

# FY2016-2017 Combined Behavioral Health Assessment and Plan Grant Application

Community Mental Health Services Block Grant (MHBG)  
Substance Abuse Prevention and Treatment Block Grant (SABG)

# DRAFT

For Public Review and Comment

Application Prepared By:

Nebraska Department of Health and Human Services  
Division of Behavioral Health



Draft Documents as of July 31, 2015

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## State Information

### State Information

#### Plan Year

Start Year 2016

End Year 2017

#### State SAPT DUNS Number

Number 808819957

Expiration Date

#### I. State Agency to be the SAPT Grantee for the Block Grant

Agency Name Nebraska Department of Health and Human Services

Organizational Unit Division of Behavioral Health

Mailing Address 301 Centennial Mall South, Third Floor, PO Box 95026

City Lincoln

Zip Code 68509-5026

#### II. Contact Person for the SAPT Grantee of the Block Grant

First Name Sheri

Last Name Dawson

Agency Name Nebraska Department of Health and Human Services

Mailing Address 301 Centennial Mall South, Third Floor, PO Box 95026

City Lincoln

Zip Code 68509-5026

Telephone 402-471-7856

Fax 402-471-7859

Email Address Sheri.Dawson@nebraska.gov

#### State CMHS DUNS Number

Number 808819957

Expiration Date

#### I. State Agency to be the CMHS Grantee for the Block Grant

Agency Name Nebraska Department of Health and Human Services

Organizational Unit Division of Behavioral Health

Mailing Address 301 Centennial Mall South, Third Floor PO Box 95026

City Lincoln

Zip Code 68509-5026

#### II. Contact Person for the CMHS Grantee of the Block Grant

First Name Sheri

Last Name Dawson

Agency Name NE DHHS Division of Behavioral Health

Mailing Address 301 Centennial Mall South, Third Floor PO Box 95026

City Lincoln

Zip Code 68509

Telephone 402-471-7856

Fax 402-471-7859

Email Address sheri.dawson@nebraska.gov

III. State Expenditure Period (Most recent State expenditure period that is closed out)

From

To

IV. Date Submitted

Submission Date

Revision Date

V. Contact Person Responsible for Application Submission

First Name Karen

Last Name Harker

Telephone 402-471-7796

Fax 402-471-7859

Email Address karen.harker@nebraska.gov

Footnotes:

## State Information

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

Fiscal Year 2016

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32
Section 1935	Core Data Set	42 USC § 300x-35
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53

Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

## ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955. as amended (42 U.S.C. §§7401 et seq.): (a)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

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

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

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

Name of Chief Executive Officer (CEO) or Designee: \_\_\_\_\_

Signature of CEO or Designee<sup>1</sup>: \_\_\_\_\_

Title: \_\_\_\_\_

Date Signed: \_\_\_\_\_

mm/dd/yyyy

<sup>1</sup>If the agreement is signed by an authorized desianee, a copy of the designation must be attached.

Footnotes:

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Fiscal Year 2016

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Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
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2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
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I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: \_\_\_\_\_

Signature of CEO or Designee<sup>1</sup>: \_\_\_\_\_

Title: \_\_\_\_\_

Date Signed: \_\_\_\_\_

mm/dd/yyyy

<sup>1</sup>If the agreement is signed by an authorized desianee, a copy of the designation must be attached.

Footnotes:

## State Information

### Disclosure of Lobbying Activities

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

[Standard Form LLL \(click here\)](#)

---

Name	<input type="text"/>
Title	<input type="text"/>
Organization	<input type="text"/>

---

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Footnotes:

## B. Planning Step 1 | page 1

July 2015

*Step 1: Assess the strengths and needs of the service system to address the specific populations. Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.*

### **Nebraska's Behavioral Health System Overview**

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

In 2007 the Nebraska Department of Health and Human Services (NDHHS) was created as one department with six divisions:

- (1) Division of Behavioral Health (DBH),
- (2) Division of Children and Family Services (DCFS),
- (3) Division of Developmental Disabilities (DDD),
- (4) Division of Medicaid and Long-Term Care (DMLTC),
- (5) Division of Public Health (DPH), and
- (6) Division of Veterans' Homes (DVH).

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

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

The Nebraska Behavioral Health Services Act designates the DBH as the chief behavioral health authority for the State [§71-806 (1)]. The DBH is both the State Mental Health Authority (SMHA) and the State Substance Abuse Authority [or Single State Authority (SSA)]. As a result, the DBH is responsible for managing both the Community Mental Health Services Block Grant (CMHSBG) and the Substance Abuse Prevention and Treatment Block Grant (SAPTBG). The

## B. Planning Step 1 | page 2

DBH administers, oversees, and coordinates the state's public behavioral health system to address the prevention and treatment of mental health and substance use disorders. The primary goal is to develop a behavioral health system that is co-occurring capable, trauma-informed, recovery-oriented, and person-centered.

### **Strategic Planning**

The tasks of incorporating consumer voice, reviewing prior planning documents, and suggesting key areas of focus were given to a joint strategic planning workgroup made up of representatives from both Advisory Committees guiding the DBH (Mental Health and Substance Abuse), the Regional Behavioral Health Authorities, and the DBH administration. The work of this group was augmented by consultation with national experts in behavioral health, as well as opportunities for public review and comment. The process was facilitated by the University of Nebraska Public Policy Center.

Hundreds of Nebraskans participated in the development of recommendations in the planning documents and initiatives that were reviewed by the joint strategic planning workgroup. Many of the recommendations evolved from stakeholders with personal experiences in the public behavioral health system.

The Nebraska Division of Behavioral Health Strategic Plan 2011 – 2015 identifies the following vision, mission, and goals for the Division of Behavioral Health.

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

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

2011-2015 Goals:

1. The public behavioral health workforce will be able to deliver 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.

Strategies for realizing the vision, meeting the mission, and achieving the DBH's goals center on Accessibility, Quality, Effectiveness, Cost Efficiency and Accountability. These strategies serve as a way to structure the actions and activities funded or directed by the DBH.

Each strategy is presented with three parts:

»» The first relates to the role of the Division of Behavioral Health as a *leader* in the public behavioral health system.

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- »» The second proposes key *partnerships* the Division of Behavioral Health should focus on as part of the strategy.
- »» The third proposes suggests *joint initiatives*.

DBH continues to use 2011-2015 Behavioral Health Strategic Plan as a guide until a new plan is established following upcoming leadership and administrative appointments under the new Governor.

Another planning focus involved the work of the Co-Occurring Disorders (COD) Service Delivery Quality Initiative Workgroup. The final report provides a roadmap with related background information reviewed and discussed by the COD Workgroup. The “Co-Occurring Disorder Service Delivery: Quality Initiative Final Report” (October 20, 2011) is intended to guide the transformation of the current system of care.

System of Care is considered the best way to plan, develop and deliver comprehensive, flexible and effective services and supports to children, youth and their families. Nebraska’s System of Care Planning Project, which began in late summer 2013, was a twelve-month planning grant awarded by the Substance Abuse and Mental Health Services Administration (SAMHSA) to develop a strategic plan for System of Care. When implemented, the strategic plan will build on partnerships, include full participation of youth and families, and create a broad, integrated process across all of Nebraska’s child-serving systems to achieve positive outcomes for children and youth with serious emotional and behavioral health needs and their families. The planning process capitalized on initial infrastructure currently in place including the support and involvement of leaders across the state’s many child-serving systems.

Families, youth and providers responded to a statewide survey for self-assessment of readiness for system of care. Strategic plan development was accomplished through 10 Core Strategy Teams that met between October 2013 and March 2014. Over 262 youth, family and system partners participated on a team. Youth voice in plan development was gathered through a series of focus groups targeting youth who were experiencing or had experienced Nebraska’s behavioral health system and other child serving systems. One hundred forty-three (143) youth participated in a focus group. The strategic plan development resulted in nine (9) goals and ninety-three (93) implementation strategies that reflect Nebraska’s diversity and complexity. Addressing the strategies and activities requires state, regional, tribal and local level actions. View the strategic plan at: <http://www.dhhs.ne.gov/soc>

The DBH Strategic Planning Process has included an overall behavioral healthcare system focus, as well as a Substance Abuse Prevention Statewide Strategic Plan. [http://dhhs.ne.gov/behavioral\\_health/Pages/2010BHStrategicPlan.aspx](http://dhhs.ne.gov/behavioral_health/Pages/2010BHStrategicPlan.aspx) and [http://dhhs.ne.gov/behavioral\\_health/Documents/DBH-PreventionStrategicPlan2013-17.pdf](http://dhhs.ne.gov/behavioral_health/Documents/DBH-PreventionStrategicPlan2013-17.pdf)

## **Public Behavioral Health System Organization: Division of Behavioral Health**

### **State Level Organization**

At the state level, the Division of Behavioral Health (DBH) is comprised of three sections: Regional Centers, Community Based Services and Office of Consumer Affairs.

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### **Regional Centers**

The Lincoln Regional Center (LRC), a Joint Commission accredited state psychiatric hospital, is operated by the Nebraska Department of Health and Human Services (NDHHS). The LRC serves people who need very specialized psychiatric services and provides services in a highly structured treatment setting. The services provided include:

- **Psychiatric Services:** These are services for people with severe and persistent mental illness who have been committed by a mental health board due to mental illness and dangerous behaviors. The primary mission of the programs is to help individuals stabilize and return to live in the community. Interdisciplinary treatment teams develop individualized treatment plans based upon assessments completed at the time of admission. Discharge planning is part of the treatment plan, and starts when an individual is admitted. Additionally, Psychiatric Services provide evaluation, assessments, and treatment for individuals as ordered by the Nebraska legal system. The program offers a structured treatment approach which is tailored to the specific needs of the individual patient. Individuals admitted to one of these areas typically have severe and persistent psychiatric disorders.
- **Sex Offender Service:** This service provides treatment for individuals with a history of sexually deviant behavior. The population includes convicted sex offenders serving sentences through the Nebraska Department of Correctional Services, and individuals who have been committed under an inpatient mental health board order for sex offender treatment. Additionally, a transition program works to release the patients with appropriate safeguards to allow them the opportunity to successfully return to the community.
- **Whitehall Campus (administered by the LRC):** This service addresses the treatment needs of male adolescents who have offended sexually. There are residential and treatment group home levels of care. Each youth has his own room. The program is family-centered and has its own school on the campus. Youth who complete treatment at Whitehall have a low incidence of reoffending sexually based on an independent study that followed the youth over seven years from completion of treatment.

The Lincoln Regional Center's scenic 107 acre campus is also the site of a State Arboretum with over 400 species of plants and trees. Nature paths and extensive wildlife help create a peaceful environment for care and treatment.

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

The Hastings Juvenile Chemical Dependency Program (HJCDP) provides residential substance abuse treatment for young men paroled from the Youth Rehabilitation Treatment Center in Kearney, Nebraska. The Hastings Regional Center is a Joint Commission accredited facility.

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For more information on the Regional Centers, see the DHHS / Division of Behavioral Health web site at: [http://dhhs.ne.gov/behavioral\\_health/Pages/beh\\_rc\\_rc.aspx](http://dhhs.ne.gov/behavioral_health/Pages/beh_rc_rc.aspx)

### **Community Based Services**

The Community Based Services section of the Division of Behavioral Health (DBH) is organized into three teams – Prevention, Treatment and Supportive Health Services, Quality and Data Performance Measurement and Federal and Fiscal Performance.

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

In addition to funding mental health and substance use disorder treatment and prevention services through the RBHAs, the DBH Community Based Services section contracts with the Lasting Hope Recovery Center in Omaha offering a range of treatment and prevention services to meet the needs of patients experiencing the challenges of mental illness and/or substance use disorders; with the Nebraska Family Helpline (888-866-8660) available for families to obtain assistance by providing a single contact point 24 hours a day, seven days a week; with family organizations to advocate for families with youth experiencing mental/emotional disorders, support the family voice and offer supportive services such as education, support groups, advocacy and mentoring; and, with the four Federally recognized Native American Tribes in the state for the provision of culturally specific mental health and substance use disorder treatment services.

### **Independent Peer Review**

DBH ensures an Independent Peer Review is addressed to assess the quality, appropriateness, and efficacy of services per the requirements under the Community Mental Health Services Block Grant (MHBG) and the Substance Abuse Prevention and Treatment Block Grant (SABG).

The DBH approach for Independent Peer Review is based on policy guidance received from SAMHSA, with the concurrence of the US Department of Health and Human Services Office of General Counsel. The SAMHSA program policy related to Independent Peer Reviews was changed to allow states the option to demonstrate compliance with 42 USC § 300x-53(a)(1)(A) and 45 CFR § 96.136 by requiring substance abuse treatment programs receiving SABG funds to obtain accreditation from a private accreditation body such as the Joint Commission on the Accreditation of Healthcare Organizations and the Commission on the Accreditation of Rehabilitation Facilities or similar organizations. The rationale is these standards for accreditation by private accreditation bodies are more stringent than those outlined in the Federal statute and regulations.

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Starting in July of 2013 DBH began working to establish a new approach consistent with revised SAMHSA program policy on using private accreditation bodies to meet this Independent Peer Review requirement under both the MHBG and SABG. The expectation of SABG and MHBG fund recipients is to have National Accreditation. The amended Division of Behavioral Health Title 206 regulations went into effect on April 11, 2015. Under Chapter 5 (Requirements for Providers Contracting with RBHAs) is the National Accreditation requirement. The expectation is to receive funds administered by the Division for service delivery, the community behavioral health providers must submit accreditation appropriate to the organization's mission by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or other nationally recognized accreditation organization(s) approved by the Director. A copy of the Title 206 regulations can be found here: [http://dhhs.ne.gov/Pages/reg\\_t206.aspx](http://dhhs.ne.gov/Pages/reg_t206.aspx)

### **Office of Consumer Affairs**

The Office of Consumer Affairs (OCA) works to build, promote, and sustain services which incorporate consumers as integral components of the recovery process throughout the system. Activities include facilitating community forums for consumers to receive feedback on the quality of services being provided and identify gaps in these services, networking with consumer led and advocacy organizations, conducting training and certifying Peer Support and Wellness Specialists, sponsoring an annual conference and other trainings for consumers and providers, disseminating information to consumers to promote health and wellness, training members of the mental health boards responsible for the civil commitment of individuals who are mentally ill and dangerous, implementing classes at the Regional Centers to teach holistic, non-medical coping techniques (e.g., yoga and meditative breathing) and serving as an integral part of the DBH administration to ensure the consumer voice is incorporated into decisions at all levels.

The OCA People's Council is designated to facilitate coordination required under the law between the Regional Behavioral Health Authorities and the Office of Consumer Affairs around consumer involvement in all aspects of service planning and delivery in the Region. The members are appointed by the Nebraska Department of Health and Human Services Director of the Division of Behavioral Health.

For more information about the Office of Consumer Affairs, see the NDHHS Division of Behavioral Health web site at: [http://dhhs.ne.gov/behavioral\\_health/Pages/beh\\_mh\\_mhadvo.aspx](http://dhhs.ne.gov/behavioral_health/Pages/beh_mh_mhadvo.aspx)

### **Regional and Local Level Organization**

The Division of Behavioral Health (DBH) contracts with six Regional Behavioral Health Authorities (RBHAs) to purchase services using the funds received under both the Community

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Mental Health Services Block Grant and the Substance Abuse Prevention and Treatment Block Grant.

Each RBHA is responsible for the development and coordination of publicly funded behavioral



health services in their Region pursuant to rules and regulations of the Nebraska Department of Health and Human Services (NDHHS). Each RBHA is governed by a Regional Governing Board consisting of one county board member (locally elected official) from each county in the Region. The administrator of the RBHA is appointed by the Regional Governing Board.

Nebraska Census by Regional Behavioral Health Authority (2013 Population Estimates)

Regional Behavioral Health Authority	RBHA Office	Counties	Population	% of Population
1 (Panhandle/Western)	Scottsbluff	11	87,104	4.7%
2 (South Western)	North Platte	17	100,642	5.4%
3 (South Central)	Kearney	22	229,646	12.3%
4 (Northeast & North Central)	Norfolk	22	206,304	11.0%
5 (Southeast)	Lincoln	16	456,138	24.4%
6 (Eastern)	Omaha	5	788,682	42.2%
<b>Totals</b>		<b>93</b>	<b>1,868,516</b>	<b>100%</b>

Each RBHA is expected to provide Network Management (develop and manage a comprehensive array of mental health and substance abuse services with sufficient capacity for their designated geographic area based on a comprehensive needs assessment/strategic plan); Prevention System Coordination (promotion of a comprehensive prevention approach, including a mix of evidence-based programs, policies, and/or practices that best addresses the selected prevention priorities); Emergency System Coordination (to meet the needs of individuals experiencing a behavioral health crisis/emergency situation); Youth System Coordination and Professional Partner Program (coordinate activities and collaborate with community-based partners to ensure that children and youth with behavioral health disorders receive the most appropriate services located within their community whenever possible); as well as Housing Coordination and Housing Related Assistance (provide leadership, planning activities and system problem solving for regional housing issues for persons with extremely low incomes who have behavioral health disorders).

It is the responsibility of the DBH and each RBHA to monitor, review, and perform programmatic, administrative, and fiscal accountability and oversight functions on a regular basis with all subcontractors. This includes financial accountability by

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developing complete and accurate budget plans, compliance with audit procedures, completion of services purchased verifications on all services, ensure timely attainment of Certified Public Accountant (CPA) audits, monitor all funding for compliance with state and federal requirements, compliance with the DBH policy regarding financial eligibility, ensure the DBH funding is used as payment of last resort, monitor all contracts for the purchase of services and related duties. Both internal and external measures for oversight of services purchased are utilized to achieve this goal.

External measures include:

1. Fiscal audit as conducted by a Certified Public Accountant, and
2. Accreditation by a nationally recognized accrediting body (as applicable)

Internal measures include:

1. Services Purchased Verifications (unit/fiscal)
2. Program Fidelity Reviews (programmatic)
3. Systematic Quality Improvement Initiatives

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

### **Prevention System Organization**

The Division of Behavioral Health (DBH) is charged with the development of prevention, treatment and recovery services for the State of Nebraska. The DBH's Prevention Manager serves as the National Prevention Network representative, the Synar Coordinator and the State Epidemiological Outcomes Workgroup (SEOW) Project Director. The focus of DBH's Prevention System is to develop a sustainable and effective prevention system that is committed to the reduction of substance abuse and its related consequences. This is accomplished by promoting safe and healthy environments that foster youth, family, and community development through the implementation of early intervention and substance abuse prevention best practices.

The DBH contracts with Regional Behavioral Health Authorities (RBHAs) for technical assistance, training, and database development to support local coalitions and community entities. The majority of prevention activities purchased by the DBH are carried out by the RBHAs Prevention Coordination system which is designed to operate at the community level, embracing local culture while leading the development of sustainable prevention activities for substance abuse and related societal problems through the life span. Funded primarily by the Substance Abuse Prevention and Treatment Block Grant, Regional Prevention Coordination staff utilize coexisting prevention efforts such as Strategic Prevention Framework – Partnerships for Success (SPF-PFS) grant and Drug Free Communities in addition to community partnerships to establish common directives and geographic and target population strategic planning to better utilize training and technical assistance initiatives.

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Nebraska's Five-Year Strategic Prevention Plan supports the DBH's overarching strategic goals and will focus statewide prevention efforts on a prioritized set of behaviors – this selection was data driven, and results of activities can be measured over time to demonstrate the success of state initiatives. These priorities are aligned with those of the Substance Abuse Prevention and Treatment Block Grant. This plan continues guide prevention prioritization, decision-making, and policy development at the State, Region and community level. Training continues for all communities receiving substance abuse prevention funding to apply the SPF process. In cooperation and partnership with Regional Prevention System Coordinators, training events are funded throughout the state to introduce, enhance and improve the use of evidence-based, promising and local prevention strategies most appropriate to their local community goals. These local goals have included the reduction of underage drinking, reduction of driving under the influence and reduction of binge drinking. Ultimately, by requiring all communities to use the SPF model, and by providing effective statewide training and technical assistance in the use of the model, greater progress is being achieved in reducing substance abuse and related health consequences across the state.

In addition, a Prevention Advisory Council (PAC) has been chartered to provide state and regional system leadership in substance abuse and mental health prevention to Nebraska's Behavioral Health system (NBHS). As a subcommittee of the State Advisory Council on Substance Abuse Services and the State Advisory Committee on Mental Health Services, the Prevention Council will guide the Department of Health and Human Services Division of Behavioral Health (DBH), and related state agency partners.

The PAC objectives are as follows:

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

### **Public Behavioral Health System Organization: NDHHS Division Partners**

Two other Divisions of the NDHHS that also contribute to the System of Care and provide mental health and substance use services for adults and/or children are the Division of Medicaid and Long Term Care and the Division of Children and Family Services.

#### **Division of Medicaid and Long-Term Care**

The Division of Medicaid and Long-Term Care (DMLTC) provides funding for an array of services to address mental health and substance use issues of children and adults, including the Medicaid Rehabilitative Option (MRO) services and 1915(b) Substance Abuse Waiver services. The DMLTC has worked extensively with the Division of Behavioral Health (DBH) to

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standardize service delivery expectations (service definitions) to ensure that Medicaid and non-Medicaid individuals are receiving similar services. Up to this time, the DBH and the DMLTC have worked with Magellan Health as their Administrative Services Only vendor, to provide utilization management for both entities for a MRO, SA Waiver, and other select services.

For the services above (MRO/SA Waiver), the DBH supplied a 40% state dollar match to access Medicaid federal funds. The DBH and the DMLTC re-evaluated this agreement and requested to make changes to eliminate the use of the DBH funds for match, via a one-time DBH shift of funds to Medicaid. The State Fiscal Year 2013-2014 budget shifted \$6 million of state general funds used to match four Medicaid Rehabilitation Option (MRO), Secure Residential, Sub-Acute Inpatient care and ten Substance Abuse Waiver services from DBH to Medicaid. This transfer places state funding used to match federal funding for Medicaid behavioral health services in the Medicaid budget program.

The DMLTC moved to an at risk environment for behavioral health treatment and rehabilitative services and is in contract with Magellan Behavioral Health. This contract went into effective in September of 2013. Continued cooperation between the DBH, the DMLTC, and the vendor is a key area of interest and coordination efforts.

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

### **Division of Children and Family Services**

The Division of Children and Family Services (DCFS) is the primary agency responsible for the state's child welfare, juvenile services, and economic assistance problems. Services include child and adult abuse, foster care, adoption, parole and community-based juvenile services, domestic violence, Supplemental Nutrition Assistance Program, Employment First, Aid to Dependent Children, Medicaid eligibility, refugee resettlement, energy assistance, childcare subsidy, child support enforcement, resource development, and two Youth Rehabilitation and Treatment Centers in Kearney and Geneva.

The DCFS consists of one Policy Section and five Service Areas. The Policy Section includes the Child Welfare Unit (CWU), the Office of Juvenile Services (OJS), the Economic Assistance and Child Support Enforcement Unit (EA/CSEU) and the Comprehensive Quality Improvement/Operations area (CQI/O). This Section coordinates the administrative supports to facilitate efficient operation of its programs, policies, and service offering. The CWU and the OJS specifically develop policy and provide technical assistance in the areas of child abuse and neglect and juvenile services to Service Area staff, other division staff, and community partners.

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The Service Areas provide direct case management services to the children and families involved with child welfare and juvenile services.

OJS operated two secure-care facilities for the detention and rehabilitation of serious youth offenders: the Youth Rehabilitation and Treatment Center in Kearney (YRTC-K) for boys, and the Youth Rehabilitation and Treatment Center in Geneva (YRTC-G) for girls. Under LB561 – 2013, the Legislature transferred responsibilities regarding the juvenile justice system. This legislation allows CFS to begin work toward an Alternative Response Model (ARM) for conducting an automatic investigation on reports of potential child abuse and/or neglect. Beginning in October of 2013, children who had been Wards of the Office of Juvenile Services (OJS) and served by CFS are now served by the Office of Probation in the Judicial Branch. The Office of Probation serves children in the Juvenile Justice system. CFS continues to focus on children who are Abused and Neglected. CFS will continue to operate the Youth Rehabilitation and Treatment Centers (YRTCs) in Kearney and Geneva.

For more details see: [http://nebraskalegislature.gov/bills/view\\_bill.php?DocumentID=18806](http://nebraskalegislature.gov/bills/view_bill.php?DocumentID=18806).

In 2012, Nebraska Legislature passed LB821, creating the 24-member Nebraska Children’s Commission. The Commission created a strategic plan for child welfare services and made recommendations on possible administrative restructuring of child welfare services. Areas examined include a policy for prescribing psychotropic drugs to state wards, the role and responsibilities for the Office of Juvenile Services, Title IV-E (Adoption Assistance and Foster Care Programs) waivers, and foster care reimbursements.

Nebraska realizes having a system focused on the well-being of children in care is a fundamental component of a healthy system. Nebraska is beginning to examine a cross-divisional effort focused on trauma and understanding its effects on the entire system and the children and families served. The DBH and the DCFS have been working in collaboration on a framework to develop a plan to address trauma at multiple system levels of the system to include children, families, front line workers, service providers, foster parents, law enforcement, and other stakeholders. Currently, Nebraska has “pockets” of this work going on; however, a coordinated effort across divisions will provide an opportunity to maximize and share resources.

**Serving Adult and Youth Populations**

The behavioral health services funded by the Division of Behavioral Health (DBH) include, but are not limited to, consumer-provided services, support services, inpatient and outpatient services, and residential and nonresidential services. These services are provided for the prevention, diagnosis, and treatment of behavioral health disorders and the rehabilitation and recovery of adults and youth with such disorders.

**List of Funded Services**

<b>Service</b>	<b>Mental Health</b>	<b>Substance Abuse</b>
<b>Emergency Services:</b>		
24 Hour Crisis Line	X	X
Civil Protective Custody (CPC)		X

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<b>Service</b>	<b>Mental Health</b>	<b>Substance Abuse</b>
Crisis Assessment	X	X
Crisis Response Teams	X	X
Crisis Stabilization	X	X
Emergency Community Support	X	X
Emergency Protective Custody (EPC)	X	
Emergency Psychiatric Observation	X	
EPC/Crisis Stabilization	X	X
Hospital Diversion	X	
Acute Inpatient Hospitalization	X	X
Subacute Inpatient Hospitalization	X	X
Post Commitment	X	
Respite – MH-SA	X	X
Social Detox		X
Urgent Medication Management		
Urgent Outpatient Psychotherapy	X	X
<b>Residential Based Services:</b>		
Dual Disorder Residential	X	X
Halfway House		X
Intermediate Residential-Substance Abuse		X
Psychiatric Residential Rehabilitation	X	
Secure Residential	X	
Short Term Residential		X
Therapeutic Community		X
<b>Outpatient Services:</b>		
Assertive Community Treatment/Alternative Act	X	
Assessment Only Justice		X
Assessment Only-MH	X	
Assessment Only-Substance Abuse		X
Community Support-MH-SA	X	X
Day Rehabilitation	X	
Day Support	X	
Day Treatment	X	
Housing Related Assistance	X	X
Intensive Case Management	X	X
Intensive Community Service	X	X
Intensive Outpatient		X
Medication Management	X	

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<b>Service</b>	<b>Mental Health</b>	<b>Substance Abuse</b>
Medication Support	X	X
Mental Health Respite	X	
Methadone Maintenance		X
Outpatient Dual	X	X
Outpatient Group Psychotherapy-MH-SA	X	X
Outpatient Family Psychotherapy-MH-SA	X	X
Outpatient Individual Therapy-MH-SA	X	X
Recovery Support	X	X
Supported Employment	X	
<b>Children/Youth Services:</b>		
Therapeutic Community/Youth/Adolescent		
Young Adult Partner - MH	X	
Transition Aged Wraparound	X	
Children/Adolescent Wraparound	X	
Children School Wraparound	X	
Children/Youth Short Term Wraparound	X	
Children/Youth Assessment/Evaluation Only	X	X
Children Day Treatment		
Children Emergency Community Support		
Children Intensive Outpatient SA		X
Children Outpatient MH-SA	X	X
Children Intensive Outpatient MH-SA	X	X
Children Medication Management	X	
Children/Youth Therapeutic Consultation	X	
Children Halfway House		X
Children Partial Care		X
Children Community Support MH		
Youth Assessment Only	X	
Crisis Inpatient Youth	X	
MH Respite Care Children/Adolescent		
Home Based Multi-Systemic Therapy	X	
Emergency Community Support - Transition Youth	X	
Supported Employment	X	X
Supported Living	X	
Children Crisis Response Team LB603		
Children Acute Inpatient Hospitalization		
<b>Flexible Funding:</b>		

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Service	Mental Health	Substance Abuse
Flex Funds Community Support	X	X
Emergency Flex Funds	X	X

**Addressing the Needs of a Diverse Population**

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

Nebraska 2013 Estimates for Race Populations

	<u>TOTAL</u>	
<u>Race Estimates in Nebraska</u>	Number	Percent of Total
Asian	37,370	2.0%
Native Hawaiian/Other Pacific	1,869	0.1%
Native American/Alaska Native	14,948	0.8%
Black/African American	85,952	4.6%
White	1,649,900	88.3%
Multiracial	42,976	2.3%
Other race	35,502	1.9%
Total	1,868,516	100.0%

Source: U.S. Census Bureau - 2013 American Community Survey Estimates for Nebraska

Division of Behavioral Health Community Based Services Consumer Race Categories

	<u>TOTAL</u>	
<u>Race of Persons Served</u>	Number	Percent of Total
Asian	241	0.8%
Native Hawaiian/Other Pacific Islander	308	1.0%
Native American/Alaska Native	1,213	3.8%
Black/African American	2,816	8.8%
White	26,803	83.8%

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Multiracial	302	0.9%
Unknown	311	1.0%
Total	31,994	100.0%

The RBHAs provide services to diverse populations as demonstrated by comparing the persons served data from State Fiscal Year 2014 to the 2013 U.S. Census data from the American Community Survey 5-Year Estimates. The percent of persons by race served are comparable to the total numbers of persons by race present in the State of Nebraska.

B.2. Planning Step 2 Identify Unmet Needs And Critical Gaps | page 1

*Step 2: Identify the unmet service needs and critical gaps within the current system. This step should identify the unmet services needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the populations relevant to each block grant within the state's behavioral health system, especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet these unmet service needs and gaps*

**Identifying Unmet Needs and Critical Gaps within Current System**

Nebraska understands how important a data driven approach is to best understand the dynamic needs of our state for both priority populations as well as the others who also depend upon funding from the Division of Behavioral Health (DBH). Nebraska has evaluated data from various internal sources on treatment data collected in addition to external resources such as the National Survey on Drug Use and Health (NSDUH), the Treatment Episode Data Set (TEDS), the Uniform Reporting System (URS), and other reliable survey sources historically used to monitor and inform decision making.

**Note on Community Behavioral Health Data**

The Division of Behavioral Health does not own a data or claims system. Magellan Behavioral Health, as Administrative Service Organization (ASO) contractor, provides the data and claims information for persons served in community settings. The DBH contracts with the six Regional Behavioral Health Authorities (RBHAs). The RBHAs contract with local providers or, in some cases, directly provides the services. At the service provision level, the data are collected and reported to the ASO contractor. Once per month the ASO contractor transfers the data to the DBH. In this section, the data reports from the ASO are sourced as "Community Behavioral Health Data - NE Division of Behavioral Health". These notes apply to those tables:

1. Data source: data extract from the Magellan Information System.
2. MH ONLY category means person was served in one or more Mental Health (MH) services funded by the DBH via the six RBHAs.
3. SA ONLY category means person was served in one or more Substance Abuse (SA) services funded by the DBH via the six RBHAs.
4. Dual ONLY category means person was served in a service category where Mental Illness and Substance Use Disorder are both the primary diagnosis. Dual Disorder Residential is at ASAM level III.5 Adult SA program. The service is Dual Diagnosed Enhanced. Staff who are capable of conducting mental health and/or substance abuse services and who hold dual credentials are present at all times.
5. COMBO means the person was served in more than one service category, in some combination of MH, SA and/or Dual.
6. Numbers in the MH only, SA only and Dual only columns indicate that only this type of service was received during the entire time period reported (State Fiscal Year).
7. Unless otherwise specified in this report, Youth means age 0-17; Adult means age 18+. In the State of Nebraska, the age of majority is 19.

B.2. Planning Step 2 Identify Unmet Needs And Critical Gaps | page 2**Overview of Adults and Youth Served for Mental Health and Substance Abuse**

In Fiscal Year 2014 (FY14), the Division of Behavioral Health funded community-based services for 31,994 individuals. Of those individuals: 21,794 people received mental health services, 13,259 people received substance use disorder services, and 475 people received dual disorder services in community settings (please note that individuals can receive services in multiple service types, therefore the sum of the service types is greater than the total count reported). When considering service breakdown by just mental health and substance use, 13,518 received treatment for substance use disorders and including state hospital services, there were 22,579 individuals who received treatment for mental health disorders. There were 13,777 adults served with SMI and 1,674 youth with SED.

*Data source:*

1. *Magellan FY14 Treatment Data*
2. *MH: FY2014 URS table 2A, 14A*
3. *SA: FY2014 SABG Behavioral Health Report Table 11*

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

The Division of Behavioral Health through the six Regional Behavioral Health Authorities serves Adults with SMI. The data tables below are from the Nebraska FY2014 Uniform Reporting System (URS).

URS Table 2A. Profile of Persons Served, All Programs Age 18+

Total age 18+	20,366	90.2%
Total	22,579	100%

Of this population reported on Table 2A, 43% are between the ages of 25-44 (9,764) and 32% are between the ages of 45-64 (7,198).

Table 14A. Profile of Persons with SMI served Age 18+

Total age 18+	13,777	89.2%
Total	15,451	100%

Of this population reported on Table 14A, 84% of the persons served are age 21-64 years (12,925).

Using these URS Table data, of the adults served age 18 and older, 68% had a Serious Mental Illness of those served who were 18 and older.

Table 14A population is a subset of the population presented in Table 2A. For the purposes of reporting on the URS Table 14A, Adults with SMI means:

- The person is receiving or is clearly eligible for Supplemental Security Income (SSI) &/or Social Security Disability Insurance (SSDI) OR
- The person is served in one of the Nebraska Behavioral Health System (NBHS) funded Community Mental Health Rehabilitation Based Services (Community Support, Assertive Community Treatment, Psychiatric Residential Rehabilitation, Day Treatment, Day Rehabilitation, Day Support, Vocational Support, or related psychiatric rehabilitation services) OR

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- The person has an Axis V – GAF Scale score of less than 60 AND a diagnosis of Axis I or II - 295.0 to 298.9 [Schizophrenia, Schizoaffective Disorder, Bipolar Affective Disorder, Major Depression, Delusional Disorder, or other major mental illness under the current edition of the Diagnostic and Statistical Manual of Mental Disorders].

**Youth with Serious Emotional Disturbance (SED)**

The Division of Behavioral Health through the six Regional Behavioral Health Authorities serves Youth with SED. The data tables below are from the Nebraska FY2014 Uniform Reporting System (URS).

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

age 0-17 years	2,210	9.8%
Total	22,579	100.0%

URS Table 14A. Profile of Persons with SED served Age 0-17

age 0-17 years	1,674	10.8%
Total	15,451	100.0%

**Capacity Management and Waiting List System for Priority Populations**

The Division of Behavioral Health operates a capacity management and waiting list systems for intravenous drug users, pregnant women, and mental health commitments. The annual contract between the DBH and the six Regional Behavioral Health Authorities (RBHAs) establish these reporting requirements.

Priority populations are based on federal and state statutes and/or regulations and require priority admission into treatment services. Contracted providers receiving Substance Abuse Block Grant Funds must offer priority populations either immediate admission into the appropriate recommended treatment, or priority placement on the waiting list and the provision of interim services within 48 hours of the request for treatment and until they are admitted into the appropriate recommended treatment. Listed below are priority levels.

P1. Pregnant and current intravenous drug using women;

P2. Pregnant substance abusing women;

P3. Current intravenous drug users;

P4. Women with dependent children, including those attempting to regain custody of their children;

Summary FY2014 Substance Abuse Capacity and Waiting List Report (July 2013 – June 2014)

→ There were 590 priority consumers waiting for services in FY2014.

→ The majority of identified priority consumers waiting for substance abuse services were women with dependent children (39%, n=229).

→ Most people identified as priority consumers waiting for substance abuse services were waiting for admission into Short-Term Residential services (63%, n=347).

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**Persons who are Intravenous Drug Users**

The Division of Behavioral Health through the six Regional Behavioral Health Authorities serves Youth and Adults who are Injecting Drug Users. Generally, a little over 5% percent of the persons served are Injecting Drug Users. Priority Populations for services include pregnant and current intravenous drug using women as well as current intravenous drug users.

Number of persons in BH services who are Injecting Drug Users

Year	SA ONLY Youth	Adult			TOTAL Youth & Adult All Services
		SA ONLY	Dual ONLY	COMBO	
FY2013	4	1,225	31	455	1,715
FY2014	6	1,245	18	466	1,735

Total Youth & Adult All Services who are Injecting Drug Users

	TOTAL		Total # of person served
	Number	Percent	
FY2013	1,715	5.4%	31,974
FY2014	1,735	5.4%	31,994

FY2014 Average Wait Days

Priority Population: IV Drugs Users

Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Total
0 (n=0)	20 (n=26)	17 (n=6)	19 (n=22)	20 (n=133)	9 (n=38)	18 (n=225)

Numerals is average days waiting | (n = number of people)

**Pregnant and Current Intravenous Drug Using Women**

The Division of Behavioral Health through the six Regional Behavioral Health Authorities serves Youth and Adults who are Pregnant Injecting Drug Users. Generally, less than one percent of the persons served are Pregnant Injecting Drug Users. Priority Populations for services include pregnant and current intravenous drug using women as well as current intravenous drug users.

Population: Pregnant Injecting Drug Users - Number of persons served

NOTE: Only reported consumers were served in Substance Abuse Services ONLY

	<b>Youth</b>	<b>Adult</b>
FY2010	0	36
FY2011	0	34
FY2012	1	35
FY2013	0	41
FY2014	0	39

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Total Youth & Adult All Services who are Pregnant Injecting Drug Users

	TOTAL	Percent	Total # of person served
FY2010	36	0.1%	36,011
FY2011	34	0.1%	35,387
FY2012	35	0.1%	34,938
FY2013	41	0.1%	31,974
FY2014	39	0.1%	31,994

FY2014 Average Wait Days

Population: Pregnant Injecting (IV) Drug Users

Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Total
0 (n=0)	4 (n=1)	21 (n=1)	6 (n=6)	15 (n=1)	6 (n=1)	8 (n=10)

Numerical is average days waiting | (n = number of people)

**Pregnant Substance Abusing Women**

The Division of Behavioral Health through the six Regional Behavioral Health Authorities serves Youth and Adults who are Pregnant Substance Abusing Women. Generally, less than one percent of the persons served are Pregnant Substance Abusing Women.

Population: Pregnant Substance Abusers

Number of persons served who are Pregnant Substance Abusers

	<u>SA ONLY</u>		<u>Dual ONLY</u>	<u>COMBO</u>	<u>TOTAL</u>		<u>TOTAL</u>	
	<u>Youth</u>	<u>Adult</u>	<u>Adult</u>	<u>Adult</u>	<u>Youth</u>	<u>Adult</u>	<u>#</u>	<u>%</u>
FY2010	4	230	4	2	4	236	240	0.7%
FY2011	4	207	5	1	4	213	217	0.6%
FY2012	6	248	2	2	6	252	258	0.7%
FY2013	0	226	0	27	0	253	253	0.8%
FY2014	1	173	0	15	1	188	189	0.6%

Total Youth & Adult All Services who are Pregnant Substance Abusers

	TOTAL	Percent	Total # of person served
FY2010	240	0.7%	36,011
FY2011	217	0.6%	35,387
FY2012	258	0.7%	34,938
FY2013	253	0.8%	31,974
FY2014	189	0.6%	31,994

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## FY2014 Average Wait Days

## Priority Population: Pregnant Women

Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Total
0 (n=0)	8 (n=1)	0 (n=0)	0 (n=0)	15 (n=3)	16 (n=8)	15 (n=12)

Numerals are average days waiting | (n = number of people)

**Women with Dependent Children**

The Division of Behavioral Health does not currently collect persons served data in the Magellan Behavioral Health data system for women with dependent children. Data are collected for the Capacity Management and Waiting List System.

## FY2014 Average Wait Days

## Priority Population: Women with Dependent Children

Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Total
11 (n=10)	28 (n=12)	9 (n=4)	7 (n=8)	28 (n=87)	28 (n=76)	26 (n=197)

Numerals are average days waiting | (n = number of people)

**Behavioral Health Services for Individuals in Rural Areas**

The Division of Behavioral Health provides community based services to individuals with mental health and/or substance use disorders who live in rural areas. The U.S. Census Bureau defines Metropolitan Statistical Area as a geographic entity containing a core urban area of 50,000 or more population. Each area consists of one or more counties and includes the counties containing the core urban area, as well as any adjacent counties that have a high degree of social and economic integration (as measured by commuting to work) with the urban core.

Source: <http://www.census.gov/population/metro/>

The following are the Metropolitan Statistical Areas in Nebraska.

Lincoln, NE Metropolitan Statistical Area

Lancaster County, NE

Seward County, NE

Omaha-Council Bluffs, NE-IA Metropolitan Statistical Area

Cass County, NE

Douglas County, NE

Sarpy County, NE

Saunders County, NE

Washington County, NE

Sioux City, IA-NE-SD Metropolitan Statistical Area

Dakota County, NE

Dixon County, NE

Source: U.S. Census Bureau, Population Division

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## Unduplicated Count of Persons Served by Age and County of Admission

Population: Rural Areas - Number of persons served with mental and/or substance use disorders who live in rural areas.

Fiscal Year	MH ONLY		SA ONLY		Dual ONLY		COMBO		Total Served in Rural Area
	Youth	Adult	Youth	Adult	Youth	Adult	Youth	Adult	
FY2010	1,175	7,497	209	4,321	1	57	73	1,475	14,808
FY2011	1,121	7,568	166	3,781	1	54	24	1,546	14,261
FY2012	1,053	7,337	166	3,779	1	51	18	1,567	13,972
FY2013	1,103	7,266	103	3,746	2	56	22	1,589	13,887
FY2014	1,230	7,629	127	3,558	1	52	23	1,578	14,198

Fiscal Year	Served in Rural Area	% served in Rural Area of total persons served	Total Number of person served by Fiscal Year
FY2010	14,808	41%	36,011
FY2011	14,261	40%	35,387
FY2012	13,972	40%	34,938
FY2013	13,887	43%	31,974
FY2014	14,198	44%	31,994

The table provides the unduplicated count of persons served in FY2010, FY2011, FY2012, FY2013 and FY2014 in rural community based programs funded by the Division of Behavioral Health. The table indicates the count by type of service by age category in rural counties.

Footnote:

- Nine (9) counties are assigned to Metropolitan Statistical Areas in Nebraska per U.S. Census Bureau.
- For the purposes of reporting this measure, the remaining 84 Nebraska Counties are classified as rural.

**State Epidemiological Outcomes Workgroup (SEOW)**

Formed in March 2007 and assumed by the Division of Behavioral Health in the fall of 2012, the SEOW is comprised of administrators, epidemiologists, and key stakeholders who collaborate to make decisions regarding the collection and reporting of data. The Nebraska SEOW seeks to produce sustained outcomes in preventing the onset as well as reducing the progression of substance abuse, mental illness, and related consequences.

One of the main functions of the SEOW is to identify the availability of data, utilization of data and prioritization of substance abuse data gaps, including missing or incomplete data. In December of 2007, the *Substance Abuse and Associated Consequences in Nebraska –An Epidemiological Profile* was published. An update was provided in the summer of 2012 and the next enhancement will include both substance abuse and mental health indicators to highlight shared or common risk and protective factors that impact both substance abuse and mental

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disorders. Through a formal charter this work will be accomplished by continuation of the SPF planning process, working across disciplines and implementing strategies that are specifically designed to create environments that support behavioral health and the ability of individuals to withstand challenges.

One of the many contributions the DBH provides to the workgroup is data from the community based substance abuse treatment information system. The DBH will lead the workgroup in its work to identify priority substance abuse issues and problems associated with related mental health disorders to maximize subsequent targeting of resources at the state and community level. In many areas, the state has a wealth of data available from which the SEOW will be able to draw assessment information. The Nebraska Young Adult Alcohol Opinion Survey, the Nebraska Risk and Protective Factor Survey and the Youth Risk Behavioral Survey provide excellent data for monitoring underage drinking and other youth substance abuse issues. However, in other areas, such as surveillance systems for monitoring Fetal Alcohol Spectrum Disorders, prescription drug abuse, or substance use among older adults, information is inadequate. It is recognized data drives decisions about resources. An absence of data impacts the attention directed toward actual major public health issues. Therefore, ensuring sustainability and ongoing operation of a SEOW is vital in order to coordinate a public health surveillance system that is capable of providing a comprehensive, focused assessment and analysis.

The opportunity to develop a more inclusive epidemiological profile will be instrumental in the efforts to increase awareness of substance abuse and mental illness among key decision makers and garner more support for increased early intervention efforts. By generating a greater understanding of the scope of the behavioral health issues affecting all Nebraskans, planning driven by the SEOW will ultimately lead to significant reductions in substance abuse and associated mental health problems across the state.

### **Priority Areas for FY2016/2017**

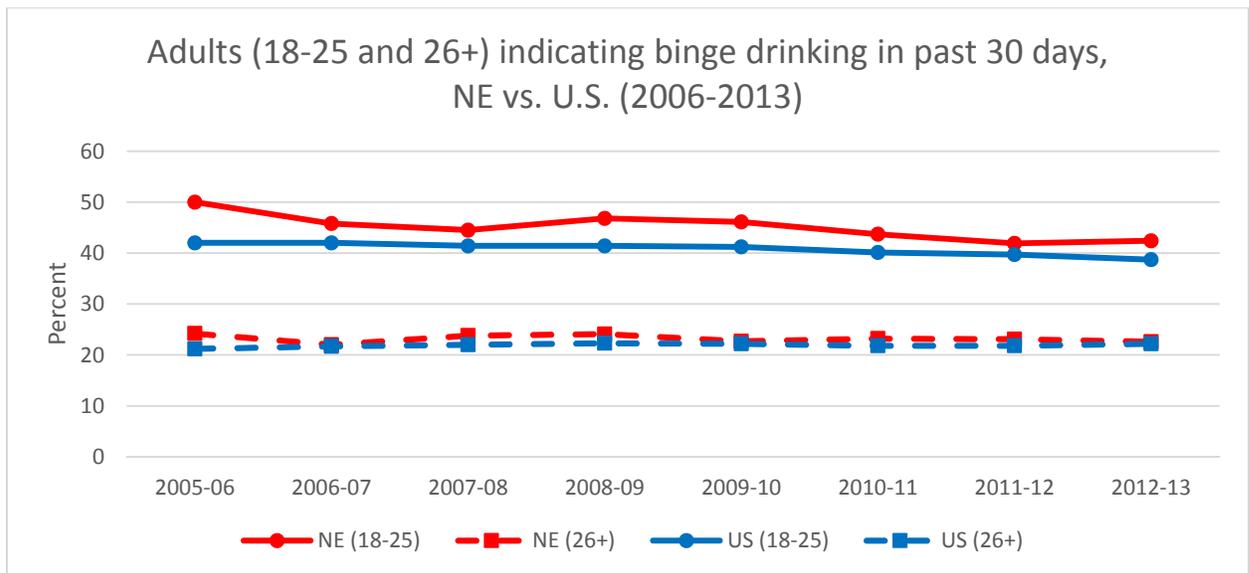
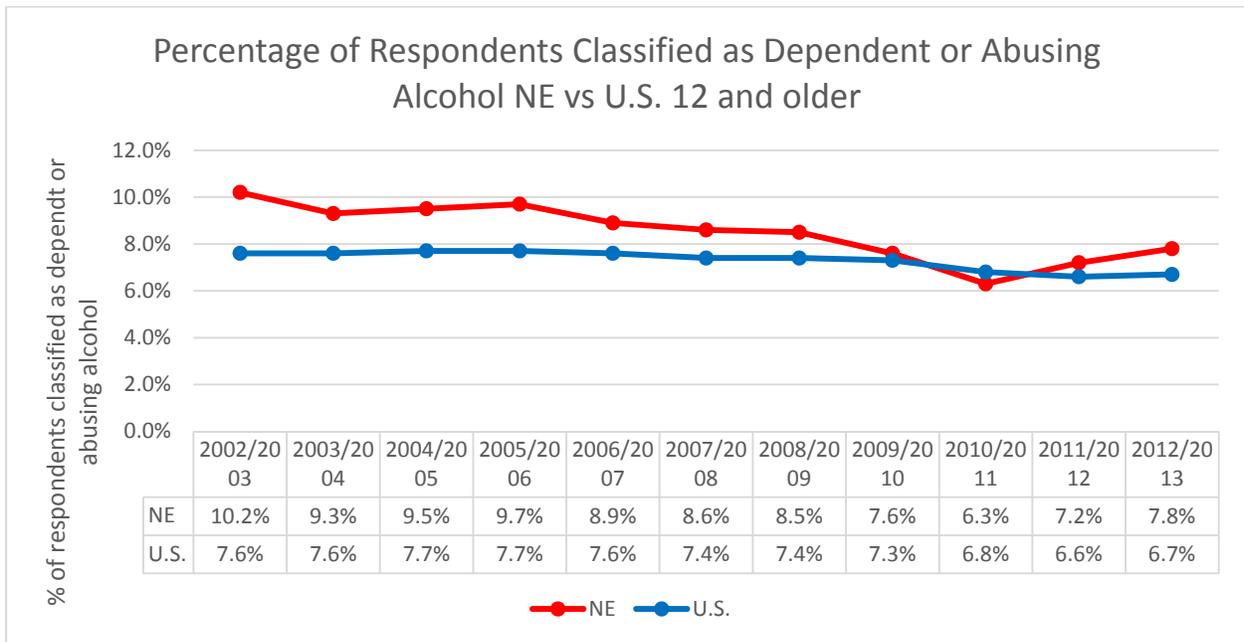
In addition to understanding the general profile for adults and youth served in the current behavioral health service system, data sources directed attention to specific areas of need. The most current set of data indicates the need for work focused on prevention of underage and binge drinking amongst youth and young adults, individuals with co-occurring mental health and substance use disorders, for those with a history of trauma, first episode psychosis, and tuberculosis. Additional data in support of each of these areas is provided below.

### **Alcohol Use Among Youth and Young Adults**

According to the United Health Foundation for American's Health Rankings 2014 Nebraska has a very high prevalence of binge drinking. They found 20% of Nebraska adults report binge drinking placing it at the 44th rank among the 50 states. Underage alcohol consumption continues to be a problem among youth in Nebraska. The National Survey of Drug Use and Health (NSDUH) indicates youth alcohol use rates, and binge drinking in particular, are higher in Nebraska compared to national rates. According to 2012-2013 survey results, 16.2% of people aged 12-20 in Nebraska reported having binge drank in the past month compared to the national average of 14.7%. Additional trends related to drinking behaviors in Nebraska are below and

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provide additional demonstration to the need to prioritize prevention efforts targeting underage and binge drinking amongst Nebraska youth and young adults



**Co-Occurring Disorders Services (COD)**

The Nebraska Behavioral Health Services Act defines "Behavioral health disorder" as mental illness or alcoholism, drug abuse, or other addictive disorder [Neb. Rev. Stat. §71-804(1)]. The Division of Behavioral Health Strategic Planning for Nebraska's Behavioral Health System (Strategic Plan 2011 – 2015) Goal 1 states, "The public behavioral health workforce will be able to deliver effective prevention and treatment in recovery oriented systems of care for people with co-occurring disorders." The DBH has a responsibility to meet consumer needs wherever they

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present in the DBH funded service system to promote recovery in those served. Through a collaborative effort, the Co-Occurring Disorders Quality Initiative has been working toward ways to improve services to adults with co-occurring mental health and substance abuse disorders and their families. This is important to help promote recovery of individuals and families as well as integrating the co-occurring service delivery system.

COD refers to co-occurring substance related and mental disorders. Consumers said to have a COD have one or more substance-related disorders as well as one or more mental disorders. At the individual level, COD exist “when at least one disorder of each type can be established independent of the other and is not simply a cluster of symptoms resulting from a single disorder.”

As identified in the DBH’s co-occurring road map, the DBH has determined that agencies will be co-occurring enhanced or co-occurring capable. The number of individuals served in both a mental health and substance abuse or dual service has risen to nearly 11%. It is quite likely these estimates underestimate actual co-occurring treatment needs. The National Alliance on Mental Illness (NAMI) reports that approximately 50% of individuals with severe mental disorders are affected by substance abuse while 37% of alcohol abusers and 53% of drug abusers also have at least one serious mental illness (NAMI, 2012).

# of person served

	Dual ONLY		COMBO		Co-Occurring		
	Youth	Adult	Youth	Adult	#	#	%
FY2012	1	72	27	3360	34,938	3460	9.9%
FY2013	3	88	30	3303	31,974	3424	10.7%
FY2014	1	61	38	3311	31,994	3411	10.7%

Source: Magellan July 2012, October 2013, and August 2014 data extracts

FY2014 mental health data shows that Nebraska has a higher rate of adults served who have co-occurring disorders than national comparison rates (29% Nebraska vs. 22% U.S.).

	NE		U.S.	
	FY2013	FY2014	FY2013	FY2014
Adults with Co-Occurring MH/SA Disorders	28.9%	29.3%	21.2%	21.6%
Children with Co-Occurring MH/SA Disorders	5.5%	5.3%	5.1%	4.4%

Source: CMHS Uniform Reporting System Multiyear Output Tables, April 2015

The COMPASS EZ tool has been selected to help address system needs related to equipped providers with the knowledge necessary to address the complexities of co-occurring disorders. A second assessment is underway for providers and will be used to determine areas for improvement. The COMPASS EZ measures 15 areas of readiness and performance including an understanding of the agency and staff readiness to become either a dual enhanced or dual capable provider which may result in increased reimbursements to agencies, especially those persons who are Medicaid eligible.

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**Trauma Informed Services**

The Adverse Childhood Experience (ACE) Study and SAMHSA's national statistics highlight the critical importance of developing a system that is trauma informed and utilizes trauma specific services. Consumers who report trauma continue to increase year after year. In FY2014, 54% of individuals receiving services reported a history of trauma compared to 42% in FY2012 and 28% in FY2010. Trauma is considered to be a near universal experience for those with behavioral health problems. Emotional abuse was the most commonly reported type of experienced trauma.

<b>Emotional Abuse</b>	35.6%
<b>Physical Abuse</b>	30.3%
<b>Traumatic Loss of a Loved One</b>	28.4%
<b>Sexual Abuse</b>	21.4%
<b>Witness to Domestic Abuse</b>	20.7%
<b>Physical Assault</b>	20.3%
<b>Serious Accident/Injury</b>	15.8%
<b>Neglect</b>	15.7%
<b>Victim of a Crime</b>	13.7%
<b>Sexual Assault/Rape</b>	13.6%
<b>Witness to Community Violence</b>	12.5%
<b>Life Threatening Medical Issues</b>	10.9%
Sanctuary Trauma	4.8%
Natural Disasters	4.5%
War/Political Violence/Torture	1.8%
Prostitution/Sex Trafficking	1.7%
Victim of a Terrorist Act	1.6%

Females reported a Trauma History (at least 1 Trauma selected) 64.8% of the time while males reported a Trauma History 45.9% of the time. Nationally it is estimated that 55% to 99% of women in substance use treatment and from 85% to 95% of women in the public mental health system report a history of trauma. (National Council for Community Behavioral Healthcare, 2012).

To develop a service system that understands the effects of trauma and avoids re-traumatizing those who seek services (trauma-informed), the DBH has sought to increase trauma awareness by using the "expectation, not the exception" guidelines in daily behavioral health service practices in addition to improving access to trauma informed care by requiring providers to complete a trauma informed services self or peer assessment tool and then develop plans for improvement. The DBH required providers, as part of the FY2012 priority, to use the Falloot and Harris Trauma Informed Care (TIC) tool (or an equivalent and approved tool) for self-assessment. Providers were given until June 30, 2013 to complete their trauma informed assessment. In FY15 providers have again used the TIC tool and are required to report results to DBH. Comparison of the most result results to previous TIC assessment results will be used to identify specific strategies aimed at improving trauma sensitivity in the behavioral health system.

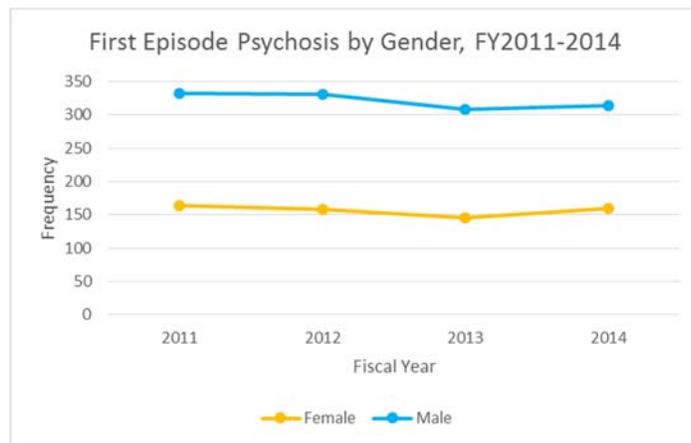
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### First Episode Psychosis

Psychosis is treatable and recovery, particularly from related problematic symptoms is possible. Research suggests early intervention can improve treatment outcomes. Psychosis in the early stages may not be detected right away. Although the majority of services funded through the DBH are for adults, many youth and young adults benefit from the DBH substance use and mental health service array. Review of recent treatment data shows a fairly consistent group of both males and females between the ages of 12 up to 26 who have a psychotic diagnosis. In FY2014 there were 473 meeting this criteria, 159 were female and 314 were male.

First Episode Psychosis by Gender, FY2011-2014

	Fiscal Year			
Gender	2011	2012	2013	2014
Female	164	158	146	159
Male	332	331	308	314
Total	496	489	454	473



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

It is important during treatment that each of these areas of functioning are addressed. DBH is working with pilot programs to implement pilot programs to address first episode of psychosis. Use of the Mental Illness Research, Education and Clinical Centers (MIRECC) version of the Global Assessment Functioning (GAF) scale will allow providers to measure and track improvements in functioning for these youth and young adults receiving treatment for first episodes of psychosis. MIRECC GAF measures occupational functioning, social functioning, and symptom severity on three subscales.

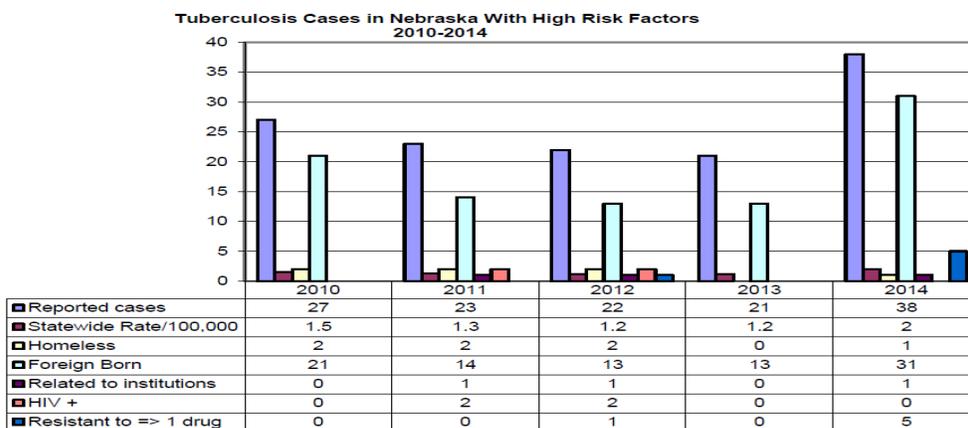
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**Additional Considerations**

**Requirements Regarding Tuberculosis**

Under the Substance Abuse Prevention and Treatment Block Grant (§96.127 Requirements Regarding Tuberculosis), the State Substance Abuse Authority (SSA) must require programs receiving funds to treat substance abuse to routinely make Tuberculosis (TB) services available to each individual receiving treatment for substance abuse. The Division of Behavioral Health is the SSA in Nebraska.

In 2014, Nebraska had 38 cases of TB, for a rate of 2 cases per 100,000 people. This represents the highest number of TB cases over the last ten years in Nebraska. The large majority of TB cases occurred with individuals who were foreign born as indicated in the chart below.



The lowest rate over the past decade was in 2013 when Nebraska had 21 cases, for a rate of 1.1 case per 100,000 people. There were 12 counties in Nebraska that reported at least one case of TB for 2014.

The DBH has no specific financial set aside for TB services. The DBH Contracts with the six Regional Behavioral Health Authorities (RBHAs) require programs to have working relationships with local health departments and to screen for communicable diseases all persons requesting services.

TB screening is provided to all persons entering a substance abuse treatment service. Additional services and/or referrals for services are made available to those individuals whose screening indicates “high risk” for TB. The Tuberculosis Program in the Nebraska Division of Public Health provides the overall coordination for the State of Nebraska. Therefore, the contract between the DBH and the RBHAs addresses the TB Screening and Services requirements.

**TUBERCULOSIS (TB) SCREENING AND SERVICES**

1. The RBHA will ensure that all providers receiving SAPTBG funds shall:
  - a. Report active cases of TB to the Division of Public Health Tuberculosis Program Manager and adhere to all reporting requirements as set forth including NRS

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Sec.71-502, 71-1626 and 173 NAC Chapters 1-6, which can be found at:  
[www.dhhs.ne.gov/reg/t173.htm](http://www.dhhs.ne.gov/reg/t173.htm)

- b. Maintain infection control procedures that are consistent with those established by the State's infection control office.
  - c. Adhere to State and Federal confidentiality requirements when reporting such cases.
2. The RBHA will ensure that providers receiving SAPTBG funding will routinely make TB services available to each individual receiving treatment for substance abuse and to monitor such service delivery.
  3. The RBHA shall establish procedures that ensure that the following (TB) services are provided, either directly or through arrangements/agreements with other public or non-profit private entities:
    - a. Screening of all admissions for TB,
    - b. Positive screenings shall receive test for TB,
    - c. Counseling related to TB,
    - d. Referral for appropriate medical evaluations or TB treatment,
    - e. Case management for obtaining any TB services,
    - f. Report any active cases of TB to state health officials, and
    - g. Document screening, testing, referrals and/or any necessary follow-up information.
  4. The RBHA is responsible for providing DBH with documentation which illustrates facilitation or provision of the above listed services and ensure that any changes are reported and on file with DBH.

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

Source: NDHHS – Division of Behavioral Health - Community-Based Services Section  
FY2014 Region Budget Plan Guidelines (February 1, 2013) Page 22-23

**Services for HIV/AIDS**

The Nebraska rate for Human Immunodeficiency Virus infection / Acquired Immunodeficiency Syndrome (HIV/AIDS) is approximately 4.2 cases per 100,000 individuals according to 2013 estimates. Thus, Nebraska is not a designated state. The term “designated state” means any state whose rate of cases of AIDS is 10 or more such cases per 100,000 individuals, as indicated by the number of such cases reported to and confirmed by the Centers for Disease Control and Prevention (CDC) for the most recent calendar year for which the data are available [See 45 C.F.R. §96.128(b)]. Nebraska HIV/AIDS 2013 counts: <http://aidsvu.org/state/nebraska/>

# Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1  
 Priority Area: Prevention: Alcohol use Among Youth and Young Adults  
 Priority Type: SAP  
 Population(s): Other (Adolescents w/SA and/or MH, LGBTQ, Rural, Criminal/Juvenile Justice, Children/Youth at Risk for BH Disorder, Homeless, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities, Under age youth who drink alcohol)

Goal of the priority area:

Reduce underage and harmful alcohol use among youth and young adults.

Objective:

Reduce the prevalence of underage drinking by high school students and the prevalence of binge drinking by youth adults ages 19 to 25.

Strategies to attain the objective:

Work with prevention coalitions across the state to continue engaging in partnerships with local schools, colleges and community groups to facilitate trainings and educational activities to enhance awareness of the risks associated with alcohol use. Support increased use of evidence-based interventions in prevention practices.

Annual Performance Indicators to measure goal success

Indicator #: 1  
 Indicator: Reduce the prevalence of underage drinking by high school students.  
 Baseline Measurement: Percentage of students in 9th-12th grade who reported drinking in the past month was 26.6% in 2011.  
 First-year target/outcome measurement: N/A because the survey is conducted every 2 years (see below).  
 Second-year target/outcome measurement: Reduce underage drinking by high school students to less than 25% by June 30, 2017.

Data Source:

Centers for Disease Control and Prevention (CDC), Youth Risk Behavior Survey (YRBS), 2001–2015

Description of Data:

The Youth Risk Behavior Surveillance System is a national school-based survey conducted by the CDC and state, territorial, tribal, and local education and health agencies and tribal governments. This survey monitors six types of health-risk behaviors that contribute to the leading causes of death and disability among youth and adults, including behaviors that contribute to unintentional injuries and violence, sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases, including HIV infection, alcohol and other drug use, tobacco use, unhealthy dietary behaviors, inadequate physical activity and the prevalence of obesity and asthma among youth and young adults.

Data issues/caveats that affect outcome measures::

This survey is conducted every 2 years, which means data will not be available in FY15/FY17. YRBS is designed to produce information to help assess the effect of broad national, state, territorial, tribal, and local policies and programs and is not designed to evaluate the effectiveness of specific interventions. Many behaviors (e.g., alcohol and other drug use) measured by YRBS are associated with educational and social outcomes, including absenteeism, poor academic achievement, and dropping out of school, therefore, the survey focuses almost exclusively on health-risk behaviors rather than on the determinants of these behaviors (e.g., knowledge, attitudes, beliefs, and skills).

Indicator #: 2  
 Indicator: Reduce the prevalence of binge drinking by young adults aged 19 to 25.

Baseline Measurement:

First-year target/outcome measurement:

N/A This survey will be repeated dependent upon the authorization of state funding in 2017 (see below).

Second-year target/outcome measurement:

Reduce the prevalence of binge drinking by young adults to less than 43% by June 30, 2017.

Data Source:

Nebraska Youth Adult Alcohol Opinion Survey (NYAOS)

Description of Data:

Nebraska Youth Adult Alcohol Opinion Survey is a state-wide survey conducted by the Nebraska Division of Behavioral Health and administered by the University of Nebraska-Lincoln Bureau of Sociological Research. The primary purpose of the survey is to (1) enhance understanding of alcohol use, impaired driving, and attitudes and perceptions related to alcohol among 19 to 25 year old young adults in Nebraska and (2) to provide data to community coalitions in Nebraska working to reduce binge drinking among young adults.

Data issues/caveats that affect outcome measures::

This survey will be repeated dependent upon the authorization of state funding.

Priority #:

2

Priority Area:

Co-Occurring Disorders

Priority Type:

SAT, MHS

Population(s):

SMI, SED, PWWDC, IVDUs, HIV EIS, TB

Goal of the priority area:

Providers better understand how to meet the complexity of needs for persons with Co-Occurring Disorders (COD) in order to improve the treatment and recovery services.

Objective:

Statewide score on selected sections of the COMPASS-EZ will increase.

Strategies to attain the objective:

Use COMPASS-EZ to improve the treatment and recovery services.

#### Annual Performance Indicators to measure goal success

Indicator #:

1

Indicator:

Providers demonstrate better ability to understand persons with Co-Occurring Disorders (COD) in order to improve the treatment and recovery services.

Baseline Measurement:

Statewide score on selected sections of the COMPASS-EZ will increase according to the baseline.

First-year target/outcome measurement:

Statewide score on selected sections of the COMPASS-EZ will increase according to the baseline.

Second-year target/outcome measurement:

Statewide score on selected sections of the COMPASS-EZ will increase according to the baseline and first year target.

Data Source:

COMPASS-EZ scores reported by providers to Regional Behavioral Health Authorities to the Division of Behavioral Health.

Description of Data:

COMPASS-EZ assessment and action planning process from developers Kenneth Minkoff, MD and Christie Cline, MD. The COMPASS-EZ is designed as a survey of a "program". In a large agency each distinct program uses the COMPASS-EZ to perform its own self-survey.

Data issues/caveats that affect outcome measures::

The increase in the number of behavioral health programs/providers able to deliver effective services to people with Co-Occurring Disorders (COD) should lead to improved prevention and treatment in a Recovery-Oriented System of Care (ROSC).

Priority #: 3  
 Priority Area: Trauma-Informed Care  
 Priority Type: SAT, MHS  
 Population(s): SMI, SED, PWWDC, IVDUs, HIV EIS, TB

Goal of the priority area:

Increase the percentage of programs which are trauma informed.

Objective:

Statewide score on selected sections of the Fallot and Harris Trauma Informed Care (TIC) tool will increase.

Strategies to attain the objective:

Providers will use data from TIC assessments to determine areas for improvement to help ensure the service system is sensitive to experienced trauma.

Annual Performance Indicators to measure goal success

Indicator #: 1  
 Indicator: Statewide scores on the Fallot and Harris Trauma Informed Care (TIC) self-assessment tool.  
 Baseline Measurement: TIC tool scores will increase according to the baseline to be developed after June 30, 2013 self-assessment deadline for providers.  
 First-year target/outcome measurement: Statewide scores on selected sections of the TIC tool will demonstrate trauma informed competency improvements compared to the statewide baseline established in FY14 from the original TIC assessments conducted.  
 Second-year target/outcome measurement: Statewide scores on selected sections of the TIC tool will demonstrate trauma informed competency improvements compared to the statewide baseline established in FY14 from the original TIC assessments conducted.

Data Source:

Trauma Informed Care (TIC) tool completed by providers then reported to Regional Behavioral Health Authorities to the Division of Behavioral Health.

Description of Data:

Statewide score on selected sections of the Fallot and Harris Trauma Informed Care (TIC) tool.

Data issues/caveats that affect outcome measures::

Under the SAMHSA Block Grant 2012-2013 the goal of the Trauma Informed Care was to develop a service system that understands the effects of trauma and avoids re-traumatizing those who seek services (trauma-informed). The new baseline is established each completed round of effort. The work continues into the current round in order to further improve the trauma informed features of the Nebraska Behavioral Health System.

Priority #: 4  
 Priority Area: First Episode Psychosis  
 Priority Type: MHS  
 Population(s): SMI, SED

Goal of the priority area:

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

Objective:

Improve functioning for youth and young adults who have experienced a first episode of psychosis.

Strategies to attain the objective:

Continue to develop recovery-oriented services and increase use of evidence-based practices which help individuals stabilize and maintain stabilization in community settings. Support Mental Health trainings to improve early intervention and support, particularly for youth having a first episode of psychosis (FEP). Establish pilot programs using the OnTrackNY system for FEP.

Annual Performance Indicators to measure goal success

Indicator #: 1  
 Indicator: Providers will help improve functioning for youth and young adults with a first episode of psychosis.  
 Baseline Measurement: Will establish baseline through pilot program use of MIRECC-GAF Expanded assessment tool.  
 First-year target/outcome measurement: To be determined after baseline established.  
 Second-year target/outcome measurement: To be determined after baseline established.

Data Source:

Mental Illness Research, Education, and Clinical Center version of the Global Assessment of Functioning Scale (MIRECC-GAF Expanded)

Description of Data:

The MIRECC GAF Expanded measures occupational functioning, social functioning, and symptom severity on three subscales. Scores for each of the three subscales will be recorded and collected to evaluate change in functioning during FEP treatment.

Data issues/caveats that affect outcome measures::

Providers will need training on MIRECC-GAF Expanded tool and establish process for data collection upon implementation of FEP pilot programs. Data may be limited to a small number of individuals qualifying for pilot programs.

Priority #: 5  
 Priority Area: Tuberculosis (T)  
 Priority Type: SAT  
 Population(s): TB

Goal of the priority area:

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

Objective:

Strategies to attain the objective:

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

Annual Performance Indicators to measure goal success

Indicator #: 1  
 Indicator: Tuberculosis (TB)  
 Baseline Measurement: Maintain the contract requirement with the Regional Behavioral Health Authorities for tuberculosis screening provided to all persons entering a substance abuse treatment service.

First-year target/outcome measurement: The contract requirement was maintained with the Regional Behavioral Health Authorities for tuberculosis screening provided to all persons entering a substance abuse treatment service.

Second-year target/outcome measurement: The contract requirement was maintained with the Regional Behavioral Health Authorities for tuberculosis screening provided to all persons entering a substance abuse treatment service.

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures::

This contract requirement is connected to the Federal requirements under the Substance Abuse Prevention and Treatment Block Grant.

Footnotes:

- The Division of Behavioral Health Priorities, expressed as goals and performance indicators, are based on the 2011-2015 Strategic Plan. These DBH Priorities are used to prepare the SFY 2016 Region Budget Plan Guidelines and the 2016-2017 SAMHSA Block Grant application. They are all connected and help move the system forward.
- The Priority Areas of Co-Occurring Disorders, Trauma-Informed Care, and Peer Support are intended to make a positive difference for all persons served including SMI, SED, PWWDC, IVDUs, HIV EIS, TB, and Others.
- Nebraska is not a HIV EIS designated state. HIV EIS means persons with or at risk of Human Immunodeficiency Virus infection / Acquired Immunodeficiency Syndrome (HIV/AIDS) who are in treatment for substance abuse.

# Planning Tables

Table 2 State Agency Planned Expenditures [SA]

Planning Period Start Date: 7/1/2015      Planning Period End Date: 6/30/2017

Activity	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	\$5,490,689		\$0	\$0	\$23,288,116	\$0	\$0
a. Pregnant Women and Women with Dependent Children*	\$463,637		\$0	\$0	\$1,754,446	\$0	\$0
b. All Other	\$5,027,052		\$0	\$0	\$21,533,670	\$0	\$0
2. Substance Abuse Primary Prevention	\$1,721,791		\$0	\$1,294,910	\$319,139	\$0	\$0
3. Tuberculosis Services	\$0		\$0	\$0	\$0	\$0	\$0
4. HIV Early Intervention Services	\$0		\$0	\$0	\$0	\$0	\$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary Prevention**							
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)							
10. Administration (Excluding Program and Provider Level)	\$379,604		\$0	\$0	\$0	\$0	\$0
13. Total	\$7,592,084	\$0	\$0	\$1,294,910	\$23,607,255	\$0	\$0

\* Prevention other than primary prevention

\*\* It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			\$0	\$0	\$0	\$0	\$0
6. Other 24 Hour Care		\$15,000	\$0	\$0	\$1,564,450	\$0	\$0
7. Ambulatory/Community Non-24 Hour Care		\$1,876,870	\$0	\$288,000	\$54,474,811	\$0	\$0
8. Mental Health Primary Prevention**		\$0	\$0	\$733,556	\$0	\$0	\$0
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)		\$106,000	\$0	\$0	\$0	\$0	\$0
10. Administration (Excluding Program and Provider Level)		\$105,151	\$0	\$0	\$0	\$0	\$0
13. Total	\$0	\$2,103,021	\$0	\$1,021,556	\$56,039,261	\$0	\$0

\* Prevention other than primary prevention

\*\* It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

# Planning Tables

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period Start Date: 7/1/2015      Planning Period End Date: 6/30/2017

Service	SABG Expenditures	MHBG Expenditures
Healthcare Home/Physical Health	\$	\$
General and specialized outpatient medical services;		
Acute Primary Care;		
General Health Screens, Tests and Immunizations;		
Comprehensive Care Management;		
Care coordination and Health Promotion;		
Comprehensive Transitional Care;		
Individual and Family Support;		
Referral to Community Services;		
Prevention Including Promotion	\$	\$





Screening, Brief Intervention and Referral to Treatment;		
Brief Motivational Interviews;		
Screening and Brief Intervention for Tobacco Cessation;		
Parent Training;		
Facilitated Referrals;		
Relapse Prevention/Wellness Recovery Support;		
Warm Line;		
Substance Abuse Primary Prevention	\$2,067,608	\$
Classroom and/or small group sessions (Education);		
Media campaigns (Information Dissemination);		
Systematic Planning/Coalition and Community Team Building(Community Based Process);		
Parenting and family management (Education);		
Education programs for youth groups (Education);		
Community Service Activities (Alternatives);		
Student Assistance Programs (Problem Identification and Referral);		

Employee Assistance programs (Problem Identification and Referral);		
Community Team Building (Community Based Process);		
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental);		
Engagement Services	\$100,952	\$111,397
Assessment;		
Specialized Evaluations (Psychological and Neurological);		
Service Planning (including crisis planning);		
Consumer/Family Education;		
Outreach;		
Outpatient Services	\$636,618	\$336,683
Individual evidenced based therapies;		
Group Therapy;		
Family Therapy ;		
Multi-family Therapy;		



Consultation to Caregivers;

Medication Services

\$1,013,811

\$59,213

Medication Management;

Pharmacotherapy (including MAT);

Laboratory services;

Community Support (Rehabilitative)

\$247,590

\$829,745

Parent/Caregiver Support;

Skill Building (social, daily living, cognitive);

Case Management;

Behavior Management;

Supported Employment;

Permanent Supported Housing;

Recovery Housing;

Therapeutic Mentoring;

Traditional Healing Services;



Recovery Supports	\$58,782	\$289,900
Peer Support;		
Recovery Support Coaching;		
Recovery Support Center Services;		
Supports for Self-directed Care;		
Other Supports (Habilitative)	\$	\$66,835
Personal Care;		
Homemaker;		
Respite;		
Supported Education;		
Transportation;		
Assisted Living Services;		
Recreational Services;		
Trained Behavioral Health Interpreters;		



Intensive Support Services	\$275,184	\$58,000
Substance Abuse Intensive Outpatient (IOP);		
Partial Hospital;		
Assertive Community Treatment;		
Intensive Home-based Services;		
Multi-systemic Therapy;		
Intensive Case Management ;		
Out-of-Home Residential Services	\$1,965,782	\$15,000
Crisis Residential/Stabilization;		
Clinically Managed 24 Hour Care (SA);		
Clinically Managed Medium Intensity Care (SA) ;		
Adult Mental Health Residential ;		
Youth Substance Abuse Residential Services;		
Children's Residential Mental Health Services ;		



Therapeutic Foster Care;		
Acute Intensive Services	\$455,145	\$234,796
Mobile Crisis;		
Peer-based Crisis Services;		
Urgent Care;		
23-hour Observation Bed;		
Medically Monitored Intensive Inpatient (SA);		
24/7 Crisis Hotline Services;		
Other	\$391,008	\$
<b>Total</b>	<b>\$7,212,480</b>	<b>\$2,001,569</b>



Footnotes:

Amounts do not include 5% allowable for Administrative expenses

# Planning Tables

## Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2015      Planning Period End Date: 9/30/2017

Expenditure Category	FY 2016 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	\$5,490,689
2 . Substance Abuse Primary Prevention	\$1,721,791
3 . Tuberculosis Services	\$0
4 . HIV Early Intervention Services**	\$0
5 . Administration (SSA Level Only)	\$379,604
6. Total	\$7,592,084

\* Prevention other than primary prevention

\*\* 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by CDC, National Center for HIV/AIDS, Hepatitis, STD and TB Prevention. The HIV Surveillance Report, Volume 24, will be used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective FY 2016 SABG allotments to establish one or more projects to provide early intervention services for HIV at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state does not meet the AIDS case rate threshold for the fiscal year involved. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would be allowed to obligate and expend FY 2016 SABG funds for EIS/HIV if they chose to do so.

Footnotes:



Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2015    Planning Period End Date: 9/30/2017

Strategy		IOM Target	FY 2016
		SA Block Grant Award	
Information Dissemination	Universal		\$85,465
	Selective		\$8,147
	Indicated		\$0
	Unspecified		\$0
	<b>Total</b>		<b>\$93,612</b>
Education	Universal		\$117,395
	Selective		\$90,118
	Indicated		\$0
	Unspecified		\$0
	<b>Total</b>		<b>\$207,513</b>
Alternatives	Universal		\$47,113
	Selective		\$0
	Indicated		\$0
	Unspecified		\$0
	<b>Total</b>		<b>\$47,113</b>
Problem Identification and Referral	Universal		\$17,898
	Selective		\$45,975
	Indicated		\$200
	Unspecified		\$0
	<b>Total</b>		<b>\$64,073</b>

Community-Based Process	Universal	\$659,911
	Selective	\$86,053
	Indicated	\$0
	Unspecified	\$0
	Total	\$745,964
Environmental	Universal	\$386,671
	Selective	\$59,295
	Indicated	\$0
	Unspecified	\$0
	Total	\$445,966
Section 1926 Tobacco	Universal	\$117,550
	Selective	\$0
	Indicated	\$0
	Unspecified	\$0
	Total	\$117,550
Other	Universal	\$0
	Selective	\$0
	Indicated	\$0
	Unspecified	\$0
	Total	\$0
Total Prevention Expenditures		\$1,721,791
Total SABG Award*		\$7,592,084
Planned Primary Prevention Percentage		22.68 %

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

Footnotes:

# Planning Tables

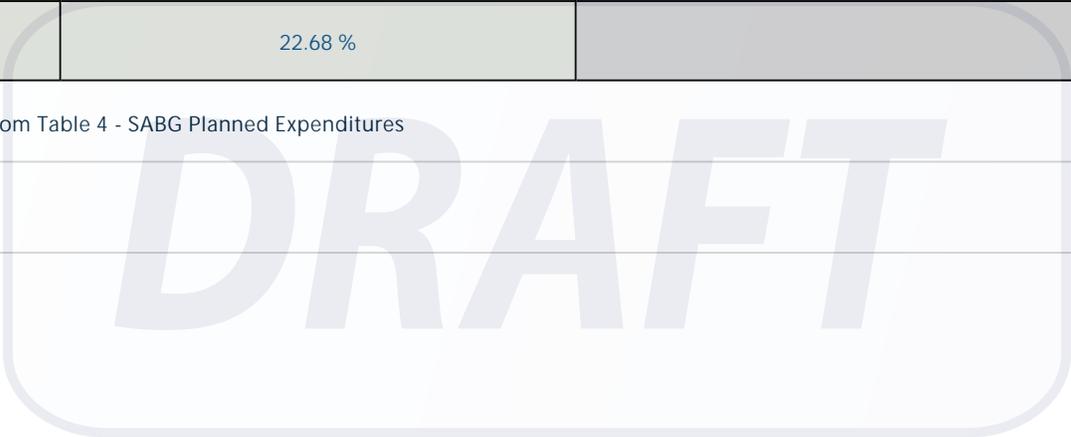
Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2015      Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award	
Universal Direct	\$361,555	
Universal Indirect	\$1,070,450	
Selective	\$289,587	
Indicated	\$200	
Column Total	\$1,721,792	
Total SABG Award*	\$7,592,084	
Planned Primary Prevention Percentage	22.68 %	

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

Footnotes:



# Planning Tables

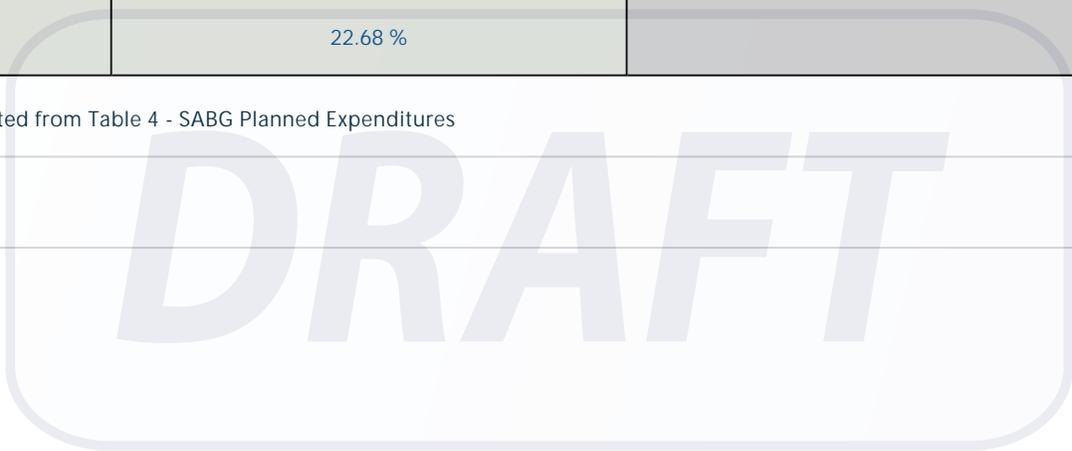
Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2015      Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award	
Universal Direct	\$361,555	
Universal Indirect	\$1,070,450	
Selective	\$289,587	
Indicated	\$200	
Column Total	\$1,721,792	
Total SABG Award*	\$7,592,084	
Planned Primary Prevention Percentage	22.68 %	

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

Footnotes:



## Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Targeted Substances	
Alcohol	b
Tobacco	b
Marijuana	b
Prescription Drugs	b
Cocaine	e
Heroin	b
Inhalants	b
Methamphetamine	e
Synthetic Drugs (i.e. Bath salts, Spice, K2)	b
Targeted Populations	
Students in College	b
Military Families	e
LGBT	e
American Indians/Alaska Natives	b
African American	b
Hispanic	b
Homeless	e
Native Hawaiian/Other Pacific Islanders	e
Asian	e
Rural	b
Underserved Racial and Ethnic Minorities	b

Footnotes:

***DRAFT***

# Planning Tables

## Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period Start Date: 10/1/2015      Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award			
	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	\$24,236	\$0	\$0	\$24,236
2. Quality Assurance	\$24,236	\$35,875	\$0	\$60,111
3. Training (Post-Employment)	\$0	\$120,000	\$0	\$120,000
4. Education (Pre-Employment)	\$0	\$80,000	\$0	\$80,000
5. Program Development	\$48,474	\$35,875	\$0	\$84,349
6. Research and Evaluation	\$0	\$0	\$0	\$0
7. Information Systems	\$0	\$0	\$0	\$0
8. Total	\$96,946	\$271,750	\$0	\$368,696

Footnotes:

# Planning Tables

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period Start Date: 7/1/2015      Planning Period End Date: 6/30/2017

Service	Block Grant
MHA Technical Assistance Activities	\$
MHA Planning Council Activities	\$
MHA Administration	\$105,151
MHA Data Collection/Reporting	\$
MHA Activities Other Than Those Above	\$
Total Non-Direct Services	\$105151
Comments on Data: <input type="text"/>	
Footnotes: <div style="text-align: center; font-size: 48px; opacity: 0.5; font-weight: bold;">DRAFT</div>	

## 1. The Health Care System and Integration

07/31/2015V

**C. Environmental Factors and Plan****1. The Health Care System and Integration**

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

**1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?**

Qualified Health Plans (QHPs) in Nebraska provided through the Federal Marketplace must meet the ten required Essential Health Benefits, including mental and substance use disorders treatment. In addition to covering physical health needs, the plans must cover hospitalization, medication management and outpatient services for behavioral health disorders when they are deemed to be medically necessary. They do not have to cover services such as case management, housing, peer support or other recovery-based services. It is not anticipated at this time that QHPs will pay for rehabilitative behavioral health services such as residential treatment programs. This may change as additional guidance on defining non-physical health rehabilitative services is provided.

Nebraska Medicaid and its at-risk managed care vendor, Magellan Healthcare, provide the following services for behavioral health consumers:

1. Crisis Stabilization Services
  - a. Crisis Assessment;\*\*
  - b. Sub-acute Hospital - Adults age 19 & over;\*\*
2. Acute Inpatient Hospital\*\*
3. Residential Services
  - a. Psychiatric Residential Treatment Facility (PRTF) - Children under age 19;
  - b. Therapeutic Group Home (ThGH) - Children under age 19;
  - c. Professional Resource Family Care (PRFC) - Children under age 19;
  - d. Dual Disorder Residential - Adults age 19 & over;\*\*
  - e. Intermediate Residential for substance abuse - Adults age 19 & over;\*\*
  - f. Short-Term Residential - Adults age 19 & over;\*\*
  - g. Halfway House - Adults age 19 & over;\*\*
  - h. Therapeutic Community for substance abuse only - Adults age 19 & over;\*\*
  - i. Community Support for substance abuse - Adults age 19 & over;\*\*
4. Outpatient Assessment and Treatment
  - a. Partial Hospitalization;
  - b. Day Treatment-Children under age 19;
  - c. Day Treatment for mental health-Adults age 19 & over;\*\*
  - d. Intensive Outpatient for mental health-Children under age 19;\*\*

## 1. The Health Care System and Integration

07/31/2015V

- e. Intensive Outpatient for substance abuse;\*\*
  - f. Medication Management;\*\*
  - g. Outpatient (Individual, Family, Group);\*\*
  - h. Injectable Psychotropic Medications;
  - i. Substance use disorder Assessment;\*\*
  - j. Psychological Evaluation and Testing;\*\*
  - k. Initial Diagnostic Interviews;
  - l. Home-based Multi-Systemic Therapy - Children under age 19;\*\*
  - m. Biopsychosocial Assessment and Addendum;\*\*
  - n. Sex Offender Risk Assessment - Children under age 19;
  - o. Community Treatment Aide (CTA) - Children under age 19;
  - p. Client Assistant Program (CAP);
  - q. Comprehensive Child and Adolescent Assessment (CCAA) - Children under age 19;
  - r. Comprehensive Child and Adolescent Assessment Addendum - Children under age 19;
  - s. Conferences with family or other responsible persons - Children under age 19;
  - t. Hospital Observation Room Services (23:59);\*\*
  - u. Social Detox - Adults age 19 & over;\*\*
  - v. Electroconvulsive Therapy (ECT) - Adults age 19 & over;
  - w. Crisis Outpatient Services - Adults age 19 & over;\*\*
  - x. Ambulatory Detoxification - Adults age 19 & over;
  - y. Psychiatric nursing (in home) - Adults age 19 & over;
5. Medicaid Rehabilitation Option (MRO)
- a. Psychiatric Residential Rehabilitation;\*\*
  - b. Secure Residential Rehabilitation;\*\*
  - c. Assertive Community Treatment (ACT) and Alternative ACT (Alt. ACT);\*\*
  - d. Community Support (MH);\*\*
  - e. Day Rehabilitation,\*\* and
6. Support Services
- a. Interpreter Services for behavioral health services;\*\*
  - b. Telehealth Transmission.

Source: DHHS Medicaid & Long Term Care Regulations, Title 482 – Nebraska Medicaid Managed Care, NAC 5-004 Services in the Behavioral Health Benefit Package

Services indicated with \*\* are also provided by the SSA/SMHA to non-Medicaid eligible consumers in the state and are paid for with a combination of SAPTBG, MHBG and state funding.

2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?

See Question #13 – State Parity Efforts.

3. Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the monitoring process.

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See *Question #13 – State Parity Efforts*.

4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?

See *Question #13 – State Parity Efforts*.

5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?

None are anticipated at this time as benefits and coverage have not changed. Nebraska is not an expansion state and therefore populations covered by Medicaid, SMHA/SSA and QHPs are different and distinct.

6. Is the SSA/SMHA is involved in the various coordinated care initiatives in the state?

DBH works with Nebraska Medicaid, Magellan of Nebraska, and the Regional Behavioral Health Authorities on physical and behavioral health integration.

7. Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?

Regional Behavioral Health Authorities work within their Regional catchment areas with FQHCs, community health centers and other entities including the publicly funded behavioral health providers to build and sustain relationships and work together to coordinate care. Information is submitted on this work to the SSA/SMHA.

8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?

Not at this time. However, the Nebraska Clean Indoor Act (Neb Rev Stat 71-5716 through 71-5735) prohibits smoking in public places and places of employment with limited exceptions for guestrooms and suites, research, tobacco retail outlets, and cigar shops. As such, all publically funded behavioral health provider offices and residential programs must be smoke free. This act does not prohibit smoking outdoors and not all programs have implemented smoke free campus policies.

9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?

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All persons receiving services funded by the DBH are registered into the ASO data system by the local authorized provider of services. Registration of consumer identifying information includes screening questions for “Tobacco Usage.” These questions are designed to assess the tobacco usage of behavioral health services consumers. The assessment of the tobacco usage is used to determine if the consumer meets the diagnostic criteria for Nicotine dependence, based on the guidelines of the latest edition of the DSM.

The provider with whom the consumer is working to complete registration into the ASO data system is responsible for conducting or referring to services to address tobacco usage.

**10. Indicate tools and strategies used that support efforts to address nicotine cessation.**

Nebraska Department of Health & Human Services Division of Public Health’s program, Tobacco Free Nebraska, is the state’s comprehensive tobacco prevention program that works to help people quit, eliminate exposure to second-hand smoke, keep youth from starting, and to reach underserved populations. Local tobacco prevention coalitions, schools, and non-profits, like the American Cancer Society, American Lung Association, and American Heart Association, often partner with TFN. Health care providers and educators, law enforcement, teachers, and community leaders also work to address the serious health issues that result from tobacco use and exposure. TFN funds Nebraska’s Quit Line, which provides free access to counseling and support services to individuals who want to quit smoking or chewing tobacco. DBH works in partnership with TFN on tobacco prevention activities including coordination of merchant compliance checks (SYNAR) and education efforts.

**11. The behavioral health providers screen and refer for: Prevention and wellness education; Health risk such as heart disease, hypertension, high cholesterol, and/or diabetes; and, Recovery supports.**

Most of Nebraska’s community-based behavioral health services are managed directly by the six Regional Behavioral Health Authorities. The RBHAs contract with local resources to provide public inpatient, outpatient, emergency and community services. All local providers of behavioral health services offer prevention and wellness education and recovery supports. In addition, prevention coalitions work to train healthcare providers on the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model and gather data on its use and efficacy.

There is no area of technical assistance need identified at this time.

## 2. Health Disparities

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### C. Environmental Factors and Plan

#### 2. Health Disparities

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

1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?
2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.
3. Are linguistic disparities/language barriers identified, monitored, and addressed?
4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.
5. Is there state support for cultural and linguistic competency training for providers?

The Division of Behavioral Health (DBH) is dedicated to providing excellent behavioral health services that are accessible to all members of the community across all subpopulations in need. DBH operates in accordance with Nebraska's Department of Health and Human Services (DHHS) Office of Health Disparities & Health Equity (OHDHE), striving for appropriate cultural and linguistic specificity for all recipients of behavioral health services. Nebraska recognizes that the enhanced National CLAS Standards "are intended to advance health equity, improve quality and help eliminate health care disparities by establishing a blueprint for individuals as well as health care organizations to implement culturally and linguistically appropriate services." DBH utilizes a 'systems of care' approach to address the behavioral health spectrum from promotion through recovery and these efforts expand across service systems to address health equity.

Although Nebraska is often viewed as having a homogenous population, it is becoming increasingly diverse with not only African American, Hispanic and Native Americans but also as the population of immigrants from the continents of Africa and Asia continues to grow. Culture in Nebraska is not only related to race/ethnicity but also to geography and economics. Nebraska is largely a rural state and the 9th least-densely populated state of the United States. The more urban areas of the state (Omaha and Lincoln) have more diverse populations than the rural/frontier areas. All areas of the state are impacted by poverty but the most affected areas are rural and frontier counties in the western and northern areas of the state.

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DBH reviews data from multiple sources to identify and monitor subpopulations vulnerable to health disparities. Subpopulation breakdowns and disparity analysis can be found in *Section B* of this application under *Planning Steps*. The OHDHE provides support and data analysis from the Behavioral Risk Factor Surveillance System (BRFSS) Survey related to the racial and ethnic minority populations each year. OHDHE is implementing a Tribal data initiative that will result in further recognition of health concerns of this population. Results of the National Survey on Drug Use and Health are utilized for state estimates and community level evaluation as available. In the DBH annual consumer survey, consumers are asked whether staff were sensitive to their cultural background, including race, religion, and language, etc. All community level data for consumers receiving behavioral health treatment funded through DBH are collected at admission and updated at annual re-registration, annual re-authorization and discharge. Individual data records are collected, allowing for classification by service type, race, ethnicity, preferred language, gender, age, and other subpopulation variables to report state, region or agency performance toward recovery as outlined in National Outcome Measures (NOMs). Other outcome measures include demographic indicators, such as the number of individuals served and the age, gender and race of consumers. The current data system does not capture LGBTQ information.

The National Center on Immigrant Integration Policy estimates that less than 5 percent of Nebraska's total population is considered as having limited English proficiency (LEP). Consumer preferred language is captured at admission to behavioral health treatment and interpreters are provided as necessary at the service provider level. Our data system does not specifically track language services but on the weekly service capacity report submitted by all six Regional Behavioral Health Authorities (RBHAs), capacity used/available for bilingual/bicultural services is tracked for ongoing review and identification of language service needs.

DBH and network partners measure, track, and respond to these disparities through use of NOMs reports, capacity and waiting list reports, Mental Health client level data, ongoing admission/discharge reports, and annual reporting at state and regional levels. This information is regularly shared with RBHAs, providers and consumers through use of ongoing Tuesday Data Calls, quality improvement workgroups and state advisory committees. DBH treatment and recovery service system data is collaboratively reviewed in order to create a holistic view of the behavioral health system and identify opportunities to improve access for disparate populations through informed infrastructure and policy as well as service delivery best practices. Ongoing review of analysis provides information to decision makers regarding potential barriers to accessing mental health and related services and the potential for under-identification of risk in some populations. This information can inform strategies and identify the need to seek additional stakeholder involvement from diverse groups. Work is intended to improve the state's capacity to promote integrated approaches, evidenced-based programs and best practices to reduce health disparities in our prevention system as well as providing recommendations to the behavioral health system of care. DBH will pursue opportunities to share data across Nebraska's DHHS divisions, including the Division of Medicaid and Long Term Care and their at-risk vendor to further develop plans that address disparities. The expected outcome of improved sensitivity to health disparities includes sharper strategies in prevention and service delivery as well as infrastructure capacity as a result of informed policy and implemented system standards. In

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addition, our approach to systems of care will result in shared processes that will inform our state's behavioral health treatment and recovery service system, public health system, and child welfare system.

Nebraska's OHDHE has made health equity for all Nebraskans a priority and is committed to improving health outcomes for culturally diverse populations of Nebraska. This office provides support to DBH related to work serving our communities with behavioral health prevention, treatment and recovery services. The partnership has been supportive of many of DBH's goals and has made a positive impact on the consumers of behavioral health services. OHDHE utilizes two goals that are shared by DBH: 1) enhance existing organizational structure by being more inclusive of providers and community members that represent Nebraska's diversity; and 2) be purposeful in identifying and evaluating tools, models, curricula, and other resources to assure that they are appropriate for addressing needs and are acceptable to Nebraska's diverse families.

Based on the identification of needs and the development of planned strategies, quality improvement initiatives are considered and guide any need for adjusting the Regional Budget Plan guidelines/Region contracts and related DBH policy. All RBHAs are expected to adhere to the principle standards of CLAS in their work and work expectations, in addition to those same expectations being relayed through their provider subcontracts. RBHAs and providers are required to provide services that are culturally and linguistically appropriate as identified in network provider contracts: develop and implement strategies and/or training that promote and represent the ethnic and gender needs of the community and incorporates the National Standards for Culturally and Linguistically Appropriate Services (CLAS). They are expected to provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. As described through the national CLAS standards, this extends through governance, leadership, and workforce to include communication and language assistance as well as engagement, continuous improvement, and accountability. Related, each Regional Behavioral Health service area utilizes a locally driven CLAS team to address and respond to cultural needs as identified within their catchment area.

Prevention strategies often include environmental approaches that seek to empower communities and thus, need to ensure that strategies to reduce health disparities consider a variety of CLAS standards to improve capacity on a variety of levels. Nebraska's movement towards a more collaborative system of care not only includes the substance abuse prevention system but stretches beyond behavioral health to include all child serving systems. This work will improve access to coordinated health care for all Nebraskan's including those typically disparate.

A recently awarded federal grant for a Nebraska DHHS System of Care (SOC) Planning Project brought together Nebraska youth and families, child-serving systems, providers, and Nebraska leaders to develop a comprehensive strategic plan for prevention-oriented, culturally and linguistically competent, youth and family driven SOC for children/youth with behavioral health concerns and their families. For this project, the CLAS Core Strategy Team (CST) (one of ten 'core strategy teams' for the SOC project) worked to develop recommendations for supporting culture and language preference within a broad array of home and community based services and supports in the child serving system of care. Central to the success of Nebraska's SOC Planning

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Project is adherence to the CLAS standards. A key focus of the planning process was to promulgate and increase commitment to CLAS standards across all levels of planning and throughout the subsequent strategic plan.

Progress from the SOC grant project will also advise DBH's federal Partnerships for Success (PFS) grant project by collectively addressing and improving CLAS at the local service delivery level and the statewide infrastructure level. OHDHE was able to provide data and training to follow through with many aspects of the PFS plan created through its health disparities impact statement. The OHDHE helped several of the DBH's PFS sub-recipients with creating plans to integrate CLAS standards and address health disparities more effectively. This includes considering organizational policy to include CLAS language, working on making materials more understandable, and new standards for recruitment of staff and stakeholders. Additionally, the Statewide Epidemiological Outcomes Workgroup (SEOW) will ensure membership reflects Nebraska communities and is considerate to health disparities in its charge. Efforts such as cultural intelligence trainings and enhanced collaboration with Tribal communities will result in a more equipped approach to implementing efficacious prevention strategies.

Within the behavioral health treatment and recovery service system, improving health equity can mean strategies that impact the providers' ability to serve disparate populations by ensuring access to quality culturally and linguistically competent services for individuals through an equipped workforce. DBH works to promote cultural awareness and diversity in the workforce through leadership, training, and direct funding of continuing education and training for providers. The DBH will utilize collaborative efforts with the OHDHE to identify strategies such as workforce training, consumer outreach and improved processes for providers to strengthen CLAS amongst our system of care. DBH is working with OHDHE to provide Cultural Intelligence training to its administrative staff and to regional center employees. DBH is encouraging the Regional Behavioral Health Authorities (RBHAs) to also participate in this free training effort, which fits well with the DBH's goal of providing more welcoming and accommodating services.

Technical assistance in the form of an all-day workshop specific to CLC/CLAS was offered to DBH staff, SOC CLAS CST members and key staff of system partners. Vivian Jackson, Ph.D., National Center for Cultural Competence, Georgetown University Center for Child and Human Development, presided over the training event that included topics specific to clarity of concepts and elements of CLC. Application/implementation exercises for CLC and CLAS, adaptable to individual spheres of influence, were offered to participants. Additional activities included looking for evidence of strategies to reduce disparities in access, service availability and outcomes, including CLAS standards. DBH staff have used this knowledge in providing technical assistance to the RBHAs and providers around planning for health disparities.

Many community and substate stakeholders reported interest in having an overview of health disparities in Nebraska in order to understand the state context they are working in, thus helping them to make informed decisions in their communities. The state team worked with the OHDHE and provided a training about health disparities across the state and how to begin engaging persons in these communities. Approximately 40 people over 2 days attended the trainings and reported the trainings helped to establish a common language across the state when talking about

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health disparities. The trainings included an introduction to the language used to talk about health disparities, a discussion of CLAS standards, and a look at statistics for Nebraska as a whole.

Across DBH programs, technical assistance is available to support the institutionalization of CLAS standards with local providers. Providers also have opportunities to participate in locally driven CLAS teams to address and respond to cultural needs as identified within their behavioral health region. Services are offered locally via network providers who are trained in health literacy, which help to address other communication needs identified within their behavioral health region. This local knowledge ensures outreach is appropriate to the cultures represented in each region of Nebraska.

There is no area of technical assistance need identified at this time.

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### 3. Use of Evidence in Purchasing Decisions

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#### C. Environmental Factors and Plan

##### 3. Use of Evidence in Purchasing Decisions

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including mental health and substance abuse services. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states use of the block grants for this purpose. The NQF and the Institute of Medicine (IOM) recommend that evidence play a critical role in designing health and behavioral health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

##### 1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.

The DBH Quality Improvement & Data Performance Administrator, Continuous Quality Improvement Specialist, Chief Clinical Officer and Deputy Director monitor developments regarding evidence-based or promising practices. Information is shared with stakeholders through communication channels, Statewide Quality Improvement Team meetings, Network Management Team meetings, and the Network of Care website.

Multiple information resources are utilized to monitor research findings, reports of research-to-practice, and best and promising practices used to prevent and treat mental and substance use disorders. For example, staff subscribe to SAMHSA's list serves and news service and utilizes resources such as *Evidence-Based Practices – Web Guide* and *National Registry of Evidence-based Programs and Practices*.

An example of a science-to-service resource is the Mid-America Addiction Technology Transfer Center (ATTC) at the University of Missouri-Kansas City, School of Nursing and Health Studies. ATTC works to foster collaboration across service systems, bridging the gap between current research and those working the front lines of addiction and mental health treatment. ATTC serves the HHS Region 7 states of Iowa, Kansas, Missouri, and Nebraska. Topical areas of emphasis include Medication-Assisted Treatment; Motivational Interviewing; Screening, Brief Intervention, and Referral to Treatment (SBIRT); Hepatitis C; and comorbid behavioral health and problem gambling.

DBH works with the Behavioral Health Education Center of Nebraska (BHECN) at the University of Nebraska Medical Center to identify behavioral health workforce needs and to improve the numbers, accessibility and competence of the Nebraska Behavioral Health Workforce. (See: <http://www.unmc.edu/bhecn/about.htm>.) DBH, BHECN and the ATTC have held joint meetings to discuss information sharing, especially as it relates to medication assisted treatment, for example.

In 2015, DBH developed information resources regarding evidence-based or promising practices available in the public community-based behavioral health service system. DBH published the guide *Trauma Informed Services FY2015* to inform consumers about the availability of trauma-informed and trauma-specific interventions across the state. DBH developed a network provider

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survey on evidence-based programs and practices (EPP), the results of which will be analyzed to develop a baseline on the use and availability of EPPs in the public behavioral health system.

DBH is developing internal infrastructure to improve data and fiscal reporting systems that will monitor the use of evidence-based programs and practices in prevention and treatment services. The new data and electronic billing systems being developed will provide for adaptability to include and expand data capture of EPP services.

#### 2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?

Many different elements of information are used in the purchasing and policy decisions involving evidence-based or promising practices, including the availability of workforce competencies, training opportunities, and program and progress outcome measures. The following Evidence-Based Practices are implemented in Nebraska:

- Assertive Community Treatment (ACT)
- Integrated Treatment for Co-Occurring Disorders (COD)
- Medication Treatment, Evaluation, and Management (MedTEAM)
- Permanent Supportive Housing
- Supported Employment
- First Episode Psychosis Coordinate Specialty Care

The specific tool kits for five of the EBPs being implemented in Nebraska are available from SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP) and the International Center for Clubhouse Development (ICCD) Clubhouse Model (<http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=189>).

Nebraska continues to develop information regarding EPP services. In May 2015, the DBH provided the Regions a tool to survey all contracted providers in the state to determine what EPPs were being utilized within programs and what fidelity monitoring of the EPPs in use was being performed. Information from this survey is currently being analyzed for baselines and will be shared with stakeholders. Two sources were consulted in developing the survey: SAMHSA's Evidence-Based Practices Tool Kit and National Registry of Evidence-Based Programs and Practices (NREPP).

#### 3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?

There are many challenges in the development and implementation of Evidence-Based Practices. To address the many complex issues, the DBH Chief Clinical Officer chartered an Evidence-Based Practices Workgroup (EBP Workgroup) under the Statewide Quality Improvement Team (SQIT) in 2013. The charge of the EBP Workgroup was to provide recommendations to the

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DBH leadership regarding a consistent and sustainable method of doing fidelity monitoring linked to outcomes on evidence-based and promising practices. The goal is to improve the use of evidence-based and promising practices to achieve more effective application of limited community resources.

The EBP Workgroup was used to educate stakeholders on the options in this area. Membership of the workgroup included staff from the Nebraska Department of Health and Human Services Division of Children & Family Services, the Division of Developmental Disabilities, the Division of Medicaid and Long Term Care, the DBH Lincoln Regional Center, and Vocational Rehabilitation.

#### 4. Does the state use a rigorous evaluation process to assess emerging and promising practices?

DBH continues efforts to identify, assess, and develop coordinated purchasing decisions with its partner agencies, including Nebraska Medicaid, Magellan of Nebraska, and Vocational Rehabilitation.

- #### 5. Which value based purchasing strategies do you use in your state:
- a. Leadership support, including investment of human and financial resources.
  - b. Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
  - c. Use of financial incentives to drive quality.
  - d. Provider involvement in planning value-based purchasing.
  - e. Gained consensus on the use of accurate and reliable measures of quality.
  - f. Quality measures focus on consumer outcomes rather than care processes.
  - g. Development of strategies to educate consumers and empower them to select quality services.
  - h. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.
  - i. The state has an evaluation plan to assess the impact of its purchasing decisions.

Evidence-Based Practices are part of the considerations taken into account on purchasing services. Many of the purchasing decisions are made in partnership with the six Regional Behavioral Health Authorities (RBHAs). Each RBHA is expected to develop and manage a comprehensive array of mental health and substance abuse services with sufficient capacity for designated geographic areas based on a comprehensive needs assessment/strategic plan. The RBHA requires a Capacity Development Plan for Behavioral Health Services submitted and approved before state and/or federal funds can be used to develop a new service or expansion of an existing service.

There are many aspects to this including but not limited to:

- Identify, recruit, enroll, retain, monitor, and continually evaluate a network of behavioral health providers according to state and federal standards, regulations, and laws.

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- Ensure that providers enrolled in the network comply with the provider responsibilities and selection criteria in accordance with the DBH provider enrollment minimum standards.
- Ensure the provider network has the capacity to deliver mental health and substance abuse services to provide a balanced behavioral health system.
- Develop and implement strategies to ensure system design and provision of services is culturally and linguistically competent and represents the ethnic and gender needs of the community.
- Develop and implement strategies to ensure that all behavioral health providers are informed about the effects of psychological trauma, consistently screen for trauma symptoms and history of traumatic events, provide ongoing assessment of trauma symptoms and problems related to that trauma, offer services that are recovery oriented and trauma sensitive and are made aware that re-traumatization may occur if safe, effective, responsive services are not available.
- Develop and sustain a regional network of behavioral health providers capable of implementing family/person centered practices and providing services for those with the co-occurring disorders of mental health and substance abuse, or individuals with developmental/intellectual disability who also have a mental health or substance abuse disorder.
- Develop and sustain services/programs that have the clinical expertise to serve special populations whose needs cannot be met by traditional behavioral health services.
- Develop and implement strategies and or initiatives that strengthen the expertise within the behavioral health workforce by coordinating and/or facilitating technical assistance and/or professional training.

There is no area of technical assistance need identified at this time.

#### 4. Prevention for Serious Mental Illness

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### C. Environmental Factors and Plan

#### 4. Prevention for Serious Mental Illness

SIMs such as schizophrenia, psychotic mood disorders, bipolar disorders and others produce significant psychosocial and economic challenges. Prior to the first episode, a large majority of individuals with psychotic illnesses display sub-threshold or early signs of psychosis during adolescence and transition to adulthood.<sup>67</sup> The “Prodromal Period” is the time during which a disease process has begun but has not yet clinically manifested. In the case of psychotic disorders, this is often described as a prolonged period of attenuated and nonspecific thought, mood, and perceptual disturbances accompanied by poor psychosocial functioning, which has historically been identified retrospectively. Clinical High Risk (CHR) or At-Risk Mental State (ARMS) are prospective terms used to identify individuals who might be potentially in the prodromal phase of psychosis. While the MHBG must be directed toward adults with SMI or children with SED, including early intervention after the first psychiatric episode, states may want to consider using other funds for these emerging practices.

No questions – Indicate areas of technical assistance.

The Division of Behavioral Health (DBH) is committed to increasing its approaches to mental illness prevention, emotional health promotion, and treatment/recovery support as part of a coordinated plan to address mental disorders. This goal can be attributed to many cross system initiatives and particularly demonstrated in the the Prevention System’s mission to promote safe and healthy environments that foster youth, family, and community development through the implementation of early intervention and prevention best practices. While not supported by MHBG funds, the following activities are currently being implemented via community based providers in support of the prevention of mental illnesses and mental health promotion:

- Child and youth resiliency development programs
- Strengthening parenting skills in early childhood
- Preventing or reducing bullying in schools
- Identifying positive peer and social support networks
- Mental Health First Aid for youth and adults
- Question, Persuade, and Refer (QPR) Gatekeeper training to recognize the warning signs of suicide
- Radio public service announcements on the early signs of depression, actions to take to address
- Reducing risk factors by developing skills in children to protect themselves from adverse childhood experiences such as physical or sexual abuse
- Mentoring and tutoring programs for children experiencing academic problems and peer relationship problems

Additionally, the longstanding statewide program, School Community Intervention & Prevention (SCIP), is designed to bring together families, school and the community by providing tools and resources to address behavioral health issues that impact children, adolescents and their families. The SCIP program offers training in four components:

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1. Identification of students exhibiting behaviors that may interfere with their ability to be successful;
2. Intervention with the student and family to share concerns, seek solutions, and explore options;
3. Referral to in-school or community resources to assist the student; and
4. Support for students within the school environment.

Team members are also educated on a variety of mental and behavioral health disorders that affect children and adolescents, providing them with a knowledge base of each disorder, including risk factors, signs and symptoms, and effects. They are given strategies on how to interact and support affected students and provided with additional resources.

The recently enacted Nebraska Mental Health First Aid Training Act (2014) specifically addresses the need to increase awareness of mental illness and addiction in the broader community. DBH is mandated to establish a mental health first aid training program, using contracts through the Regional Behavioral Health Authorities, to help the public identify and understand the signs of a mental illness or substance abuse problem or a mental health crisis. In addition, the mental health first aid training program will provide the public with skills to help a person who is developing or experiencing a mental health or substance abuse problem or a mental health crisis and to de-escalate crisis situations if needed.

Specific initiatives funded directly by the MHBG funds for adults with SMI or children with SED are described in the following narrative *Question #5 – Evidence-Based Practices for Early Intervention (5 percent set-aside)*. This approach is briefly described below.

Nebraska will be taking an innovative, evidence-based team approach to providing recovery-oriented treatment to young people who have recently begun experiencing psychotic symptoms. These symptoms may include unusual thoughts and beliefs, disorganized thinking or hallucinations, such as hearing or seeing things that others do not. The new program helps young adults aged 15 through 25 with newly-emerging psychotic disorders achieve their goals for school, work, and relationships.

Nebraska's program is about helping young people stay in school or stay employed while learning how to manage their illness. By intervening early, people will learn to take control of their health and to maintain wellness. The new program will follow principles of care that include shared decision making, youth friendly and welcoming environments, and flexible, accessible recovery oriented services. The program will serve young adults with psychoses who have taken antipsychotic medication for psychosis for a cumulative period of no longer than 12 months. The program will be piloted in two of Nebraska's Behavioral Health Regions.

There is no area of technical assistance need identified at this time.

## 5. Evidence-Based Practices for Early Intervention (5 percent set-aside)

1. An updated description of the states chosen evidence-based practice for early intervention (5% set-aside initiative) that was approved in its 2014 plan.

The Nebraska First Episode Psychosis Coordinated Specialty Care (FEP CSC) Pilot Program is utilizing the evidence-based practice Coordinated Specialty Care model. The FEP CSC Pilot Program will provide enhanced services serving first episode psychosis in youth and young adults in the behavioral health system by strengthening interactions between providers and optimizing treatment and alliances. The goals of the FEP CSC Pilot Program are to develop and implement an individualized, person-centered plan that will help the consumer manage symptoms, identify any co-morbid conditions that should be treated, provide for on-going risk assessment, provide education so clients and families can learn to manage the illness and develop coping skills, and focus on consumer goals and recovery.

There are no existing first episode psychosis-focused teams in Nebraska so building teams involves inter-agency collaborations to bring together expertise for intensive integrated FEP specialty care and develop a network to coordinate their interaction. This involves existing local providers and the Region Behavioral Health Authority (RBHA). Nebraska, as a minimum allotment Mental Health Block Grant 5% Set Aside state, used FFY14 block grant funds for targeted investments to build core capacities and regional collaborations to develop FEP expertise.

The FEP CSC Pilot Program is being implemented in two of the six behavioral health service regions of the state, based on the target population of adolescents and young adults, where they are located and where services are being delivered. The two separate, independent FEP CSC Pilot Program teams are located in Region 6 RBHA in the Omaha metropolitan area (population 900,000) and in Region 3 RBHA in the Kearney micropolitan area (population 150,000). The two teams are separated by 190 miles. These areas were selected because of concentration of youth identified as experiencing FEP as well availability of providers to provide services.

Key ingredients of the team model being developed and supported by the FEP CSC Pilot Program are training for team members, focusing on both process and programmatic outcomes, shared decision making by the team, low dose anti-psychotic medication, individual therapy, family education and support, and supported employment and education services.

Team roles include a Team Leader (Masters level clinician), Individual Therapist, Family Therapist, Supported Employment/Education Specialist (SEES), and Prescriber. No role will be full time (FTE). Shared decision making within the team will be facilitated by weekly team meetings of the team roles of Team Leader, SEES, Prescriber, Therapist(s).

2. An updated description of the plan's implementation status, accomplishments and/ any changes in the plan.

There have been no changes to the approved 2014 plan. Implementation of the plan has begun. Two FEP CSC teams have been organized and have begun meeting as a team. Both teams have received training on the CSC model delivered by the Center for Practice Innovations in July 2015. Enhanced service coverage has been developed and authorized to provide for FEP CSC

### ***5. Evidence-Based Practices for Early Intervention (5 percent set-aside)***

team leadership and team level activities, which have been identified as especially important in providing effective and coordinated treatment in a FEP program. This enhanced service coverage will fill the coverage gap for these activities which neither public nor private insurance programs generally cover.

Each team operates within a program network of services within their respective RBHA. Both FEP CSC teams are decentralized, with one larger provider sponsoring two or three team members and working with other local mental health providers and supported employment/education specialists to provide the full range of necessary services. This has necessitated additional provisions and agreements to minimize duplication of efforts as well as to allow for information sharing.

Within the respective RBHA, the RBHA Youth System Coordinator will assist the FEP CSC teams with outreach and referral services for the pilot program. They will also assist the FEP CSC Team Leader coordinate key activities and administrative needs of the FEP CSC Team.

Administrative needs that are necessary to coordinating the activities of the FEP CSC teams are being developed collaboratively with the Team Leaders, team members, and the host agencies supporting the FEP CSC team. Budgeting and reimbursement tasks, including billing, budget management, and expense tracking will utilize the local host agency processes and procedures, per the existing contracts for services with the RBHA.

Expert consultation and support will be available to each FEP CSC “Team” and team members by “Team Role” through consultation calls with program experts at the Center for Practice Innovations through the first twelve months following the pilot program start-up.

Accomplishments of the plan include development of programmatic criteria and processes, provisions for building core capacities through team training activities, identification of program outcome measures and assessment sets, developing a common data collection process for reporting and fidelity monitoring using program data and structured participant assessments.

#### **3. The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.**

The Nebraska FEP CSC Pilot Program teams are completing training in the CSC model, program assessment tools and CSC team roles. Planned activities for FY2016 include initial participant enrollment in October 2015 following completion of administrative and programmatic activities.

- Secure programmatic agreements
- Development of program referral networks
- Establish common data reporting system
- Establish reporting system timelines

**5. Evidence-Based Practices for Early Intervention (5 percent set-aside)**

- 4. A budget showing how the set-aside and additional state or other supported funds, if any, for this purpose.

In FFY16, the pilot teams are projecting ten youth will be enrolled by the end of the first year. Estimated costs for serving ten youth are as follows:

Service	FFY16	SMHA	Medicaid	Totals
	MHBG	State Funds*		
Individual Outpatient/Education	\$34,306	\$-	\$50,288	\$84,594
Family Outpatient/Education	34,306	-	60,788	95,094
Medication Management	17,660	-	44,584	62,244
Supported Employment/Education	19,074	80,922	-	99,996
Team Meetings		37,920	-	37,920
<b>Total</b>	<b>\$105,346</b>	<b>\$118,842</b>	<b>\$155,660</b>	<b>\$379,847</b>

\*Additional SMHA State Funds will be utilized for services as needed.

- 5. The states provision for collecting and reporting data, demonstrating the impact of this initiative.

The Nebraska FEP CSC Pilot Program will collect and report outcomes measures and fidelity measures for review by program planners and administrators to answer key questions around program implementation. Fidelity and outcome information will include CSC components of team structure and functioning, psychopharmacology, individual psychotherapy, family intervention, and supported employment/education.

The Nebraska FEP CSC Pilot Program utilized the consulting services of OnTrackUSA with the Center for Innovate Practice to establish a consistent reporting system across both teams for collecting and reporting outcome measures. The program will use the following outcome and assessment set.

**5. Evidence-Based Practices for Early Intervention (5 percent set-aside)**

FEP CSC Pilot Program Outcome and Assessment Set Items to be Used at Specific Time Points										
Tool to be completed by:										
FEP CSC Team						Individual Participant				
Timeframe						Timeframe				
Tool	Admission*	q3mos	q6mos	Discharge	As indicated	Tool	Admission	q3mos	q6mos	Discharge
Columbia Suicide Severity Rating Scale (C-SSRS) - Risk Assessment	X		X	X	X	OnTrackNY Modified Colorado Symptom Index	X	X		X
MIRECC GAF Expanded	X		X	X		Quality of Life	X	X		X
						Experience			X	X

\*Admission: Completed at first Team meeting after everyone has seen the participant.

Fidelity measures will serve to demonstrate the impact of the initiative. The Nebraska FEP CSC Pilot Program will utilize the *First Episode Psychosis Services Fidelity Scale (FEP-FS)* developed by Donald Addington, et al. The fidelity tool has been demonstrated to: work across a variety of programs; be reliable; has face validity; has suggested quality standard; and, has discriminative validity.

No technical assistance needs are identified at this time.

## 6. Participant Directed Care

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### C. Environmental Factors and Plan

#### 6. Participant Directed Care

As states implement policies that support self-determination and improve person-centered service delivery, one option that states may consider is the role that vouchers may play in their overall financing strategy. Many states have implemented voucher and self-directed care programs to help individuals gain increased access to care and to enable individuals to play a more significant role in the development of their prevention, treatment, and recovery services.

No questions – Indicate areas of technical assistance.

The Nebraska Division of Behavioral Health (DBH) supports and promotes the use of person-centered service delivery and participant directed care within our Regional and Provider system. Nebraska's public behavioral health system governing regulations "Standards of Care" identify the right of each consumer to: Receive behavioral health services in the most integrated setting appropriate based on an individualized and person-centered assessment, and actively and directly participate in decisions which incorporate independence, individuality, privacy, and dignity and to make decisions regarding care and treatment.

This is evidenced by person-centered planning within the Regional Centers, the work the Office of Consumers Affairs completes to actively promote Consumer involvement, peer work within the Regional Behavioral Health Authority (Regions) and Provider systems and voucher programs supporting people with behavioral health needs. DBH supports and funds participant directed care opportunities through a housing voucher program and an outpatient therapy voucher program for rural residents.

#### Housing Voucher Program:

The Nebraska housing assistance program is part of the Permanent Supportive Housing capacity to support stable and safe housing for recovery by people with behavioral health disorders and very or extremely low income. Housing assistance assists individuals obtain and/or maintain affordable housing in the community, including assistance for rental payments, utility payments, security and utility deposits, and other housing-related costs, including household formation costs. Housing assistance is "tenant-based" and supports the activity of the Regional Housing Coordinator in coordinating an assessment of housing needs for adults with behavioral health disorders.

The types of services that comprise the "support" in supportive housing are responsive to the needs of the people receiving housing assistance, developed by the consumers in their Individual Service Plan with their behavioral health service providers. This is distinct and separate from the housing assistance service received from the housing assistance provider.

Housing assistance provided by the State of Nebraska is designed for people who are not capable of independent living without behavioral health services and supports in order to remain successfully in the community. Housing assistance funds are intended to serve as a "bridge" to other housing alternatives, including self-support or other affordable housing options.

## 6. Participant Directed Care

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Housing assistance programs are funded with state funds. The Nebraska Housing Related Assistance program serves eligible adults with serious mental illness or co-occurring; it is funded through a state documentary stamp tax. Additional housing assistance, funded with State general funds, is available to consumers who face barriers to remain successfully in the community; these funds are available to support eligible adults with a substance abuse disorder, serious mental illness, or co-occurring disorder.

### Outpatient Therapy Voucher Program

In response to the rural/farm crisis that started during the 1980's, Interchurch Ministries of Nebraska (IMN) began the formation of a coalition of its member church denominations and agencies and organizations with a direct interest in hardships faced by people residing in rural Nebraska. IMN is a multid denominational organization of churches working together to meet the needs of people across Nebraska.

Because of the crisis nature of the problems faced by rural Nebraskans, the coalition was quickly realized. Church representatives, along with representatives from the Farmers Union, National Farmers' Organization, Nebraska Department of Agriculture, Nebraska Legal Services, Women in Farm Economics, the University of Nebraska at Lincoln Agriculture Extension Division, and financial lenders throughout the state, worked closely to build the response network, and make it available to anyone working in Nebraska agriculture.

Established in 1984, the Nebraska Rural Response Hotline (1-800-464-0258) is one of the primary confidential services provided by the Farm Crisis Response Council through IMN. When a farmer, rancher or rural resident calls the Hotline, an experienced staff person will answer to respond directly to callers, discuss issues and needs, provide helpful information and refer callers to attorneys, licensed behavioral health counselors, financial counselors, clergy, other farmers or mediation.

With the aim of providing cost free, confidential mental health crisis counseling readily available to distressed farm and rural families, IMN established the Counseling, Outreach and Mental Health Therapy (COMHT) Program. Access to this program is gained by calling the Hotline number. During the call, the person is offered the names and telephone numbers of participating licensed mental health providers located within the caller's geographical area, along with a voucher to cover costs of the one hour session. The caller has 30 days to use the voucher with the licensed mental health provider of their choice.

There is no area of technical assistance need identified at this time.

## 7. Program Integrity

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### C. Environmental Factors and Plan

#### 7. Program Integrity

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

##### 1. Does the state have a program integrity plan regarding the SABG and MHBG funds?

The Division of Behavioral Health (DBH) ensures block grant funds and state dollars are used in accordance with SAMHSA's expectations that the FY2016/2017 block grant funds to be directed toward four purposes:

- To fund priority treatment and support services for individuals without insurance or who cycle in and out of health insurance coverage;
- To fund those priority treatment and support services not covered by Medicaid, Medicare or private insurance offered through the exchanges, and that demonstrate success in improving outcomes and/or supporting recovery;
- To fund universal, selective, and targeted prevention activities and services; and
- To collect performance and outcome data to determine the ongoing effectiveness of behavioral health prevention, treatment, and recovery support services, and to plan the implementation of new services on a nationwide basis.

The program integrity plan involves a number of Division of Behavioral Health (DBH) administrative tools including the annual Region Budget Plan Guidelines and the contracts with the six Regional Behavioral Health Authorities (Regions). The DBH expends most of the Community Mental Health Services Block Grant (MHBG) and Substance Abuse Prevention and Treatment Block Grant (SABG) via the Regions. The DBH policy on the use of state and federal funds is expressed in the annual Region Budget Plan (RBP) Guidelines. The Fiscal Year (FY) 2016 RBP Guidelines were provided to the Regions on January 29, 2015. The product of the RBP goes into the development of the contract between the DBH and the Regions.

##### 2. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?

Under the FY2016 contracts, the DBH expects the Regions to develop and manage a comprehensive array of mental health and substance abuse services with sufficient capacity for designated geographic area based on a comprehensive needs assessment/strategic plan (Regional Budget Plan - Network Management A.2. Expectations). In developing and managing this network of services, Regions are expected to include in their planning the federal mandates under the SAMHSA Block Grant (MHBG and SABG).

In addition, it is the responsibility of the DBH and Regions to monitor, review, and perform programmatic, administrative, and fiscal accountability and oversight functions on a regular

## 7. Program Integrity

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basis with all subcontractors. If the Region is a direct provider of services, the DBH is responsible for the oversight functions for the services provided directly by the Region.

3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:
  - a. Budget review;
  - b. Claims/payment adjudication;
  - c. Expenditure report analysis;
  - d. Compliance reviews;
  - e. Client level encounter/use/performance analysis data; and
  - f. Audits.

The DBH and the Regions use internal and external measures for oversight of services purchased through the contract between the DBH and the Region. External measures are performed by entities outside of the Nebraska Behavioral Health System (NBHS), and include fiscal audits as conducted by a Certified Public Accountant and accreditation by a nationally recognized accrediting body. Internal measures are performed by entities within the NBHS, and include Services Purchased Verifications (unit/fiscal) and Program Fidelity Reviews (programmatic.) Services Purchased Verifications ensure that services billed for were in fact provided and verified by review of client files. Program Fidelity Reviews specifically address adherence to service, statutory and regulatory requirements for all providers receiving federal funding

The written procedures standardized in the document titled “Audit Manual” provide a systematic approach (across all Regions and the DBH) to the oversight of network management, including the monitoring and reviewing of services in the network. Each Region is charged with developing written procedures, based on the components outlined in the manual, for use in the review of services purchased from all subcontracted entities. Regions should include all of the components included in the manual in their written procedures. Any changes made to the NBHS manual are reflected in the Region’s written procedures.

Sheri Dawson (Director Appointee) is the DBH Deputy Director for Community Services and currently serves as the Acting Director of the Division of Behavioral Health. Three administrators who report to Sheri Dawson have responsibilities for the DBH program integrity plan.

- Karen Harker is the Fiscal and Federal Performance Administrator whose responsibilities include appropriate use of funds, audits, contract development, and related financial duties.
- Susan Adams is the Network Services Administrator whose responsibilities include managing the annual RBP, contracts, and program fidelity reviews.
- Heather Wood is the Quality Improvement and Data Performance Administrator whose responsibilities include data collection, analysis and reporting.

Nebraska State Statute mandates the DBH approval of an annual RBP review for all Regions that includes budget and planning information for management of the network and provision of services. RBP expectations are clearly outlined and given annually to the Regions in the RBP Guidelines. The purpose of the RBP is to ensure that Nebraska’s publically funded Behavioral

## 7. Program Integrity

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Health System promotes accessibility, quality, effectiveness, efficiency, and accountability. The Regions are encouraged to work collaboratively with the DBH staff to select the priorities that best address assessed needs of the Region. Services should continue to promote wellness, resiliency, and recovery, and be delivered in a coordinated, accessible, family and consumer driven system. The Network Operation Team staff and the Federal and Fiscal Team staff review each RBP addressing whether the plan has met expectations outlined in the RBP Guidelines, including adherence to federal guidelines, and makes recommendations to the Division Director and Deputy Director of Community Based Services regarding approval of the plan.

The Services Purchased Verification is conducted to verify that services claimed for reimbursement have been delivered to a consumer. There are two types of services purchased verifications: unit verification for fee for service (FFS) services and expense verification for non-fee for service (NFFS) services. A verification of services purchased includes a review of any documentation to verify that the services purchased were delivered. This can include clinical records, progress notes, financial records, and/or other documentation as deemed necessary. Services purchased verifications are conducted on an annual basis on all contracted services as reflected by Authorization Documents, Registration Documents, and Provider Logs.

The DBH and the Regions conduct Program Fidelity Reviews. The purpose of a Program Fidelity Review is to review program plans and services delivered to ensure consistency and conformance with service definitions, state regulations, policies, and contract requirements governing mental health and substance abuse programming and specific MHBG and SABG program requirements. The Program Fidelity Review is conducted a minimum of once every three years. National accreditation may preclude the review of certain surveyed items as determined by Regional Network administration. Program Fidelity Reviews include a component which specifically addresses provider adherence to Federal requirements entitled the “Nebraska Program Monitoring Tool for Federal Substance Abuse Prevention and Treatment Performance Partnership Block Grant Compliance”.

The Nebraska Department of Health and Human Services (NDHHS) Grants Management Section reviews A-133 Audits to identify any areas of non-compliance. The DBH staff contacts the contractor to follow-up on any areas of non-compliance and solicits corrective action plans to be accepted, corrected, or modified by NDHHS.

**4. Describe payment methods, used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.**

The DBH ensures payment methodologies are appropriate using tools such as the RBP and annual contracts. For example, the RBP defines what allowable costs are consistent with policy from the NDHHS and SAMHSA. Use of state and/or federal funds are limited to the cost of items such as employment of personnel, technical assistance, consultation, operation of programs, renting suitable space, and maintenance of facilities.

In addition, the Regions can initiate the development of programs and services. The expectations of Regions includes the development and management of a comprehensive array of mental health and substance abuse services with sufficient capacity for designated geographic area based on a comprehensive needs assessment/strategic plan. This is the method by which the Regions

## 7. Program Integrity

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develop and maintain the appropriate types and quantities of services delivered within their designated geographic area.

### 5. Does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?

The state sets a standard for quality prior to accepting providers into the Nebraska Behavioral Health System. The DBH contracts with the six Regions to enroll providers in their networks. Each Region requires providers to meet minimum standards as outlined in the Minimum Standards protocol developed by the DBH. Regions, with review from the DBH, issue proposals for bidding for new services they desire within their networks. Regional staff, DBH staff, and consumers evaluate proposals for quality based on bid requirements and best practices.

State service definitions in the NAC 206 Regulations serve as standards of care. The services are audited by the Regions or the DBH for fidelity to the standards. In addition, a variety of work groups (such as the audit work group, State Quality Improvement Team, and fiscal managers) meet regularly to promote compliance with standards and requirements.

Once in the network, Region and DBH staff members provide technical assistance to the providers in the provision of quality recovery oriented services and supports. Annual training and technical assistance, along with Program Fidelity Reviews, allow providers ample opportunity for improvement in service delivery. In addition, the State requires licensing and National Accreditation for most providers to ensure quality and safety infrastructure within their organizations.

### 6. How does the state ensure block grant funds and state dollars are used for the four purposes?

The DBH has administrative systems designed to monitor the proper use of the federal Block Grant funds and state dollars. The DBH has developed a Financial Eligibility Policy and Fee Schedule. The policy specifies that the DBH is the Payer of Last Resort for behavioral health services for consumers who meet financial eligibility criteria as specified in this policy and fee schedules. It also specifies that the DBH will not reimburse for Medicaid eligible services provided to Medicaid consumers. If the consumer has accrued a personal needs allowance and creates savings that disqualify him/her from a benefit such as Medicaid, the full cost of the service must be assessed to the consumer until he/she qualifies for the Medicaid benefit. It also specifies that the DBH will not pay for any portion of services required to be paid by a Medicaid recipient to meet a share of cost obligation.

As the Affordable Care Act is implemented, these monitoring systems are designed to adjust to the new health insurance coverage expectations. To facilitate this adjustment process, the DBH included in the annual RBP Guidelines and the contracts with the Regions the SAMHSA direction for block grant funds to be directed toward four purposes as specified in the Federal Register and discussed in #1 above.

There is no area of technical assistance need identified at this time.

## 8. Tribes

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### C. Environmental Factors and Plan

#### 8. Tribes

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands.

1. Describe how the state has consulted with tribes in the state and how any concerns were addressed in the block grant plan.
2. Describe current activities between the state, tribes and tribal populations.

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

Each Tribe creates an annual work plan and communicates these to the Division of Behavioral Health. These plans identify the services most beneficial to their respective members for Division of Behavioral Health funding to support. This becomes the basis for their contract. The services performed must meet either the Indian Health Services (IHS) service definitions criteria or the Division of Behavioral Health's service definitions. Each Tribe can select which service provision standards they will utilize. As with all contracts for services from the Division of Behavioral Health, audits and site visits are conducted to ensure service provision is occurring as indicated. If the program is using IHS standards, the IHS review is accepted as the program review. However, auditing to ensure the service is being performed as billed is still completed.

The four federally recognized tribes with whom the Division of Behavioral Health awards \$1.5 million of state funds in contracts, are invited to participate in advisory committees, local and statewide meetings regarding services, trainings on behavioral health topics, and other state activities and initiatives.

In the past year, funding was also provided to an organization serving Oglala Sioux Tribe in western Nebraska to develop a culturally responsive Tribal Family Peer Support service to assist families and youth with behavioral health needs. The curriculum could be utilized or adapted for use by the other Tribes in the state if desired.

The Division of Behavioral Health will continue its efforts to engage tribal representatives in planning, trainings, and initiatives, as well as support the culturally appropriate provision of services to their tribal members.

There is no area of technical assistance need identified at this time.

## 9. Primary Prevention for Substance Abuse

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### C. Environmental Factors and Plan

#### 9. Primary Prevention for Substance Abuse

Federal law requires that states spend no less than 20 percent of their SABG allotment on primary prevention programs, although many states spend more. Primary prevention programs, practices, and strategies are directed at individuals who have not been determined to require treatment for substance abuse. Federal regulation (45 CFR 96.125) requires states to use the primary prevention set-aside of the SABG to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance abuse.

1. Please indicate if the state has an active SEOW, the types of data collected, populations targeted and data sources used.

Led by the DBH, Nebraska's SEOW meets quarterly to assess and analyze substance abuse and mental health data, track key indicators, and disseminate reports to decision makers at the state and community level. An executive SEOW comes together between each quarterly meeting in effort to expedite approval of products developed by the workgroup and to support, review, and monitor implementation of chartered committee objectives. The overarching goal of the SEOW is to enhance a sustainable state prevention system with the capacity to complete a comprehensive assessment (epi profile) identifying priority substance abuse issues and problems associated with related mental health disorders in order to maximize utilization of resources at the state and community level.

Much of our analytic strategy uses substance use as an illustrative dependent variable, but it is important to note that we apply this strategy to both outcome and process measures. The SEOW examines the impact of our efforts by using selected indicators of substance use and related risk and protective factors for the identified priority areas. Data is drawn from the following sources: (1) Uniform Crime Reports (UCR), for alcohol-related arrests and liquor law violations; (2) the Nebraska Department of Roads, for alcohol-related motor vehicle crashes, injuries, and fatalities; (3) Nebraska Hospital Discharge Data; (4) participant-level National Outcome Measures for youth and adults; (5) Community-Level Instrument information on intervention implementation; (6) Youth Risk Behavior Surveillance System (7) the Nebraska Risk and Protective Factor Student Survey (state-developed); (8) the Nebraska Young Adult Alcohol Opinion Survey (state-developed); (9) Nebraska Annual Social Indicators Survey (state-developed); (10) College alcohol surveys; (11) NSDUH and (12) the BRFSS (including state added questions).

Data is most commonly collected and broken out by gender, race, youth aged 10-20, young adults 19-25, adults, gender and counties identified as communities of high need/high risk for substance abusing behaviors. Given the state's growing minority population, it is vital to investigate health disparities related to substance abusing behaviors. Data is not available that identifies any other vulnerable groups in the state that will be targeted, however, efforts will be made to collect diverse demographic data to track this information.

## 9. Primary Prevention for Substance Abuse

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2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.

As a requirement of DBH's annual Regional Budget Planning process at least 50 percent of the SABG Primary Prevention dollars received by community coalitions must be used to fund community based and environmental strategies. Beyond this, the sub-recipients of the SABG have the flexibility to implement a variety of evidence-based programs, policies, and substance abuse prevention practices in their community as long as the interventions are supported by a local need assessment and driven by a planning process using the Strategic Planning Framework.

3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?

DBH's Five Year Strategic Plan for Prevention addresses capacity building with the goal of strengthening leadership, infrastructure and workforce at the State and Regional levels in order to support strong community coalitions and their volunteer members. The plan includes two major activities (1) ensure sound structure, active membership, and on-going leadership role of the State's substance abuse prevention advisory council and (2) promote leadership through technical assistance and training to establish statewide priorities for Regions and communities. DBH is currently engaged in a technical assistance effort with CSAP/JBS to formalize core competencies, conduct a workforce needs assessment survey and develop an overarching workforce development plan that can address the prevention goals identified in the strategic plan to sustain a professionalized workforce. Technical assistance (TA) is being provided in separate phases and the consultants are currently developing an evaluation plan and instruments to measure the progress of Nebraska's substance abuse prevention Workforce Development Plan, Training/TA plan and Training/TA providers.

4. Please describe: the state's licensing or certification program for the substance abuse prevention workforce; its formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and assess community readiness to implement prevention strategies.

Nebraska's prevention system has identified a set of prevention professional core competencies and as part of the assistance described above is working to formalize the skills, knowledge and abilities that will be required for each level of the prevention workforce. The state does not have a licensing or certification program at this time. However, DBH now requires that all paid Prevention staff (both Regional and community coalitions) complete 12 hours of continuing education relevant to the prevention of mental illness and/or substance use disorders and support proficiency across the agreed upon set of core competencies.

The influence of the Strategic Prevention Framework (SPF) has multiplied through the work of the Regional Prevention Coordination System which now provides SPF-based training and technical assistance to all area coalitions. Community coalitions benefit enormously from this hands-on, face-to-face training and technical assistance that takes them through every step of the prevention planning process and allows them to network and strategize with their peers.

## 9. Primary Prevention for Substance Abuse

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Bolstered by the provision of specific techniques and tools designed for each stage of the SPF process, communities have demonstrated significant increases in their capacity to engage in effective planning. Regional Prevention Coordinators, through a contractual partnership with the State and community coalitions, will continue to build on existing success by further providing extensive community-based training and technical assistance to assess community readiness, identify outcomes and prioritize the most effective interventions in the development of local sustainability plans.

5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed?

A variety of data sources are used to assess the impact of substance abusing behaviors, intervening variables and consequences. Outcome evaluations typically focus on assessing the effectiveness of selected prevention strategies in terms of intended goals and objectives. Strategy selection and use of data is described further in questions #1, 2, 6, 7 and 8.

6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.

Yes, with strong stakeholder feedback considered, DBH has developed their overarching statewide strategic goals and focus of prevention efforts on a prioritized set of behaviors. Launched in the fall of 2013, Nebraska's five year strategic plan for substance abuse prevention documents goals and objectives for the statewide prevention system. This selection was data driven, and results of activities can be measured over time to demonstrate the success of state initiatives. State, regional and local sub-recipients of the SABG use the strategic plan to guide their local planning efforts and ensure that services requested for funding align with the larger statewide initiative. See more at [http://dhhs.ne.gov/behavioral\\_health/Documents/DBH-PreventionStrategicPlan2013-17.pdf](http://dhhs.ne.gov/behavioral_health/Documents/DBH-PreventionStrategicPlan2013-17.pdf)

7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.

State prevention staff, in collaboration with the Prevention Advisory Council, serve as the evidence-based workgroup for the State of Nebraska. A decision making process has been developed to review and select appropriate programming. This involves completion of an assessment of available evidence of effectiveness, consideration of the overarching state and

*9. Primary Prevention for Substance Abuse*

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local level prevention strategy, and an understanding of the local level climate and capacity to implement. Nebraska has a small paid prevention workforce statewide that would overlap substantially with the Prevention Advisory Council if an additional committee were to be formed. We have found that the process of reviewing concerns related to evidence-based prevention is best done in conjunction with other advisory efforts.

The strategic plan for prevention provides overarching goals and objectives for the statewide prevention system. Sub-recipients also work from their available data, logic models and history to create a coordinated prevention strategy at the local level. Additionally a guidance document, created during Nebraska's Prevention Framework State Incentive Grant Evidence-Based Practices Workgroup, provide sub-recipients with a set of tools to help them select and seek approval for the most appropriate prevention strategies to implement in their community.

8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies.

DBH funds community coalitions to develop products for **information dissemination** that provide and promote, awareness, knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities. Many of our community coalitions showcase their products via brochures, flyers, public service (radio) announcements, billboards, newspapers inserts and during speak engagements, public health fairs, and parent teacher conferences. Visibility and reach of social norming campaigns have also expanded by use of social media as well as screen messaging at movie theaters and signage at sports arenas.

DBH funds **educational** programs and curriculums aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities. State staff, Regional Prevention Coordinators and coalition leaders present to various advisory committees, board groups, schools, youth groups, community and public interest groups upon request. Examples of these primary prevention programs include but are not limited to the following:

- Across Ages
- All Stars
- CASASTART - Striving Together to Achieve Rewarding Tomorrows
- Character Counts
- Common Sense Parenting
- LifeSkills Training Program
- Me360
- Parent and Family Skills Training
- Project Northland
- Protecting You/Protecting Me
- PRIME For Life
- Slick Tracy

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- Strengthening Families
- Too Good for Drugs
- Too Smart to Start Drugs
- W.A.I.T. (Abstinence Education)
- Why Try
- Educational materials developed in support of Red Ribbon Week, Prevention Week, and safe Prescription Drug disposal.

DBH sponsors a variety of **alternative** activities such as youth trainings and/or summits throughout the school year and summer breaks designed to develop youth leadership within their home communities. Another frequently used strategy is partnerships with law enforcement to coordinate promotional letters sent to students to encourage safer and wise choices during prom and graduation season. Nebraska also has many successful mentoring programs, namely Teammates and the Big Brothers Big Sisters Mentoring Program that provide positive alternatives to our youth. Other strategies include the Health Rocks Teen program, Community drop-in centers and drug free dances/parties.

DBH has one direct prevention provider, Lincoln Medical Education Partnership's School Community Intervention and Prevention (SCIP) program, which provides statewide **problem identification and referral** services. SCIP provides prevention, education, and early intervention services and trains teams within schools to help recognize a child's behavioral health needs at early on-set, rather than waiting until they have progressed to a more critical level and are more difficult to address. Following a student's referral to SCIP, the team assesses the need for further action, coordinating an intervention with the student and/or their parent/guardian when necessary. A plan is developed to address the concerns and increase the student's opportunity to succeed in school. This plan may include a referral to a school resource or to partnering behavioral health agencies who can provide a screening for the student, at no cost to the family. A number of contracted prevention providers offer DUI/DWI Education Programs as well as Parent and Family Skills Training throughout the year to selective and indicated populations. Several institutes of higher learning also fund Brief Alcohol Screening Intervention of College Students (BASICS).

As described earlier, the majority of our SABG is dedicated to the support of **community-based processes** that include organizing, planning, evaluating and enhancing the effectiveness of funded programs, policies, and practice implementation, interagency collaboration, coalition building, and networking. Regional Prevention Coordinators and coalition leads are specifically funded to provide training, technical assistance, systematic planning, multi-agency coordination and guidance for community teambuilding activities. Funding through this strategy for coordination of local coalitions and other community activities is intended to ensure prevention services are available, accessible and that duplication of efforts is minimized.

**Environmental** strategies represent the other majority half of funding efforts to establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population. The primary program used for this strategy is Communities Mobilizing for Change on Alcohol (CMCA) and Challenging College Alcohol Abuse. Other environmental strategies

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implemented throughout the year include compliance checks for alcohol and tobacco, sobriety checkpoints and party patrols. In support of the State's social norms campaign to prevent underage drinking, the prevention system continues to focus on preventing the sale and use of alcoholic beverages products to minors. This includes implementation of social host ordinances at the local level, regular provision of Responsible Beverage Server Training (RBST) and Training for Intervention Procedures (TIPS). Concentrated review of use policies and procedures is active in every region of the state via the Life of An Athlete Program. Specific program activities include: revision of student codes of conduct to support healthy lifestyle choices; policy changes that encourage positive behavior among the athletic community; youth leadership training to develop team unity; and student athlete, coach, parent, and community education on the impact of lifestyle choices and how to make healthier ones.

Please describe why these specific programs, practices and strategies were selected.

DBH's Prevention System is striving to create population level change, thus it is imperative that communities be targeted with prevention initiatives that demonstrate measurable change in behaviors or in important risk factors that lead to behavior change. DBH supports a structured, community-based approach to substance abuse prevention through the Strategic Prevention Framework. By following the framework, we've chosen to promote youth development, reduce risk-taking behaviors, strengthen assets and resiliency, and prevent problem behaviors across the life span.

**9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?**

DBH updates and provides annual budgetary guidance for use of SABG dollars through a number of methods. The first has been to ensure the language within our State to Region contract is consistent with the federal register and SABG application instructions. Thus, it is a standard contractual requirement that SABG dollars can only be used to fund primary substance abuse prevention services. These requirements are also outlined in the Regional Budget Guidelines published each year as part of community RFP process. Additionally, DBH performs a variety of audits with their providers, including a Programmatic Activity Review for an entity receiving SABG dollars for prevention. The programmatic review is required for all community coalitions funded by the SABG and is conducted annually in partnership with Regional Prevention Coordinators.

**10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?**

DBH's Five Year Strategic Plan for Prevention calls for Nebraskans to have access to effective prevention services that produce measurable outcomes and use resources efficiently. The primary method to gather and evaluate process data is reported through the Nebraska Prevention information reporting System (NPIRS). This is an internet based reporting system designed to collect prevention activity data for prevention strategies, interventions or activities funded via contract with the DBH. NPIRS is available for use by internal state staff as well as any entity

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conducting prevention activities in Nebraska which includes but is not limited to community coalitions, private not for profit agencies, and Regional Behavioral Health Authorities. Key feature of NPIRS include: internet based reporting, reporting at multiple levels and coordinated reporting between various funding sources. The systems collects the following types of process data:

- Number of T/TA activities and Numbers served by T/TA
- Number of sub-recipients reporting monthly data
- Number of evidence-based programs, policies, or practices implemented
- Number of people served/reached by Institute of Medicine prevention category
- Number and demographics reached through selected strategies
- Use Leveraged and/or Braided Funding Sources

Additionally the requirement for submission of an annual work plan and training plan outline from each of the Regional Prevention Coordinators is reviewed and discussed on a quarterly basis. It is the expectation is that Regional work plans are designed to address the T/TA needs identified in their catchment area and that progress in these areas are monitored on an ongoing basis. Although intended as evaluation measure for the state's SPF Partnerships for Success grant, Coalition Capacity Member and Coalition Coordinator Surveys are fielded and taken into consideration of DBH's overarching T/TA efforts.

**11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?**

As part of Nebraska's Substance Abuse Prevention Statewide Strategic Plan eight performance indicators are collected and monitored to evaluate the effectiveness of Nebraska's prevention system. The table below indicates each of these indicators and a corresponding target goal set for 2017.

Nebraskans Prevention Performance Indicators		
Indicator	Indicator Type	2017 Target
Percent of high school students who consume alcohol	Lifetime Use	25%
Percent of young adults aged 19 and 20 who report consuming alcohol currently	30 Day Use	43%
Percent of young adults ages 19 to 25 who report binge drinking	30 Day Use	43%
Percent of males aged 19 and 20 who report binge drinking	30 Day Use	35%
Percent of high school students who report using prescription drugs not prescribed by a physician	30 Day Use	10%

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Percentage of Adults aged 18 and older who report using prescription drugs not prescribed by a physician	Past Year Use	4%
Percentage of high school students who report using marijuana	Past Month Use	11%
Percentage of tobacco retailers who sell tobacco products to minors	Past Year Sold	Less than 20%

These performance indicators are an essential part in evaluating the prevention system. The identification and prioritization of outcomes helps monitor the progress of Nebraska's prevention system and holds the DBH accountable for these prevention targets as the system moves forward. Ultimately, DBH strives to reduce rates of substance abuse among students and young adults while increasing the amount of positive lifestyle choices made.

There is no area of technical assistance need identified at this time.

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## C. Environmental Factors and Plan

## 10. Quality Improvement Plan

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

No questions – Indicate area of technical assistance needed.

**In an attachment to this application, states must submit a CQI plan for FY 2016-FY 2017.**

As an attachment to this section, please find the state CQI plan for FY 2016-FY2017, *“The DHHS-Division of Behavioral Health Continuous Quality Improvement Program Plan FY16/17 – DRAFT”*.

The DBH Continuous Quality Improvement (CQI) Program establishes accountability for continually improving DBH as an organization and the services provided to consumers and families in the state of Nebraska. DBH is committed to creating a culture that fosters quality improvement and sets clear direction through an annual plan. The DBH CQI Program will ensure: Services are appropriate to each consumer's needs and accessible when needed; Consumers and families participate in all process of the CQI program and their views and perspectives are valued; Services provided incorporate best practice, evidence-based practices, and effective practices; and Services are of high quality and provided in a cost-effective manner. The CQI Program is based on the assumptions that working together creates a system of coordinated services to better meet the needs of consumers and families; Stakeholders want to improve consumer and family outcomes; Stakeholders participate in monitoring activities, data reporting and information sharing.

**Our Vision:** DBH leads Nebraska in the improvement of systems of care that promote and facilitate resilience and recovery.

**Our Mission:** The mission of the DBH and its Quality Improvement Program is to promote wellness, recovery, resilience and self-determination in a coordinated, accessible consumer and family-delivery system.

The DBH's approach to quality improvement is based on the following core principles:

- Customer Focused.** Understanding and respecting needs and requirements of all customers and

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- striving to exceed expectations.
- **Strengths Based.** Effective growth and change build on the consumer/family and system's strengths.
  - **Recovery Oriented.** Services are characterized by a commitment to promoting and preserving wellness and choice. This approach promotes maximum flexibility to meet individually defined goals in a consumer's recovery journey.
  - **Representative Participation and Active Involvement.** Effective programs involve a diverse representation of stakeholders. The stakeholders are provided the resources, education and opportunity to make improvements required and influence decision making.
  - **Data Informed Practice.** Successful QI processes create feedback loops, using data to inform practice and measure results. There is a commitment to seek IT structures, staff, skills and other resources in the provision of data.
  - **Use of Statistical Tools.** For continuous improvement of services, tools and methods are needed that foster knowledge and understanding through use of analytic tools such as run charts, cause and effect diagrams, flowcharts, Pareto charts, histograms, and control charts to turn data into information.
  - **Continuous Quality Improvement Activities.** Quality improvement activities emerge from a systematic and organized framework for improvement. This framework, adopted by the Division of Behavioral Health, is understood, accepted and utilized throughout the service delivery system, as a result of continuous education and involvement of stakeholders at all levels in performance improvement.
  - **Plan, Do, Study, Act.** (PDSA) Develops a plan to test the change (Plan), carrying out the test (Do), observing and learning from the consequences (Study), and determining what modifications should be made to the test (Act).
  - **Results-Based Accountability.** Results-Based Accountability (RBA) is a disciplined way of thinking and taking action that communities can use to improve the lives of those we serve. RBA will provide an opportunity for the State, Regions, Regional Centers and providers to measure whether consumers are better off as a result of the service received.

Through a planned and shared communication approach, DBH works to ensure all stakeholders have knowledge of and participation in ongoing QI activities as a means of continually improving performance. Planned communication methods include posting QI information on the DHHS-DBH public website, use of listserves, presentations, trainings, as well as through various coordinated groups with ongoing annual activities. Stakeholders include Consumers and Families, DBH Administration and Staff, Consultants, Regional Staff, Regional Centers, Service Providers, Advocacy Groups and Office of Consumer Affairs Participants, DHHS Partners, etc. Working relationships are described below.

**Division of Behavioral Health Administration** – The DBH Director and Deputy Director establish and communicate priorities for the annual plan and review feedback from stakeholders in the reporting structure.

**Behavioral Health Advisory Committees (MH & SA)** - Contributes to the development and implementation of the Annual CQI Plan and activities. The committees meet quarterly and as needed for special topics.

**Regional Administrator and Network Management Team (NMT) Meetings** - Ensure that quality improvement processes are operationalized and prioritized at the community team level. Regional Administrators meet regularly with DBH Administration and the NMT is held quarterly.

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**Statewide Quality Improvement Team (S.O.I.T.)** - primarily responsible for the identification and prioritization of opportunities for regional/community improvement, quality initiatives and development of the annual plan. 50% of voting membership should have a disclosed lived behavioral health experiences.

**Regional Community Quality Improvement Teams (R.C.O.I.T.)** - Contributes to the development and implementation of local QI activities as it relates to local needs and the DBH CQI Program Plan. Meetings are held on a regular basis.

**Tuesday Data Calls** - Review data and progress towards RBA to ensure that quality improvement processes are operationalized and prioritized at the community and state level. Calls are held twice a month.

**COI Statewide Learning Collaborative** - A formation of a statewide learning collaborative with DBH, including the six Regions across Nebraska and the three State Regional Centers will be formed. The collaboration of these system partners supports working together in collaboration, creating a system of coordinated services to better meet the needs of consumers and families and supporting our providers. The collaborative will utilize an “all teach-all learn” philosophy to work collaboratively, holding ourselves accountable to delivering the highest quality services to the community and to our State’s consumers and families in a cost effective manner utilizing Results-Based Accountability (RBA) and the Plan, Do, Study, Act (PDSA). The collaboration will support educational webinars quarterly with topics chosen as a group. An all-day spring event will be held to allow for DBH Staff, Regions and Regional Centers to come together for collaboration, sharing of their data stories, celebration of successes as well as inviting providers, community partners and additional stakeholders to join. The collaborative will work together to plan and coordinate the event.

**QI Program Goals for FY16/17 include:**

1. Implementation of Results-Based Accountability (RBA) across the Regions and State.
2. Review data utilizing the RBA framework and PDSA to drill and tell the story behind the data.
3. Design and implement new data templates to more readily understand and have a process for telling the story behind the data.
4. Implement a Learning Collaborative with DBH, Regions and Regional Centers for collaboration between system partners working together to be accountable to delivering the highest quality services to the State’s consumers, families and communities.

**RBA Performance Measurement for FY16** - Data collected will be utilized to evaluate each of the following areas with particular interest on co-occurring disorders, trauma, prevention, and recovery.

**Result – Statewide Population**

*Definition: A condition of well-being for children, adults, families, or communities.*

1. **Nebraskans are physically and emotionally healthy.**

**Indicators - Statewide Population**

*Definition: A measure which helps quantify the achievement of a result.*

**1. Decrease in substance use:**

- Binge drinking 12-17
- Binge drinking 18+ /19+
- Marijuana use 12-17

**2. Decrease in Nebraskans needing involuntary emergency inpatient care:**

- Involuntary hospitalizations through EPC admissions
- Mental Health Board commitments

**Performance Measures – Region/Program Level**

*Definition: A measure of how well a program, agency, or service system is working.*

**1. How well do we do it?**

- % positive response to general satisfaction with services received
- % positive response to staff sensitive to trauma
- % programs with improvement in trauma informed scores
- % programs with improvement in co-occurring capable/enhanced scores
- % consumers discharged with treatment completed status

**2. Is anyone better off?**

- #/% positive response to improved QOL
- #/% positive response to improvement in symptoms
- Average # days / % of consumers who binge drank in last 30 days
- #/% decrease in substance use

**Emergencies & Critical Incidents** - The Division of Behavioral Health's approach to addressing emergencies and critical incidents is covered in the Nebraska Behavioral Health All-Hazards Disaster Response and Recovery Plan. The purpose of this plan is to provide a framework for organizing the behavioral health response to emergencies, critical incidents, other high profile events and disasters in Nebraska. This plan addresses mental health and substance abuse issues which may follow these sudden, tragic, unexpected events. These behavioral health services can help mitigate the severity of adverse psychological reactions to these tragic and unexpected events by helping to restore social and psychological functioning for individuals, families, and communities. Emergencies, critical incidents and other high profile events may or may not be considered a "disaster." However, the plan was developed to provide enough information to guide decision making even if it is a localized event not rising to the level of a state disaster declaration. DBH has developed and maintained relationships with other state officials who have disaster duties, a hotline provider and Behavioral Health Regions' disaster coordinators. Each Regional Behavioral Health Authority has prepared volunteers to assist survivors, responders and communities through the application of "psychological first aid." These volunteers are managed locally in accordance with plans developed and maintained by each Region.

DBH participates in and supports the Behavioral Health Emergency Response Team (BHERT) and the Risk Communication Cadre as part of its preparedness activities. These are two of the formal State Resources available if needed when emergencies, critical incidents, high profile events or disasters strike. BHERT is a mechanism for organizing and deploying state disaster behavioral health resources. The primary value of the team to local areas is rapid deployment of behavioral health personnel experienced in disaster-related community needs assessment,

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coordination of resources, and training. BHERT is also a resource for state-run facilities under emergency response operations.

Risk Communication Cadre is a pool of behavioral health professionals with competency in risk communication, risk assessment, and public information. The Risk Communication Cadre is identified jointly by the Division of Behavioral Health and Department of Health and Human Service's Public Information Officers. These professionals will assume the role of consultants to State Public Information Officials (PIO's). The group meets regularly with PIO's to craft messages with behavioral health content for use in all phases of disaster. For more information on the Nebraska Behavioral Health All-Hazards Disaster Response and Recovery Plan see: <http://www.disastermh.nebraska.edu/resources/currentplan.php>.

**Complaints & Grievances** - Consumers must be able to freely voice complaints and recommend changes without being subject to coercion, discrimination, reprisal, or unreasonable interruption of care, treatment, and services. DBH has included procedures for complaints and grievances within the Nebraska Administrative Code (NAC) Title 206 regulations. The Mental Health Commitment Act also provides for the individual rights of persons subject to a Mental Health Board (MHB) hearing:

[http://dhhs.ne.gov/behavioral\\_health/Pages/beh\\_commit\\_commit.aspx](http://dhhs.ne.gov/behavioral_health/Pages/beh_commit_commit.aspx).

The DBH relies upon its requirement for enrolled providers to maintain national accreditation as one means for assuring the protection of consumer and family rights. The standards of the national accreditation bodies require consumer and family rights protection and grievance processes. Each provider must establish a written consumer grievance policy with the following components:

1. Consumers and as applicable, their legal representative(s) and family of their choosing must be informed of and given a copy of written procedures for addressing and resolving grievances established by each provider (see consumer rights in 206 NAC 6-001);
2. Consumers, families, staff, and others must have access to the provider's grievance process;
3. The consumer's grievance must be responded to by the provider in a timely manner and the provider must document its response to the consumer;
4. If the consumer's grievance is not addressed satisfactorily through the provider's complaint process, the provider must give adequate information, including telephone numbers and addresses, to the consumer to enable the consumer to contact the Division of Behavioral Health, Office of Consumer Affairs; the Division of Public Health, Facility Complaint Intake and the Investigations Section, the designated Protection and Advocacy organization for Nebraska; the Consumer Specialist of the Regional Behavioral Health Authority (RBHA); the office of the Ombudsman; the Department's System Advocate, and the vendor who is contracted for system management. This information must also be readily available to consumers, families, staff, and others. More information on processes and standards for response to complaints and grievances can be found in regulations: [http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health\\_and\\_Human\\_Services\\_System/Title-206/Chapter-06.pdf](http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-206/Chapter-06.pdf).

No technical assistance needs are identified at this time.

*10 Quality Improvement Plan –Attachment: Quality Improvement Plan for FY2016-FY2017*

**DHHS-Division of Behavioral Health**  
**Continuous Quality Improvement Program Plan**  
**FY16/17 - DRAFT**

**Section 1**

**Introduction**

***Vision:***

The Division of Behavioral Health leads Nebraska in the improvement of systems of care that promote and facilitate resilience and recovery.

***Mission:***

The mission of the Division of Behavioral Health (DBH) and its Quality Improvement Program is to promote wellness, recovery, resilience and self-determination in a coordinated, accessible consumer and family-delivery system.

***Commitment:***

DBH is committed to creating a culture that fosters quality improvement and sets clear direction through an annual plan.

***Purpose:***

The DBH Continuous Quality Improvement (CQI) Program establishes accountability for continually improving DBH as an organization and the service provided to consumers and families in the state of Nebraska.

The Division of Behavioral Health CQI program will ensure:

- Services are appropriate to each consumer's needs and accessible when needed;
- Consumers and families participate in all process of the CQI program and their views and perspectives are valued;
- The services provided incorporate best practice, evidence-based practices, and effective practices;
- Services are of high quality and provided in a cost-effective manner.

***Definition:***

CQI is an ongoing process of using data to plan, identifying opportunities for improvement, implementing changes, studying and analyzing results and celebrating improvements.

The CQI Program is based on the following assumptions:

- Working together creates a system of coordinated services to better meet the needs of consumers and families;
- Stakeholders want to improve consumer and family outcomes;
- Stakeholders participate in monitoring activities, data reporting and information sharing.

*10 Quality Improvement Plan –Attachment: Quality Improvement Plan for FY2016-FY2017*

**Core Principles**

The DBH's approach to quality improvement is based on the following core principles:

- **Customer Focused.** Understanding and respecting needs and requirements of all customers and striving to exceed expectations.
- **Strengths Based.** Effective growth and change build on the consumer/family and system's strengths.
- **Recovery Oriented.** Services are characterized by a commitment to promoting and preserving wellness and choice. This approach promotes maximum flexibility to meet individually defined goals in a consumer's recovery journey.
- **Representative Participation and Active Involvement.** Effective programs involves a diverse representation of stakeholders. The stakeholders are provided the resources, education and opportunity to make improvements required and influence decision making.
- **Data Informed Practice.** Successful QI processes create feedback loops, using data to inform practice and measure results. There is a commitment to seek IT structures, staff, skills and other resources in the provision of data.
- **Use of Statistical Tools.** For continuous improvement of services, tools and methods are needed that foster knowledge and understanding. CQI organizations use a defined set of analytic tools such as run charts, cause and effect diagrams, flowcharts, Pareto charts, histograms, and control charts to turn data into information.
- **Continuous Quality Improvement Activities.** Quality improvement activities emerge from a systematic and organized framework for improvement. This framework, adopted by the Division of Behavioral Health, is understood, accepted and utilized throughout the service delivery system, as a result of continuous education and involvement of stakeholders at all levels in performance improvement.
- **Plan, Do, Study, Act.** (PDSA) Develops a plan to test the change (Plan), carrying out the test (Do), observing and learning from the consequences (Study), and determining what modifications should be made to the test (Act). (See Appendix 1).
- **Results-Based Accountability.** Results-Based Accountability (RBA) is a disciplined way of thinking and taking action that communities can use to improve the lives of those we serve. RBA will provide an opportunity for the State, Regions, Regional Centers and providers to measure whether consumers are better off as a result of the service received. (See Appendix 2).

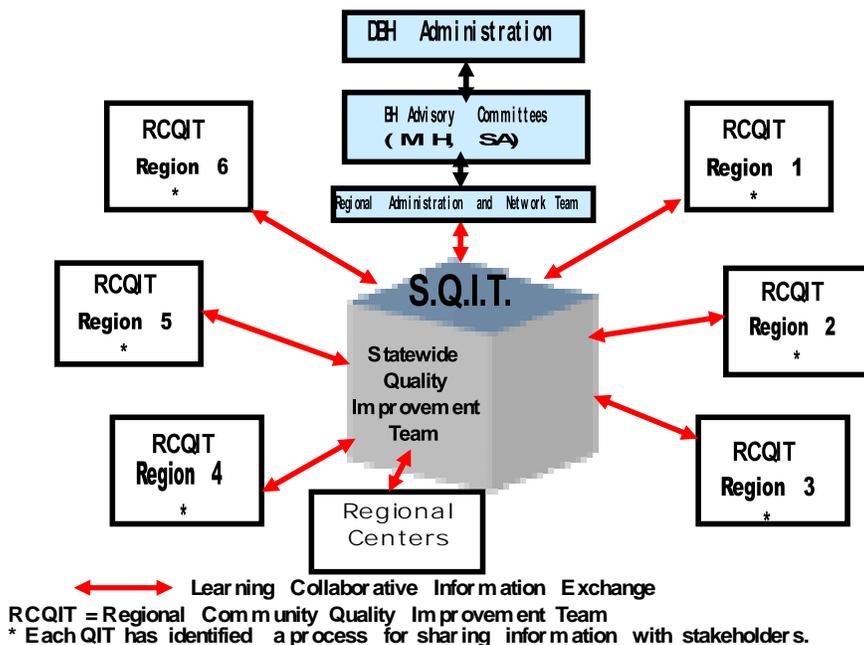
10 Quality Improvement Plan –Attachment: Quality Improvement Plan for FY2016-FY2017

**Section 2 Leadership and Organization**

**Leadership and Stakeholders:**

Leaders, through a planned and shared communication approach, ensure all stakeholders have knowledge of and participation in ongoing QI activities as a means of continually improving performance. Planned communication methods include posting QI information on the DHHS-DBH public website.

The CQI process must be stakeholder driven. Stakeholders include Consumers and Families, DBH Administration and Staff, Consultants, Regional Staff, Regional Centers, Service Providers, Advocacy Groups and Office of Consumer Affairs Participants, DHHS Partners, etc. Working Relationships are pictured and described below.



*10 Quality Improvement Plan –Attachment: Quality Improvement Plan for FY2016-FY2017*

**Division of Behavioral Health Administration** – The DBH Director and Deputy Director establish and communicate priorities for the annual plan and review feedback from stakeholders in the reporting structure.

**Behavioral Health Advisory Committees (MH & SA)** - Contributes to the development and implementation of the Annual CQI Plan and activities. The committees meet quarterly and as needed for special topics.

Membership includes but is not limited to:

- Consumers and Families
- Providers
- Regional Staff
- Justice/Law Enforcement
- DHHS Partners
- Community Stakeholders

The responsibilities include:

- Receiving information from DBH Administration
- Advising DBH and S.Q.I.T. on the development of the CQI Plan and activities
- Providing input into the creation of quality improvement initiatives
- Assisting in the development of education and communication processes
- Serving as Consultants to DBH representing various viewpoints and concerns
- Reviewing CQI reports and making recommendations
- Assessing Consumer and Family satisfaction survey and other results

**Regional Administrator and Network Management Team (NMT) Meetings** - Ensure that quality improvement processes are operationalized and prioritized at the community team level. Regional Administrators meet regularly with DBH Administration and the NMT is held quarterly.

Membership includes:

- Regional Administrators
- DBH Team
- Network Team

The responsibilities include:

- Reviewing information from DBH Administration, Advisory Committees
- Providing leadership to the R.C.Q.I.T.
- Assessing recommendations received from R.C.Q.I.T and S.Q.I.T and proposing action
- Reviewing reports, making recommendations for change and ensuring action with R.C.Q.I.T. as needed
- Providing technical assistance to the R.C.Q.I.T. regarding DBH quality initiatives

*10 Quality Improvement Plan –Attachment: Quality Improvement Plan for FY2016-FY2017*

**Statewide Quality Improvement Team (S.Q.I.T.)** - Primarily responsible for the identification and prioritization of opportunities for regional/community improvement, quality initiatives and development of the annual plan. 50% of voting membership should have a disclosed lived behavioral health experiences.

Membership includes:

- Office of Consumer Affairs Representatives
- Regional Staff
- Consumer Specialists and other Consumer / Family Members
- Providers
- Regional Center Staff

Consultants include:

- Magellan Staff
- DHHS Partners (Medicaid and CFS)
- DBH Staff

Responsibilities of SQIT include:

- Revising the Annual QI Program Plan
- Evaluating the effectiveness of the QI Program each year
- Monitoring quality improvement activities of the R.C.Q.I.T.
- Recommending system-wide corrective actions for improvement
- Offering recommendations on policies, procedures, service definitions, data quality
- Analyzing results of Consumer, Family and other satisfaction surveys or studies
- Ensuring adequate training exists to support the QI Program
- Ensuring communication of S.Q.I.T. activities to the agency/organizations/individuals the member represents
- Evaluating and monitoring RBA State Priorities

**Regional Community Quality Improvement Teams (R.C.Q.I.T.)** - Contributes to the development and implementation of local QI activities as it relates to local needs and the DBH CQI Program Plan. Meetings are held on a regular basis.

Membership includes:

- Consumers
- Regional Staff
- Providers
- Other Community Stakeholders

*10 Quality Improvement Plan –Attachment: Quality Improvement Plan for FY2016-FY2017*

Responsibilities of R.C.Q.I.T. include:

- Bringing community stakeholders together to participate in quality improvement activities
- Developing, implementing and monitoring the community QI Program
- Ensuring data collection and information are used to manage and improve service delivery at the local level
- Providing ongoing information about performance and improvements to persons served
- Supports accreditation processes and compliance with contracts and DBH regulations
- Audits and reviews findings of service providers on an annual basis
- Evaluating and monitoring RBA State Priorities

**Tuesday Data Calls** - Review data and progress towards RBA to ensure that quality improvement processes are operationalized and prioritized at the community and state level. Calls are held twice a month.

Membership includes:

- Regional Staff
- Regional Centers
- DBH Data/QI and Network Staff
- Office of Consumer Affairs Representatives

The responsibilities include:

- Reviewing data from DBH and Region drill-downs
- Assessing data collection processes and data quality in Centralized Data System
- Providing leadership and clarification to the R.C.Q.I.T.
- Assessing recommendations received from R.C.Q.I.T and S.Q.I.T and proposing action related to data performance
- Reviewing reports, providing education webinars, making recommendations for change and ensuring support for RBA progress

**CQI Statewide Learning Collaborative** - In conjunction with the DHHS-DBH Continuous Quality Improvement Plan for FY16, a formation of a statewide learning collaborative with DBH, the six Regions across Nebraska and the three State Regional Centers will be formed. The collaboration of these system partners supports working together in collaboration, creating a system of coordinated services to better meet the needs of consumers and families and supporting our providers.

The collaborative will utilize an “all teach-all learn” philosophy to work collaboratively, holding ourselves accountable to delivering the highest quality services to the community and to our State’s consumers and families in a cost effective manner utilizing Results-Based Accountability (RBA) and the Plan, Do, Study, Act (PDSA).

*10 Quality Improvement Plan –Attachment: Quality Improvement Plan for FY2016-FY2017*

Results-Based Accountability (RBA) will provide an opportunity for the State, Regions, Regional Centers and providers to measure whether consumers are better off as a result of the services. RBA is a disciplined way of thinking and taking action that communities can use to improve the lives of those we serve. RBA will allow a consistent, statewide, data-driven approach to quality improvement.

CQI is ultimately about learning. It is about delving into details, doing PDSA's and continuously making improvements. Challenging ourselves to be accountable to delivering the highest quality services to the State's consumers, families and community. Working together in collaboration creates a system of coordinated services to better meet the needs of individuals and families.

The collaboration will support educational webinars quarterly with topics chosen as a group. An all-day Spring Event will be held to allow for DBH Staff, Regions and Regional Centers to come together for collaboration, sharing of their data stories, celebration of success as well as inviting providers, community partners and stakeholders to join. The collaborative will work together to plan and coordinate the event.

### **Section 3**

### **Annual Goals**

**QI Program Goals for FY16/17 include:**

1. Implementation of Results-Based Accountability (RBA) across the Regions and State.
2. Review data utilizing the RBA framework and PDSA to drill and tell the story behind the data.
3. Design and implement new data templates to more readily understand and have a process for telling the story behind the data.
4. Implement a Learning Collaborative with DBH, Regions and Regional Centers for collaboration between system partners working together to be accountable to delivering the highest quality services to the State's consumers, families and communities.

*10 Quality Improvement Plan –Attachment: Quality Improvement Plan for FY2016-FY2017***Section 4 RBA Performance Measurement**

Data collected will be utilized to evaluate each of the following areas with particular interest on co-occurring disorders, trauma, prevention, and recovery.

**FY16 DBH State Priorities****Result – Statewide Population**

*Definition: A condition of well-being for children, adults, families, or communities.*

**1. Nebraskans are physically and emotionally healthy.****Indicators - Statewide Population**

*Definition: A measure which helps quantify the achievement of a result.*

**1. Decrease in substance use:**

- Binge drinking 12-17<sup>1, 2</sup>
- Binge drinking 18+<sup>1</sup>/19+<sup>3</sup>
- Marijuana use 12-17<sup>1, 2</sup>

**2. Decrease in Nebraskans needing involuntary emergency inpatient care:**

- Involuntary hospitalizations through EPC admissions<sup>4</sup>
- Mental Health Board commitments<sup>4, 5</sup>

**Performance Measures – Region/Program Level**

*Definition: A measure of how well a program, agency, or service system is working.*

**1. How well do we do it?**

- % positive response to general satisfaction with services received<sup>6</sup>
- % positive response to staff sensitive to trauma<sup>6</sup>
- % programs with improvement in trauma informed scores<sup>7</sup>
- % programs with improvement in co-occurring capable/enhanced scores<sup>8</sup>
- % consumers discharged with treatment completed status<sup>4</sup>

**2. Is anyone better off?**

- #/% positive response to improved QOL<sup>6</sup>
- #/% positive response to improvement in symptoms<sup>6</sup>
- Average # days / % of consumers who binge drank in last 30 days<sup>6</sup>
- #/% decrease in substance use<sup>4</sup>

**Data Sources:**

<sup>1</sup> National Survey on Drug Use and Health

<sup>2</sup> Youth Risk Behavior Survey

<sup>3</sup> Young Adult Alcohol Opinion Survey

<sup>4</sup> Provider Entered Treatment Data

<sup>5</sup> Electronic Commitment Reporting Application

<sup>6</sup> Consumer Survey Data

<sup>7</sup> Trauma-Informed Program Self-Assessment Scale by Fallot and Harris

<sup>8</sup> COMPASS-EZ™ by ZiaPartners, Inc.

*10 Quality Improvement Plan –Attachment: Quality Improvement Plan for FY2016-FY2017***Section 5****Emergencies & Critical Incidents**

**Emergencies & Critical Incidents** - The Division of Behavioral Health’s approach to addressing emergencies and critical incidents is covered in the Nebraska Behavioral Health All-Hazards Disaster Response and Recovery Plan. The purpose of this plan is to provide a framework for organizing the behavioral health response to emergencies, critical incidents, other high profile events and disasters in Nebraska. This plan addresses mental health and substance abuse issues which may follow these sudden, tragic, unexpected events. These behavioral health services can help mitigate the severity of adverse psychological reactions to these tragic and unexpected events by helping to restore social and psychological functioning for individuals, families, and communities. Emergencies, critical incidents and other high profile events may or may not be considered a “disaster.” However, the plan was developed to provide enough information to guide decision making even if it is a localized event not rising to the level of a state disaster declaration. DBH has developed and maintained relationships with other state officials who have disaster duties, a hotline provider and Behavioral Health Regions’ disaster coordinators. Each Regional Behavioral Health Authority has prepared volunteers to assist survivors, responders and communities through the application of “psychological first aid.” These volunteers are managed locally in accordance with plans developed and maintained by each Region.

DBH participates in and supports the Behavioral Health Emergency Response Team (BHERT) and the Risk Communication Cadre as part of its preparedness activities. These are two of the formal State Resources available if needed when emergencies, critical incidents, high profile events or disasters strike. BHERT is a mechanism for organizing and deploying state disaster behavioral health resources. The primary value of the team to local areas is rapid deployment of behavioral health personnel experienced in disaster-related community needs assessment, coordination of resources, and training. BHERT is also a resource for state-run facilities under emergency response operations.

Risk Communication Cadre is a pool of behavioral health professionals with competency in risk communication, risk assessment, and public information. The Risk Communication Cadre is identified jointly by the Division of Behavioral Health and Department of Health and Human Service’s Public Information Officers. These professionals will assume the role of consultants to State Public Information Officials (PIO’s). The group meets regularly with PIO’s to craft messages with behavioral health content for use in all phases of disaster. For more information on the Nebraska Behavioral Health All-Hazards Disaster Response and Recovery Plan see: <http://www.disastermh.nebraska.edu/resources/currentplan.php>.

*10 Quality Improvement Plan –Attachment: Quality Improvement Plan for FY2016-FY2017***Section 6****Complaints & Grievances**

**Complaints & Grievances** - Consumers must be able to freely voice complaints and recommend changes without being subject to coercion, discrimination, reprisal, or unreasonable interruption of care, treatment, and services. DBH has included procedures for complaints and grievances within the Nebraska Administrative Code (NAC) Title 206 regulations. The Mental Health Commitment Act also provides for the individual rights of persons subject to a Mental Health Board (MHB) hearing:  
[http://dhhs.ne.gov/behavioral\\_health/Pages/beh\\_commit\\_commit.aspx](http://dhhs.ne.gov/behavioral_health/Pages/beh_commit_commit.aspx).

The DBH relies upon its requirement for enrolled providers to maintain national accreditation as one means for assuring the protection of consumer and family rights. The standards of the national accreditation bodies require consumer and family rights protection and grievance processes. Each provider must establish a written consumer grievance policy with the following components:

1. Consumers and as applicable, their legal representative(s) and family of their choosing must be informed of and given a copy of written procedures for addressing and resolving grievances established by each provider (see consumer rights in 206 NAC 6-001);
2. Consumers, families, staff, and others must have access to the provider's grievance process;
3. The consumer's grievance must be responded to by the provider in a timely manner and the provider must document its response to the consumer;
4. If the consumer's grievance is not addressed satisfactorily through the provider's complaint process, the provider must give adequate information, including telephone numbers and addresses, to the consumer to enable the consumer to contact the Division of Behavioral Health, Office of Consumer Affairs; the Division of Public Health, Facility Complaint Intake and the Investigations Section, the designated Protection and Advocacy organization for Nebraska; the Consumer Specialist of the Regional Behavioral Health Authority (RBHA); the office of the Ombudsman; the Department's System Advocate, and the vendor who is contracted for system management. This information must also be readily available to consumers, families, staff, and others. More information on processes and standards for response to complaints and grievances can be found in regulations:  
[http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health\\_and\\_Human\\_Services\\_System/Title-206/Chapter-06.pdf](http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-206/Chapter-06.pdf).

*10 Quality Improvement Plan –Attachment: Quality Improvement Plan for FY2016-FY2017*

**Appendix 1**

**Plan-Do-Study-Act (PDSA) Model**

**Plan – Plan for a specific improvement activity**

- Recognize opportunity for improvement
- What are the issues?
- Plan a change – who, what, when
- Determine how change will be measured

**Do - Do carry out the plan for improvement**

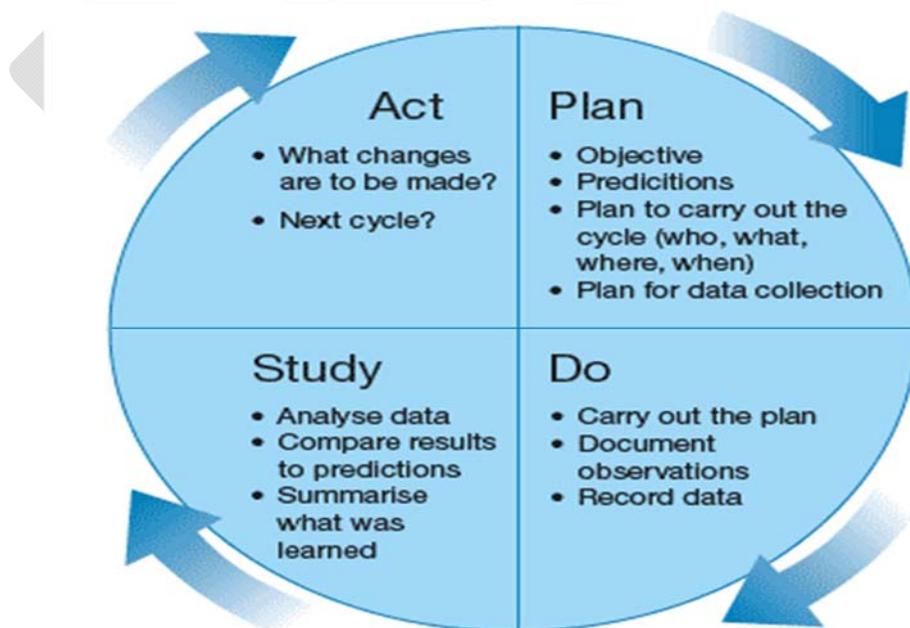
- Gain approval and support of the selected improvement solution
- Implement the improvement solution
- May use a trial or pilot implementation
- Document observations and data

**Study - Study the data and determine results**

- Data is analyzed to compare the results of the new process with those of the previous one
- Check for improvement and results
- What was learned?

**Act – Action for full implementation or reject and try again**

- Take action based on what was learned
- Adopt the solution formally as needed, develop policy, etc.
- If there is no improvement refine/revise the solution
- If successful, take action to ensure ongoing improvement



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**Appendix 2**

## The RBA “TURN-THE-CURVE” TEMPLATE

*This template is an overview of the step-by-step RBA “turn-the-curve” decision-making process.*



**1 What is the “end”?**

*Choose either a result and indicator or a performance measure.*



**2 How are we doing?**

*Graph the historic baseline and forecast for the indicator or performance measure.*



**3 What is the story behind the curve of the baseline?**

*Briefly explain the story behind the baseline: the factors (positive and negative, internal external) that are most strongly influencing the curve of the baseline.*



**4 Who are partners who have a role to play in turning the curve?**

*Identify partners who might have a role to play in turning the curve of the baseline.*



**5 What works to turn the curve?**

*Determine what would work to turn the curve of the baseline. Include no-cost/low-cost strategies.*



**6 What do we propose to do to turn the curve?**

*Determine what you and your partners propose to do to turn the curve of the baseline.*

The *Results-Based Accountability™ Guide* uses and is based upon concepts and materials developed by Mark Friedman, author of *Trying Hard is Not Good Enough* (Trafford 2005) and founder and director of the Fiscal Policy Studies Institute.

## 11. Trauma

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### C. Environmental Factors and Plan

#### 11. Trauma

Trauma<sup>75</sup> is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed, that is, based on the knowledge and understanding of trauma and its far-reaching implications.

1. Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?
2. Describe the state's policies that promote the provision of trauma-informed care.
3. How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?
4. Does the state provide trainings to increase capacity of providers to deliver trauma specific interventions?

The Division of Behavioral Health (DBH) has created a public policy statement to promote the provision of Trauma-Informed System of Care which describes our commitment to transform publically funded systems by strengthening the understanding of the broad effect of trauma, including safety, on the lives and communities of all Nebraskans. The State of Nebraska is committed to infusing trauma informed awareness, knowledge and skills into the organizational cultures, practices and policies that impact the system of care for children and adults.

DBH has included definitions and language in the regulations to support trauma-informed care and provide clarity in expectations related to psychological trauma, trauma-informed services and coordination of a trauma-informed system. More on regulation can be found at:

[http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health and Human Services System/Title-206/Chapter-06.pdf](http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health%20and%20Human%20Services%20System/Title-206/Chapter-06.pdf)

The DBH believes that all system of care stakeholders and providers:

- a) Understand their role and capacity to ensure trauma-informed responses in every interaction with children, adolescents and adults;
- b) Are informed about the effects of psychological trauma and ensure agency wide commitment to a trauma-sensitive environment;
- c) Ensure staff at every level is equipped with appropriate competencies to effectively address trauma;
- d) Ensure that early assessment for trauma occurs utilizing research based strategies;
- e) Ensure that all consumer interactions and services are recovery-oriented and trauma-sensitive; and
- f) Understand that re-traumatization may occur if safe, effective, responsive services and practices are not available.

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Through the Division of Behavioral Health (DBH) Regional Budget Plan (RBP) Guidelines and contracts with the six Regional Behavioral Health Authorities (RBHAs), it is expected that providers connect individuals with trauma histories to trauma-focused therapy. Expectations set include that network development and coordination across each Region network must develop and implement strategies to ensure that all behavioral health providers are informed about the effects of psychological trauma, consistently screen for trauma symptoms and history of traumatic events, provide ongoing assessment of trauma symptoms and problems related to that trauma, offer services that are recovery oriented and trauma sensitive and are made aware that re-traumatization may occur if safe, effective, responsive services are not available.

DBH directs providers to screen clients for a personal history of trauma. However, disclosure of trauma by consumers takes a trusting relationship and may not be at time of admission. Respecting consumer disclosure, trauma screening information may be available at admission and is required at discharge and is updated at the time of the annual registration. Aggregate, de-identified data is shared quarterly with the Regional Behavioral Health Authorities (RBHAs) and providers to identify gender and age specific trauma trends, training needs, and trauma specific service considerations. The DBH uses the philosophy of screening as a universal precaution. It is the expectation not the exception. When screenings were initiated, the DBH provided specific instructions to providers about the process of screening which was based on the Harris and Fallot Universal Trauma Screening Guidelines (2001). Key principles include being aware of the individual's needs, strengths and vulnerabilities prior to the screening, and using the screening as early as possible in the assessment process.

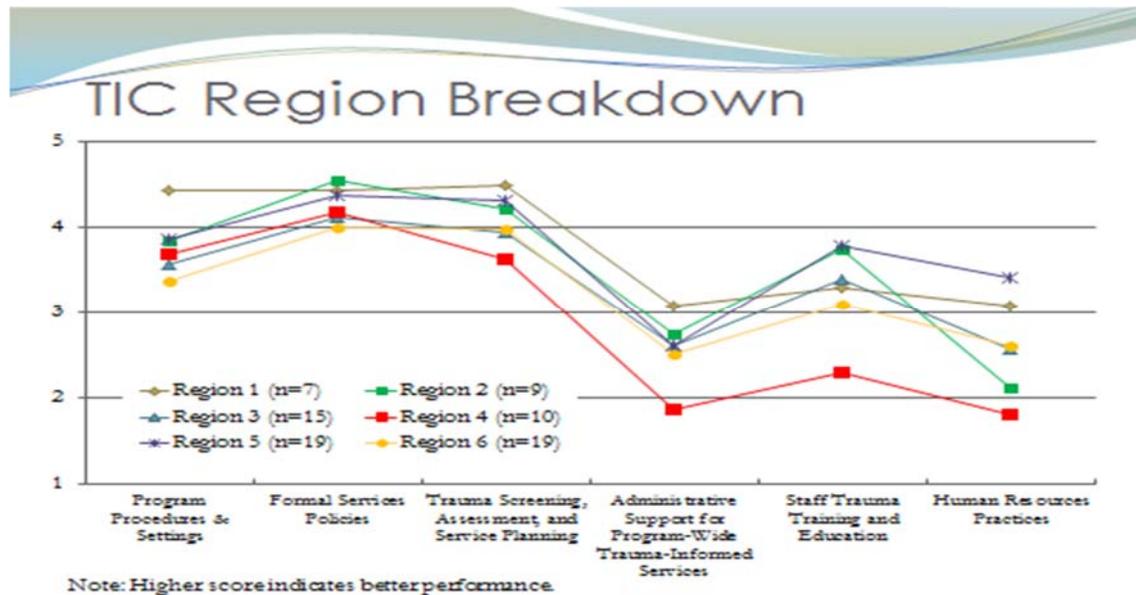
RBHAs must also annually submit a list of the number of the trauma specific services that providers have available, to support consumer choice in selecting trauma services. Over the last few years, the DBH noted a range of services listed as trauma specific. A repository was developed and placed on our Network of Care website.

[http://dhhs.ne.gov/behavioral\\_health/Documents/FY15TraumaInformedDec2014.pdf](http://dhhs.ne.gov/behavioral_health/Documents/FY15TraumaInformedDec2014.pdf)

The DBH Strategic Plan requires effectiveness and specifies a continuous quality improvement (CQI) process for services funded by the DBH, focusing on a number of factors including trauma. Providers were trained on the Harris and Fallot TIC tool and required to complete the self/peer assessment in 2013. Results of the 2013 TIC self/peer assessment are as follows:

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After the Trauma-Informed Care (TIC) was completed in 2013, results were reviewed and strengths for continued growth as well as opportunities for improvement were reviewed. Focus has been aimed at improvement in consideration of trauma across all service components including but not limited to: Program Procedures and Settings; Formal Service Policies; Trauma Screening, Assessment, and Service Planning; Program Procedures and Settings; Administrative Support for Program-Wide Trauma-Informed Services; Human Resources Practices; and Staff Trauma Training and Education. A reassessment using the TIC tool was required in FY2015. Results of the reassessment are to be submitted to the DBH by August 1, 2015 so that analyses can be conducted for continuation of improvement efforts and training.

DBH also promotes Trauma Informed Care through a statewide initiative to promote trauma-informed care, Trauma Informed Nebraska (TIN). The purpose of TIN is to promote the development and implementation of a statewide, consumer-driven, recovery-oriented, trauma-informed system that ensures all behavioral health providers are informed about the effects of psychological trauma and are aware of the origin and effects of trauma on survivors. Through TIN, the DBH, and the Behavioral Health Education Center of Nebraska (BHECN), hundreds of trainings called Trauma 101 and Recovery, have been completed over the last several years. A train the trainer process was established to ensure there is ongoing training throughout the state. Trauma 101 and Recovery includes: Introductions/Opening Exercise; Define PTSD and Trauma; Trauma Informed and Trauma Specific; Symptoms of PTSD/Triggers; ACES Study/Survey/Applications; Screening; Healing Neen Video; PTSD and Substance Use Disorder; Memory and Trauma; Creating Safe Environments; Vicarious Trauma – Exercise; Treatment Approaches; Trauma/Addiction/Recovery; Resources.

Trauma educational opportunities and resources about trauma specific services are not uncommon. Materials on Seeking Safety, PCIT and TF-CBT are examples. Nebraska has had a number of providers and RBHAs involved in the National Learning Community on trauma. Excellent training material and resources have been shared.

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RBHAs have sponsored and funded training for provider EBP training for PCIT and TF-CBT which are trauma specific services. DBH and the Lasting Hope Recovery Center sponsored an Intergenerational Trauma conference. Regional Trauma Informed Care Team (RTIC) work with providers on providing trauma trainings. Trauma Champion teams continued their work and planned staff care and community partner trainings. Some examples of training done across the Regions are: Compassions Fatigue Training, Sharon Wise Training, Trauma Informed Care, Motivational Interviewing.

Nebraska's Statewide Behavioral Health Conference, "Success, Hopes and Dreams" is an annual behavioral health conference focused on strengthening individuals, youth and families, and the system to be responsive to the voice of individuals, youth and families. The conference provides training opportunities in various SOC topics, such as Consumer inclusion, advocacy and education; Behavioral health for children and families; Emerging trends in behavioral health; Integration and collaboration of services; Peer support and peer-run services; Recovery, individual wellness, and growth; Trauma and trauma informed care.

A Transformation Transfer Initiative (TTI) grant opportunity helped with the creation of the web based resource: [www.dhhs.ne.gov/trauma](http://www.dhhs.ne.gov/trauma). Additionally through this project an overview of current trainings is posted to the Office of Consumer Affairs webpage and facilitators were trained in the Trauma Informed Peer Support Model.

DBH places great importance on continuing the strengthening of partnerships to help address trauma needs system wide. In 2014/2015, BHECN entered into a contract with several divisions within Department of Health and Human Services, including DBH, to coordinate implementation of trauma informed care training and services. Lead staff from Divisions are asked to participate in a Steering Committee to offer input to create a trauma informed care core training curriculum and develop further recommendations for trauma informed care across the department. BHECN partnered with Raul Almazar, a consultant with SAMHSA who has extensive experience working with communities and state departments across the country on trauma informed care. Raul assisted BHECN in developing the project deliverables that will take place over the course of the contract. The result will be the development of a core curriculum on trauma and trauma informed care to be utilized for all staff within each division, the development a page on the BHECN website dedicated to trauma informed care resources, and trauma informed care and compassion fatigue training across divisions.

There is no area of technical assistance need identified at this time as DBH is utilizing the technical assistance delivered by BHECN.

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## C. Environmental Factors and Plan

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Expansions in insurance coverage will mean that many individuals in jails and prisons, who generally have not had health coverage in the past, will now be able to access behavioral health services. Addressing the behavioral health needs of these individuals can reduce recidivism, improve public safety, reduce criminal justice expenditures, and improve coordination of care for a population that disproportionately experiences costly chronic physical and behavioral health conditions. Addressing these needs can also reduce health care system utilization and improve broader health outcomes. Achieving these goals will require new efforts in enrollment, workforce development, screening for risks and needs, and implementing appropriate treatment and recovery services. This will also involve coordination across Medicaid, criminal and juvenile justice systems, SMHAs, and SSAs.

1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?

No. Nebraska is not a Medicaid expansion state so coverage expansion has not occurred.

2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?

A variety of programs have been established throughout Nebraska with the goal of enhancing law enforcement's response toward individuals with mental illness and/or substance use disorders. Screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders. The Division of Behavioral Health (DBH) is using the Sequential Intercepts for Change.

Intercept 1 - Law Enforcement/ Emergency services

Intercept 2 - Initial detention/Initial court hearings

*Intercept 1 – Training to Law Enforcement*

**Crisis Intervention Team:** In Omaha, a Crisis Intervention Team (CIT) model was developed and adopted as a cooperative community partnership involving law enforcement agencies, mental health service providers, mental health consumers, family members, and community funders. Through participation in this program, CIT police officers learn to recognize common forms of mental illness and to utilize the most effective means of communicating with people undergoing crisis. The officers are trained to de-escalate the individuals in crisis and allow the consumer to participate in the decision-making regarding their treatment. CIT officers must successfully complete 40 hours of training to become certified. To learn more about the Heartland Crisis Intervention Team program see The Kim Foundation website at:

[http://www.thekimfoundation.org/html/edu\\_training/crisis-intervention.html](http://www.thekimfoundation.org/html/edu_training/crisis-intervention.html)

**Behavioral Health Threat Assessment** (BETA): Region V Systems and the Lincoln Police Department provide Behavioral Health Threat Assessment (BETA), a 40-hour advanced training designed to assist Nebraska law enforcement personnel to obtain better outcomes when working on issues involving persons with mental illness. The training is also open to behavioral health professionals. This training includes advanced mental health training (such

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as how to identify and describe signs and symptoms of mental illness), systems issues, and how to conduct a basic threat assessment. There will be heavy involvement in the training by consumers of mental health, helping students learn to connect at several levels and improve positive outcomes between law enforcement and people who have mental health problems. For more information on BETA see the website at:

<http://www.region5systems.net/trainings>

**Behavioral Health/Rural Law Enforcement Training Videos** are designed to better equip law enforcement officers to respond to persons in a mental health crisis by training them to recognize signs and symptoms of mental illness; understand mental illness and its impact on the lives of the people it affects; develop de-escalation techniques which they can use when encountering an individual with a mental health crisis; and how to connect persons to appropriate community-based behavioral health services. The key message was two-fold:

1. Give officers a sense of what a person with a mental health crisis would act and sound like, and
2. Give the officers a set of techniques they can use to de-escalate the crisis.

The video series uses experts from law enforcement and behavioral health to describe a likely scenario and the techniques, combined with 3 demonstration scenarios depicting how an individual experiencing Psychosis, Depression, or Mania would likely act and sound, and how an officer uses the de-escalation techniques. Other videos in the training series explain the resources available to the officers. For more information see:

[http://dhhs.ne.gov/behavioral\\_health/Pages/beh\\_video\\_09.aspx](http://dhhs.ne.gov/behavioral_health/Pages/beh_video_09.aspx)

*Intercept 1*

**Crisis Response Team:** This is a statewide service pairing mental health professionals and emergency community support staff providing law enforcement with expert consultation and resources. This is designed to prevent custody relinquishment for behavioral health consumers when less restrictive measures will promote safety and allow access to services

**Problem-Solving Courts:** Within the Nebraska Judicial Branch is the Problem-Solving Court which includes Adult Drug Courts, Juvenile Drug Courts, Family Drug Courts, Young Adult Court, and Driving Under the Influence (DUI) Court. These Problem-Solving Courts seek to promote outcomes benefiting not only the offender, but also the victim and society as well. Studies show these types of courts are having a positive impact on the lives of offenders and victims and in some instances are saving jail and prison costs. For more information on Problem-Solving Courts see: <http://www.supremecourt.ne.gov/5250/problem-solving-courts>

*Intercept 2*

Regional Behavioral Health Authorities have developed specialized screening and services provided for individuals with mental and/or substance use disorders within their respective Networks.

Region 3 – Behavioral Health funds screening services in both the Adams and Buffalo County Jails. These screenings are completed by a team of individuals including: jail booking personnel, nursing, community-based case manager, Licensed Mental Health

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Practitioner (LMHP) and possibly a Psychiatrist or an Advanced Practice Registered Nurse (APRN). Screening in both jails begins as part of the booking process for the individual and if flagged passes through a several tiered screening to ensure inmates with mental health and/or substance abuse immediate safety needs are met. Inmates are further screened to assess their recovery needs and, if possible, how those needs can be met within the jail and upon discharge to the community. A Crisis Response Therapist is available for crisis evaluations, 24/7 through a contracted service. Inmates can also be evaluated through telemedicine for medication management with a community based Psychiatrist or an APRN, based on the recommendation of team.

Region 5 – Lancaster County Community Corrections offers in custody and out of custody screening for Felony and Misdemeanor Pretrial Release and/or Mental Health Jail Diversion, and Misdemeanor Veteran’s Diversion programs. These programs offer: 1) intensive supervision with electronic monitoring, when required, 2) random drug and alcohol testing, 3) case management services to address basic needs 4) employment or vocational rehabilitation, and 5) pretreatment assessment and diagnosis for psychiatric intervention. This includes the Matrix Model Substance Abuse intervention treatment to program participants (Drug Court, pretrial and Mental Health Jail Diversion). It is a 16-week Intensive Outpatient Program (IOP) with a 32-week aftercare services. It is an evidence based program endorsed by SAMHSA and the National Drug Court Association. For more information on the Matrix Model see SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP): <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=87>

Region 6 - Behavioral Health funds the Intensive Case Management (ICM) services in Douglas County, Sarpy County and Washington County county jails. Target population of the service is transition age youth, 18 through 25 years of age. At time of booking, individuals are screened for multiple risk factors such as mental illness, substance use, homelessness, and related areas. Potential participants are identified through this process. A face to face meeting is then conducted with the potential participant to introduce ICM and develop a collaborative and individualized treatment plan. If issues arise while in county jail the staff can call upon the psychiatrist (if available to the specific county) to evaluate the inmate.

**Fee for Service Voucher Program:** Many criminal offenders do not have the financial ability to pay for their own rehabilitative programs. The Fee for Service Voucher Program was created to reduce the financial barriers of specifically identified offenders receiving substance abuse treatment through a financial assistance program. Vouchers are not intended to supplant other means of financial assistance for offenders, but instead as a resource available to parole and probation officers for offenders when a need exists. Whenever possible, offenders are expected to contribute toward the financial obligations associated with evaluations and treatment. Services provided for by the Fee for Service Voucher Program include Substance Abuse Evaluations, Outpatient Treatment, Intensive Outpatient Treatment and Short-Term Residential Treatment. The Fee for Service Voucher program is funded through a combination of general funds and offender fees. The voucher program is administered by the Office of Probation Administration. As of July 1, 2009, the target

population eligible for vouchers includes Felony Drug Offense Offenders, Parole Offenders, Felony Offenders under Sanction or Violation Status, Class I Misdemeanor Drug Offense, and 3rd Offense DUI and Felony DUI.

3. Do the SMHA and SSA coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?

The Nebraska Behavioral Health Services Act designates the Division of Behavioral Health (DBH) as the chief Behavioral Health Authority for the State of Nebraska [§71-806 (1)]. The DBH serves as both the State Mental Health Authority (SMHA) and the State Substance Abuse Authority (SSA). The DBH supports the development of programs for the diversion of individuals with mental and/or substance use disorders when appropriate. Network system coordination efforts are described below.

### **Regional Behavioral Health Authority**

#### **Region 1-Scottsbluff, Kimball, Cheyenne, Dawes Counties:**

Behavioral Health staff from the service programs of Emergency Community Support, Community Support MH/SA and the Professional Partner Program visit monthly with individuals at the Scotts Bluff County Detention Center, and to give presentations of available service options. Through jail staff, individuals interested in seeking services request appointments with behavioral health program staff to initiate the service enrollment process in preparation for their transition from jail into the community of their choice. The success of the Scotts Bluff County Detention Center's program spurred behavioral health professionals in Kimball and Cheyenne Counties to initiate the program in respective jails.

Crisis Response services for an individual in jail, specifically regarding MH/SA assessment, have been utilized at the Scotts Bluff County Detention Center.

In Dawes County, the Crisis Rapid Response Emergency Community Support Specialist responds after the Crisis call, and meets with the individual in jail to develop a plan in preparation for this person's release. The individualized plan can include Emergency Community Support, obtaining an identification card, a Social Security number, and referrals for assessment and/or other behavioral health services.

#### **Region 2- Arthur, Chase, Dawson, Dundy, Frontier, Gosper, Grant, Hayes, Hitchcock, Hooker, Keith, Lincoln, Logan, McPherson, Perkins, Red Willow, and Thomas Counties:**

Behavioral Health staff provided Mental Health and Substance Use education and training with law enforcement and county jail staff and, should an individual, or jail staff member on behalf of an individual, request behavioral health support, the Region responds.

Individualized services could include Emergency Community Support, Community Support, Outpatient Therapy, Crisis Assessment or any other service requested. Likewise, when an

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individual who is receiving services finds him/herself in jail, the Region becomes actively involved in the discharge process.

*Region 3 – Adams and Buffalo Counties:*

South Central Behavioral Services provides the Emergency Community Support services as well as therapy through their outpatient and crisis response contract with Region 3. Last year, Buffalo County served 33 individuals with discharge planning via Emergency Community Support services. Adams County served 28 individuals with discharge planning via Emergency Community Support services.

*Region 4 – Antelope, Boone, Boyd, Brown, Burt, Cedar, Cherry, Colfax, Cuming, Dakota, Dixon, Holt, Keya Paha, Knox, Madison, Nance, Pierce, Platte, Rock, Stanton, Thurston, and Wayne Counties:*

Behavioral Health staff from the service programs of Emergency Community Support and Community Support MH/SA coordinate with county jail staff to perform assessments as requested. Region 4 has a Behavioral Health provider that goes into the county jails and facilitates a mental health group.

Region 4 Emergency Coordinator communicates with the individual County Attorneys in regards to individuals who are currently in county jail regarding disposition of the individuals.

Region 4 Crisis Response teams are responsive to the needs of individuals incarcerated in the county jails and conduct crisis response assessments when the need is identified.

*Region 5 – Lancaster County*

As noted above, the programs offer a variety of services including: 1) intensive supervision with electronic monitoring, when required, 2) random drug and alcohol testing, 3) case management services to address basic needs 4) employment or vocational rehabilitation, and 5) pretreatment assessment and diagnosis for psychiatric intervention.

*Region 6 – Douglas, Sarpy, and Washington Counties*

Region 6 funds the Intensive Case Management program for transitional age youth 18-24 who are being released from a county jail. Region 6 is a member of the Douglas County Mental Health Diversion Advisory committee. Region 6 also participates in the monthly Douglas County Criminal Justice System Management Council. Region 6 works directly with the Board of Mental Health County attorney and jail staff when inmates become committed. The Region 6 emergency services behavioral health task force also has a standing agenda item for criminal justice behavioral health issues.

**Services Provided Correctional Facilities & the Reentry Process For Those Individuals**

The Nebraska Department of Correctional Services (NDCS) Behavioral Health program consists of about 130 professionals including psychiatrists, mid-level psychiatric providers, psychologists, mental health practitioners, social workers, nurses, and drug and alcohol abuse

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counselors. The focus is to provide clinical treatment services to the priority populations including those with severe mental illness, violent offenders, substance dependent offenders, and sex offenders.

Please note that the state prison system is different from the county jail system. Many people are arrested and sent to county jail facilities during the course of any given year, however only a very small percentage of this group go on to state prison. The general criteria for state prison is commission of a felony and having a sentence of one year or longer.

**Re-Entry Program:**

NDCS has focused on providing re-entry services for mentally ill inmates prior to release. Social workers help offenders plan to discharge and assist with identifying treatment resources, benefits, and housing. NDCS also works closely with the NDHHS Regional Behavioral Health Authorities regarding discharge planning for high needs cases. Utilizing a comprehensive form of case management, NDCS focuses on issues including substance abuse, mental health, housing, employment, education, mentoring, transportation, criminal thinking, vocational, and parenting/family reunification needs. NDCS partners with community based service providers including the NDHHS, the Department of Labor, along with faith-based prison ministries and other social service entities. NDCS partnered with Christian Heritage and secured a grant from the National Fatherhood Initiative to facilitate the successful family reunification program, InsideOut Dads, within the NDCS facilities. Additionally, through collaboration with the Reentry Alliance of Nebraska, inmates who are transitioning back into the community are partnered with a support group to help them be successful in the community. Successful reintegration of offenders back into society is the objective. NDCS believes forging these partnerships with the community best serves the interest of all Nebraskans. NDCS utilizes a formalized review process to make decisions related to inmate classification and programming.

**Regional Behavioral Health Authority Activities for the Population****Region 3 – Adams and Buffalo Counties**

Services the inmate is given or referred to in the community are trauma-informed, recovery-based, and focused on the individual needs of the inmate.

Initial diversion begins with prevention. Twenty three of local justice system stakeholders and providers from both the juvenile and adult system participated in GAINS/SAMSHA training, "How Being Trauma Informed Improves Justice Outcomes". These justice system stakeholders sit as part of the team doing the coordination, diversion, and communication regarding recovery services both within the jail and the community, and are based on team recommendations.

Region 3 Behavioral Health Services continues to provide training to the justice community and providers meeting as a system on a quarterly basis. Additional trainings have included partners from our justice system participating in risk assessment training provided by behavioral health/law enforcement experts. Region 3 has also provided trainings on the utilization of telehealth within jails and the benefits to inmate, community, and jail facility.

**Region 5 – Lancaster County**

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Program ensures care coordination and follow up with participants involved in the justice system programs for their personal needs and issues. Criminogenic factors are always taken into consideration when identifying support services and follow up care.

Staff in this department work closely with local providers and the court system daily. These cooperative relationships result in information sharing and are essential to success for the participants, as well as offering a seamless process for the Criminal Justice System.

#### Region 6 – Douglas, Sarpy, and Washington Counties

The Intensive Case Management program specifically addresses these issues in their goal setting and treatment planning.

Education is provided through the task force meetings in which law enforcement, jail staff, and legal staff participates. Jail staff also participates in Crisis Intervention Trainings presented by the Heartland Crisis Intervention Training Council where Region 6 is a member.

4. Are cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

Training and development collaborations include the Justice Behavioral Health Committee, the Youth Behavioral Health Services Stakeholder Committee, and Probation – Behavioral Health Regions Partnership Meeting.

#### **Justice Behavioral Health Committee**

The Justice Behavioral Health Committee's mission is to ensure integration, cooperation, and active communication between the justice system and treatment systems; substance abuse and mental health.

The Justice Behavioral Health Committee provides a venue for a collaborative working relationship between justice and treatment providers for the ultimate goal of effective competent client care. Our vision involves educational endeavors, data monitoring, provider competency, and strategic planning.

Expected Outcomes of this collaborative work includes:

1. Safer Community
2. Recidivism Reduction
3. Risk Reduction
4. Effective & Competent Client Care
5. Adherence to and expansion of the Nebraska Standardized Model.

Members serving on the Justice Behavioral Health Committee include representation from Nebraska's justice and behavioral health systems. Representation consists of:

1. The Chief of the Community Corrections Division of the Nebraska Commission on Law Enforcement and Criminal Justice
2. The Deputy Probation Administrator for Community Based Programs & Field Services
3. The Deputy Probation Administrator for Operations & IT Representative

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4. The Justice Behavioral Health Specialist, Probation Administration
5. Two Chief Probation Officers - one juvenile, one adult
6. The Executive Director of the Crime Commission or a permanent designee
7. The Statewide Coordinator for Problem-Solving Courts
8. A representative from the Department of Health and Human Services, Division of Behavioral Health
9. A representative from the Department of Health and Human Services, Division of Medicaid and Long Term Care
10. Two representatives from the Behavioral Health Regions
11. The Director of Children & Family Services or a permanent designee
12. Two Licensed Mental Health Practitioners – one must be on the LMHP Licensing Board
13. Two Licensed Alcohol and Drug Counselors – one must be on the LADC Licensing Board
14. A University Criminal Justice representative
15. The Parole Administrator or a permanent designee
16. A psychiatrist
17. The Department of Correctional Services Medical Director or a permanent designee
18. A representative from the Department of Correctional Services, Behavioral Health or Substance Abuse or a permanent designee
19. Two licensed psychologists – one must be from the HHS Regulation and Licensure Credentialing Division or Board of Psychologists
20. A County Attorney
21. A Criminal Defense Attorney
22. A Consumer
23. The Director of Consumer Affairs for Behavioral Health
24. A representative or designee from United States Probation
25. A representative or designee from United States Pretrial Services
26. A representative from a county based community corrections or behavioral health diversion program
27. A director of a private substance abuse treatment program treating justice clients
28. A registered service provider utilizing the standardized model with justice clients
29. The Department of Correctional Services Director of Research
30. Member at large. Not required to fill this position.
31. Member to represent the managed care behavioral health entity.

The co-chairpersons of the Justice Behavioral Health Committee shall be selected from the Members of the committee, through the nomination and ballot voting process. One of the co-chairs shall be a representative of the justice perspective and one shall be a representative of the behavioral health perspective. Each co-chair shall serve a term of three years. Co-chairpersons shall not both be elected in the same year, except in the event of extenuating circumstances of one of the serving co-chairpersons.

### **Youth Behavioral Health Services Stakeholder Committee**

A new workgroup was formed to explore how our systems can collaborate to improve outcomes for the youth we collectively serve. Stakeholders from the Divisions of Medicaid and Long Term Care, Children and Family Services, Behavioral Health, Magellan Behavioral Health and others were convened to look at the Assessment Process/Evaluation as prepared and delivered to the court, discuss roles, data sharing, successes, communication and other issues to strengthen the services provided to youth on probation.

### **Probation – Behavioral Health Regions Partnership Meeting**

The Division of Behavioral Health staff participate in the Probation – Behavioral Health Regions Partnership Meeting to increase the ability of the Regional provider networks to provide services which are designed to meet the needs of the criminal justice population. This includes development of a network of providers who can perform assessments addressing criminogenic

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needs and services for this population. At a meeting, the Division of Behavioral Health, Probation and RBHAs, the following information is presented and discussed:

- Processes for change would involve pooling resources: CFS, Medicaid, Probation, DBH, others
- The first pillar, INTAKE, would benefit from the expansion of mobile crisis teams for youth and families
- The second pillar, PRE-ADJUDICATION/INVESTIGATION, would benefit from development/availability of more high end evaluation, development of more telehealth capability; universality of evaluations is critical
- CASE MANAGEMENT probation officers need and will receive training on family centered practice to work with families; quantity of contact will no longer be mandated but focus on quality; officers receiving extensive training included tiers for supervisors; caseload sizes will be dictated by risk for offending
- RE-ENTRY needs Regional involvement to ensure services available upon release from youth detention; re-entry specialists have helped with transition; want to emphasize treatment instead of incarceration while youth are at the centers; community aid has been increased to assess needs and develop plans for diversionary system
- Emphasize partnerships, working together to determine needs, maximize funding streams and develop new services.
- Opportunities to access Multisystemic Therapy and Functional Family Therapy training to providers in Nebraska without the cost of building capacity for service being borne by the providers. These are evidence based practices to better serve youth/families with behavioral health needs.
- Encourage involvement of managed care early in process to avoid difficulties in payment methodologies that will not support the cost of the service.
- Development of a continuum of services rather than a one size fits all.

Work continues to build on the issues described above.

There is no area of technical assistance need identified at this time.

### 13. State Parity Efforts

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#### C. Environmental Factors and Plan

##### 13. State Parity Efforts

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders.

1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity?
2. Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?
3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?

##### *MHPAEA and Health Plans and Health Insurance Issuers*

The State of Nebraska is one of 27 States using the Federally-facilitated Marketplaces (FFM). The DBH, Nebraska Department of Insurance (DOI), and DHHS Division of Medicaid and Long Term Care (DHHS Medicaid) work with internal and external stakeholders to educate and raise awareness about parity. The DOI coordinates with the FFM both individually and through the National Association of Insurance Commissioners to ensure compliance and provide guidance to address frequently asked questions from stakeholders.

The ACA builds on MHPAEA and provides that mental health and substance use disorder services are one of ten essential health benefits categories. The DOI works with plans, issuers, and their service providers to help them understand and come into compliance with MHPAEA. The role of DOI is to review all of the plans that are proposed to be placed on the exchange to ensure that they are compliant with federal and state law. Next, the DOI determines whether or not the plan(s) submitted are Qualified Health Plans (QHP), which are the only plans eligible to be placed on the FFM. DOI also reviews the rates to ensure they are compliant with state requirements and are adequate considering the whole of the companies book of business.

These responsibilities of the DOI are administered by the following departmental divisions:

- The DOI Consumer Affairs Division investigates consumer complaints if there are deficiencies per consumers;
- The DOI Life and Health Division reviews policies for compliance; and,
- The DOI Market Conduct Division examines companies to assure compliance with the insurance code. If violations are found, the legal division initiates administrative actions against the carrier.

##### *Consumer Assistance for the Health Insurance Marketplace*

The DOI continues to engage in significant public outreach events to improve consumer knowledge about parity. Presentations to diverse audiences, including the Nebraska Behavioral Health Advisory Council, provide information regarding parity requirements of the ACA and MHPAEA.

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And, DOI utilizes communication and information mechanisms targeting consumers that are consumer friendly and easily accessible. For example, DOI has developed online tools to allow for consumer-friendly searches that allow users to search for information about their options and where they can find assistance. Consumers are able to share, print, and download informational materials about services, assistance and (re)enrollment.

- DOI developed and maintains an informational [website](#) about the marketplace, including a glossary of terms, frequently asked questions and details about options for individuals and small businesses under the ACA and MHPAEA;
- DOI has a Facebook page with updates and information about the FFM;
- DOI has created a registration database of [Registered Navigators](#) and [FFM: Registered Agents and Brokers](#) available to assist consumers and provides these listings on its website.

Nebraska does not operate a Consumer Assistance Programs under the ACA, however the DOI requires Navigators and other consumer assistance entities receiving federal money for assistance activities to register with the state. DOI is utilizing the registration database to operate and maintain an easily accessed online resource for consumers, supporting Navigators' public education efforts, distribution of information, and referrals to consumer assistance offices. Navigator entities in Nebraska are the Community Action Partnership Nebraska and the Ponca Tribe of Nebraska.

Technical Assistance Request: With the anticipated release of the "Mental Health Parity Tool" by the Centers for Medicare and Medicaid Services in 2016, the availability of technical assistance on the application of the tool would be beneficial.

*14. Medication Assisted Treatment*

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**C. Environmental Factors and Plan*****14. Medication Assisted Treatment***

There is a voluminous literature on the efficacy of FDA-approved medications for the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for medication-assisted treatment of these disorders is described in SAMHSA TIPs 4085, 4386, 4587, and 4988. SAMHSA strongly encourages the states to require that treatment facilities providing clinical care to those with substance use disorders be required to either have the capacity and staff expertise to use MAT or have collaborative relationships with other providers such that these MATs can be accessed as clinically indicated for patient need. Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

1. How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?
2. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?
3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, advocacy with state payers)?

The Nebraska Division of Behavioral Health (DBH) contracts with the six Nebraska Behavioral Health Regions and includes a provision in these contract that SUD providers may not refuse to serve individuals receiving Medication Assisted Treatment. The DBH will continue to promote and sponsor training opportunities and disseminate materials to increase provider competence in this area.

The DBH partners with a variety of entities to educate providers on Medication Assisted Treatment (MAT). It is through these partnerships that DBH is able to reach providers to provide education and support. Examples of these collaborations are described below.

Magellan of Nebraska seeks to increase the use of acamprosate, naltrexone (both in oral and injectable form), buprenorphine-and new medications as their proven benefits emerge-in treatment of substance use disorders where clinically appropriate. The program not only focuses on patients who have been discharged from inpatient substance use treatment programs, but also targets individuals receiving outpatient case or disease management services. Through MAT measures, Magellan of Nebraska monitors the number of cases in which physicians are prescribing medications and follows member readmission rates.

As part of this intervention, Magellan of Nebraska continually collaborates with its health plan partners to help facilitate the incorporation of these medications into client formularies. Additionally, Magellan of Nebraska focuses on provider education efforts to

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illustrate the importance of using appropriate medications when developing members' substance use disorder treatment plans

The Behavioral Health Education Center of Nebraska (tasked with growing and developing the Behavioral Health workforce in Nebraska) in conjunction with the Mid-America ATTC will be hosting two trainings in Nebraska in 2015:

**Medication-Assisted Treatment: Tools for Successful Recovery** With an array of effective FDA-approved medications now available for addressing the emerging prescription and opioid use epidemic, it is vital that specialty substance use disorder (SUD) treatment and healthcare providers learn more about (MAT. Equally important, policy makers, problem-solving court personnel, and social service professionals will learn how supporting the use of medication, combined with evidence-based behavioral therapies, can save lives and reduce healthcare costs.

**www.Complex.Care: Improving Treatment for Patients with Chronic Pain, Addiction, & Mental Health Disorders** with R. Corey Waller, M.D., M.S. With chronic pain as one of the most common complaints in primary care and hospital settings, physicians are finding they need to know more about the three things for which they received the least amount of training: 1.) appropriate risk screening for addiction, 2.) safer pain treatment protocols, and 3.) how to treat patients with behavioral health conundrums. This presentation will address each of these very common needs and show how to provide better care to patients with complex issues in less time, decreasing costs. At the conclusion of this event, the participant should be better able to identify the most common clinical and social findings for patients who present with chronic pain, gather information on improving patient outcomes for those presenting with chronic pain, explain the basics of treating and referring patients diagnosed with substance use disorders, state the most common behavioral health diagnoses and explain the basics of providing the best care and referring patients with behavioral health diagnoses.

To promote education of providers, the DBH maintains linkages on its website to the Mid-America ATTC website and their “Buprenorphine Treatment: A Training for Multidisciplinary Addiction Professionals.” Once on this site, providers can also access a variety of resources, information and training materials on MAT.

There is no area of technical assistance need identified at this time.

### C. Environmental Factors and Plan

#### 15. Crisis Services

In the on-going development of efforts to build an evidence-based robust system of care for persons diagnosed with SMI, SED and addictive disorders and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises.

No questions – Indicate areas of technical assistance.

The Nebraska Division of Behavioral Health recognizes the importance of having services in place to assist individuals in crises. State regulations provide service definitions that describe the types of crisis services individuals can receive in different areas of Nebraska. Below is the list of crisis services along with their definition:

- **Emergency Psychiatric Observation:** Emergency Psychiatric Observation provides less than 24 hours of care in a secure, medically supervised hospital setting for evaluation and stabilization of acute psychiatric and/or substance use disorder symptoms.
- **Crisis Stabilization:** Crisis Stabilization is intended to provide immediate, short-term, individualized, crisis-oriented treatment and recovery services needed to stabilize acute symptoms of mental illness, alcohol and/or other drug use, and/or emotional distress. Individuals in need exhibit a psychiatric and/or substance use disorder crisis with a moderate to high risk for harm to self/others and need short-term, protected, supervised, residential placement. The intent of the service is to treat and support the individual throughout the crisis; provide crisis assessment and interventions; medication management; linkages to needed behavioral health services; and assist in transition back to the individual's typical living situation.
- **Crisis Assessment:** Crisis Assessment is a thorough assessment for a consumer experiencing a behavioral health crisis. The Crisis Assessment must be completed by the appropriate professional. The Crisis Assessment takes place in a setting such as a Mental Health Center, Hospital, or Substance Abuse Treatment Center. The Crisis Assessment will determine behavioral health diagnosis, risk of dangerousness to self and/or others, recommended behavioral health service level and include the consumer's stated assessment of the situation. Based on the Crisis Assessment, appropriate behavioral health referrals will be provided.
- **Emergency Protective Custody Crisis Stabilization:** Crisis Stabilization is designed to provide custody, screening, emergency mental health evaluation, and crisis intervention to individuals placed in emergency protective custody under the auspices of Nebraska Mental Health Commitment Act by law enforcement. Crisis Stabilization services include immediate, short-term, individualized, crisis-oriented treatment and recovery needed to stabilize acute symptoms of mental illness, alcohol and/or other drug abuse, and/or emotional distress. Individuals in need exhibit a psychiatric and/or substance use disorder crisis as defined under the Commitment Act at risk for harm to self/others and need short-

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term, protected, supervised services. The intent of the service is to treat and support the individual throughout the crisis; provide crisis assessment and interventions; medication management; linkages to needed behavioral health services; and assist in transition back to the individual's typical living situation.

- **24-Hour Crisis Line**: The 24-Hour Crisis Line must be answered by a live voice 24 hours a day and 7 days a week and have the ability to link to a licensed behavioral health professional, law enforcement, and other emergency services. The 24-Hour Crisis Line is designed to assist consumers in pre-crisis or crisis situations related to a behavioral health problem. The desired outcome is ensuring the safety of the consumer in a time of distress that has the potential to lead to a life-threatening situation.
- **Mental Health Respite**: Mental Health Respite is designed to provide shelter and assistance to address immediate needs which may include case management on a 24/7 basis to consumers experiencing a need for transition to another home or residential setting or a break from the current home or residential setting. Mental Health Respite provides a safe, protected, supervised residential environment on a short-term basis. The intent of the service is to support a consumer throughout the transition or break, provide linkages to needed behavioral health services, and assist in transition back into the community.
- **Emergency Community Support**: Emergency Community Support is designed to assist consumers who can benefit from support due to a behavioral health need and who are either currently residing in a community setting or transitioning from a psychiatric hospital into a community setting. Emergency Community Support services include case management, behavioral health referrals, assistance with daily living skills, and coordination between consumer and/or consumer's support system and behavioral health providers.
- **Crisis Response**: Crisis Response is designed to use natural supports and resources to build upon a consumer's strengths to help resolve an immediate behavioral health crisis in the least restrictive environment by assisting the consumer to develop a plan to resolve the crisis. The service is provided by licensed behavioral health professionals who complete brief mental health status exams and substance use disorder screenings, assess risk, and provide crisis intervention, crisis stabilization, referral linkages, and consultation to hospital emergency room personnel, if necessary. The goal of the service is to avoid an Emergency Protective Custody hold or inpatient psychiatric hospitalization.
- **Urgent Medication Management**: Urgent Medication Management is the level of outpatient treatment where the sole service rendered by a qualified provider is the evaluation of the consumer's need for psychotropic medications and provision of a prescription. Urgent Medication Management is provided within 72 hours of contact and referrals for this service must come from a provider within a Region's behavioral health network.

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- **Urgent Outpatient Psychotherapy:** Urgent Outpatient Therapy is an intense intervention for consumers with an urgent/emergent behavioral health crisis. The purpose of the service is to support the consumer in achieving crisis resolution and determining next steps for further treatment if needed. Urgent Outpatient Psychotherapy services are intended to assure that consumers receive immediate treatment intervention when and where it is needed.
- **Hospital Diversion:** Hospital Diversion is a peer-operated service designed to assist consumers in decreasing psychiatric distress, which may lead to hospitalization. It is designed to help consumers rethink crisis as an opportunity to change toward a more self-determined independent life. Meaningful involvement can ensure that consumers lead a self-determined life in the community, rather than remaining dependent on the behavioral health system for a lifetime. Hospital Diversion offers consumers the opportunity to take control of their crisis or potential crisis and develop new skills through a variety of traditional self-help and proactive tools designed to maintain wellness. Trained Peer Companions are the key ingredients in helping other consumers utilize self-help tools. Peer Companions provide contact, support, and/or referral for services, as requested, during and after the stay as well as manning a Warm Line. Hospital Diversion is located in a family/home setting in a residential district that offers at least 4-5 guest bedrooms and is fully furnished for comfort. Participation in the service is voluntary.

Technical Assistance Request: Information describing how other states are addressing Emergency Departments' wait times for psychiatric patients.

*16. Recovery*

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**C. Environmental Factors and Plan*****16. Recovery***

The implementation of recovery-based approaches is imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?

The Division of Behavioral Health Strategic Plan (2011-2015) addresses the following:

- Vision – The Nebraska public behavioral health system promotes wellness, recovery, resilience and self-determination in a coordinated, accessible consumer and family-driven system.
- Mission – The Division of Behavioral Health provides leadership and resources for systems of care that promote and facilitate resilience and recovery for Nebraskans.

2011-2015 Goals:

1. The public behavioral health workforce will be able to deliver 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.

Strategies - The Division of Behavioral Health will:

1. Strategy 1: Insist on Accessibility – Increase access to appropriate and effective integrated behavioral health services, particularly for vulnerable populations.
2. Strategy 2: Demand Quality – Improve the quality of public behavioral health services for children and adults.
3. Strategy 3: Require Effectiveness – Improve outcomes for children and adults through the use of effective services.
4. Strategy 4: Promote Cost Efficiency – Develop flexible and balanced funding to support an efficient and accountable person-centered, recovery oriented system of services.
5. Strategy 5: Create Accountable Relationships – Encourage transparent, accountable relationships with and among system stakeholders.

For more details see [http://dhhs.ne.gov/behavioral\\_health/Pages/2010BHStrategicPlan.aspx](http://dhhs.ne.gov/behavioral_health/Pages/2010BHStrategicPlan.aspx).

## 16. Recovery

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The Division of Behavioral Health (DBH) NAC Title 206 Chapter 2 – Definitions offer the following terms which support recovery and recovery values: [http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health\\_and\\_Human\\_Services\\_System/Title-206/Chapter-02.pdf](http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-206/Chapter-02.pdf)

- Peer Support Services
- Person Centered Care
- Recovery
- Recovery-Oriented System of Care (ROSC)
- Rehabilitation
- Secondary Consumer
- Strength-based
- Trauma-informed Services
- Trauma-informed System
- Treatment

The State has documented evidence of hiring people in recovery.

- The DBH has hired the Administrator for the Office of Consumer Affairs (OCA) whom has lived experience and works to promote the DBH mission and vision and increase consumer involvement across Nebraska.
- The DBH has hired a person with lived experience to support youth and family services within the division and serve as a cross systems specialist to work across divisions to promote the DBH mission and vision.
- Regional Consumer Specialists – see the list on the DBH Office of Consumer Affairs, Consumer Involvement web page: [http://dhhs.ne.gov/behavioral\\_health/Pages/DBHOCAConsumers.aspx](http://dhhs.ne.gov/behavioral_health/Pages/DBHOCAConsumers.aspx)
- Recovery Specialists have been hired by the Lincoln Regional Center.
- DBH contracts directly with consumer run/affiliated organizations such as the Nebraska Federation of Families for Children’s Mental Health, Mental Health Association of Nebraska, Nebraska Recovery Network, and the Nebraska chapter of the National Alliance on Mental Illness (NAMI Nebraska) to support consumer and family leadership.
- The OCA People’s Council facilitates coordination required under the law between the RBHAs and the Office of Consumer Affairs around consumer involvement in all aspects of service planning and delivery in the Region.

## 2. How are treatment and recovery support services coordinated for any individual served by block grant funds?

Case management facilitates the achievement of individual wellness through advocacy, assessment, planning, linking, communication, education, resource management, and service facilitation. Additionally, block grant funded providers are to be welcoming, engaging and continually improving integrated services to the populations they serve, including those with developmental disabilities who have mental health and substance abuse disorders and all other individuals who have complex needs. Recovery support services are initiated at the onset of the individual’s treatment planning and service delivery process. To the extent possible, the development of a service plan is to be a collaborative process involving the consumer, family members, and other support/service systems. A key component of service coordination is the expectation to develop and sustain strong working relationships with community partners who provide the necessary supports and services which assist individuals with behavioral health disorders (e.g. law enforcement, community hospital(s), housing providers, vocational/employment agencies, educational institutions, child welfare representatives, advocacy organizations, criminal justice). It is vital for those involved in in cross system collaboration to maintain communication in order to fully assess the effectiveness of on-going services and to determine if additional services are needed.

3. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?

The DBH Strategic Plan is designed to move the system to improve services for these populations through "person-centered and self-directed" approaches of care in recovery-oriented systems. Within the framework of recovery-oriented systems of care, the person centered approach allows for greater flexibility for cultural adaptations within service delivery.

The model of peer support utilized by Peer Support and Wellness Specialists in Nebraska is Intentional Peer Support. It is a trauma informed and culturally competent model of peer support, incorporating the principle of respecting the worldview of others. There are over 230 certified Peer Support and Wellness Specialists in Nebraska. Additional information on this model and its implementation is located at [www.dhhs.ne.gov/trauma](http://www.dhhs.ne.gov/trauma).

Supporting this model is the OCA *Facilitator's Circle*, a group of people trained in the Nebraska Certified Peer Support and Wellness Specialist training. The mission of the *Facilitator's Circle* is to identify, equip, train, certify, and further educate peers with the skills required to provide relationship building and trauma informed peer support for people utilizing behavioral health services.

Nebraska is implementing an initiative that promotes trauma-informed care statewide, the Trauma Informed Nebraska (TIN). TIN is to develop a statewide, consumer-driven, recovery-oriented, trauma-informed system that ensures all behavioral health providers are informed about the effects of psychological trauma and are aware of the origin and effects of trauma on survivors.

4. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer-run services?

DBH is in the process of updating and promulgating new regulations, referred to as Nebraska Administrative Code (NAC). Within the draft Title 206 Behavioral Health Services Regulations are Service Definitions. One example of standards in this area are under the Crisis Services, the service definition for: HOSPITAL DIVERSION. The basic definition is:

Hospital Diversion is a peer-operated service designed to assist consumers in decreasing psychiatric distress, which may lead to hospitalization. It is designed to help consumers rethink crisis as an opportunity to change toward a more self-determined independent life. Meaningful involvement can ensure that consumers lead a self-determined life in the community, rather than remaining dependent on the behavioral health system for a lifetime. Hospital Diversion offers consumers the opportunity to take control of their crisis or potential crisis and develop new skills through a variety of traditional self-help and

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proactive tools designed to maintain wellness. Trained Peer Companions are the key ingredients in helping other consumers utilize self-help tools. Peer Companions provide contact, support, and/or referral for services, as requested, during and after the stay as well as manning a Warm Line. Hospital Diversion is located in a family/home setting in a residential district that offers at least 4-5 guest bedrooms and is fully furnished for comfort. Participation in the service is voluntary.

The hospital diversion services are being developed by providers with national accreditation. The Mental Health Association of Nebraska is CARF Accredited and operates Keya House. Community Alliance is CARF Accredited and operates Safe Harbor Peer Services

The OCA Facilitator's Circle conducts a minimum of one to two Peer Support and Wellness Specialist (PSWS) trainings per year. Peer support training programs are for individuals with experience with any lived behavioral health condition and/or trauma. Certification and training is a great opportunity for those who are working/volunteering in the behavioral health field serving military, veterans, individuals, families, and/or children/youth who have been impacted by a behavioral health condition and/or trauma.

The DBH offers a certification program. Eligibility to take the exam through the DBH OCA is for persons who have completed a forty hour (40) Peer Support Training Program and have a certificate of attendance/completion from training facilitators of the program.

Information on the training brochure is found at [http://dhhs.ne.gov/behavioral\\_health/Documents/NEOCAPeerTrainingBrochure2014.pdf](http://dhhs.ne.gov/behavioral_health/Documents/NEOCAPeerTrainingBrochure2014.pdf) and the certification program is found at [http://dhhs.ne.gov/behavioral\\_health/Pages/DBHOCAPeer.aspx](http://dhhs.ne.gov/behavioral_health/Pages/DBHOCAPeer.aspx).

The DBH offers multiple training opportunities for the professional workforce on recovery principles and recovery oriented practice and systems, including the role of peer providers. In May 2015 the DBH secured consultation from the Technical Assistance Collaborative Center, INC. (TAC). The workforce was invited to attend the presentation titled: Building Provider Capacity to deliver services aligned with principles and practices of Recovery, Wellness and Community Integration. Participants gained a further understanding of recovery, wellness, and community integration, as well as how to increase overall system capacity to deliver recovery oriented services to support community integration.

In 2014 the Nebraska Department of Health Human Services (DHHS) and the University of Nebraska Medical Center Behavioral Health Education Center of Nebraska (BHECN) entered into a tri Division contract. The purpose of this partnership is to coordinate the implementation of trauma informed care training and resources to support the DHHS service delivery. These divisions include: DBH, Division of Public Health, Division of Children and Family Services, and the Office of Consumer Affairs. As part of this contract BHECN has secured consultation services from Trauma-Informed Care expert, Raul Almazar. The agreement will aim to develop a statewide resource for the professional workforce on the causes and effects of trauma and to provide a singular source for training on trauma-informed care. The trauma informed care training will utilize the core principles established in SAMHSA's *Concept of Trauma and Guidance for a Trauma- Informed Approach*, which includes the following principles:

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1. Safety
2. Trustworthiness and Transparency
3. Peer Support
4. Collaboration and Mutuality
5. Empowerment, Voice and Choice
6. Cultural, Historical, and Gender Issues

5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?

The DBH Office of Consumer Affairs (OCA) focuses on four areas:

- Consumer/Peer Support - consumers helping consumers; Relationships - build and strengthen consumer involvement; Planning - how to get the best out of the system; and Advocacy - how to find the best information and resources out there now.

OCA supports the implementation of recovery-oriented approaches through its work with:

- Two Peer Support studies have been completed:
  - [http://dhhs.ne.gov/behavioral\\_health/Documents/Nebraska%20Peer%20Support%20Certification%20Study.pdf](http://dhhs.ne.gov/behavioral_health/Documents/Nebraska%20Peer%20Support%20Certification%20Study.pdf)
  - [http://dhhs.ne.gov/behavioral\\_health/Documents/Nebraska%20Peer%20Support%20Focus%20Group-Survey%20Report%20Final.pdf](http://dhhs.ne.gov/behavioral_health/Documents/Nebraska%20Peer%20Support%20Focus%20Group-Survey%20Report%20Final.pdf)
- The Nebraska Network of Care Website to provide information for consumers: [http://dhhs.ne.gov/behavioral\\_health/Pages/networkofcare\\_index.aspx](http://dhhs.ne.gov/behavioral_health/Pages/networkofcare_index.aspx)
- Peer Support and Wellness Specialists: [http://dhhs.ne.gov/behavioral\\_health/Pages/DBHOCAPeer.aspx](http://dhhs.ne.gov/behavioral_health/Pages/DBHOCAPeer.aspx)
- Webinars: [http://dhhs.ne.gov/behavioral\\_health/Pages/beh\\_mh\\_mhconsumer\\_webinars.aspx](http://dhhs.ne.gov/behavioral_health/Pages/beh_mh_mhconsumer_webinars.aspx)
- Website page dedicated to Trauma: [http://dhhs.ne.gov/behavioral\\_health/Pages/trauma.aspx](http://dhhs.ne.gov/behavioral_health/Pages/trauma.aspx)
- Consumer Involvement in Advisory meetings: [http://dhhs.ne.gov/behavioral\\_health/Pages/DBHOCAPeoplesCouncil.aspx](http://dhhs.ne.gov/behavioral_health/Pages/DBHOCAPeoplesCouncil.aspx)

As noted elsewhere in the application, DBH also has:

- Family Peer Support Navigators
- Peer-Run Crisis Diversion Services
- Peer-Run Warmlines- Lincoln, Omaha, and North Platte
- Housing Related Assistance
- Supported Employment

6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in

treatment and recovery planning).

NAC 206 Chapter 6-000 outlines consumer and families standards of care. Chapter 6 outlines the following:

- 6-001 Consumer Rights
- 6-002 Complaints
- 6-003 Consumer Grievances
- 6-004 Trauma Informed Services
- 6-005 Consumer Eligibility and Payment for Services
- 6-006 Records
- 6-007 Assessment
- 6-008 Discharge Planning
- 6-009 Individual Treatment, Rehabilitation, and Recovery Plan
- 6-010 Progress Notes
- 6-011 Discharge Summary
- 6-012 Staffing
- 6-013 Length of Stay
- 6-014 Standards common to all Mental Health and Substance Use Disorder Treatment and Rehabilitation Programs.
- 6-015 BH services for Adults
- 6-016 Behavioral Health Services for Children and Youth
- 6-017 Prevention Services
- 6-018 Housing Related Assistance

See [http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health and Human Services System/Title-206/Chapter-06.pdf](http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health%20and%20Human%20Services%20System/Title-206/Chapter-06.pdf).

**7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?**

In addition to the partnerships with the RBHAs, the DBH contracts with the following to support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services.

- Nebraska Federation of Families for Children's Mental Health- Provide Network Management of state wide family peer support and family navigator services.
- Mental Health Association of Nebraska- to provide the annual NE Behavioral Health: Success, Hopes, and Dreams conference
- Nebraska Recovery Network- to provide recovery events and education and awareness
- NAMI Nebraska to support consumer and family leadership, support groups, and training.

**8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.**

DBH conducts an annual Behavioral Health Consumer Survey. The survey solicits input from adult and youth consumers receiving mental health and/or substance abuse services from the publicly funded, community-based behavioral health system in Nebraska. The survey consists of

forty questions and aims to assess the quality and impact of the services received by measuring seven domains: Access, Quality and Appropriateness, Outcomes, Participation in Treatment Planning, General Satisfaction, Functioning and Social Connectedness.

The DBH data team analyzes the seven domains at the state level and compares outcomes longitudinally to previous iterations of the Consumer Survey dating back to 2006. Domains are also analyzed at the regional level, and by consumer race/ethnicity, gender, age, service type, and length of stay. In addition to the service domains, physical health status of consumers was also examined.

Consumers and family members participate on the DBH Statewide Quality Improvement Team (SQIT). SQIT is primarily responsible for the identification and prioritization of opportunities for regional and statewide improvement affecting the Nebraska Behavioral Health System, implementation of quality initiatives and development of the annual Continuous Quality Improvement (CQI) plan.

Under the Nebraska Behavioral Health Services Act each Region is expected to encourage and facilitate the involvement of consumers in all aspects of service planning and delivery. The Region is to coordinate such activities with the DBH Office of Consumer Affairs. Each Region is also expected to have a Regional Advisory Committee consisting of consumers, providers, and other interested parties.

In 2013 and 2014, DBH and OCA engaged consumers and families in two activities to assess consumer outreach activities. In 2013, DBH worked with the University of Nebraska Public Policy Center to conduct a survey and focus groups in each of the behavioral health regions of Nebraska. There were four groups that participated in the surveys and focus groups: Adult peer support specialists, family peer support specialists, consumers of adult peer support, and consumers of family peer support. In 2014, OCA convened a study group to review and identify strategies and recommendations to optimize consumer and family involvement. The final work product, *Consumer and Family Involvement in Nebraska*, is planned to be released in late 2015.

**9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.**

OCA promotes and provides information and resources focused on wellness strategies and recovery education to consumers and families and providers. It accomplishes this by promoting workforce recruitment and training efforts through the Peer Support and Wellness Specialist Certification program, People's Council, Open Door Calls, Statewide Behavioral Health Conference, and coordinated activities with the RBHA Regional Advisory Committees.

And, DBH's prevention system utilizes universal, selective and indicated prevention interventions intended to prevent or reduce the risk of developing a behavioral health problem. Early intervention strategies designed to create environments and conditions that support behavioral health and the ability of individuals to withstand challenges are also promoted

throughout this system.

**10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?**

The State of Nebraska recognizes that safe and stable housing are components needed for recovery by people who have behavioral health disorders who also experience extremely low income.

The governing regulations of Nebraska's public behavioral health system specifically identifies consumer rights, including the right to receive services and housing in the most integrated and supportive, as well as least restrictive, settings possible. The State plan and corresponding funding mechanism that address housing needs of persons served are identified in the Housing Assistance Program's Manual.

Following the Tenant Based Rental Assistance model as defined by the U.S. Department of Housing and Urban Development (HUD), the purpose of the Housing Assistance Program is to address housing needs for people with behavioral health disorders. This includes the use of rental assistance, other housing-related assistance, facilitation of community integration and a housing first approach as strategies to prevent homelessness as well as sustain stable housing while persons served continue to receive behavioral health services to support their recovery. Assistance provided by the Housing Assistance Program affords opportunity for a consumer to achieve or remain in permanent, affordable, community integrated housing of his/her choice while receiving behavioral health services supportive of recovery.

Through contract with each of the six Behavioral Health Authorities (Regions), the Housing Assistance Program is administered by these entities throughout the state. As Nebraska is a mix of rural and metropolitan communities, this approach allows for local variances in housing unit types, consumer choice and associated costs.

The Division also maintains contracts with providers for:

- Oxford House, for persons served who are in treatment for addiction, and,
- Nebraska Projects for Assistance in Transition from Homelessness (PATH)

**11. Describe how the state is supporting the employment and educational needs of individuals served.**

Successful employment remains a recognized component for persons on the path to recovery. As funded by the Division of Behavioral Health, the service of Supported Employment is an available option for persons with behavioral health needs. Consumers enrolled in community based services (i.e., Community Support, Outpatient therapy) who identify the desire for a job will be referred to Supported Employment. In partnership with the Regions and the Nebraska Department of Vocational Rehabilitation, the Division of Behavioral Health developed and implemented a Milestone based pilot project. This pilot helped establish a one year baseline and

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determination of best practices in the implementation of supported employment services with persons who have behavioral health needs. A cost study was also conducted as part of this project.

Working closely with Regional staff and providers of Supported Employment services within each Region, recorded consumer data was analyzed, and the DBH funded Milestones were determined.

Educational needs are identified through various sources with referrals made accordingly. For adults considering job advancement or recreational growth, Community Support Workers facilitate access to local Community Colleges, larger four year Colleges and Universities, or to educational opportunities on-line. The Professional Partner Program facilitates educational opportunities for youth (through age 26 years) through the development of the Individualized Program Plan. The Case Manager, known as the Professional Partner, assists the youth in finding the best fit for educational opportunities, while the Program's associated Wrap Around funding supports enrollment, materials and other fees.

Technical assistance is requested in developing peer services and peer bridgers involvement in the behavioral health system.

17. *Community Living and the Implementation of Olmstead*

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## C. Environmental Factors and Plan

**17. *Community Living and the Implementation of Olmstead***

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings.

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.

The State of Nebraska does not have an Olmstead plan for behavioral health services. Nebraska's public behavioral health system governing regulations identify the right of each consumer to receive behavioral health services in the most integrated setting appropriate based on an individualized and person-centered assessment. The Nebraska Division of Behavioral Health continues to improve and enhance the capacity of the state behavioral health system to support this goal.

2. How are individuals transitioned from hospital to community settings?

DBH has partnered with each RHBA to ensure that appropriate community-based services are in place state-wide. Community-based services may range from intensive, hospital-level care to a secure, specialized wing of a nursing home, other residential facility, or day treatment program.

The transition period from the hospital to community settings, in particular, is one of the most vulnerable times for consumers. The DBH and RHBA incorporate core strategies for care transition from hospital to community setting in the discharge planning process. This process is governed by regulations established in the [Nebraska Administrative Code Title 206 – Behavioral Health Services](#).

Discharge planning must occur in advance of a consumer's discharge from any behavioral health service. The discharge plan must be strength-based, recovery-oriented, trauma-informed and include participation by the consumer and family/legal guardian as appropriate. The discharge plan must be documented in the consumer's record.

The discharge plan must:

1. Begin on admission and be updated on an ongoing basis with the direct and active participation of the consumer and family/legal guardian, as appropriate and with the consumer's consent.
2. Be a component of the Individual Treatment, Rehabilitation, and Recovery Plan and be consistent with the goals and objectives identified with the direct and active participation of the consumer, family/legal guardian as appropriate.

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3. Address the consumer's need for ongoing services to promote recovery. A crisis/safety/relapse plan must be in place and address triggers, helpful intervention strategies, and contact information for resources useful in a crisis;
4. Document all referrals; and
5. Document pre-discharge planning, recommendations, and/or arrangements for a post-treatment/ rehabilitation/recovery plan including but not limited to: Accessing and using medication, Housing, Employment, Transportation, Social connectedness – formal and informal support systems, and Plans to address unmet goals.

All service providers contribute to the formulation of the discharge plan based on their respective knowledge and expertise, observations of the patient, and their discipline-specific plan/recommendations for aftercare.

3. **What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?**

The Nebraska Division of Behavioral Health has been working to build a person-centered, recovery-oriented system of care. As part of this process, DBH has also sought to assess its role in supporting the community integration of individuals served through the system. DBH is working with the Technical Assistance Collaborative, Inc. (TAC) to identify cross agency/division opportunities to support community integration and internally to incorporate recommendations to enhance support of community integration activities.

In April 2015, the DHHS DBH updated the [Nebraska Administrative Code Title 206 – Behavioral Health Services](#). “Standards of Care” regulations to incorporate recommendations regarding community integration planning and implementation efforts.

In November 2012, the Nebraska Division of Behavioral Health began a review of its current approach toward supporting individuals with mental illness in integrated community settings within the context of its overall system activities and implementation of its new five year strategic plan, the [Nebraska Division of Behavioral Health Strategic Plan 2011-2015](#). As part of this process, DBH identified and initiated three assessment and planning efforts to assess its systems of care.

First, DBH initiated a study in 2012 to assess its role in supporting community integration of individuals served through the public behavioral health system. April 2014, DBH released the report [Community Integration in Nebraska's Behavioral Health System](#), which provides a limited evaluation of DBH's activities in the context of community integration, including observations, identified themes that emerged during the planning process, and guidance regarding ways that DBH can strengthen its approach to supporting community integration within the overall implementation of its strategic plan.

Second, in November 2014, DBH released the final report [Nebraska DBH System Enhancement Initiative](#) upon completion of the 2013 Behavioral Health System Enhancement Initiative (SEI).

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SEI identified and began the implementation of necessary supports to discharge individuals from the Lincoln Regional Center (LRC), Nebraska's State Hospital. The SEI was charged with developing specific recommendations for thirty-six individuals currently at LRC who have been there for longer than one year, as well as developing recommendations for systemic improvements. This initiative involves key stakeholders and also utilized a survey tool that was distributed to LRC and Regional Behavioral Health Authorities (RBHA) administrators and key staff to identify contributing barriers to discharge and preliminary recommendations to resolve these issues.

In 2014, DBH partnered with Region 6 RBHA to conduct focus groups with key stakeholders from Region 6 to explore strategies that would strengthen and promote recovery-oriented services and opportunities for integrated, community living. This initiative identified high-priority gaps within Region 6's system and made recommendations to address these gaps. The report, [Omaha/Region 6 Adult Behavioral Health SOC Assessment and Planning](#), was released in November 2014. At this time, each of the other five RBHAs are in the process of assessing service gaps in their areas. Once this is completed, a plan for addressing these gaps statewide will be developed.

DBH continues to assess and implement recommendations to strengthen its approach to supporting community integration within the overall implementation of its strategic plan, as identified in April 2014. In 2015, DBH leadership and LRC leadership have hosted focus groups, developed workgroups, and reviewed collaborative activities with system partners, including The Office of Consumer Affairs and the Behavioral Health Education Center of Nebraska (BHECN).

**Workgroup Activities:**

- Housing focus group has met to review current options for affordable housing including supported housing, and identify possibilities for expansion and partnership.
- Provider focus group has met to build provider capacity to deliver services aligned with principles and practices of Recovery, Wellness and Community Integration.
- An emergency services workgroup has met to build successful partnerships to support coordination of recovery oriented systems and community integration.
- An Office of Consumers Affairs workgroup has met to review the role of the Office of Consumers Affairs and People's Council.
- A Peer Support Partnership workgroup has met to identify and build on the partnership between DBH and BHECN.

**4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?**

The State of Nebraska is not involved in any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI.

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**5. Is the state involved in a partnership with other state agencies to address community integration?**

DBH incorporates sister agencies and key system stakeholders into its various planning processes. Among these include the strategic planning process that led to the five year strategic plan and the State Advisory Committee on Mental Health Services that is required as part of the federal block grant planning process. These mutual planning processes provide a forum for DBH to develop and advance its ideas on mental health system priorities, such as person-centered planning and recovery supports. They have also led to DBH's active role in facilitating affordable housing opportunities for its target population and addressing housing-related issues when they arise.

There is no area of technical assistance need identified at this time.

*18. Children and Adolescents Behavioral Health Services*

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**C. Environmental Factors and Plan*****18. Children and Adolescents Behavioral Health Services***

MHBG funds are intended to support programs and activities for children with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults. SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi-system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?

The Nebraska Department of Health and Human Services (DHHS) Division of Behavioral Health (DBH) serves as the chief behavioral authority for the State of Nebraska as dictated in Neb. Rev. Stat. §71-806. In relationship to Nebraska's System of Care (SOC), DHHS DBH has the authority and responsibility to direct and coordinate the public behavioral health system, including integration and coordination of the system; comprehensive statewide planning for the provision of an appropriate array of community-based behavioral health services and continuum of care; development and management of data and information systems; prioritization and approval of all expenditures of funds received and administered by the division; and promotion of activities in research and education to improve the quality of behavioral health services, recruitment and retention of behavioral health professionals, and access to behavioral health programs and services. DHHS DBH works in partnership with six Regional Behavioral Health Authorities (RBHA) to carry out its charge.

The RBHA have structures and mechanisms to support a coordinated system of care approach to support recovery and resilience of children and youth with behavioral health needs. The RBHA develop local systems of care across the state responsive to local needs and building upon the unique strengths and communities of each region, forging partnerships with youth, families, providers, DHHS divisions of Children and Family Services (CFS) and Medicaid and Long-Term Care (DHHS Medicaid), county leaders, local system stakeholders, and community leaders and members.

RBHA funding is intended to serve individuals who are not Medicaid eligible or do not have insurance coverage. Each RBHA braids funding from state, federal, and local county sources to develop local networks of providers to provide an array of non-traditional supports not covered by Medicaid, ranging from emergency to resiliency-oriented supports to wraparound. System coordination is central to their purpose, coordinating the local behavioral health system in the region through strategic strengths-based/recovery-focused processes that empower individuals

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and communities to assure that network providers, system partners and the many stakeholders of the behavioral health system work in a coordinated manner that supports individuals across the life span to promote resiliency and achieve recovery. Each RBHA has established multi-stakeholder collaborative structures to coordinate efforts in formal functional areas for Consumers (including youth) and Family Involvement and Inclusion, Network Management, Emergency Services System, Prevention Services System, and Youth System of Care (YSC). Each RBHA has implemented since 1995 a Professional Partner Program (PPP) using a fidelity-based version of the wraparound care coordination model to support services to families who have children with serious emotional disorders and to ensure that youth and families have a voice and ownership in developing an accessible, comprehensive, individualized family support plan.

Each RBHA Network includes a Youth Systems coordination function, responsible for the children's behavioral health system within their respective Region. The Youth Systems Coordinator coordinates activities and collaborates with community based partners to ensure that children and youth with behavioral health disorders receive the most appropriate services located within their community, whenever possible. They also collaborate with the RBHA Network providers and other agencies serving youth to engage in activities that address the behavioral health needs of youth transitioning into adulthood. Youth Systems Coordinators promote quality improvement by participating in statewide youth system coordination, enhance SOC principles, assess RBHA Network providers of youth services for FCP, and provide technical assistance when needed and as appropriate to increase providers' ability to incorporate Family Centered Practice models (FCP) and SOC principles into their practices.

The YSC, PPP, and Family Navigator and Family Peer Support (FN/FPS) services infrastructure facilitates the involvement of youth, families, and system partners at the regional and individual family levels. Over time the DBH and DHHS CFS have coordinated services provided and to date both contract to provide PPP and FN/FPS. The YSC, PPP, and FN/FPS structures in each RBHA, alongside parallel structures for child welfare through the DHHS CFS's five Service Areas (SAs) are long-standing and provide a key component of the foundation upon which the SOC strategic plan implementation efforts are built. While their geographic boundaries are not fully aligned, there is much overlap and each RBHA works with assigned SAs. This enhanced regional alignment is key to sustainability, as both RBHAs and SAs have established networks among SOC stakeholders in each region.

In late summer 2014, the Nebraska's Children's Mental Health System of Care Planning Project was completed. The SOC Strategic Plan offers the central organizing structure to capitalize on infrastructure currently in place including the support and involvement of leaders across the state's many child-serving systems. Accomplishments of the NE SOC to date include:

- Families, youth and providers responded to a statewide survey for self-assessment of readiness for system of care. Over 1,100 people participated.
- Strategic plan development was accomplished through 10 Core Strategy Teams that met between October 2013 and March 2014. Over 262 youth, family and system partners participated on a team.

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- Youth voice in plan development was gathered through a series of focus groups targeting youth who were experiencing or had experienced Nebraska's behavioral health system and other child-serving systems. A total of 143 youth participated in focus groups.
- The strategic plan development resulted in 9 goals broken down into a comprehensive set of important implementation strategies that reflect Nebraska's diversity and complexity. Addressing the strategies and activities requires state, regional, tribal and local level actions.
- Responded to the readiness assessment: Prioritized gaps and opportunities. Created the Related System of Care Initiatives document, an environmental scan that highlights the strengths of the existing infrastructure by identifying current system of care initiatives occurring across the state as directed or sponsored by agencies, programs and organizations represented by members on the PMT. Identified state-level teams and commissions with areas of focus corresponding or correlating to NeSOC goals, strategies and priorities.
- Developed mechanism for moving forward: Formed informal workgroups tasked with development of draft work plans specific to one or more of the eight strategies. The workgroups are; 1) Continuous Quality Improvement, 2) Training and TA, 3) Cross-System Development and 4) Financial Investment. These groups will continue among the identified standing work teams in the governance structure of NeSOC implementation.
- Initiated Financial Investment Blueprint Project, initiated by a DBH contract with TriWest Group.
- Planned for potential implementation funding: Investigated and formulated a potential application for a System of Care Implementation Cooperative Agreement offered by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. Developed the SOC Implementation Grant Services Crosswalk to correlate the state's current behavioral health services and supports with the required behavioral health services and supports identified in the RFA. The application project was ultimately deferred to the anticipated 2016 funding opportunity.
- Addressed future NeSOC governance and funding: Convened ad hoc work teams to address those identified strategies that relate to NeSOC governance and funding approaches.
- Investigated action steps for youth and family partners: Convened ad hoc group to look at ways to incorporate youth and family as equal partners during the course of NeSOC implementation. Recommended representation of these groups within each level of the NeSOC governance structure. Considered youth focus group results for future development of training, coaching and peer-to-peer opportunities.
- Took initial steps towards NeSOC implementation: Identified and prioritized eight strategies that can be implemented at low/no cost from the 93 strategies listed in the Nebraska SOC Strategic Plan as follows:

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**No/Low Cost Strategies**

1. Explore and identify requirements necessary to build a culturally responsive, trauma informed and community-based crisis continuum across systems that includes a dedicated on-call team, in-home services and brief out-of home options for children and youth in crisis, such as crisis residential, respite, therapeutic foster care, and emergency shelter.
2. Identify options for braided funding approaches to support a culturally responsive, trauma-informed and community-based crisis continuum across systems.
3. Develop a competency training/education inventory to be used across systems and inclusive of the following eight domains: trauma-informed/capable care; child and adolescent development; cultural and linguistic competence; children and youth with developmental disabilities and behavioral health needs; screening/assessment/evaluation/referral; family and person centered practice; treatment planning/ interventions/service delivery; quality improvement; professionalism and ethics. Support the development of SOC principles and practices education/training for the system workforce and identify resources to disseminate education/training throughout the state.
4. Develop standards for supporting equal partnership for children, youth and family participation in SOC activities, including financial support needed to fully participate in SOC activities.
5. Develop a SOC governance structure for a locus of accountability at the state level and support the implementation of the strategic plan by the SOC Leadership Team. Support the formation of regional, tribal and community SOC teams that build upon current local strengths, and assume locus of accountability for SOC efforts at the local level. Form the SOC Leadership Team, inclusive of equal representation of youth, family, and system partners charged with pursuing dissemination and implementation of the Nebraska SOC Strategic Plan.
6. Identify regulations, barriers and gaps that prevent effective collaboration and/or development of a single services plan for children, youth, and families across systems.
7. Map current children and youth service and support opportunities, eligibility requirements, funding sources, and relevant policies, practices and regulations across systems.
8. Identify a common Quality Improvement process that supports monitoring, evaluation and outcome measures and can be used across systems.

A dynamic environment surrounding services for children and families currently exists in Nebraska. The collaborative relationship between the DBH and the DHHS CFS is strengthened through monthly on-site meetings of the DBH Deputy Director and Section Administrators, the RBHA Administrators, and the DHHS CFS Service Area Administrators. These administrators maintain a forward thinking focus in the identification and removal of barriers posing a threat to the smooth and seamless transition of Nebraska youth into adulthood. With the State Legislature's focus on serving children and families, along with child welfare reform, the Nebraska Children's Commission was developed to provide oversight of legislative efforts to improve the children's behavioral health system.

**2. What guidelines have and/or will the state establish for individualized care planning for children/youth with serious mental, substance use and co-occurring disorders?**

In collaboration with system partners, the DBH developed and implemented guidelines, as outlined in the PPP manual, for children and young adults with mental and substance use disorders and their families for individualized care planning. The PPP manual is reviewed at least annually, with updates identified and incorporated as needed based upon quality improvement processes led by DBH. Most recently in 2015, the PPP program evaluation, outcomes, and admission criteria are being assessed in order to continue to identify improvements that better assess the impact of PPP on children and youth, better measure family functioning over time, improve quality care, increase access to High Fidelity Wraparound Services, increase involvement of children, youth, and families, and continue in efforts to build strong partnerships across child serving agencies to implement family centered care.

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With ten wraparound components at its core, an individualized service plan is developed for each youth/young adult and his/her family, based upon the strengths and concerns of the youth/young adult and his/her family across life domains, including mental health, substance abuse, residential, family, education, vocational, financial, social/recreational, medical, legal, safety, and cultural.

The Professional Partner, youth/young adult and family identifies Wraparound team members who will contribute to the development of an Individual Family Service Plan (IFSP) (or Plan of Care - for the purposes of transition aged programs). The IFSP must be a clear, outcome focused plan with time sensitive and measureable goals and objectives that are purposed to support the safety, well-being, recovery and resiliency of the youth. The identified goals and objectives will directly reflect the information reported in the Intake/Interpretative Summary.

The format for the IFSP plan may vary but must include at a minimum:

- Clear demonstration of youth/young adult/family partnership in the plan development
- Youth/young adult and Family Strengths
- Presenting Problems
- Goals and Expected Outcomes/Pre-Discharge Plan
- Objectives/Interventions must be measureable and timely
- Team Members, both formal and informal
- Safety planning

The PPP implements a quarterly review/revision of the IFSP and ongoing monitoring and evaluation of service provision to improve outcomes. For short term programs, IFSP plans are reviewed no less frequently than once every 30 days.

In addition to the IFSP the following sets of data are submitted to the DBH and reviewed at least quarterly:

- Youth and family characteristics (demographic data);
- Youth and family progress as the plan is implemented;
- Examination of the organizational variables that potentially influence the success of the PPP (e.g., amount of involvement by youth/young adult and family, mixture or make-up of the multi-disciplinary team responsible for development of the service plan, implementation of the service plan);
- Change over time in family functioning. Change over time is collected with the utilization of the Protective Factor Survey.
- Change over time in the impact of the functional impairment resulting from behavioral health challenges. Change over time is collected with the utilization of the Child and Adolescent Functional Assessment Scale (CAFAS) OR Preschool and Early Childhood Functional Assessment (PECFAS). The following areas are reviewed:
  - School/Work Role Performance
  - Home Role Performance
  - Community Role Performance
  - Behavior Toward Others
  - Moods/Emotions
  - Self-Harmful Behavior

## 18. Children and Adolescents Behavioral Health Services

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- Substance Use
  - Thinking
  - Review of the effects and costs of the services and supports.
  - Suicide Behaviors Questionnaire- Revised (SBQ-R) and Early Identification, Referral and Follow –up Form (EIRF) data
3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?

In 2011, Legislative Bill (LB) 821 established the Nebraska Children’s Commission (Commission), a 26-member body charged with creating a statewide strategic plan to reform child welfare programs and services, including children’s behavioral health. The Commission is comprised of representatives of the three branches of state government and members of the general public including: guardians ad litem, prosecuting attorneys, foster and biological parents, children’s services providers, child advocacy organizations, foster care review board members, court-appointed special advocate volunteers, and youth currently or previously in foster care. The Commission serves as a permanent forum for collaboration among state, local community, public, and private stakeholders across child serving programs and services with the intent to improve the safety and well-being of Nebraska children and families.

In 2012, Nebraska explored and planned for the launch of an Alternative Response (AR) Model within CFS to allow families an opportunity to address issues prompting the child abuse/neglect reporting without removing children at low risk of harm from their natural environment. An AR stakeholder group has been formed with members including DBH, CFS, RBHAs, CFS’s Service Administrators, the Federation of Families, and others. LB 853 allows the statutory change to current investigations and make way for pilots of the AR Model, to begin in State Fiscal Year 2015, in a limited and evaluative manner. AR is an effort to change further the state’s culture away from thinking that the safety of a child can only be achieved through removal from the family home. The focus of the pilot is more on enhancing the family’s protective factors while maintaining the child’s safety. As such, communities enrolled in the pilot are collaborating in ways that inform and strengthen the System of Care.

Beginning in January of 2015 through June 2015, an invited group of individuals were convened under the SOC planning grant’s Project Management Team (PMT) banner. The group met on a monthly basis to contemplate how to implement strategies from the strategic plan within existing resources. Mentioned above are the accomplishments to date of the Ne SOC planning and initial implementation projects. Additional accomplishments include operationalizing implementation of NeSOC Strategic Plan through the Standing Work Team mechanism. The following standing work teams will be implemented

The **Continuous Quality Improvement (CQI)** standing work team will be charged with identifying and implementing evaluation measures that can be applied across systems. Further development of the work plan will be the function of the CQI Standing Work Team once convened.

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The **Training and Technical Assistance** work team will be charged with identifying and implementing training across systems at the regional, tribal and community levels. Further development of the work plan will be the function of the Training and TA Standing Work Team once convened.

The **Cross-System Development** work team is charged with further development and implementation of system of care principles and practices across systems, organizations and other entities. Further development of the work plan will be the function of the Cross-System Development Standing Work Team once convened.

The **Financial Investment** work team is charged with developing a financial investment blueprint of cross-system services, supports, and funding streams for children and youth and to leverage these resources to maximize funding sources. The team will develop a work plan that addresses tailoring of services and payments to different population needs across state agencies. This team is working with an outside consultant funded by the Division of Behavioral Health, in the initial phases of the blueprint project with work to be completed as follows.

**Strategy:** *Identify options for braided funding approaches to support a culturally responsive, trauma-informed and community-based crisis continuum across systems.*

- **Phase 1: April to June 30, 2015**

Focuses on the initial design of the blueprint and data collection.

- Two brainstorming meetings with DHHS representative agencies.
- Providing background information on each agency to TriWest.
- Collecting specific data utilizing a standardized format for requested information.
- Drafting an outline of the Blueprint Report.

- **Phase 2: July 1, 2015 to Winter 2016**

Focuses on data analysis and report preparation.

- Reviewing the analysis of Phase I data collection activities and working with agencies to refine and correctly interpret the information.
- Drafting an overview of each agency, including mission, goals, scope of services, a description of the provider community, and successes and challenges.
- Preparing draft findings and recommendations about the opportunities to leverage funding to maximize resources.
- Reviewing drafts with each agency to refine and correctly interpret findings and recommendations.

**4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?**

Inherent in each of the DBH contracts with the RBHAs within the Youth System Coordination and Professional Partner Program Network is the expectation of development and sustainability of a Regional Youth System of Care through the hosting, sponsorship and provision of education and training opportunities that create workforce expertise. An additional contractual requirement is that each RBHA structure funding in priority order for evidence/science based/promising practices, such as, but not limited to, early intervention, family support services, and respite. At

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the RBHA level, trainings are identified through needs assessments and provider requests for technical assistance, as well as ongoing formal and informal reviews of services provided. As active participants in the RBHAs and Youth System of Care, Nebraska’s Family Organizations provide training in evidenced based practices and activities in support of families.

At the state level, the Professional Partner Program sponsors two statewide training events per calendar year in which all Professional Partners and their supervisors are required to attend, with encouragement for participation from youth and families along with representatives from family organizations, the DHHS CFS, Juvenile Justice, school districts and other interested parties.

Central to the success of Nebraska’s SOC Planning Project is adherence to the National Standards for Culturally and Linguistically Appropriate Services (CLAS). A key focus of the planning process was to promulgate and increase commitment to the CLAS standards across all levels of planning and the subsequent strategic plan. Technical Assistance in the form of an all-day workshop specific to CLC/CLAS was offered to all CST members as well as members of the Project Management Team, project leadership and key staff of system partners. Vivian Jackson, Ph.D., National Center for Cultural Competence, Georgetown University Center for Child and Human Development, presided over the day’s agenda which included topics specific to clarity of concepts and elements of CLC.

In addition the Training and Technical Assistance work team will be charged with identifying and implementing training across systems at the regional, tribal and community levels. Further development of the work plan will be the function of the Training and TA Standing Work Team once convened.

**Strategy:** *Develop a competency training/education inventory to be used across systems and inclusive of the following eight domains: trauma-informed/capable care; child and adolescent development; cultural and linguistic competence; children and youth with developmental disabilities and behavioral health needs; screening/assessment/evaluation/referral; family and person centered practice; treatment planning/ interventions/service delivery; quality improvement; professionalism and ethics. Support the development of SOC principles and practices education/training for the system workforce and identify resources to disseminate education/training throughout the state.*

**Training and TA Work Plan**

<b>Targeted Outputs</b>
A. Identify and map existing Training and TA resources including training data bases and physical (on-site) trainings at state and national level. Identify gaps and opportunities.
B. Compile inventory list and map community-based/integrated trainers available on each of the eight domains identified in the strategy.
C. Assess need through survey of communities and collaborations about training, TA and trainers offered, invested in and used.
D. Identify training initiatives amenable to inclusion of youth and families as trainers, participants and/or target audience.

The **Cross-System Development** work team is charged with further development and implementation of system of care principles and practices across systems, organizations and other entities and will also be working to identify training needs across the system. The

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following strategies apply: **1)** Explore and identify requirements necessary to build a culturally responsive, trauma informed and community-based crisis continuum across systems that includes a dedicated on-call team, in-home services and brief out-of home options for children and youth in crisis, **2)** Identify regulations, barriers and gaps that prevent effective collaboration and/or development of a single services plan for children, youth, and families across systems. **3)** Map current children and youth service and support opportunities, eligibility requirements, funding sources, and relevant policies, practices and regulations across systems.

**5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?**

Utilization of services is monitored at both the regional and state level, with findings documented, reported, and made available at least annually and as needed. Using a collaboratively developed and agreed upon Services Purchased review format and procedures, representative chart samples of each provided service for children and youth undergo on-site inspection to ensure appropriate provision of identified services.

A second collaboratively developed component, the Program Fidelity review is conducted a minimum of every three years (with an additional need based option). This review addresses the services' adherence to established professional and program standards. As with the Services Purchased review format, representative chart samples of each provided children's service undergo on-site inspection to ensure appropriate provision of identified services. In many cases, the Services Purchased and Program Fidelity reviews are conducted jointly. Should reviews reveal deficit areas, the state provides service providers with technical assistance in their development of a corrective action plan, with return monitoring of the implemented plan until deficiencies are corrected.

For contracted children's services, including those services provided through the Professional Partner Program, expenditures are monitored through a multi-leveled, detailed monthly line item review of submitted RBHA and provider billing documents. Adjustments and budgetary shifts are made throughout the contract year to ensure appropriate funding levels.

Outcomes for youth receiving services through the Professional Partner Program and FN/FPS programs are monitored monthly at the local team level, with ongoing adjustments in the plan to meet the youth's desired goal. With the use of standardized instruments (e.g., Child and Adolescent Functional Assessment Scale), information is collected, aggregated, and presented for discussion at the state level. Through this process, and recognizing the importance of the family unit in the youth's success, the DBH collaboratively developed and made priority, a measurable goal for families to experience an increase in their ability to better function as a unit.

Youth outcomes are reviewed by the respective RBHA at least quarterly, and are shared annually and as needed through administrative and Network Team meetings. Combined statewide data are analyzed and trended quarterly by the DBH Quality Improvement and Data Team and presented for review and discussion at least annually and as needed. Through the DBH Managed Care partner, Magellan Behavioral Healthcare, National Outcome Measures data for children and those enrolled in the Professional Partner Program is collected and analyzed. A separate data

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base for the PPP is maintained in the DBH and collected data undergo quarterly and as needed review, and are shared through administrative and other team meetings.

The **Continuous Quality Improvement (CQI)** standing work team will be charged with identifying and implementing evaluation measures that can be applied across systems. Further development of the work plan will be the function of the CQI Standing Work Team once convened.

**Strategy:** Identify a common Quality Improvement process that supports monitoring, evaluation and outcome measures and can be used across systems.

**CQI Work Plan Targeted Outputs:**

Targeted Outputs
A. Establish and define a youth service population of interest.
B. Map what outcomes/ indicators are currently being tracked by the major systems: Education, Children & Family Services, Medicaid, DBH, Public Health, Juvenile Justice, etc.
C. Operationalize functional outcomes listed in the SOC Strategic Plan to promote quantitative data collection and analysis.
D. Establish baseline data for the identified youth service population of interest across systems.
E. Develop a pilot project to impact youth service system super users.

Identifying baseline data and outcome measures, correlating to the functional and process outcomes, will be a function of the CQI Standing Work Team. System of Care evaluation results completed by SAMHSA in their *Report to Congress 2012-2013*, provides valuable analysis of outcomes and serves as a resource for the CQI work team for further development of measures and outcomes associated with NeSOC. Below are examples of baseline and outcome measures aligned with the functional outcomes as previously described.

**Baseline:**

- Percentage of youth successfully discharged from residential levels of care vs. total residential level of care discharges. (Baseline measure)
- Identification of most common service discharged to from residential care. (Baseline measure that would promote insight into potential SOC service/step down gaps)

**Outcome Measures:**

- Percentage of youth successfully discharged from a residential care setting into community based services who had 180 days community tenure post-discharge. (Outcome Measure)
- Percentage of youth discharged from a residential setting who had a readmission to a residential setting or higher level of care (ie. Acute Inpatient) at 90 and 180 days post discharge. (Outcome Measure)

6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state’s lead agency of education?

No, not at this time.

*18. Children and Adolescents Behavioral Health Services*

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7. What age is considered the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

The age that a child/adolescent is no longer eligible to receive behavioral health services in the child/adolescent system is 19 years of age. If a youth is identified as needing continued care as they transition to adulthood, DHHS CFS begins the process to educate and connect the youth to the RBHA.

The 2013 Legislative Session also included numerous bills that impacted the building of services and supports for children. There was legislation introduced to expand Medicaid state plan services to children ages 4-21 with SED who have been diverted or deinstitutionalized (LB270); expand telehealth services for schools (LB556) and juvenile youth (LB605); extend Title IV foster care eligibility until age 21 (LB216); change Foster Care Licensures and Kinship Home/Relative Home provisions to support permanency with kin and relatives (LB265); expand funding for counseling, mental health treatment and supportive services to improve child and caretaker well-being without having to remove children from their homes (LB425).

In 2014 LB 853 was passed which is a bill that updates Young Adult Bridge to Independence Act which provides foster care transition services and authorizes a pilot program for alternative response in certain Nebraska child welfare cases. The bill makes a number of changes to the existing Young Adult Bridge to Independence Act, including:

- Stipulating that payments made on behalf of a former state ward after the appointment of a guardian would no longer terminate on or before the individual's 19th birthday if he or she is eligible for extended guardianship assistance
- Requiring continuation of services by the department until age 21 if a former ward is in the bridge to independence program regardless of whether he or she is regularly attending school or training programs
- Requiring the state Department of Health and Human Services (DHHS) to provide information on community resources if a former ward voluntarily terminates a support agreement; and
  - Requiring that a DHHS independence coordinator meet with former wards who are determined no longer eligible for the program.

LB853 also requires DHHS, in consultation with the Nebraska Children's Commission, to develop an alternative response implementation pilot program. Implementation will include provision of concrete supports and voluntary services, including mental health and substance abuse services and assistance with child care, food, clothing, housing and transportation.

There is no area of technical assistance need identified at this time.

*19. Pregnant Women and Women with Dependent Children*

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**C. Environmental Factors and Plan*****19. Pregnant Women and Women with Dependent Children***

Substance-abusing pregnant women have always been the number one priority population in the SAMHSA block grant (Title XIX, Part B, Subpart II, Sec.1922 (c)). A formula based on the FY 1993 and FY 1994 block grants was established to increase the availability of treatment services designed for pregnant women and women with dependent children. The purpose of establishing a “set-aside” was to ensure the availability of comprehensive, substance use disorder treatment, and prevention and recovery support services for pregnant and postpartum women and their dependent children. This population continues to be a priority, given the importance of prenatal care and substance abuse treatment for pregnant, substance using women, and the importance of early development in children. For families involved in the child welfare system, successful participation in treatment for substance use disorders is the best predictor for children remaining with their mothers. Women with dependent children are also named as a priority for specialized treatment (as opposed to treatment as usual) in the SABG regulations. MOE provisions require that the state expend no less than an amount equal to that spent by the state in a base fiscal year for treatment services designed for pregnant women and women with dependent children.

1. The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.

The Nebraska Division of Behavioral Health (DBH) places a high priority on Women’s Services through the Regional Behavioral Health Authorities (Region). In the State to Region services contracts, the Regions are required to closely monitor provider compliance with the following priorities for admission to behavioral health services, including emergency, inpatient, residential, and non-residential services reimbursed under the contract:

- Substance Abuse priority populations:
  1. Pregnant Injecting Drug Users
  2. Other Pregnant Substance Users
  3. Other Injecting Drug Users
  4. Women with Dependent Children
  5. All Others

Providers serving women will publicize the availability of these services and publicize that a pregnant woman will receive priority admission.

2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.

DBH manages the Weekly Substance Abuse Capacity Report and Weekly Substance Abuse Priority Waiting/Interim Services List for the priority populations. It is reviewed on a weekly basis and shows the number of beds/slots available for pregnant women and women with dependent children by the number of beds/slots utilized against capacity by agency at the program level, as well as, individuals on the Waitlist. The Regions also ensures checks and balances are in place that allows for maintaining weekly contact with the individuals on the Waitlist and will ensure that individuals on the Waitlist are admitted into treatment at the earliest

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possible time, to the most appropriate level of care, and within a reasonable geographic area that is acceptable to the individual.

In the State to Region services contracts, the Regions are required to provide treatment to pregnant women and women with dependent children within 48 hours of those individuals requesting treatment. In the event that capacity does not exist for the individual to immediately receive treatment, the individual will receive Interim Services. Interim Services are provided between the time the individual requests treatment and the time they enter treatment. Interim Services are provided within 48 hours and until the individual can receive the appropriate treatment service, based upon the level of care identified in the substance abuse evaluation.

3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.

Refer to the answer in Question #2 above.

4. Discuss who within your state is responsible for monitoring the requirements in 1-3.

Each Region sends their Weekly Substance Abuse Capacity Report and Weekly Substance Abuse Priority Waiting/Interim Services List data to the Nebraska Division of Behavioral Health Data Team. The Data Team aggregates the regional data to track trends on a state level, including:

- a. total and available substance abuse treatment service capacity
- b. substance abuse treatment programs that are at or above 90% capacity
- c. the number of individuals who are waiting for substance abuse treatment by priority population level
- d. the length of time individuals remain on the waiting list, and
- e. if individuals are receiving interim services.

Please note that all individuals who are documented on the Weekly Substance Abuse Priority Waiting/Interim Services List must receive interim services while waiting.

The Data team shares this information with DBH staff, including the Field Representatives/Contract Managers for each Region and Region staff. The Field Representatives/Contract Managers then reviews their Region's capacity and waitlist and discusses any issues revealed with Region staff.

5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP).

DBH has 11 Women's Set Aside Providers across the state that provide an array of services for pregnant women and women with dependent children. All Regions in Nebraska have services available for pregnant women and women with dependent children. Below is the list of the providers and the services they provide:

19. *Pregnant Women and Women with Dependent Children*

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- Panhandle Mental Health Center: Outpatient Substance Abuse Services
- Human Services, Inc.: Short Term Residential
- Region II Human Services Arm in Arm Program: Community Support
- St. Francis Alcohol and Drug Treatment Center: Outpatient Substance Abuse Services
- South Central Behavioral Services: Outpatient Substance Abuse Services
- The Bridge Inc.: Therapeutic Community
- Well Link, Inc.: Dual Disorder Residential & Intermediate Residential
- St. Monica's: Community Support & Therapeutic Community
- Lincoln Medical Education Foundation: Substance Abuse Assessment & Outpatient Substance Abuse Services
- Heartland Family Services: Intensive Outpatient Therapy & Therapeutic Community
- Santa Monica: Halfway House

In addition to providing treatment services, these providers must ensure the following services are available:

- Gender-specific substance abuse treatment and other therapeutic interventions for women that may address issues of relationships, sexual and physical abuse, and parenting
- Pre-natal care
- Primary medical care for women who are receiving substance abuse services
- Primary pediatric care including immunizations for children of women receiving substance abuse services
- Therapeutic interventions for children in custody of women in treatment which may, among other things address their development needs, and their issues of sexual and physical abuse and neglect
- Transportation services to ensure that women and children have access to services
- Child care while receiving services
- Sufficient case management to ensure access to services

**5a. How many of the programs offer medication assisted treatment for the pregnant women in their care?**

The Women's Set Aside Providers refer participants to their primary care physicians for medication assisted treatment.

**5b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?**

All Regions in Nebraska have services available for pregnant women and women with dependent children. Designated providers are required by contractual agreements to provide or ensure that services are available. The Women's Set Aside Providers refer participants to their primary care physicians for medication assisted treatment.

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6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP).

Refer to the answer in Question #5 above.

- 6a. How many of the programs offer medication assisted treatment for the pregnant women in their care?

Refer to the answer in Question #5a above.

- 6b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?

Refer to the answer in Question #5b above.

There is no area of technical assistance need identified at this time.

DRAFT

20. Suicide Prevention

07/31/2015

C. Environmental Factors and Plan

20. Suicide Prevention

1. Provide the most recent copy of your state’s suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised National Strategy for Suicide Prevention (2012).

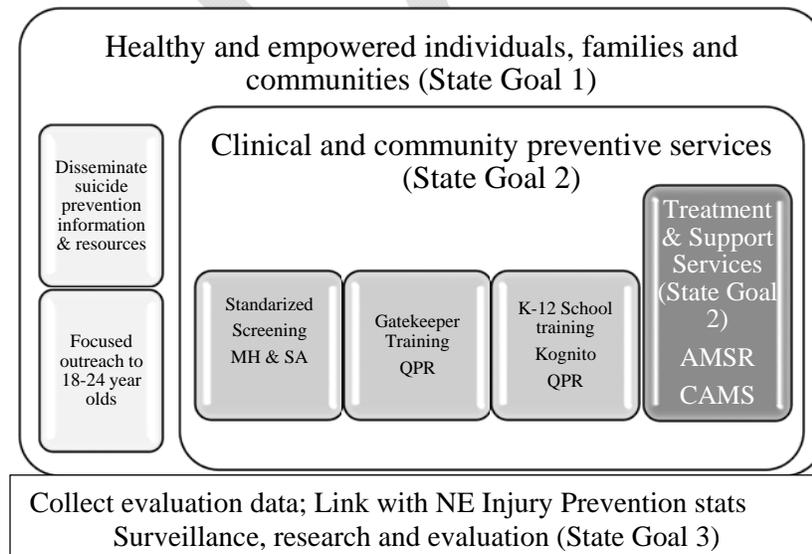
The Nebraska state suicide prevention plan is current through 2015 and can be found at <http://www.suicideprevention.nebraska.edu/Documents/2014/SuicideCoalitionReport2013.pdf>

These goals were prioritized through a multiple stage process including a statewide summit and a strategic planning process led by the Nebraska State Suicide Prevention Coalition (NSSPC). The NSSPC works throughout the year to promote suicide prevention activities statewide via local coalitions and other grassroots initiatives. The NSSPC supplements the state plan with an up to date activity plan (last revised in 2013). Together these documents provide overall direction for Nebraska’s suicide prevention work.

There are three goals within the current plan:

1. Nebraskans will view suicide as a preventable public health problem. [Healthy and empowered individuals, families and communities]
2. Empirically supported suicide prevention programs are implemented across Nebraska. [Clinical and community preventive services; Treatment and support services]
3. Data is used to evaluate effectiveness of suicide prevention in Nebraska. [Surveillance, research and evaluation]

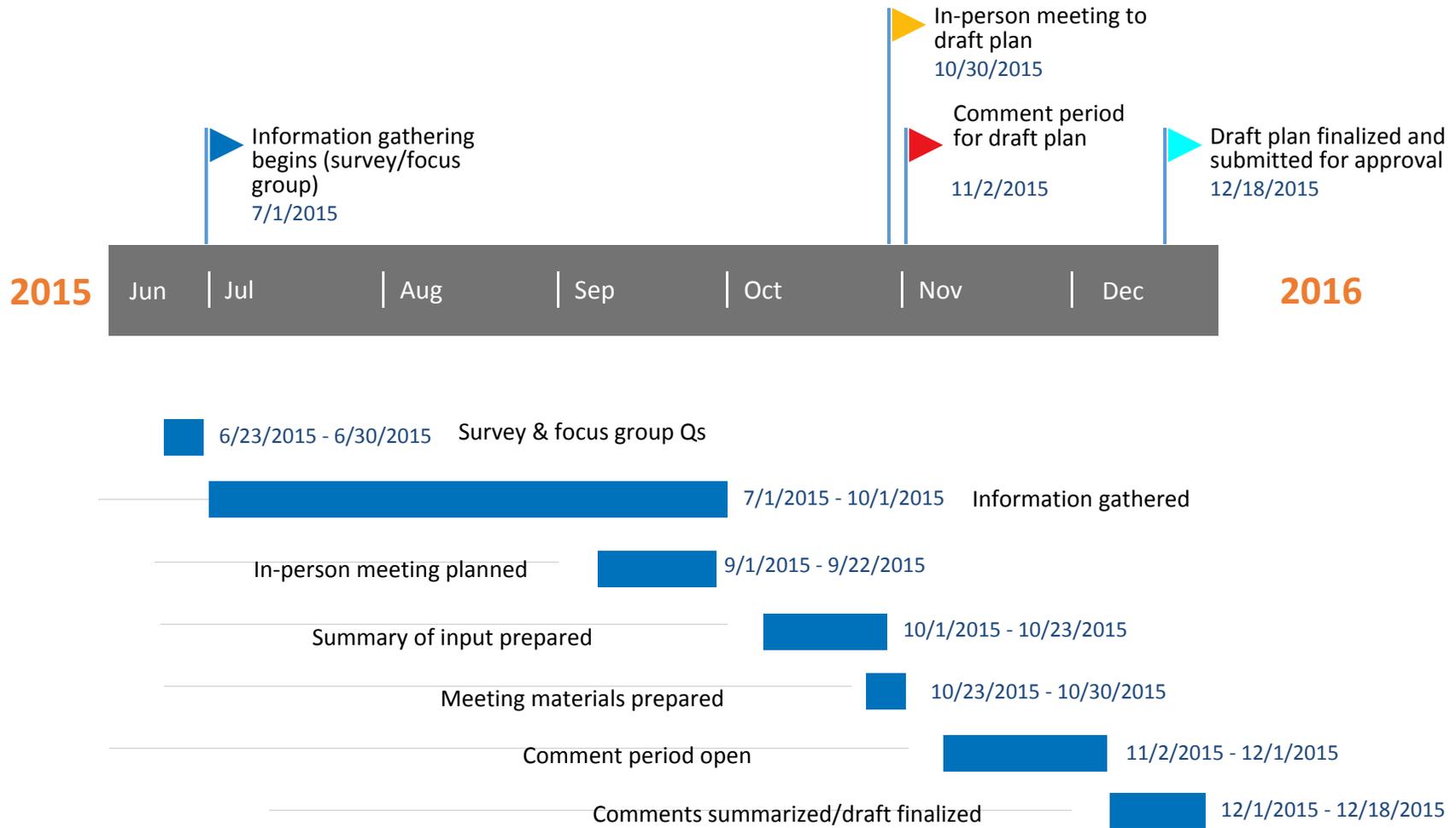
As a 2014 recipient of the Garrett Lee Smith Youth (GLS) Suicide Prevention grant and in continued partnership with the NSSPC, the DHHS Division of Behavioral Health is actively engaged in a strategic planning process to update the State’s suicide prevention plan. System change will be promoted by working through the DHHS and Regional Behavioral Health Authorities to ensure suicide prevention becomes an expected component of service delivery and data collection. Figure x illustrates how GLS grant activities fit within the 2012 national framework and will influence revision of the current statewide plan to support suicide prevention across the lifespan.



In effort to be as inclusive as possible, while also revising the state’s goals in alignment with National Strategy for Suicide Prevention, engagement of a broad range of stakeholders will serve two purposes, a) to gain input and b) to gain consensus.

See proposed planning process below.

## Proposed State Suicide Prevention Plan Update Process - 2015



20. Suicide Prevention

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2. Describe how the state’s plan specifically addresses populations for which the block grant dollars are required to be used.

The following logic model demonstrates how the plan is related to the needs Nebraska is facing and the outcomes we hope to achieve. Through continued monitoring and evaluation, the state will be able to target the evidence-based practices to areas and populations of greatest need and address disparities in subpopulations.



Needs	Approach	Outcomes
<b>10 – 24 year olds have high suicide rates in Nebraska</b>	State coordinated, locally implemented EBP’s including means restriction	Reduced youth suicide rate in Nebraska
<b>Treatment professionals are not routinely assessing risk of suicide</b>	AMSR and CAMS Clinician Training	Increase # clinicians trained to asses, manage and treat youth at risk for suicide
<b>Adults in contact with youth need to recognize and act on signs of suicide risk</b>	QPR gatekeeper training; social marketing activities (including restriction of lethal means of suicide)	Gatekeepers prepared to recognize and act on suicide risk in every behavioral health region of Nebraska
<b>School personnel need to understand warning signs of suicide and how to intervene</b>	Kognito and QPR gatekeeper training; SPRC School Suicide Prevention Specialist Training	Schools use effective suicide prevention approaches Increase # persons in public school systems trained to identify risk of suicide Increase # of youth at risk who are identified, referred & receive services
<b>Youth in families with a legacy of suicide are at risk for suicide</b>	Implement LOSS teams in each regional behavioral health region	Quality post-vention services are available in Nebraska Increased # of LOSS teams in state
<b>Youth with behavioral health disorders are at high risk for suicide</b>	Implement standardized screening (Professional Partners; Family Navigators; Regional Network Providers in mental health and substance abuse)	Standardized screening protocols are sustained and tracked for youth with behavioral health disorders at risk for suicide
<b>Young adults in Nebraska are at risk for suicide</b>	Focused outreach to young adults in communities and on post-secondary campuses (community colleges, Cosmetology schools, Massage schools, Universities, workforce development programs, returning military work development programs, youth in transition to adulthood programs)	Increased awareness of suicide prevention among young adults Increased awareness of National Suicide Prevention Hotline Decreased number of suicides for young adults

3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. See attachment.

20. Suicide Prevention – Question #3: New Plan Progress Update Attachment

**2015 Nebraska State Suicide Prevention Leadership and Plan  
Nebraska Suicide Plan Progress Update:**

The Division of Behavioral Health is building on the success experienced during Nebraska's previous GLS grant (2009 – 2012) by continuing to serve the entire State. The state sustained several key youth suicide prevention strategies at the end of Nebraska's previous GLS grant in 2012 (requiring suicide screening for wraparound programs; requiring suicide screening for family peer support programs; supporting the state suicide prevention coalition; supporting the national suicide prevention hotline). Additionally, legislation was passed this year making youth suicide prevention training a requirement for all K-12 public schools.

The principle of 'one is too many' led the Nebraska State Suicide Prevention Coalition to suggest the grant be used to implement strategies based upon system improvement rather than focusing only on geographic areas of high need. While activities are intended to reach across the lifespan, the State is focusing on two primary two subpopulations: **1) youth in K-12 schools and 2) youth with behavioral health disorders.**

Nebraska's has chosen to focus on youth with behavioral health disorders because they are at high risk for suicide and cross over into many other systems. DHHS believes we can make the most significant systemic changes in the behavioral health system in Nebraska that will in turn impact the multiple systems that children and youth with behavioral health disorders are often involved in (e.g., child welfare, juvenile justice). Since our behavioral health system is state coordinated but locally controlled, we believe that focusing our efforts in this area will also positively impact local communities.

Children and youth 10-21 will be impacted four ways:

1. K-12 school personnel will receive gatekeeper training (Kognito or QPR)
2. Screening for youth with serious emotional problems served through Professional Partner Program
3. Screening for youth in contact with family navigators in the child welfare system
4. Screening for youth serviced through crisis services and office or home-based therapy provided by regional network service providers

Young adults will be reached three ways:

1. Focused outreach to post-secondary settings (awareness/QPR)
2. Focused outreach to community work development programs
3. Awareness activities directed at the community level

As a result of the previous GLS grant and suicide prevention plan the preferred gatekeeper training model was established by the state to create a common language for identification and referral of children and youth at risk for suicide. We have ten (out of an original 24) trainers who were recertified to continue this training this year. Additional trainers will be prepared and placed within each behavioral health region. The State continues to use the four in-state AMSR trainers to expand training to each regional area. The state is working to enhance sustainability

*20. Suicide Prevention – Question #3: New Plan Progress Update Attachment*

by planning linkages with the University of Nebraska Medical Center’s Behavioral Health Education Center of Nebraska (BHECN), an established training organization dedicated to improving the competency of Nebraska’s behavioral health workforce. In the previous grant the state chose the SBQ-R screening tool and integrated its use with the Professional Partner Programs in each Region and introduced it to Family Navigators in the child welfare system. The Division of Behavioral Health is re-instituting reporting of screening data collected by Professional Partners, re-introducing and familiarizing the Family Navigators with the screening tool, making referrals and data collection/reporting. The Division of Behavioral Health is also expanding use of the SBQ-R to regional network providers and building on data collection and reporting expectations into the system.

The following Evidence Based Practices are currently being implemented to help meet the goals state suicide prevention plan:

1. **Kognito Training Suite for School Personnel in Grades K-12 - online training** simulations designed to build skills and increase confidence so that one individual can influence a positive change in another’s behavior. Their core approach is based on research in neuroscience, social cognition and game mechanics.
2. **QPR (Question, Persuade, Refer) Gatekeeper training** – continue efforts to assist communities with implementing culturally appropriate suicide prevention strategies and preventing youth/young adult suicide by using local trainers.
3. **SBQ-R Screening tool** - continue to promote these protocols and expand their use to network providers serving children and youth.
4. **AMR (Assessing and Managing Suicide Risk) clinician training** – a one-day in-person training in every Region to be offered each year of the grant.
5. **CAMS (Collaborative Assessment and Management of Suicidality) clinician training** – to be augmented with AMSR and addresses practical clinical practices such as charting, treatment planning and assessing risk systematically.
6. **LOSS (Local Outreach to Suicide Survivors) postvention model** – identify communities that are ready for LOSS implementation. Develop team in conjunction with local law enforcement and are deployed immediately after a suicide to provide information and support to survivors.
7. **Means Restriction** – continue distributing information about restricting lethal means of suicide in communities and hospitals. Build on development of the discharge protocol that was adopted by the NE State Trauma Board in 2012.

The Division of Behavioral Health will ensure suicide prevention remains a priority in our system by expanding requirements for standardized screening in contractual agreements with providers; continuing to track suicide and self-injury data from hospitals; making suicide prevention reporting to system oversight and monitoring groups an imperative; moving post-secondary systems toward requiring gatekeeper training; and creating local demand for effective suicide prevention practices within state and local systems.

## 21. Support of State Partners

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## C. Environmental Factors and Plan

**21. Support of State Partners**

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities.

1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.
2. Attach any letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA, including the state education authorities, the SMAs, entity(ies) responsible for health insurance and the health information Marketplace, adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency, etc.

The Division of Behavioral Health works with a wide variety of public and private entities to promote recovery, prevention and treatment initiatives to ensure success of MHBG and SAPTBG programs. Below is a sampling of these relationships:

- DHHS Division of Medicaid and Long Term Care
  - Sharing of data to evaluate and monitor public behavioral health system
  - Children's System of Care (SOC) Committee and participating in development of SOC Financial Blueprint
  - Coordinated service definitions for medically necessary BH services
  - Trauma Informed Care Initiative
  - Regular staff meetings on behavioral health issues, managed care, legislation, etc.
- DHHS Division of Children & Family Services
  - Alternative Response implementation, evidence-based practices to assess a family's strengths and needs and the likelihood of abuse or neglect if children remain at home while receiving services.
  - Coordination of services for children's wraparound and Family Peer support services for children and youth with behavioral health needs or at risk for out of home placement
  - Children's System of Care Committee and participating in development of SOC Financial Blueprint
  - Nebraska Homeless Assistance Program
    - Coordination and participation in continuums of care for outreach and assistance to homeless individuals experience behavioral health disorder
    - Promotion and funding for SOAR
  - Trauma Informed Care Initiative
  - Trauma trainings for Staff and service providers
- DHHS Division of Public Health
  - Children's System of Care Committee and participating in development of SOC Financial Blueprint

## 21. Support of State Partners

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- Health workgroups
- Promotion of and education about health equity
- Tobacco cessation, prevention of tobacco sales to minors and retailer education on tobacco sale laws
- Trauma trainings for staff and service providers
- Co-Sponsor of annual Healthy Youth Nebraska conference
- Trauma Informed Care Initiative partnership
- Prescription and Opioid Abuse, PDHP
- Student Health And Risk Prevention (SHARP) survey workgroup
- DHHS Division of Developmental Disabilities
  - Children's System of Care Committee and participating in development of SOC Financial Blueprint
  - Case reviews and problem solving
- Interchurch Ministries of Nebraska
- Lincoln Medical Education Partnership – School Community Intervention & Prevention (SCIP)
  - Statewide prevention and early intervention services for youth with behavioral health concerns
- Nebraska Supreme Court and the Administrative Office of the Courts & Probation,
  - Coordination of services definitions
  - Children's System of Care Committee and participating in development of SOC Financial Blueprint
  - Trauma Informed Care Initiative
  - Justice Behavioral Health Committee
    - Standardized Model for Delivery of Substance Use Disorder Services for juvenile and adult probationers/problem-solving court participants
    - Training for completing Addiction Severity Index and Children's Addiction Severity Index
- Nebraska Department of Education
  - Children's System of Care Committee and participating in development of SOC Financial Blueprint
  - Suicide education in schools
  - Student Health And Risk Prevention (SHARP) survey workgroup
- Nebraska Department of Highway Safety
  - Co-sponsor of statewide underage drinking prevention media campaign
  - Impaired driving prevention and education
- Nebraska State Patrol
  - Submission of MHBD Commitment for Federal gun checks
- Nebraska Vocational Rehabilitation
  - Coordinated provisions of Supported Employment for behavioral health consumers including implementation of braided funding for milestones designating steps for successful consumer outcomes (e.g., permanent competitive

## 21. Support of State Partners

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employment); joint oversight and evaluation of service providers of the milestone approach; sharing of data to monitor and measure outcomes

- Nebraska Department of Economic Development and Nebraska Investment Financing Association (NIFA) – promotion of housing options for consumers and housing planning
- Regional Behavioral Health Authorities – All initiatives and services in the state
- Nebraska State Suicide Prevention Coalition – suicide education, intervention and prevention; LOSS team development and support
- Nebraska Federation of Families with Children’s Mental Health
  - Children’s System of Care Committee and participating in development of SOC Financial Blueprint
  - Family navigator
  - Peer certification program development
  - Promotion of and advancement of peer involvement and Recovery Orientated Systems of Care
- Nebraska Children & Family Foundation
  - Children’s System of Care Committee and participating in development of SOC Financial Blueprint
- Prevention Partnership Committee
  - Promotes child wellbeing, and providing safe, stable, nurturing relationships and environments for children and families
- Nebraska Prevention Center for Alcohol and Drug Abuse
  - Nebraska Colligate Consortium to reduce high-risk drinking and the negative effects of excessive alcohol use
- University of Nebraska-Lincoln: survey research, evaluation and support
  - Bureau of Sociological Research (BOSR) – annual Consumer Survey
  - Office of Research & Economic Development (Survey, Statistics and Psychometrics)
- University of Nebraska Medical Center
  - Student Nurse training
  - Collage of Public Health
- University of Nebraska Medical Center Behavioral Health Education (BHECN)
  - Trauma training;
  - Development, support of peer training
  - Workforce development, education and training of professionals
- Magellan of Nebraska
- University of Nebraska Public Policy Center
  - Evaluation state peer certification process
  - Coordination of suicide prevention services and intervention
  - Coordination of Disaster Behavioral Health services

Please see attachments of letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA.

22. *State Behavioral Health Planning/Advisory Council  
and Input on the Mental Health/Substance Abuse Block Grant Application*

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**C. Environmental Factors and Plan**

**22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application**

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating mental health and substance abuse agencies, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance abuse, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance abuse prevention and treatment advisory council to ensure that the council reviews issues and services for persons with, or at risk for, substance abuse and substance use disorders.

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).

The [Nebraska Behavioral Health Services Act](#) is the enabling legislation which mandates the DBH role as the chief behavioral health authority for the State of Nebraska. This enabling legislation also established the State Advisory Committee on Mental Health Services and the State Advisory Committee on Substance Abuse Services. When meeting in joint session, the two advisory committees serve as the State Behavioral Health Advisory Council.

The DBH administers, oversees, and coordinates the state's public behavioral health system to address the prevention and treatment of mental health and substance use disorders. Through integration and coordination of the public behavioral health system, the DBH works to develop a behavioral health system that is co-occurring capable, trauma-informed, recovery-oriented, and person-centered.

The joint committee continues its active involvement in the state plan by providing advice and assistance to the DBH on the ongoing planning efforts that inform and shape planning at State, regional, and local levels. This includes guiding review of behavioral health services initiatives, strategic plan and needs assessment, Consumer Survey, Results-based Accountability, Continuous Quality Improvement and other efforts guiding activities across the systems, and prioritization of state planning activities in the state application. Recent activities include:

February 13, 2014 Joint Committee Meeting

Meeting topics included: Needs Assessment and Readiness Assessment for the System of Care initiative; Peer Support and Wellness studies developed for the Transformation Transfer Initiative; Nebraska Behavioral Health Annual Consumer Survey data.

May 8, 2014 Joint Committee Meeting

Meeting topics included: Subcommittee work activities of Prevention Advisory Council; System of Care Stakeholder Town Hall Meetings; DBH Strategic Plan; findings from the Peer Support Survey; SAMHSA Block Grant Review and Updates.

August 14, 2014 Joint Committee Meeting

Meeting topics included: Marijuana and Synthetic Drug Use in Nebraska; Nebraska's use of

22. *State Behavioral Health Planning/Advisory Council  
and Input on the Mental Health/Substance Abuse Block Grant Application*

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prevention research to guide prevention strategies; Nebraska Housing and Community Development Consolidated Plan planning activity; Subcommittee work activities of Prevention Advisory Council.

November 13, 2014 Joint Committee Meeting

Meeting topics included: Affordable Care Act and MHPAEA in Nebraska; SAMHSA Block Grant Implementation and Priority Indicators review and updates; Subcommittee work activities of the Prevention Advisory Council; Annual SYNAR Report review and update.

January 27, 2015 Joint Committee Meeting

Meeting topics included: SAMHSA Block Grant First Episode Psychosis 5% Set Aside; Youth Suicide Prevention planning and activity; SAMHSA 2016/2017 Block Grant Needs Assessment and Priorities; Office of Consumer Affairs – Network of Care, OCA Survey.

March 17, 2015 Joint Committee Meeting

Meeting topics included: Subcommittee work activities of the Prevention Advisory Council; Office of Consumer Affairs: Mission, Vision, and Core Functions; Role of the Lincoln Regional Center (State Hospital) Medical Director; Community Integration Strategy planning; Suicide Prevention and LOSS Teams; SAMHSA 2016/2017 Block Grant Needs Assessment and Priorities.

August 13, 2015 Joint Committee Meeting

SAMHSA 2016/17 Block Grant – Review and recommendations on the Needs Assessment, Priorities, Application; Community Integration/Olmstead planning; Advisory Committee Structure planning.

Additional information is available on the DBH website.

[State Advisory Committee for Mental Health Services](#)

[State Advisory Committee for Substance Abuse Services](#)

**2. What mechanism does the state use to plan and implement substance abuse services?**

In its capacity as the SSA, also known as Single State Authority, the DBH has established mechanisms to comprehensively consider the substance abuse needs statewide and develop methods for addressing them. These mechanisms include the state Prevention Advisory Council (a subcommittee of the State Advisory Committee on Substance Abuse Services), DBH's Strategic Plan (with its co-occurring emphasis), DBH's Five Year Strategic Plan for Prevention, Nebraska's Substance Abuse Prevention Statewide Strategic Plan, the Nebraska State Epidemiological Outcome Workgroup (SEOW) and the Regional Prevention Coordination System.

The Five Year Strategic Plan for Prevention addresses capacity building with the goal of strengthening leadership, infrastructure and workforce at the State and Regional levels in order to support strong community coalitions and their volunteer members. The Prevention Advisory Council, in collaboration with state prevention staff, serve as the evidence-based workgroup for

22. *State Behavioral Health Planning/Advisory Council  
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the State of Nebraska. The Nebraska Substance Abuse Prevention Statewide Strategic Plan identifies and prioritizes outcomes utilized to monitor the progress of Nebraska's prevention system and through continuous quality improvement processes measures progress toward achieving prevention targets. For more information on these mechanisms to plan and implement substance abuse services please see *Section 9. Primary Prevention for Substance Abuse*.

3. **Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?**

Yes. The joint committee is integrated as the Behavioral Health Advisory Council by which it addresses behavioral health conditions, including mental health and substance abuse. Nebraska adopted the joint committee structure in 2010 and continues to successfully utilize this model.

The expertise and experience of the members of the State Advisory Committee on Substance Abuse Services enables the joint committee to review plans provided by the state and provide advice and assistance to the DBH. Examples of recent issues and concerns addressed to the joint committee include:

- Incorporation of the Prevention Advisory Council as a standing subcommittee of the State Advisory Committee on Substance Abuse Services;
- Integration of mental health promotion, substance abuse prevention, trauma-informed care, and shared risk and protective factors;
- Nebraska System of Care 2014 Strategic Planning Project – Planning for Transformation through Partnerships;
- Patient Protection and Affordable Care Act and Mental Health Parity and Addiction Equity Act in Nebraska;
- Combined Behavioral Health Assessment and Plan Implementation and Priority Updates;
- Peer Support and Wellness as part of the Transformation Transfer Initiative.

4. **Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?**

The Behavioral Health Advisory Council composite members are representative of the service population across the State of Nebraska. Committee membership is defined by state statute and appointment to the committees is by executive action of the Governor of the State of Nebraska.

State statute requires committee members to have a demonstrated interest, commitment and specialized knowledge, experience, or expertise relating to the provision of mental health/substance abuse services. Membership is composed of individuals in recovery, family members of individuals in recovery, parents of children with SED, providers of mental health

22. *State Behavioral Health Planning/Advisory Council  
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and substance use disorder services, representatives of partner state agencies, and other interested citizens.

Council members are appointed from representative areas across the State. Twenty three of the thirty council members reside urban areas (77%), seven reside in rural areas (16%) and two (7%) reside in frontier areas. Nebraska is a large geographic state with low population density, with nearly two-thirds of the total population living in 13 of its 93 counties; nearly 95 percent of its land area is considered rural and 46.8 percent of its land area is classified as *Frontier and Remote*, using the most restrictive classification developed by the [USDA Economic Research Service](#) and the [Federal Office of Rural Health Policy](#).

5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

Nebraska Revised Statute 71-814 (2) established the responsibilities and duties of the State Advisory Committee on Mental Health Services: “The committee shall be responsible to the division and shall (a) serve as the state’s mental health planning council as required by Public Law 102-321, (b) conduct regular meetings, (c) provide advice and assistance to the division relating to the provision of mental health services in the State of Nebraska, including, but not limited to, the development, implementation, provision, and funding of organized peer support services, (d) promote the interests of consumers and their families, including, but not limited to, their inclusion and involvement in all aspects of services design, planning, implementation, provision, education, evaluation, and research, (e) provide reports as requested by the division, and (f) engage in such other activities as directed or authorized by the division.”

Nebraska Revised Statute 71-815 (2) established the responsibilities and duties of the State Advisory Committee on Substance Abuse Services: “The committee shall be responsible to the division and shall (a) conduct regular meetings, (b) provide advice and assistance to the division relating to the provision of substance abuse services in the State of Nebraska, (c) promote the interests of consumers and their families, (d) provide reports as requested by the division, and (e) engage in such other activities as directed or authorized by the division.”

The DBH will be seeking on-site technical assistance in November 2015.

*Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.*

See the tables *Behavioral Health Advisory Council Members* and *Behavioral Health Council Composition by Member Type*.

## Environmental Factors and Plan

### Behavioral Health Advisory Council Members

Start Year:

End Year:

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Adria Bace (MH)	State Employees	Dept of Education	301 Centennial Mall So Lincoln, NE 68509 PH: 402-471- 2471 FAX: 402-471-5022	adria.bace@nebraska.gov
Cameron White (MH)	State Employees	DHHS Div of Medicaid and Long Term Care	PO Box 94661 Lincoln, NE 68509 PH: 402-471-1920	cameron.white@nebraska.gov
Mark Schultz (MH)	State Employees	Vocational Rehabilitation	2828 Stratford Avenue Lincoln, NE 68508 PH: 402-471-1202	mark.schultz@nebraska.gov
Linda Krutz (MH)	State Employees	NE Crime Commission	301 Centennial Mall South - 5th floor Lincoln, NE 68509 PH: 402-471-4327	Linda.Krutz@nebraska.gov
Nathan Busch (MH)	State Employees	DHHS Division of Children & Family Services	301 Centennial Mall So Lincoln, NE 68508 PH: 402-471-1791	nathan.busch@nebraska.gov
Kasey Moyer (MH)	Providers		Mental Health Assoication, 1645 N Street, #A Lincon, NE 68508 PH: 402-441-4371	kmoyer@mha-ne.org
Joel Schnieder (MH)	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		17110 Palisades Drive Omaha, NE 68136 PH: 402-681-5439	velvethammer1@cox.net
Diana Waggoner (MH)	Family Members of Individuals in Recovery (to include family members of adults with SMI)		13609 California, #210 Omaha, NE 68154 PH: 402-708-1960	diana@waggoneragency.com
Janet Johnson (SA)	Providers		Choices Treatment Center, 2737 No. 49th Street, Lincoln, NE 68504 PH: 402-476-2300	janet.l.johnson09@gmail.com
Ann Ebsen (SA)	Others (Not State employees or providers)		309 Oakridge Court Papillion, NE 68005 PH: 402-331-8830	aebesen@aol.com
Jay Jackson (SA)	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Jackson Services, 30612 205th Ave Columbus, NE 68601 PH: 402-562-3755	jayjackson@jackson-services.com
Randy See (SA)	Others (Not State employees or providers)		529 Hermitage Court Grand Island, NE 68801 PH: 308-381-8721	randy.see@hallcountyne.gov
Kathleen Hanson (MH)	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1330 Lincoln Mall, Apartment A404 Lincoln, NE 68508 PH: 402-817-1135	Khanson1757@msn.com
Karla Bennetts (MH)	Parents of children with SED		301 N Briggs Street Wilcox, NE 68982 PH: 308-991-6099	kbennetts@familiescares.org

Rachel Pinkerton (MH)	Family Members of Individuals in Recovery (to include family members of adults with SMI)		Valley, NE 68064 PH: 402-763-8352	rachelpinkerton@hotmail.com
Rev. Bradley Hoefs (MH)	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		3410 No. 205th Street Elkhorn, NE 68022 PH: 402-968-3683	bradhoefs@yahoo.com
Sheri Dawson (MH & SA)	State Employees	DHHS Division of Behavioral Health	DHHS- Division of Behavioral Health, 301 Centennial Mall So Lincoln, NE 68508 PH: 402-471-7818 FAX: 402-471-7859	sheri.dawson@nebraska.gov
Ingrid Gansebm (SA)	Providers		54597 862 Road Osmond, NE 68765 PH: 402-748-3983	igansebm@region4bhs.org
Michael Phillips (SA)	Providers		7624 Sherman Drive Omaha, NE 68134 PH: 402-953-4617	mike.phillips@douglascounty-ne.gov
Patti Jurjevich (MH)	Providers		3801 Harney Street Omaha, NE 68131 PH: 402-444-6573	pjurjevich@regionsix.com
Kimberly Mundil (SA)	Providers		14901 NW 37th Street Raymond, NE 68428 PH: 402-610-3566	kimberly.mundil@bryanhealth.org
Paige Hruza (SA)	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1306 N 112th Circle, #C5922 Omaha, NE 68554 PH: 308-850-0554	Paige51266@yahoo.com
Mary Thunker (MH)	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		8911 Decatur Street Omaha, NE 68114 PH: 402-640-8196	mthunker@gmail.com
Beverly Ferguson (MH)	Parents of children with SED		3405 Portia Place Norfolk, NE 68701 PH: 402-371-2745	bfergy04@cableone.net
Phyllis McCaul (MH)	Parents of children with SED		933 "A" Street Lincoln, NE 68502 PH: 402-441-4361	pmccaul@region5systems.net
Ashley Pankonin (MH)	Parents of children with SED		33060 RD 769 Grant, NE 69140 PH: 308-352-6720	ashleypankonin@gmail.com
Dusty Lord (SA)	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1901 SW 11th St Lincoln, NE 68522 PH: 402-805-5502	djdustylord@hotmail.com
Todd Stull (SA)	Providers		16262 "L" Street Omaha, NE 68135 PH: 402-917-7132	toddstullmd@insideperformance.net
Mary Wernke (SA)	Family Members of Individuals in Recovery (to include family members of adults with SMI)		1849 County Road 74 Hemingford, NE 69348 PH: 308-487-6397	mary@letterperfect.net
Bob Doty (MH)	State Employees	NE Dept of Economic Development	P.O. Box 94666 Lincoln, NE 68509 PH: 402-471-2095	bob.doty@nebraska.gov

Footnotes:

## Environmental Factors and Plan

### Behavioral Health Council Composition by Member Type

Start Year:

2016

End Year:

2017

Type of Membership	Number	Percentage
Total Membership	34	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	7	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	3	
Parents of children with SED*	4	
Vacancies (Individuals and Family Members)	<input type="text" value="3"/>	
Others (Not State employees or providers)	2	
Total Individuals in Recovery, Family Members & Others	19	55.88%
State Employees	7	
Providers	7	
Federally Recognized Tribe Representatives	0	
Vacancies	<input type="text" value="1"/>	
Total State Employees & Providers	15	44.12%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="0"/>	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="0"/>	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Persons in recovery from or providing treatment for or advocating for substance abuse services	<input type="text" value="0"/>	

\* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

The Behavioral Health Advisory Council is actively involved developing the state plan, including participating in and review of behavioral health services initiatives, needs assessment, Consumer Survey, Results-based Accountability, Continuous Quality Improvement and other efforts guiding activities across the systems, and prioritization of state planning activities in the state application. The application will be distributed to members of the Behavioral Health Advisory Council prior to the August 13, 2010 joint advisory committee meeting. At the August 13, 2010 meeting, the application will be presented to the members for discussion and their recommendations. Following the August 13, 2010 meeting, the DBH will review all recommendations to modify the application prior to official submittal to SAMHSA.

