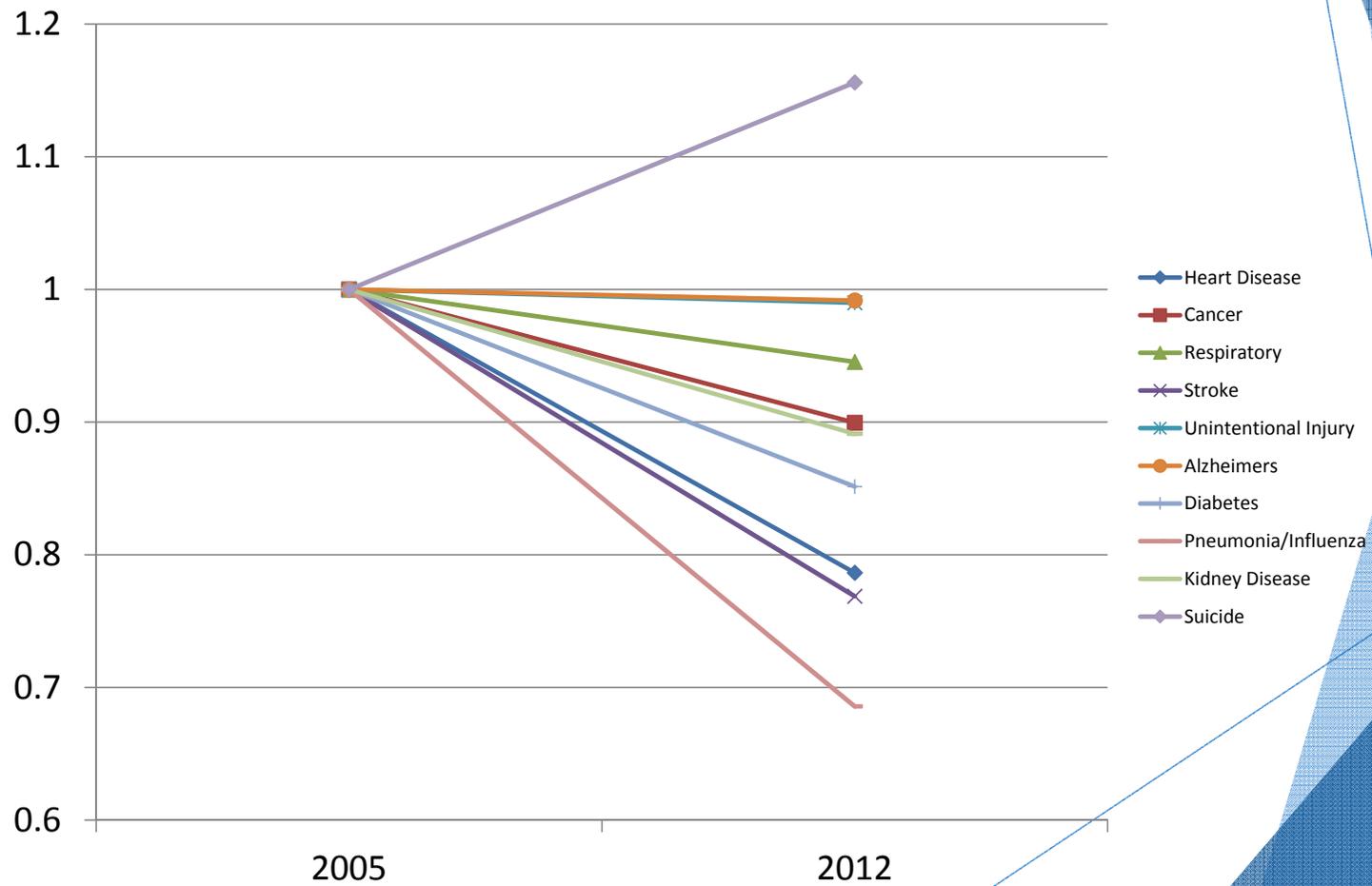
# Suicide Prevention Update

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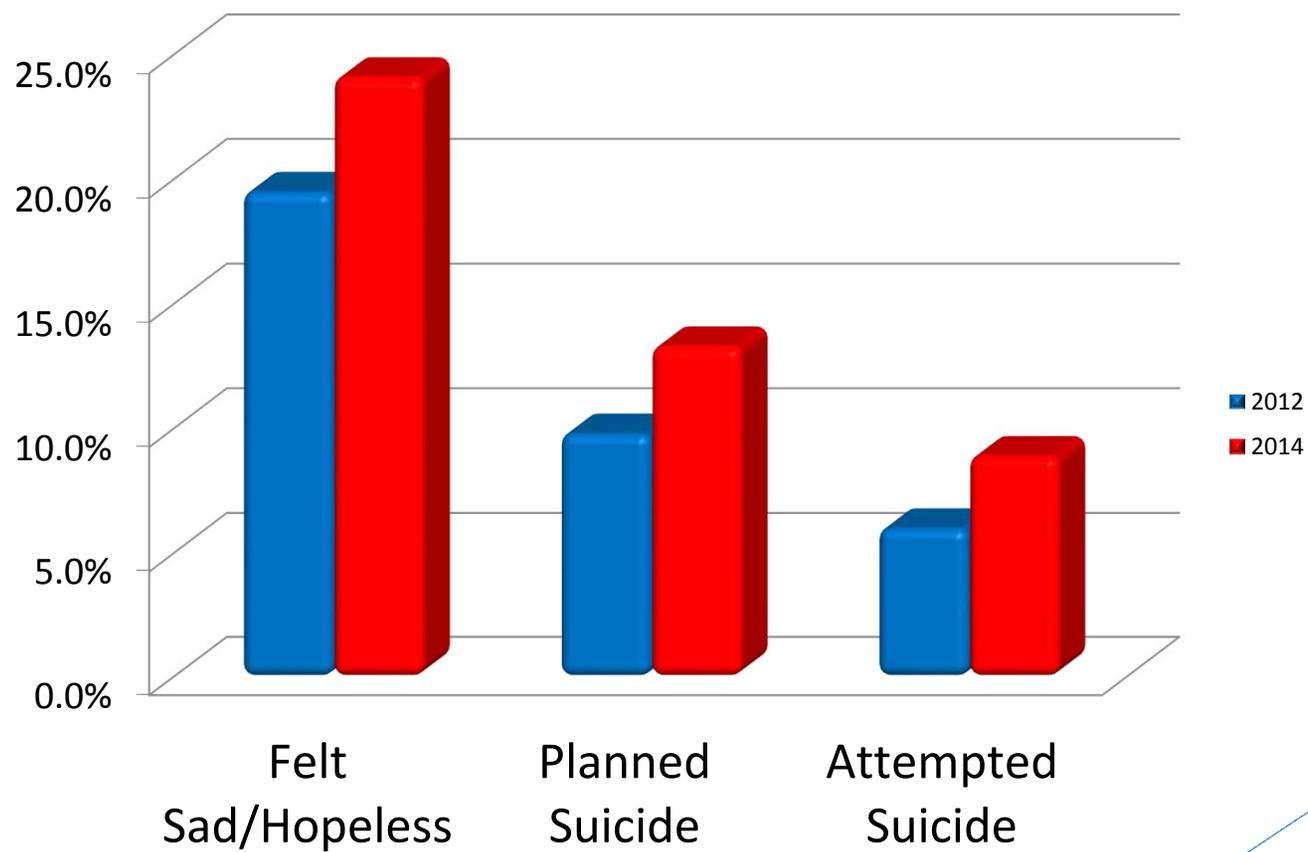
# Top 9 Causes of Death in the USA



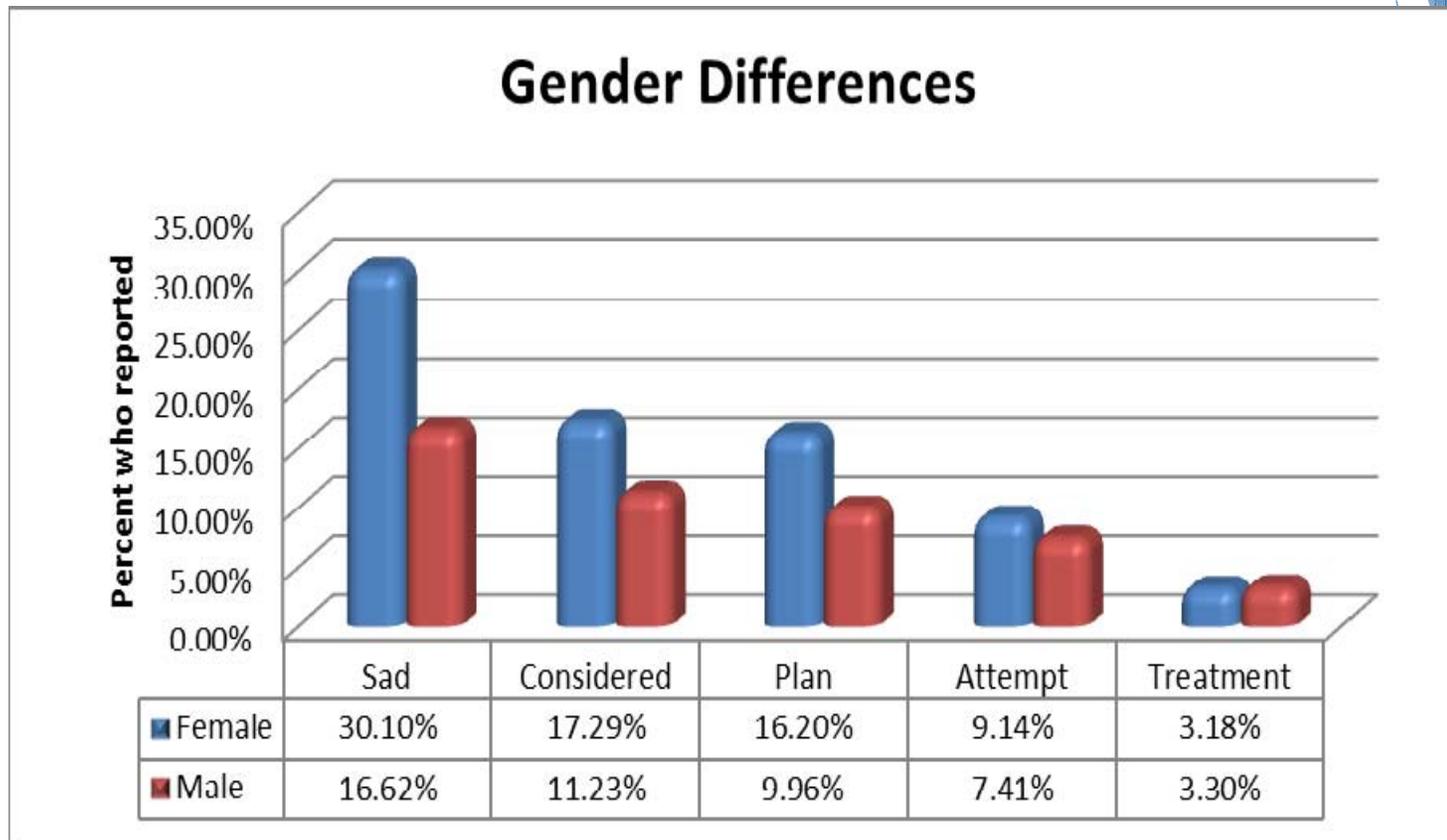
# Top 10 Causes of Death in the USA



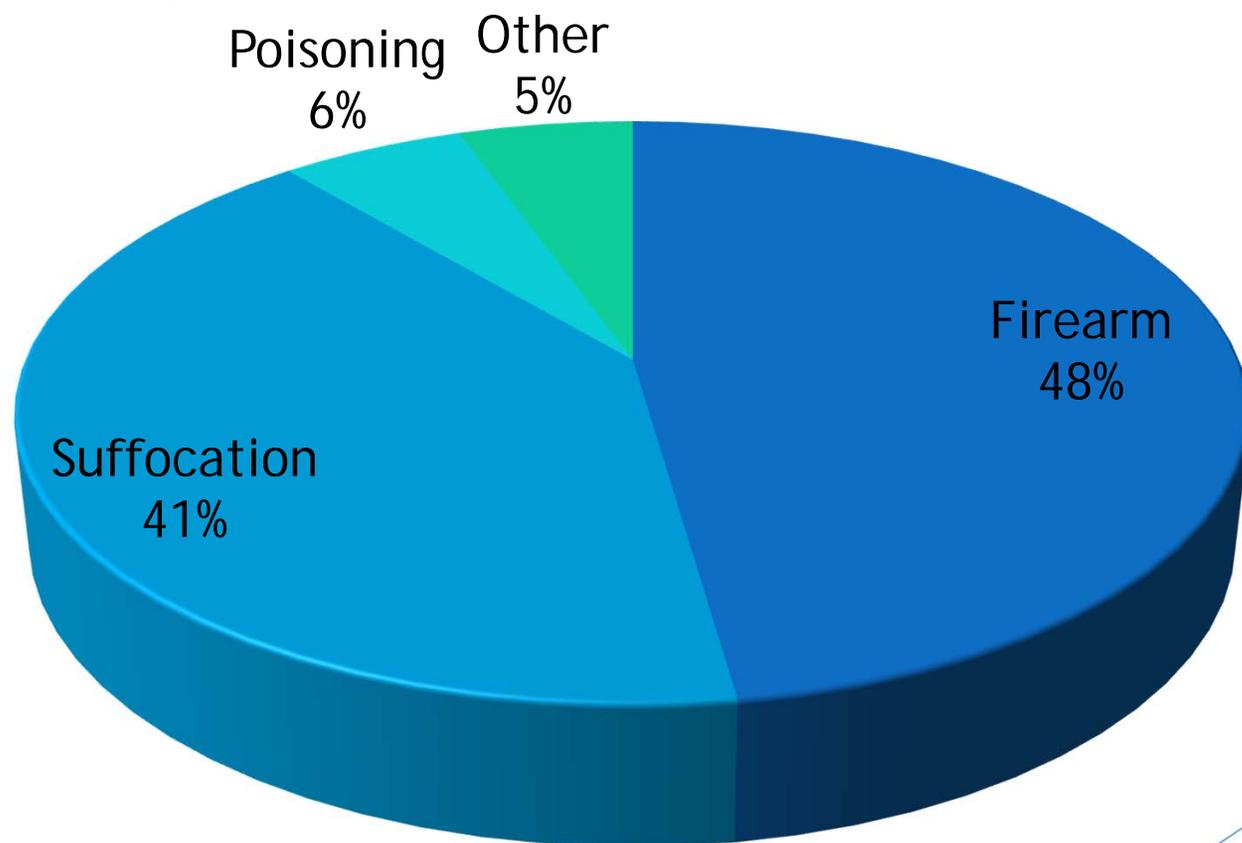
# Youth Risk Behavior Survey, 2012 & 2014



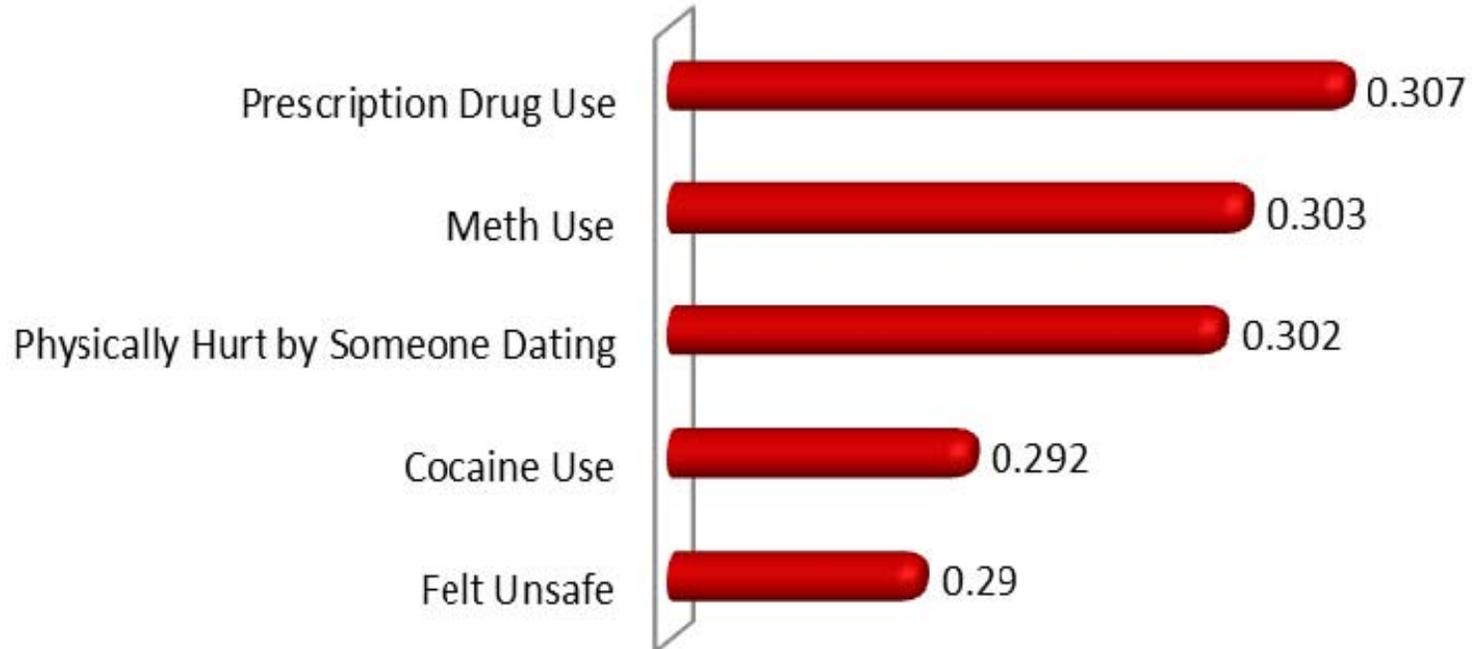
# Youth Risk Behavior Survey, 2012 & 2014



# Method of Suicide in Nebraska 11-24 year olds, 2005-2014



## Correlation Coefficients for Suicide Attempts



# SAMHSA funds for Youth Suicide Prevention

- ▶ Awarded funds for 5 years, for a total of \$3,646,939
- ▶ Funding cycle is from October 1, 2014 - September 30, 2019
- ▶ Nebraska's project serves youth ages 10-24 across the state of Nebraska
- ▶ 2 subpopulations of focus:
  - ▶ Youth in K-12 schools
  - ▶ Youth with behavioral health disorders
- ▶ Currently in Year 2, Quarter 3

# Year 1 Highlights: Behind the Scenes

- ▶ Project Management Team formed; monthly conference calls with the PMT and SAMHSA
- ▶ Groundwork on development of the Nebraska Statewide Suicide Prevention Plan completed
- ▶ Data reporting system built and managed by the Public Policy Center
- ▶ Of the \$733,232 awarded in Year 1, Nebraska expended \$626,746 [86%]
- ▶ A carryover request for Year 1 was approved by SAMHSA for the \$106,577 [14%] unspent in Year 1

# Year 1 Highlights: Evidence Based Practices

- ▶ Collaborative Assessment & Management of Suicidality [CAMS]: 261 clinicians were trained to assess, manage, and treat youth at risk of suicide, goal was to train 250
- ▶ Kognito: 28,385 school personnel completed Kognito on-line training, goal was to train 20,000
- ▶ General Awareness: 266,563 adults in Nebraska reported general awareness of signs of suicide and the National Hotline, goal was 210,488
- ▶ LOSS Teams: Region 3 (Central Nebraska), Region 5 (Lincoln/Lancaster), and Region 6 (Metro Area Omaha) have LOSS Teams, goal was to have 1 LOSS Team

# Year 2 Progress

- ▶ Outreach Specialist Position is moved to DHHS, Division of Behavioral Health
- ▶ 3 brochures translated to Spanish
- ▶ LOSS Team 101: Creating Local Response to Suicides training completed in March 8, 2016
- ▶ 3 members of PMT attended federal grantee meeting in May
- ▶ Carryover funds expended on
  - ▶ Materials for LOSS teams to give to families
  - ▶ 6<sup>th</sup> Annual LOSS Team Conference, Postvention is Prevention
  - ▶ Promotion of National Suicide Prevention Lifeline
  - ▶ Safe Messaging
  - ▶ *Ask A Question: Save A Life* DVD

# Statewide Suicide Prevention Plan

- ▶ The plan builds on the 2012 National Strategy for Suicide Prevention by embracing an ecological approach to suicide and the organization of goals and objectives in four interconnected strategic directions
- ▶ Communities, local coalitions, and regions are encouraged to create action plans with the shared 4 strategic directions
- ▶ An addition to the plan is a sample Action Plan

# Prevention Advisory Council



# PAC Charter Objectives

- ▶ The PAC objectives are as follows:
  - ▶ Accomplish the mission and vision of the DHHS Division of Behavioral Health's Five Year Strategic Plan for Prevention (see brief attached);
  - ▶ Be the driving force for statewide prevention system partnership, collaboration and growth;
  - ▶ Continually grow the prevention workforce and improve upon leadership within the NBHS to assist communities to create and/or enhance sustainable, collaborative coalitions which implement effective prevention policies, practices, and programs; and
  - ▶ Position the Prevention System to be in compliance with federal grant requirements and deliverables by monitoring progress.

# Agenda Items

- ▶ Opening Remarks by Courtney Phillips, DHHS CEO
- ▶ Suicide Prevention Grant Updates and Data Report
- ▶ Partnerships for Success Grant Updates
- ▶ Success Stories - Environmental Prevention
- ▶ Marijuana Use Prevention
- ▶ Tobacco Free Nebraska Programming Update
- ▶ Recap Site Visit
- ▶ Emerging Trends

# Structure and Function of the PAC

- ▶ 13 voting members, representing state, regional and community level partnerships.
  - ▶ Have 13 members selected by the Director of the DBH
  - ▶ Have never voted
  - ▶ Have no responsibilities beyond that of other audience members
- ▶ Invite stakeholder from across the prevention system and partner organizations
  - ▶ Invitee list is over 100 people, attendance is typically between 30 and 40 people
- ▶ Have a discussion-based, open-forum style format
  - ▶ PAC audience and members appreciate this format and wish to keep it

# Structure and Function of the PAC

- ▶ Should we retain the structure as is with appointed members and audience members?
  - ▶ If so, what should the appointed members do?
- ▶ It has been recommended that we provide a newsletter between meeting to provide updates so meetings can be more focused on action and less on grant updates.
  - ▶ Would this be a good way to communicate?
- ▶ Are there other objectives we should be accomplishing as a council?
  - ▶ What are these objectives?

## For More Information, Contact

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[Tiffany.Mullison@nebraska.gov](mailto:Tiffany.Mullison@nebraska.gov)

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[Nikki.Roseberry-Keiser@nebraska.gov](mailto:Nikki.Roseberry-Keiser@nebraska.gov)

## **Access Measures**

**Access:** All members will receive the service(s) they need at the right time.

### ***Supported Housing:***

- 1) Supported Housing voucher applications will be reviewed and determinations made within 3 days of receipt by the Regions. Consumers will be notified of determination within 5 days of receipt of the complete application.
- 2) Housing vouchers will be issued within 14 days of the application being approved.
- 3) Consumers will be offered a safe, stable housing option within 90 days of the voucher being issued
- 4) 95% of consumers admitted to Supported Housing will report satisfactory access to services.

### ***Supported Employment:***

- 1) Consumers referred to Supported Employment services will admit to Supported Employment services within XX days of complete referral received.
- 2) 95% of consumers admitted to Supported Employment services will report satisfactory access to services.

### ***Short Term Residential:***

- 1) 95% of consumers meeting Priority Criteria will be offered admission to Short Term Residential services within 14 days of referral.
- 2) 95% of all consumers will be offered admission to Short Term Residential services within 30 days so referral.
- 3) 95 % of consumers admitted to Short Term Residential will report satisfactory access to services.

### ***Medication Management***

- 1) 95% Consumers referred for Medication Management as an Inpatient post-discharge service will be offered an appointment within 21 days of discharge.
- 2) 95% of consumers admitted to Medication Management will report satisfactory access to services.

Division of Behavioral Health Strategic Plan Development

Tasks	6/23/2016	7/1/2016	7/15/2016	7/31/2016	8/1/2016	8/15/2016	8/31/2016	9/1/2016	9/15/2016	10/1/2016	10/15/2016	11/1/2016	12/1/2016	12/31/2016
Present Strategic Plan Development Process to Joint Advisory Committee.														
Solicit recommendations for <b>Strategic Planning Committee (SPC) and Plan Structure.</b>														
Initial Review - Draft Needs Assessment														
Develop SPC Charter, Appoint SPC Members														
Convene <b>1st SPC Meeting - Develop Priority Needs</b>														
Public Input/Comment - Priorities														
Strategy Teams - Training														
Strategy Team - Meetings (3)														
<b>2nd SPC Meeting - Review Strategy Teams' Work Products</b>														
<b>3rd SPC Meeting - Draft Goals, Objectives, Performance Measures</b>														
Draft Strategic Plan Outline														
Public Input/Comment - Draft Strategic Plan														
Finalize Strategic Plan														

Division of Behavioral Health

Public

Strategic Planning Committee

Strategy Teams

# DHHS Division of Behavioral Health

## Status Update – Planning & Needs Assessment

June 21, 2016

*DBH helps systems that help people recover.*

1

### DHHS Mission:

*Help People Live Better Lives*

### DBH Vision:

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

-- *Simply put*: The Division of Behavioral Health strives to be the gold standard of BH care by facilitating hope, recovery and resiliency.

### DBH Mission:

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

-- *Simply put*: DBH helps systems that help people recover.

### 2011-2015 Goals:

1. The public behavioral health workforce will be able to delivery effective prevention and treatment in recovery-oriented systems of care for people with co-occurring disorders.
2. The Division of Behavioral Health will use financing mechanisms which support innovative service content, technology and delivery structures (e.g., telehealth; in-home acute services; Peer Support Services).
3. The Division of Behavioral Health will reduce reliance on the Lincoln Regional Center for general psychiatric services.
4. An effective system to safely manage sex offenders in outpatient settings will be ready for implementation.

## State of Nebraska Priorities

The Governor and the DHHS CEO have set priorities. The Division of Behavioral Health is working on these priorities.

- More efficient and effective state government
  - *DBH – Will improve the operational effectiveness and cost effectiveness of the regional center and regional behavioral health authorities.*
- More customer focused state government
  - *DBH – Will improve “how well we serve” consumers*
- Growing Nebraska
  - *DBH – Will implement strategies that will improve access to competitive employment for individuals with behavioral health challenges*
- Improving public safety
  - *DBH – Will improve access to the Lincoln Regional Center*
- Reducing regulatory complexity
  - *DBH – In collaboration with DPH, complete proposal for the combination of MHC and SATC facility licensure standards to decrease the regulatory expectations on providers and promote co-occurring service delivery*

3

## Bridge Strategic Plan 2016 Priorities

- Data informed needs assessment June 2016
- 3-yr. Strategic Plan (2017-2020) December 2016
- Data driven performance indicators:
  - Accessibility
  - Quality
  - Effectiveness
  - Cost Efficiency
  - Accountable Relationships
- Activities, Work Plans and Performance Measures developed February 2016
- Tracking initiated March 2016 and reviewed/updated monthly (examples to follow)

4

## Division of Behavioral Health Performance Tracking

### Accessibility

Activity: Implement access measures	Due Date	Comments & Status
Measures identified	June 30, 2016	*6-7/16: Final draft in review with RBHA & Advisory Cmtes.
Data system able to monitor, collect data	June 1, 2016	*5/16: Go Live occurred 5/16/16
Activity: Initiate Phase I Children's SOC implementation	Due Date	Comments & Status
Implementation grant application	April 2016	*4/16: Application submitted.
Activity: Evaluate First Episode Psychosis Coordinated Specialty Care	Due Date	Comments & Status
Training, team & provider calls with On-Track completed monthly.	Monthly	*6/16: On track
Pilot data submitted to DBH	Quarterly	*6/16: On track

## Division of Behavioral Health Performance Tracking

### Effectiveness

Activity: Planning process for integrated housing for BH consumers.	Due Date	Comments & Status
Policies and focus groups conducted	March – April 2016	*5/16: TAC completed on site visits, on track
3 year Strategic Supportive Housing plan	June 30, 2016	*6/16: 2 <sup>nd</sup> Draft in review.
Activity: Increase delivery of effective Supported Employment	Due Date	Comments & Status
Statewide increase in number of employed consumers.	December 2016	*6/16: Final draft SE measures under review.
Activity: Operationalize MAT	Due Date	Comments & Status
Implement interdivisional team and work plan	Monthly	*5/16: On track – w/PH, MLTC, problem solving courts *6/16: Initial mtgs. With MCOs
Practice pain management guidelines	Sept. 2016	*6/16: DBH lead w/PH, etc.

## Division of Behavioral Health Performance Tracking

### Quality

Activity: Operationalize CDS	Due Date	Comments & Status
Trainings - % provider/agencies participation in training	June 2016	*5/16: Go Live 5/16/16. Trainings: TADs, authorizations, interfaces - 88%
Activity: Conduct annual consumer survey	Due Date	Comments & Status
% general satisfaction 85%	May 2016	*5/16: on track distribution
Activity: Cross system collaboration /increase capacity for trauma informed care	Due Date	Comments & Status
Cross system assessment & recommendations	March 2016	*5/16 RC assessed w/recommendations. Implementing cross sx team (PH, DBH, CFS, MLTC, DD)

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## Division of Behavioral Health Performance Tracking

### Accountable Relationships

Activity: Implement formal links to expand consumer involvement in planning and service delivery.	Due Date	Comments & Status
Patient Advisory Council (PAC) implemented LRC.	July 2016	*4/16: Draft procedures completed. Operational review in May.
Charter for integration between OCA and PAC	July 2016	*5/16: Draft charter under review. Office of Facilitation & Recovery operationalized. OCA adopted as subcommittee to Joint Advisory Committee
Activity: Address BH workforce shortages	Due Date	Comments & Status
BHECN workforce analysis & plan	June 2016	*5/16: on track analysis. Exploring expansion of residency/internships including RC.

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## Overview of the state's needs assessment process

9

## Division of Behavioral Health Needs Assessment Purpose

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- Strategic Planning
- Identifying areas of greatest strength and need
- Consumer and Stakeholder Feedback
- State and Regional Plans of Expenditure
- Public Comment
- Inform policy and grant activities

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## Division of Behavioral Health Needs Assessment Process

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- Determine framework, methodology, scope
- Inventory services, supports, data
- Collection and Analysis of statewide data
- Identify themes, areas of strengths and need
- Collaborate with stakeholders to establish statewide and regional priorities - Strategic Planning
- Apply to State and Regional budget plans

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## Division of Behavioral Health Needs Assessment Report Outline

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- Methods/Approach
- Demographic Profile
- Burden of MI and SU related disorders and Treatment Use
- MH, SU, Co-Occurring, Adverse Childhood Experience, other
- State funded service programs
- Delivery system, utilization by state and region, outcome measures
- Hospitalization related to mental/substance disorders
- In-patient and Crisis/Emergency utilization, trend and cost analysis

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## Division of Behavioral Health Needs Assessment Report Outline

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- Capacity for Integrated Care and Telehealth
- Behavioral Health workforce
- Professional shortage areas, capacity, characteristics, development efforts
- Special Populations (DD, Justice, Homeless, Veterans)
- Housing, Employment & Supportive Care Capacity & Need
- Evidence-Based Practice and Public Health
- Consumer Survey & Stakeholder Feedback
- Summary and Recommendations

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## Division of Behavioral Health Needs Assessment Status

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- Statewide community engagement focus groups with consumers and key stakeholders currently underway
- Broad-based on-line survey in final development
- Analysis and interpretation of various types of data ongoing
- Preliminary report due June 30, 2016

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# Thank You!



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Bill Number	Introducer	Title	Committee	Hearing Date	General File	Select File	Final Reading	Gov. Signed
LB 670	Krist	Require a hearing prior to release for persons taken into custody for mental health reasons	Judiciary	2/17/16	IPP			
LB 674	Krist	Provides financial support to families of disabled individuals	HHS	3/3/16	IPP			
LB 696	Howard	Provide for a Medicaid state plan waiver to provide coverage for treatment of opioid abuse	HHS	2/10/16	IPP			
LB 697	Howard	Provide for a Medicaid state plan amendment application relating to functional family therapy	HHS	3/3/16	IPP			
LB 733	Watermeier	Appropriate funds to the Department of Correctional Services <i>**Portions amended into LB 956 by AM 2216**</i>	Approp.	2/10/16	IPP			
LB 746	Campbell	Adopt the Nebraska Strengthening Families Act, change provisions for guardians ad litem and services for children, and create the Normalcy Task Force. (Campbell priority bill) <i>**Portions amended into LB 746 by AM 2381**</i>	HHS	1/21/16 AM 1903	2/22/16 AM 1903 adopted, advanced to SF	3/7/16 AM 2381 adopted, advanced to FR	4/12/16	4/20/16
LB 774	Scheer	Provides a sales and use tax exemption for purchases by nonprofit substance abuse treatment centers.	Revenue	2/5/16	3/8/16 AM 2422 adopted, advanced to ER	3/24/16 ER 224 adopted, advanced to FR	4/4/16	4/18/16
LB 780	Schumacher	Change provisions relating to emergency protective custody	Judiciary	2/3/16	IPP			

Bill Number	Introducer	Title	Committee	Hearing Date	General File	Select File	Final Reading	Gov. Signed
LB 782	Schumacher	Provide for a Medicaid state plan amendment relating to coverage for family planning services	HHS	2/18/16	IPP			
LB 793	Watermeier	Changes provisions and penalties relating to certain assaults, escape and contraband.	Judiciary	2/24/16	IPP			
LB 815	Stinner	Changes provisions relating to petitions for removal of a person's firearms-related disabilities or disqualifications.	Judiciary	3/3/16	IPP			
LB 816	Scheer	Changes provisions relating to release of patient and resident records, and eliminates certain reporting requirements.	HHS	2/17/16	3/7/16 AM 2336 adopted, advanced to ER	3/22/16	3/24/16	4/6/16
LB 845	Pansing-Brooks	Provide requirements relating to confinement of juveniles and provide a duty for the Inspector General of Nebraska Child Welfare <b>**Portions amended into LB 894 by AM 1962**</b>	Judiciary	1/20/16	IPP			
LB 910	Bolz	Change provisions relating to parole administration (Judiciary priority bill) <b>**Provisions amended into LB 1094 by AM 2721**</b>	Judiciary	2/4/16 AM 2328	IPP			
LB 911	Bolz	State intent relating to fund transfers for behavioral health systems of care <b>**Provisions amended into LB 956 by AM 2216**</b>	Approp.	2/8/16	IPP			
LB 915	McCollister	Create a veterans' treatment court pilot project <b>**Portions amended into LB 919 by AM 2171**</b>	Judiciary	2/5/16	IPP			

Bill Number	Introducer	Title	Committee	Hearing Date	General File	Select File	Final Reading	Gov. Signed
LB 919	Williams	Change provisions relating to problem solving court programs (Williams priority bill) <b>**Portions amended into LB 919 by AM 2171**</b>	Judiciary	2/5/16 AM 2171	3/1/16 AM 2171 adopted, advanced to SF	3/10/16	4/12/16	4/20/16
LB 923	Stinner	Appropriates funds for federally qualified health centers. <b>** Provisions/portions amended into LB 956 by AM 2216**</b>	Approp.	2/8/16	IPP			
LB 931	Bolz	Provide for financial incentives for certain assisted-living facilities and change distribution of the Behavioral Health Services Fund <b>**Portions amended into LB 956 by AM 2216**</b>	Approp.	2/8/16	IPP			
LB 951	Harr	Adopts the Affordable Housing Tax Credit Act. <b>** Provisions/portions amended into LB 884 by AM 2522**</b>	Revenue	2/10/16	IPP			
LB 954	Krist	Change provisions relating to access to records for and investigations by the Inspector General of Nebraska Child Welfare (Exec Board priority bill)	Exec Board	1/22/16 AM 2072	2/11/16 AM 2072 adopted, advanced to SF	2/24/16 AM 2279 adopted, advanced to FR	3/1/16 passed with ER clause	3/7/16
LB 980	Morfeld	Changes penalty provisions for certain violations relating to or committed by persons experiencing or witnessing a drug overdose.	Judiciary	2/10/16	IPP			

Bill Number	Introducer	Title	Committee	Hearing Date	General File	Select File	Final Reading	Gov. Signed
LB 985	Schumacher	Provide reporting duties for regional behavioral health authorities	HHS	2/1/16	IPP			
LB 998	Schumacher	Provides for emergency community crisis centers and change provisions relating to emergency protective custody.	HHS	2/24/16	IPP			
LB 1013	Gloor	Changes tax on cigarettes and other tobacco products and provide for distribution of proceeds.	Revenue	2/24/16	IPP			
LB 1023	Ebke	Requires development of treatment protocols for and a needs assessment of committed offenders and correctional facilities.	Judiciary	2/4/16	IPP			
LB 1032	McCollister	Adopts the Transitional Health Insurance Program Act and provide duties for the Department of Health and Human Services.	HHS	2/10/16	3/10/16 AM 2473	IPP		
LB 1033	Campbell	Create and advisory committee relating to persons with disabilities within the Department of Health and Human Services (Speaker priority bill)	HHS	1/26/16 AM 2048	3/9/16 AM 2048 adopted, advanced to SF	3/17/16 advanced to FR	4/12/16	4/18/16
LB 1058	Crawford	Changes provisions relating to enforcement of certain tobacco restriction provisions.	Judiciary	2/25/16	IPP			
LB 1094	Judiciary	Changes provisions relating to evidence, sentencing, certain criminal penalties, criminal mischief, assault, theft, forgery, and probation. (Seiler priority bill)	Judiciary	2/4/16	3/10/16 AM 2337 adopted, advanced to ER	3/29/16	4/7/16	4/19/16

Res Number	Introducer	Title	Committee	Hearing Date	General File	Select File	Final Reading	Gov. Signed
LR 413	Watermeier	Creates the Task Force on Behavioral and Mental Health.	Executive	2/8/16				Pres/ Spkr signed 3/1/16

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**Bill Proposal #:** \* - insert data, e.g. HHS #1 - \*

**State Agency:**

**Date:**

**Contact:**

**Phone:**

**One - Liner:** \* - insert short title here- \*

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1. Provide a description and rationale for introducing this legislation. Address any unique or creative approaches involved and why this proposal requires legislation.

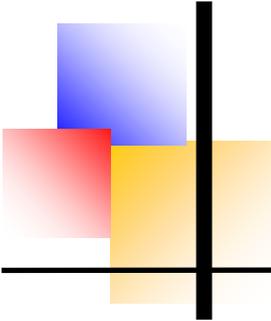
2. Type of Proposal. Check all that apply.

- Update of current law. Provide LB state statute citation.
- Repeal of current law
- Implement federal law. Provide statutory citation(s).
- Federal mandate to State
- State or federal mandate to local government
- Implement/Respond to a court order. Attach court opinion/order.
- Extend or expand current program or policy
- Create new program or policy
- Eliminate/Reduce/Streamline Agency Operations or Programs
- Other (e.g., technical). Explain

3. Is this proposal an agency priority for 2017? Explain why?

4. Give the legislative, judicial and administrative history of this proposal including any action taken in prior years. List prior year LB's, LR's, court decisions (etc). If this is a technical bill, are there any opponents who might want to reopen discussion on the original bill?
  
5. List probable supporters and opponents and give the likely reason for their positions.
  
6. List other agencies or political subdivisions impacted by this proposal. List their position on this proposal.
  
7. Miscellaneous Items:
  - a. Please describe any added or reduced costs, fees, or savings related to the proposed legislation.
  
  - b. Are there any items that could be construed as an "unfunded mandate"? If so, what?
  
  - c. Will this proposal require additional staffing, office space, equipment, automobiles or technology?

***Completion of the attached 2017 Fiscal Note is also required for Proposal Submission.***



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## OCA PEOPLE'S COUNCIL

### 2016 DATES & LOCATIONS

<b>February 09, 2016</b>	<b>9:30-am-3:15 pm</b>	<b>Lincoln Community Foundation Building 215 Centennial Mall S Lincoln, NE</b>
<b>May 12, 2016</b>	<b>9:30-am-3:15 pm</b>	<b>Lincoln Community Foundation Building 215 Centennial Mall S Lincoln, NE</b>
<b>August 02, 2016</b>	<b>9:30-am-3:15 pm</b>	<b>Lincoln Community Foundation Building 215 Centennial Mall S Lincoln, NE</b>
<b>November 01, 2016</b>	<b>9:30-am-3:15 pm</b>	<b>Lincoln Community Foundation Building 215 Centennial Mall S Lincoln, NE</b>

