Nebraska – FY2014 and 2015

Combined Behavioral Health Assessment and Plan: Substance Abuse Prevention & Treatment Application and Mental Health Application

Submitted August 28, 2013

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I: State Information

State Information

Plan Year

Start Year:
2014

End Year:
2015

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
Scot

Last Name
Adams

Agency Name
Nebraska Department of Health and Human Services - Division of Behavioral Health

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

City
Lincoln

Zip Code
68509-5026

Telephone
402-471-8553

Fax
402-471-9449

Email Address
scot.adams@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

Scot

Last Name

Adams

Agency Name

Nebraska Department of Health and Human Services - Division of Behavioral Health

Mailing Address

301 Centennial Mall South, Third Floor, PO Box 95026

City

Lincoln

Zip Code

68509-5026

Telephone

402-471-8553

Fax

402-471-9449

Email Address

scot.adams@nebraska.gov

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

From

To

IV. Date Submitted

NOTE: this field will be automatically populated when the application is submitted.

Submission Date

8/28/2013 11:49:40 AM

Revision Date

V. Contact Person Responsible for Application Submission

First Name

James

Last Name

Harvey

Telephone

402-471-7824

Fax

402-471-7859

Email Address

Jim.Harvey@nebraska.gov

Footnotes:

I: State Information

Assurance - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

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.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
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.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name	Scot L. Adams, Ph.D.
Title	Director - Division of Behavioral Health
Organization	NE Department of Health and Human Services

Signature: _____ Date: _____

Footnotes:

I: State Information

Assurance - Non-Construction Programs

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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.
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.
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17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name	Scot L. Adams, Ph.D.
Title	Director - Division of Behavioral Health
Organization	NE Department of Health and Human Services

Signature: _____ Date: 8/20/2013

Footnotes:

I: State Information

Certifications

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug -free work-place in accordance with 45 CFR Part 76 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), ?, (d), ?, and (f).

For purposes of paragraph ? regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget

Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. Certifications 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).

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

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

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

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

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

Name	Scot L. Adams, Ph.D.
Title	Director - Division of Behavioral Health
Organization	NE Department of Health and Human Services

Signature: _____ Date: _____

Footnotes:

I: State Information

Certifications

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a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

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a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), ?, (d), ?, and (f).

For purposes of paragraph ? regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

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Office of Grants Management
Office of the Assistant Secretary for Management and Budget

Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

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

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

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

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

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

Name	Scot L. Adams, Ph.D.
Title	Director - Division of Behavioral Health
Organization	NE Department of Health and Human Services

Signature: _____ Date: 8 Feb 2013

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements (Form 3) - Fiscal Year 2014 [SA]

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
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

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.

Name of Chief Executive Officer (CEO) or Designee: Scot L. Adams, Ph.D.

Title: Director - Division of Behavioral Health, NE DHHS

Signature of CEO or Designee[1]: _____ Date: _____

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

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements (Form 3) - Fiscal Year 2014 [SA]

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Name of Chief Executive Officer (CEO) or Designee: Scot L. Adams, Ph.D.

Title: Director / Division of Behavioral Health, NE DHHS

Signature of CEO or Designee[1]: _____ Date: 8/20/2013

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

Footnotes:

Dave Heineman
Governor

STATE OF NEBRASKA
OFFICE OF THE GOVERNOR
P.O. Box 94848 • Lincoln, Nebraska 68509-4848
Phone: (402) 471-2244 • gov.heineman@gov.ne.gov

August 12, 2009

Ms. Barbara Orlando, M.S.
Grants Management Specialist
Office of Program Services, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1091
Rockville, MD 20857

Dear Ms. Orlando:

On behalf of the State of Nebraska, I hereby authorize Kerry T. Winterer, Chief Executive Officer, of the Department of Health and Human Services, to make all required applications, agreements, certifications and reports related to the Substance Abuse Prevention and Treatment Block Grant.

Kerry T. Winterer, Chief Executive Officer
Nebraska Department of Health and Human Services
PO Box 95026
Lincoln, NE 68509-5026

Effective immediately and until further notice, please send all Grant Awards and similar notices concerning the Substance Abuse Prevention Treatment Block Grant to:

Scot L. Adams, Ph. D., Director
Division of Behavioral Health
Nebraska Department of Health and Human Services
P.O. Box 95026
Lincoln, NE 68509-5026

Thank you for your attention to this matter

Sincerely,

Dave Heineman

Dave Heineman
Governor

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DHHS
Nebraska Department of Health
and Human Services

State of Nebraska

Dave Heineman, Governor

August 7, 2009

Ms. Barbara Orlando, M.S.
Grants Management Specialist
Office of Program Services, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1091
Rockville, MD 20857

Dear Ms. Orlando:

On behalf of the State of Nebraska, I hereby authorize Scot Adams, Director, Division of Behavioral Health of the Department of Health and Human Services, to make all required applications, agreements, certifications and reports related to the Substance Abuse Prevention and Treatment Services Block Grant.

Scot Adams, Ph. D., Director
Division of Behavioral Health
Nebraska Department of Health and Human Services
P.O. Box 95026
Lincoln, NE 68509-5026

Effective immediately and until further notice, please send all Grant Awards and similar notices concerning the Substance Abuse Prevention and Treatment Block Grant to:

Scot Adams, Ph. D., Director
Division of Behavioral Health
Nebraska Department of Health and Human Services
P.O. Box 95026
Lincoln, NE 68509-5026

Thank you for your attention to this matter

Sincerely,

Kerry T. Winterer
Chief Executive Officer
Department of Health and Human Services

Helping People Live Better Lives

An Equal Opportunity/Affirmative Action Employer

printed with soy ink on recycled paper

I: State Information

Chief Executive Officer's Funding Agreements (Form 3) - Fiscal Year 2014 [MH]

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart I 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 I of the Public Health Service Act		
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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		
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Section 1947	Nondiscrimination	42 USC § 300x-57
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Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

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Name of Chief Executive Officer (CEO) or Designee	Scot L. Adams, Ph.D.
Title	Director - Division of Behavioral Health, NE DHHS

Signature of CEO or Designee[1]: _____ Date: _____

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

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements (Form 3) - Fiscal Year 2014 [MH]

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
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I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart I 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.

Name of Chief Executive Officer (CEO) or Designee: Scot L. Adams, Ph.D.

Title: Director - Division of Behavioral Health, NE DHHS

Signature of CEO or Designee[1]: _____ Date: 8/20/2013

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

Footnotes:

STATE OF NEBRASKA

Dave Heineman
Governor

OFFICE OF THE GOVERNOR
P.O. Box 94848 • Lincoln, Nebraska 68509-4848
Phone: (402) 471-2244 • gov.heineman@gov.ne.gov

August 12, 2009

Ms. Barbara Orlando, M.S.
Grants Management Specialist
Office of Program Services, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1091
Rockville, MD 20857

Dear Ms. Orlando:

On behalf of the State of Nebraska, I hereby authorize Kerry T. Winterer, Chief Executive Officer, of the Department of Health and Human Services, to make all required applications, agreements, certifications and reports related to the Community Mental Health Services Block Grant.

Kerry T. Winterer, Chief Executive Officer
Nebraska Department of Health and Human Services
PO Box 95026
Lincoln, NE 68509-5026

Effective immediately and until further notice, please send all Grant Awards and similar notices concerning the Community Mental Health Services Block Grant to:

Scot L. Adams, Ph. D., Director
Division of Behavioral Health
Nebraska Department of Health and Human Services
P.O. Box 95026
Lincoln, NE 68509-5026

Thank you for your attention to this matter.

Sincerely,

Dave Heineman

Dave Heineman
Governor

August 6, 2009

Ms. Barbara Orlando, M.S.
Grants Management Specialist
Office of Program Services, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1091
Rockville, MD 20857

Dear Ms. Orlando:

On behalf of the State of Nebraska, I hereby authorize Scot Adams, Director, Division of Behavioral Health of the Department of Health and Human Services, to make all required applications, agreements, certifications and reports related to the Community Mental Health Services Block Grant.

Scot Adams, Ph. D., Director
Division of Behavioral Health
Nebraska Department of Health and Human Services
P.O. Box 98925
Lincoln, NE 68509-8925

Effective immediately and until further notice, please send all Grant Awards and similar notices concerning the Community Mental Health Services Block Grant to:

Scot Adams, Ph. D., Director
Division of Behavioral Health
Nebraska Department of Health and Human Services
P.O. Box 98925
Lincoln, NE 68509-8925

Thank you for your attention to this matter

Sincerely,

Kerry T. Winterer
Chief Executive Officer
Department of Health and Human Services

I: 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	Scot L. Adams, Ph.D.
Title	Director - Division of Behavioral Health
Organization	NE Department of Health and Human Services

Signature: _____ Date: _____

Footnotes:

I: 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	Scot L. Adams, Ph.D.
Title	Director - Division of Behavioral Health
Organization	NE Department of Health and Human Services

Signature: Date: 8/20/2013

Footnotes:

II: Planning Steps

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

Narrative Question:

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.

Footnotes:

FY 2014-2015 SAMHSA Block Grant Application
- Community Mental Health Services Plan and Report
- Substance Abuse Prevention and Treatment Plan and Report

August 27, 2013

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.

Nebraska's Behavioral Health System Overview

Behavioral Health in Nebraska includes three distinct service areas: Mental Health, Substance Use Disorders and Problem Gambling. 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 DBH administers, oversees, and coordinates the state's public behavioral health system to address the prevention and treatment of mental health, substance use, and problem gambling 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 the three Advisory Committees guiding the DBH (Mental Health, Substance Abuse, and Problem Gambling), 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.
»» The second proposes key *partnerships* the Division of Behavioral Health should focus on as part of the strategy.
»» The third proposes suggests *joint initiatives*.

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.

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 and
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.

Regional Centers
The Lincoln Regional Center (LRC), a 250-bed 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 120-bed 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 program is licensed for 40 beds and has an average length of stay of approximately 4-6 months. The Hastings Regional Center is a Joint Commission accredited facility.

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

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 providers for the treatment of individuals with problem gambling disorders; 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 Division of Behavioral Health Community-Based Services (DBH-CBS) contracted with the Nebraska Association of Behavioral Health Organizations (NABHO) to carry out Peer Reviews of selected programs. For years this Independent Peer Review process assessed the quality, appropriateness, and efficacy of treatment services provided in Nebraska for individuals served by mental health and/or substance abuse programs, and ensured at least five percent (5%) of the entities providing services in the State under such program were reviewed. This contract ended June 30, 2013.

The new approach 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.

Starting July 1, 2013 DBH is 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. In place of the DBH contracting with NABHO, there will be an expectation of SABG and MHBG fund recipients to have National Accreditation. This is already in Title 204 regulations covering Community Mental Health Programs (see Chapter 5 section 001.03B3) http://dhhs.ne.gov/Pages/reg_t204.aspx. This is also encouraged for community substance abuse programs under contract with the Regions. Many community substance abuse programs have national accreditation. The Division of Behavioral Health Title 206 proposed regulations went to public hearing on August 1, 2013. 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 (Chapter 5, section 001.3; draft as of 6/27/13).

Office of Consumer Affairs

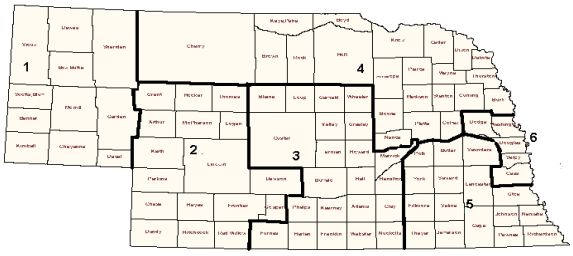
The Office of Consumer Affairs (OCA) works to build, promote, and sustain services which incorporate consumers as integral components of the recovery process throughout the system. Activities include facilitating community forums for consumers to receive feedback on the quality of services being provided 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

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 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 (Year 2010)

Regional Behavioral Health Authority	RBHA Office	Counties	Population	% of Population
1 (Panhandle)	Scottsbluff	11	87,789	4.8%
2 (West Central)	North Platte	17	101,415	5.6%
3 (South Central)	Kearney	22	226,320	12.4%
4 (Northeast & North Central)	Norfolk	22	207,781	11.4%
5 (Southeast)	Lincoln	16	444,920	24.4%
6 (Eastern)	Omaha	5	758,116	41.5%
Totals		**93**	**1,826,341**	**100%**

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 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 and treatment services for the State of Nebraska. The DBH's Prevention System Coordinator serves as the National Prevention Network representative, the Synar Coordinator and the State Epidemiological Outcomes Workgroup (SEOW) Project Director. The focus of the Prevention System Coordinator 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.

Using a multi-pronged approach, the DBH supports the statewide Nebraska Prevention System through interagency coordination, as well as funding prevention activities, directly and through a Regional Prevention Coordination System. The DBH contracts for technical assistance, training, and database development to support Regional Behavioral Health Authorities (RBHAs), coalitions and community entities. Direct interagency coordination activities include: Synar committee, partnering with Tobacco Free Nebraska, improving workforce development opportunities for preventionists, facilitating the Nebraska SEOW, and collaborating with the other state partners to continue the work of the Strategic Prevention Framework (SPF).

The majority of prevention activities purchased by the DBH are carried out by the RBHAs Prevention Coordination system. Funded primarily by the Substance Abuse Prevention and Treatment Block Grant, Regional Prevention Coordination staff utilize coexisting prevention efforts such as Strategic Prevention Framework – State Incentive Grant (SPF-SIG) 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. Regional Prevention Coordination Systems are designed to operate at the community level, embracing local culture while leading the development of sustainable prevention activities for substance abuse, addictive disorders, and related societal problems through the life span. The Regional Prevention Coordination Systems' delivery of such technical assistance contributes greatly to the development of community based prevention coalitions and has proven to be an invaluable asset not only to the DBH but to the statewide prevention system as well.

Maintaining consistent and frequent communication among the Regional Prevention Coordination System staff and with the DBH is a key factor in the success of our statewide prevention system. 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. Near the end of the SPF-SIG a new round of strategic planning for prevention was developed.

Nebraska's Five-Year Strategic Prevention Plan will support 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. The plan will guide prevention prioritization, decision-making, and policy development at the State, Region and community level. 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.

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 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.

Recently, the DMLTC has chosen to move to an at risk environment for behavioral health treatment and rehabilitative services and has signed an intent to contract with Magellan Health. This contract should be effective in September of 2013. Continued cooperation between the DBH, the DMLTC, and the new vendor are expected to occur. See D. Affordable Insurance Exchange for more details on Medicaid.

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. 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. Meanwhile, beginning October 1, 2013, children who have been Wards of the Office of Juvenile Services (OJS) and served by CFS will be served by the Office of Probation in the Judicial Branch. The Office of Probation will serve children in the Juvenile Justice system. CFS will continue 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.

The CWU and the OJS serve almost 11,000 youth placed in state custody each year. At any point in time, Nebraska averages approximately 6,800 youth in state custody. The CWU serves about 5,200 youth and the OJS serves about 1,600 youth. This does not include families being assessed for safety, non-court involved cases, or youth in the process of obtaining an OJS evaluation.

In addition to its focus on service delivery, the DCFS is currently working on a major initiative called Families Matter. Families Matter is a multi-year initiative to reform Nebraska's child welfare and juvenile services. The program operates under the belief that children grow best in their own homes; that children should be reunified or moved to permanency through adoption or guardianship in a timely manner; and, that families should get services earlier and be offered services after they leave NDHHS. The goals of Families Matter include: fewer children made state wards; more children served in family settings; and more timely permanency objectives.

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.

Based on an examination of the system, there is proposed legislation to continue to reform the child welfare system in Nebraska. LB502 provides a demonstration project to allow for "Alternative Response" to child abuse and neglect reports. These projects would be planned in consultation with the Nebraska Children's Commission. Following planning, NDHHS could use Alternative Response in up to five designated locations, with a report due to the Legislature on December 15, 2014.

Through the Alternative Response initiative, Nebraska expects to change its culture in regards to thinking safety of a child can only be achieved through removal from the family home, and to enhance the family's protective factors while maintaining the child's safety. This includes having a system that allows families to access needed services and supports without the formal involvement of the court system. Nebraska is in a time of great change in regards to the transparency and collaboration between the DCFS and their stakeholders. In 2012, the Nebraska Legislature passed legislation creating the Nebraska Children's Commission. The commission is comprised of stakeholders, child welfare advocates, and NDHHS staff dedicated to ensuring system reform.

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. DCFS is currently working on a Trauma Informed Care Self-Assessment in order to develop a strategic plan moving forward

As required by recent state legislation, the NDHHS applied for a Title IV-E waiver on January 13, 2013. Title IV-E waivers allow states greater flexibility in the use of federal Title IV-E funds. Title IV-E funds are restricted to paying for out-of-home care as well as some training and

administrative costs. If approved, the Title IV-E waiver will focus on safely reducing the number of children in foster care as well as ensuring the physical and mental health needs of children in foster care are being met. The waiver also allows for a broader range of services such as prevention services, and a wide range of intervention, support and therapy services. The intent of the flexibility provided for in the waiver is to improve the delivery of child welfare services by designing programs to keep children out of the system, to maintain children in their family homes, to accelerate the movement toward permanency, and to provide aftercare services that help to stabilize situations after exiting the system. In the long range, there should be general fund savings from enhanced preventative services and improvements in the child welfare system.

The DCFS recently implemented the Structured Decision-Making Model in all five Services Areas. Structured decision-making is an approach to child protective services that uses clearly defined and consistently applied decision-making criteria for screening for investigation, determining response priority, identifying immediate threatened harm, and estimating the risk of future abuse and neglect. Child and family needs and strengths are identified and considered when developing and monitoring progress toward a case plan. The DCFS recently contracted with the Regional Behavioral Health Authorities (RBHAs) in Nebraska to implement a wraparound model to assist families whose children are at risk of becoming state wards, providing assistance for families to promote children's well-being in their current home.

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

Service	Mental Health	Substance Abuse
Emergency Services:		
24 Hour Crisis Line	x	x
Civil Protective Custody (CPC)		x
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

Service	Mental Health	Substance Abuse
Post Commitment	x	
Respite Mental Health	x	
Social Detox		x
Urgent Medication Management	x	
Urgent Outpatient Psychotherapy	x	x
Residential Based Services:		
Dual Disorder Residential	x	x
Halfway House		x
Intermediate Residential-Substance Abuse		x
Pyschiatric Residential Rehabilitation	x	
Secure Residential	x	
Short Term Residential		x
Therapeutic Community		x
Outpatient Services		
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	
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	
Children/Youth Services:		

Service	Mental Health	Substance Abuse
Therapeutic Community/Youth/Adolescent	x	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	x	
Children Emergency Community Support	x	x
Children Intensive Outpatient SA		x
Children Outpatient MH-SA	x	x
Children Intensive Outpatient MH	x	
Children Medication Management	x	
Children/Youth Therapeutic Consultation	x	
Children Halfway House		x
Children Partial Care		x
Children Community Support MH	x	
Youth Assessment Only	x	
Crisis Inpatient Youth	x	
MH Respite Care Children/Adolescent	x	
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		
Flexible Funding		
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 Minority Health, 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 2010 Census racial populations

	TOTAL	
Race	Number	Percent of Total
Asian	32,293	1.8%
Native Hawaiian/Other Pacific	1,279	0.1%
Native American/Alaska Native	18,427	1.0%
Black/African American	82,885	4.5%
White	1,572,838	86.1%
Multiracial	39,510	2.2%
Other race	79,109	4.3%
Total	1,826,341	100.0%

Source: U.S. Census Bureau, 2010 Census for Nebraska

Division of Behavioral Health Community Based Services - Regional Behavioral Health Authorities

	Total	
Race of Persons Served	#	%
Asian	226	0.6%
Native Hawaiian/Other Pacific Islander	411	1.2%
Native American/Alaska Native	1,146	3.3%
Black/African American	3,331	9.5%
White	28,972	82.9%
Multiracial	259	0.7%
Unknown	593	1.7%
Total	34,938	100.0%

The RBHAs provide services to diverse populations as demonstrated by comparing the persons served data from State Fiscal Year 2012 to the 2010 U.S. Census data. The percent of persons by race served are comparable to the total numbers of persons by race present in the State of Nebraska.

Strengths and Needs of the Behavioral Health System

Hospital Diversion in Nebraska

Hospital Diversion services in Nebraska are provided by peers trained in Intentional Peer Support. The goal of this model of peer support is to redefine the crisis as a learning experience, reducing hospitalizations, increasing wellness planning and community connections.

- Keya House is one such hospital diversion that operates a 4-bedroom respite program where guests can stay up to 5 days to refocus during a crisis. They also have a Warmline for guests to stay in contact with peers. For more information on Keya House, see their web site at: http://keya.mha-ne.org/.
- Safe Harbor is another hospital diversion service in Nebraska. It operates similar to a living room model, where a peer can stay for 24 hours during a crisis and work on increasing wellness and community connections. They also have a Warmline component to their program. For more information on the Safe Harbor program, see the article on the web site at: http://www.community-alliance.org/userfiles/File/Journeys_Summer2012.pdf

Women's Set Aside Services

The Division of Behavioral Health (DBH) places a high priority on Women's Services through the Regional Behavioral Health Authorities (RBHAs). Each RBHA closely monitors and adopts the priorities set within the Substance Abuse Prevention and Treatment Block Grant and the DBH for admission to behavioral health services. This includes emergency, inpatient, residential, and non-residential services to ensure pregnant women, women who use/abuse injectable drugs, and women with dependent children are placed in services as soon as possible.

In FY2012, eleven providers in the state were designated as being Women's Set Aside Qualifying Services programs to meet the unique needs of pregnant women, women who use/abuse injectable drugs, and women with dependent children in need of treatment. In addition, to providing treatment services, these providers must ensure the following 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 developmental 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

Service Provider: Pregnant Women and Women with Dependent Children

Region	Provider Name	Provider City
1	Human Services Inc.	Alliance
1	Region 1 Behavioral Health Authority/PMHC	Scottsbluff
2	Region 2 Behavioral Health Authority	North Platte
3	South Central Behavioral Services	Kearney
3	St. Francis ADTC	Grand Island
3	The Bridge	Hastings
4	WELL (Women's Empowering Life Line)	Norfolk
5	Lincoln Medical Education Partnership	Lincoln
5	St. Monica's	Lincoln
6	Heartland Family Services	Omaha

SABG Table 8 for Nebraska implementation report (November 2012)

Co-Occurring Disorder Services

Co-Occurring Disorder (COD) Services are a DBH State priority. The DBH Strategic Plan 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 Statewide Quality Improvement Team (SQIT) Co-Occurring Disorders Workgroup completed a road map to the co-occurring service delivery system. Nebraska must develop the “No Wrong Door” approach to serving consumers. The Co-Occurring Disorders Workgroup road map initiatives are:

I. Nebraska will develop a co-occurring disorder system of care which is consumer driven and consumer centered. This system of care will include common vision - coordinated advisory committees - consumer input.

II. Nebraska will develop a strong infrastructure to support co-occurring disorder services-consumer experiences no wrong door. The infrastructure will include regulations/service definitions - data and technology - financial - service delivery - workforce development - prevention and early intervention - screening, assessment and treatment planning.

III. Nebraska will develop strong partnerships across all systems to ensure an expanded continuum of care. These systems include: criminal justice settings - primary health care - educational settings - homeless settings - human service settings.

The principle of “No Wrong Door” is a belief that to truly care for and treat a person, all professionals should be capable of identifying and addressing the mental health and addiction disorders of the individual seeking service, without requiring them to seek alternative services on their own. The DBH has used this to guide policy, system and infrastructure development, and quality improvement initiatives focused on co-occurring mental illness and substance use disorders. Examples include requiring provider assessments to include mental health, substance abuse, problem gambling and physical health issues; utilizing data systems to identify persons with multiple diagnoses on each axis to assist with data reporting and quality improvement

activities for persons served with co-occurring disorders; partnering with the Division of Public Health to review death records of individuals from the state hospitals to identify opportunities to improve health and impact the age of death for many individuals with mental illness; and, incorporate physical health questions in the DBH's Annual Consumer Survey and utilizing these results with stakeholders to develop plans for improvement.

Trauma Informed Services

Trauma Informed Care (TIC) services are another Division of Behavioral Health (DBH) State priority. Trauma Informed Care cuts across all identified behavioral health, adult and child treatment service populations. Trauma impacts children and family outcomes. The DBH Strategic Plan requires effectiveness and specifies a Continuous Quality Improvement process for services funded by the DBH, focusing on a number of factors including trauma. Work to improve access to a Trauma Informed Care service delivery system includes: increased number of behavioral health providers who have completed a Trauma Informed Service self-assessment or Peer Assessment Tool; RBHAs establish Region-wide initiatives to advance trauma informed care; and the DBH Central Office prioritizing opportunities for improvement.

Nebraska's trauma informed system is evolving and there are many steps remaining before it is complete. For example, the DBH is completing a Trauma Informed Care Review (Harris and Fallot TIC tool) at the system level this year and continues to develop the concept of trauma care as a universal precaution. Additionally, the DBH needs to engage other NDHHS partners to fully integrate trauma care across systems.

The system has taken many great steps toward becoming trauma informed and trauma specific. The Trauma Informed Nebraska (TIN) initiative is growing in all of the regional behavioral health systems. RBHAs are encouraging completion of the TIC tool, and sponsoring mini-grants for the development of trauma informed and trauma specific care. Providers are viewing the focus on trauma as integrative and recovery oriented rather than additive. At a recent statewide quality improvement meeting, providers and RBHAs thanked the DBH for keeping trauma informed care as a priority. Together with our partners, we consciously and continuously evolve to promote recovery.

Additional Considerations

Services for Tuberculosis

The Division of Behavioral Health (DBH) has no specific financial set aside for tuberculosis (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 all persons requesting services for communicable diseases. The TB Screening and Services requirements are listed under ATTACHMENT F - Federal Block Grant Requirements.

In FY2011, Nebraska had a total of 23 cases of TB, for a rate of 1.3 cases per 100,000 people. This represents the lowest number of TB cases and the lowest attack rate over the last five years in Nebraska. Of the 23 cases of tuberculosis in Nebraska in FY2011, 14 were foreign born, two (2) were homeless, one case was from a nursing home and two cases were co-infected with Human Immunodeficiency Virus (HIV). There were no cases with drug resistance among the

culture-confirmed cases. Nebraska has 93 counties, ten (10) of which reported cases of tuberculosis in FY2011. Nebraska Tuberculosis Prevention and Control Program is in the Division of Public Health. The Nebraska TB web site is at: http://dhhs.ne.gov/publichealth/Pages/cod_tuberculosis_tbindex.aspx#Data

Services for HIV/AIDS

The Nebraska rate for Human Immunodeficiency Virus infection / Acquired Immunodeficiency Syndrome (HIV/AIDS) is 4.3 cases per 100,000 individuals. 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)].

Designated States for the FY2011 SAPT Block Grant Uniform Application (page 185) are on the SAMHSA web site at: http://tie.samhsa.gov/Documents/pdf/FY_2011_SAPTBG_Uniform_Application.pdf

Tobacco Cessation and Synar

Nebraska's Synar and tobacco cessation efforts include, but are not limited to, the control of tobacco products and the enforcement of laws pertaining to tobacco control. The Division of Behavioral Health (DBH) serves as the lead agency for the Synar workgroup that coordinates and discusses planned activities of each agency represented, shares resources, interpretations of laws, and reviews potential next steps toward participation in the Federal Drug Administration's tobacco compliance activities. The DBH is also responsible for ensuring the completion of random, unannounced inspections of any business which manufactures, sells or distributes tobacco products to ensure compliance with laws limiting access of tobacco products by any individual under the age of 18.

As part of the Nebraska comprehensive tobacco cessation and merchant education process the state checks to see if youth under 18 can buy tobacco products. The sales rate to minors is conducted by the Nebraska State Patrol and local Peace Officers. The national standard for Retail Violation Rate (RVR) is below 20 percent. The 2012 Synar RVR is at 14% - a tremendous decline from when the state's rate was 33.2% in 1996. It is also worth noting that according to the Youth Risk and Behavior Survey, the youth smoking rate is at an all-time low (15%) and well below the U.S. rate (18%). The table below shows the Nebraska rate for the last four calendar years. The trends are reported on the DBH web site at: http://dhhs.ne.gov/publichealth/Pages/hew_sua_synar.aspx].

Nebraska Retail Violation Rate (RVR)

Calendar Year	Rate
CY2009	13.5%
CY2010	10.7%
CY2011	10.7%
CY2012	14%

A Memorandum of Understanding was developed through the Synar workgroup. This agreement constitutes an ongoing effort to implement a tobacco control policy to reduce under aged tobacco use, to provide information exchange on best practices used or funded by the agreeing organizations, and to establish consistent data elements for the measurement of enforcement efforts, surveys or studies, either by state agencies or locally funded tobacco coalitions.

With the implementation of the 2008 Nebraska Clean Indoor Air Act, Nebraska has made tremendous progress in reducing exposure to secondhand smoke within the state. The Act eliminates smoking in enclosed indoor workspaces including restaurants, bars, gaming establishments, and other indoor public places. The Division of Public Health - Tobacco Free Nebraska program is the primary lead in the state's smoking cessation efforts and played a vital role in the establishment of the NDHHS' toll-free information and quit line.

Homelessness

Persons who are homeless and have mental illness in Nebraska have specialized needs that may not be met by more traditional service delivery methods. The Division of Behavioral Health (DBH) utilizes a Project for Assistance in Transition from Homelessness (PATH) Grant to support Regional Behavioral Health Authorities (RBHAs) with the highest rates of homelessness. Providers conduct outreach and case management to engage homeless individuals with mental illness and direct them toward needed services.

In addition to PATH funds, the Nebraska Homeless Assistance Program (NHAP) within NDHHS supports a network of shelter, supportive housing, and service providers who strategically plan for and provide a balance of emergency, transitional, and permanent housing and service resources to address the needs of people who are homeless so they can make the critical transition from homelessness to jobs, independent living, and permanent housing. For more information on NHAP see the NDHHS web site at:
http://dhhs.ne.gov/children_family_services/Pages/fia_nhap_aboutnhap.aspx

The DBH also administers specific funding under the Nebraska Housing Related Assistance program to provide Supported Housing for adults with a serious mental illness who are extremely low income. The program is designed to be person centered, recovery oriented, and focused on a positive outcome of promoting independent housing and living for individuals in the program. Stable affordable housing is often the biggest barrier for individuals attempting to transition from residential services to independent living. As such, the DBH continues to seek creative options and funding to provide this necessity for individuals in recovery.

II: Planning Steps

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

Narrative Question:

This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

Footnotes:

FY 2014-2015 SAMHSA Block Grant Application
- Community Mental Health Services Plan and Report
- Substance Abuse Prevention and Treatment Plan and Report

August 7, 2013

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

This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the state‘s behavioral health care system, especially for those required populations described in this document and other populations identified by the state as a priority.

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

SAMHSA‘s Behavioral Health Barometer is intended to provide a snapshot of the state of behavioral health in America. This annual report will present a set of substance use and mental health indicators measured through two of SAMHSA‘s populations- and treatment facility-based survey data collection efforts, the NSDUH and the National Survey of Substance Abuse Treatment Services (N-SSATS). Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as, a mechanism for tracking change and trends over time. It is hoped that the Behavioral Health Barometer will assist the agency in furthering its mission of reducing the impact of substance abuse and mental illness on America‘s communities.

SAMHSA will provide each state with its state-specific outcome data for several indicators from the Behavioral Health Barometer. States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others. The data sets that states could use for developing their needs assessment and plans are included in the attachment.

Through the Healthy People Initiative, HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People35, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national-level enabling better comparability. States should consider this resource in their planning.

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.

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

According to the National Association of State Mental Health Program Directors Research Institute (NRI) the prevalence of adults with Serious Mental Illness (SMI) is 74,298. The prevalence of youth with Serious Emotional Disturbance (SED) is 22,415.

Nebraska

Adults SMI *	74,298
Youth SED **	22,415

Based on estimated population in 2011

* Number of Persons with Serious Mental Illness, Civilian Population, Age 18+ (5.4%)

** Number of Children with Serious Emotional Disturbance, age 9 to 17

source: 2011 SMI and SED Prevalence Estimates for Table 1
State Data Infrastructure Coordinating Center (SDICC)
National Association of State Mental Health Program Directors Research Institute (NRI)
http://www.nri-inc.org/projects/SDICC/urs_forms.cfm
Accessed on April 9, 2013

In FY2012, there were 23,535 individuals who were served in MH services and 15,544 individuals who were served in SA services. There were 15,092 adults served with SMI; 1,340 youth with SED. Consumers with SMI and SED received 8,692 Evidence Based Practice services.

	Youth		Adult		Total		
	Male	Female	Male	Female	Male	Female	Total
Mental Health	1,067	683	10,806	10,979	11,873	11,662	23,535
- SED	835	505	-	-	835	505	1,340
- SMI	-	-	7,240	7,852	7,240	7,852	15,092
Substance Abuse	159	134	9,875	5,376	10,034	5,510	15,544

Data source:

1. *MH: FY2012 URS table 2A, 14A*
2. *SA: FY2013 SABG Behavioral Health Report Table 12*

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 FY2012 Uniform Reporting System (URS).

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

Total age 18+	21,785	92.6%
Total	23,535	100%

Of this population reported on Table 2A, 45% are between the ages of 25-44 (10,578) and 33% are between the ages of 45-64 (7,674).

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

Total age 18+	15,092	91.8%
Total	16,432	100%

Of this population reported on Table 14A, 86% of the persons served are age 21-64 years (14,098).

Using these URS Table data, of the adults served Age 18+, 69% (15,092 from Table 14A) had a Serious Mental Illness of the 21,785 Persons Served Age 18+ reported on Table 2A.

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
- 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].

Older Adults with Serious Mental Illness (SMI)

The Division of Behavioral Health through the six Regional Behavioral Health Authorities (RBHAs) serves Older Adults with SMI. The data tables below are from the Nebraska FY2012 Uniform Reporting System (URS).

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

age 65+ years	653	2.8%
Total	23,535	100.0%

URS Table 14A. Profile of Persons with SMI served by Age

age 65+ years	449	2.7%
Total	16,432	100.0%

In addition to the services from the RBHAs, the Nebraska Department of Health and Human Services (NDHHS), Division of Medicaid and Long Term Care, State Unit on Aging (SUA) also funds services. The SUA, funded by the Older Americans Act, the Nebraska Community Aging Services Act, and the NDHHS, has broad responsibilities for addressing the concerns of older Nebraskans. The SUA grants state and federal funds to the eight Area Agencies on Aging in Nebraska to support local programs and services. With the assistance of local individuals and

advisory groups, each Area Agency on Aging determines needs and develops a plan to provide an appropriate array of services for its aging population. For more information on the State Unit on Aging see the web site at:
http://dhhs.ne.gov/medicaid/Aging/Pages/AgingHome.aspx

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 FY2012 Uniform Reporting System (URS).

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

age 0-17 years	1,750	7.4%
Total	23,535	100.0%

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

age 0-17 years	1,340	8.2%
Total	16,432	100.0%

Consumer Survey

We continue to experience an increase in our response rates to the Division of Behavioral Health annual consumer survey which thus provides valuable data when reviewing the needs of our current service system for adults and youth. 50% of adult consumers and youth caregivers surveyed in FY2012 provided feedback regarding their behavioral health care. A majority of adult consumers (83.6%) were generally satisfied with services compared to those who were dissatisfied with the services they received (6.5%); the remainder were neutral.

Caregiver reports through the youth consumer survey URS table report show that in FY2011 67% were satisfied with Access to Services for Nebraska youth compared to the U.S. rate of 83%. Additionally in FY2011 for Nebraska caregivers, only 64% were satisfied with Outcome from Services. While early estimates from FY2012 show improvement, the need for work in these areas persists.

Capacity Management and Waiting List System

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 FY2012 Substance Abuse Capacity and Waiting List Report (July 2011 – June 2012)

- → Regional capacity used is above 90% for Halfway House, Intensive Outpatient Program, Methadone Maintenance, Short-Term Residential, Outpatient Dual, Outpatient, Dual Disorder Residential, and Therapeutic Community services.
- → There were 591 priority consumers waiting for services in FY2012.
- → The majority of identified priority consumers waiting for substance abuse services were women with dependent children (45%, n=280).
- → Most people identified as priority consumers waiting for substance abuse services were waiting for admission into Short-Term Residential services (57%, n=336).
- → 379 out of 494 (76.7%) priority consumers were successfully removed from the waiting list in FY2012.
- → Women with dependent children (19.1 days) and therapeutic community (23.9 days) had the longest average wait days, respectively.

Summary FY2013 Substance Abuse Capacity and Waiting List Report (July 2012 – June 2013)

- → Regional capacity used is above 90% for Halfway house, community support, intensive outpatient, short-term residential, and therapeutic community services, Methadone maintenance, outpatient dual, and recovery support.
- → There were 589 priority consumers waiting for services in FY2013.
- → The majority of identified priority consumers waiting for substance abuse services were women with dependent children (43%, n=269)
- → Most people identified as priority consumers waiting for substance abuse services were waiting for admission into Short-Term Residential services (59%, n=347).
- → 381 out of 522 (73%) priority consumers on the waiting list were successfully admitted into services in FY2013.
- → Pregnant Women (22.3 days) and therapeutic community (26 days) had the longest average wait days, respectively.

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 four 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 served who are Injecting Drug Users

Year	SA ONLY Youth	Adult			TOTAL Youth & Adult All Services
		SA ONLY	Dual ONLY	COMBO	
FY2010	13	1,347	61	43	1,464
FY2011	9	1,445	59	46	1,559
FY2012	6	1,476	64	53	1,599

Total Youth & Adult All Services who are Injecting Drug Users

	TOTAL		Total # of person served
	Number	Percent	
FY2010	1,464	4.1%	36,011
FY2011	1,559	4.4%	35,387
FY2012	1,599	4.6%	34,938

FY2012 Average Wait Days
Priority Population: IV Drugs Users

Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Total
10 (n=5)	12 (n=11)	11 (n=26)	10 (n=9)	13 (n=114)	9 (n=58)	11 (n=223)

Numeral 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

	Youth	**Adult**
FY2010	0	36
FY2011	0	34
FY2012	1	35

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

FY2012 Average Wait Days
Population: Pregnant Injecting (IV) Drug Users

Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Total
0	0	0	7 (n=1)	14 (n=3)	11 (n=3)	11 (n=7)

Numeral 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

	SA ONLY		Dual ONLY	COMBO	TOTAL		TOTAL	
	Youth	Adult	Adult	Adult	Youth	Adult	#	%
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%

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

FY2012 Average Wait Days
Priority Population: Pregnant Women

Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Total
14 (n=2)	0	0	9 (n=1)	21 (n=6)	13 (n=11)	15 (n=20)

Numeral is 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.

FY2012 Average Wait Days

Priority Population: Women with Dependent Children

Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Total
24 (n=64)	13 (n=8)	23 (n=22)	16 (n=9)	15 (n=90)	20 (n=87)	19 (n=280)

Numeral is 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
Internet Release Date: September 2010
http://www.census.gov/population/metro/files/lists/2009/List1.txt

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

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

The table provides the unduplicated count of persons served in FY2010, FY2011, & FY2012 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.
  (Source: Nebraska Division of Behavioral Health – January 14, 2013)

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 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 FY2014/2015

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 binge drinking, youth and family functioning, individuals with co-occurring mental health and substance use disorders, for those with a history of trauma, peer support, and tuberculosis. Additional data in support of each of these areas is provided below. Additionally, Nebraska feels it is important to continue to support the growing number of Peer Support and Wellness Specialists within the behavioral health care system. Continuation of contract requirements will be used to address Tuberculosis service needs within the behavioral health care system.

Alcohol Use Among Youth

Underage alcohol consumption continues to be a problem among youth in Nebraska. The National Survey of Drug Use and Health (NSDUH) indicates that youth alcohol use rates, and binge drinking in particular, are higher in Nebraska compared to national rates. Furthermore, fewer Nebraska youth report a perceived risk of binge drinking once or twice a week.

The most recent data captured through use of the Nebraska Young Adult Alcohol Opinion Survey (NYAAOS) displays an increase in binge drinking for Nebraska males aged 19 and 20. In 2010, males 19-20 reported having binge drank in the past 30 days at a rate of 26.3%. The rate reported in 2012 was an astonishing 40.1%. This dramatic increase has underscored the need for more intense prevention measures focused on this particular sub-population in Nebraska. When evaluating this trend across the state, 6 of 9 coalition groups (67%) surveyed reported an increase in the past 30-day binge drinking episodes. Additional indicators for Nebraskan males ages 19-20, broken down by coalitions across the state, show 56% percent of coalition areas had an increased perception that peers have binge drank, 78% increased in acceptability for 18 to 20 year old underage drinking, and a 78% increased perception that there is no to little risk related with binge drinking once or twice a week. To address this issue, work needs to be done at younger ages so that the perceived risk is improved and drinking patterns will likewise improve.

Among the goals of the State Epidemiological Outcomes Workgroup is to produce sustained outcomes in preventing the onset, and reducing the progression of underage drinking among Nebraskans aged 12 to 20. This will be accomplished by heightening the intensity at which State, sub-state (hereinafter referred to as Regional), and community level resources are leveraged, re-distributed and/or re-aligned to support the Substance Abuse and Mental Health Services Administration's (SAMHSA) Strategic Prevention Framework (SPF) process, in particular among communities of high need and among subpopulations vulnerable to disparities.

- Alcohol is listed as the most common drug of choice for both adults and youth receiving public mental health or substance abuse services in Nebraska (Magellan, 2011).
- According to the Division of Behavioral Health FY2012 Consumer Survey, the average days of binge drinking for the consumers with substance abuse problems were twice that of the mental health consumers.
- Consistently, more youth in Nebraska report alcohol use in the past 30 days compared to national rates as shown in Table 1 (YRBS data).
- As shown in Table 2, youth in Nebraska consistently report rates of binge drinking higher than or very close to national rates.
- Table 3 shows that fewer Nebraska youth report a perception that there is great risk of harm from binge drinking once or twice a week. (NSDUH data)

In recent years we have begun to see a change in pattern, however, if improvements are to be made in changing the perception of risk associated with underage binge drinking, more work will need to be completed.

Table 1: Alcohol Use in past 30 days

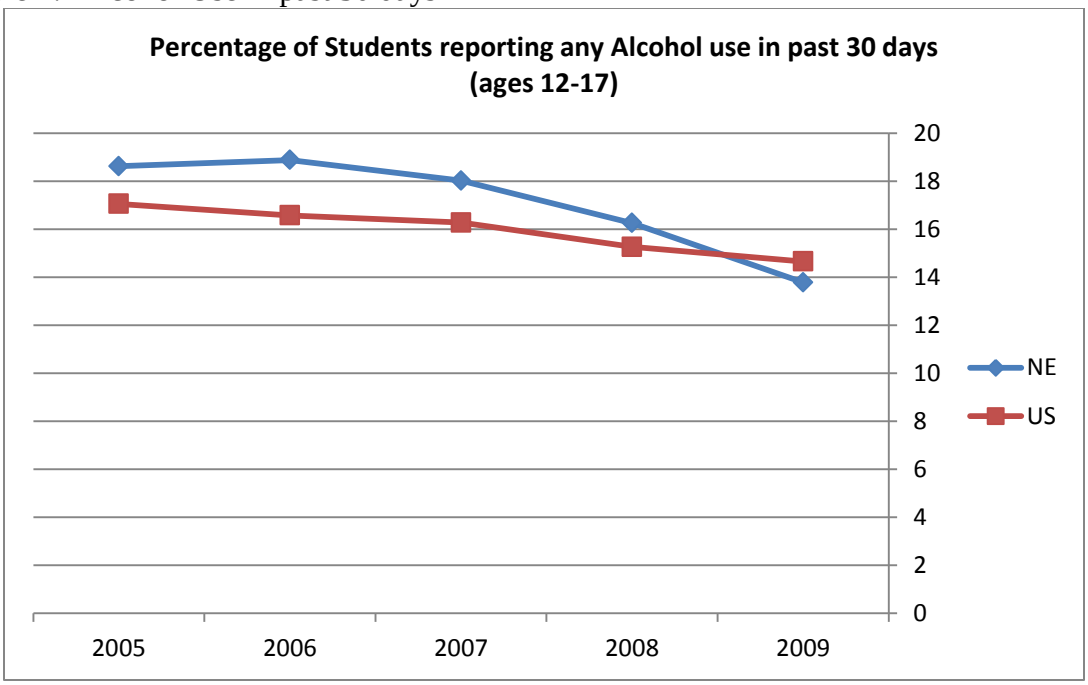


Table 2: Binge drinking

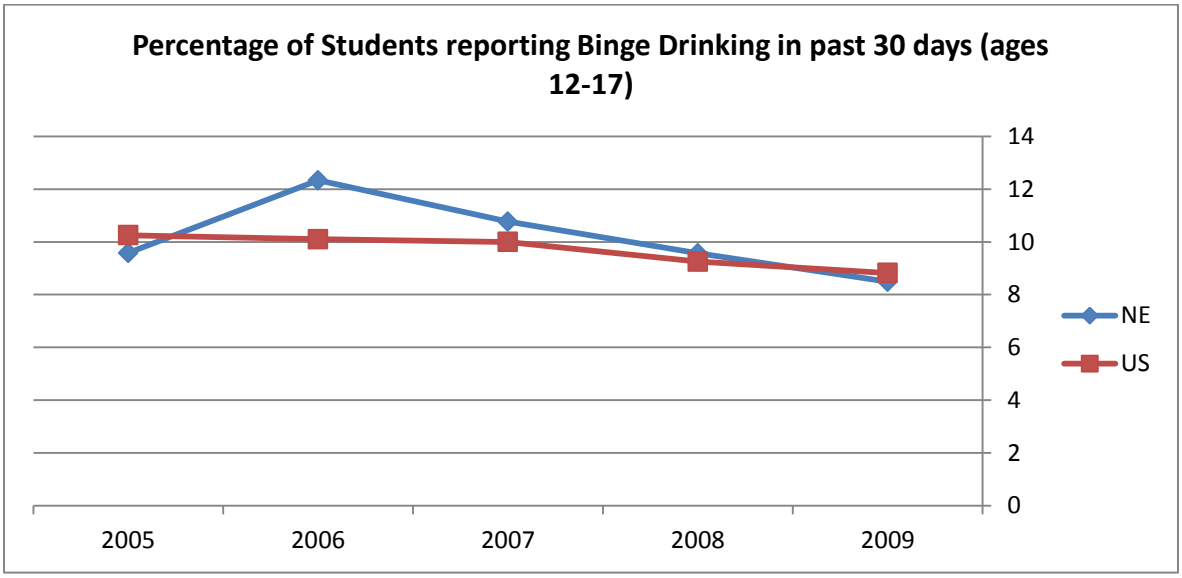


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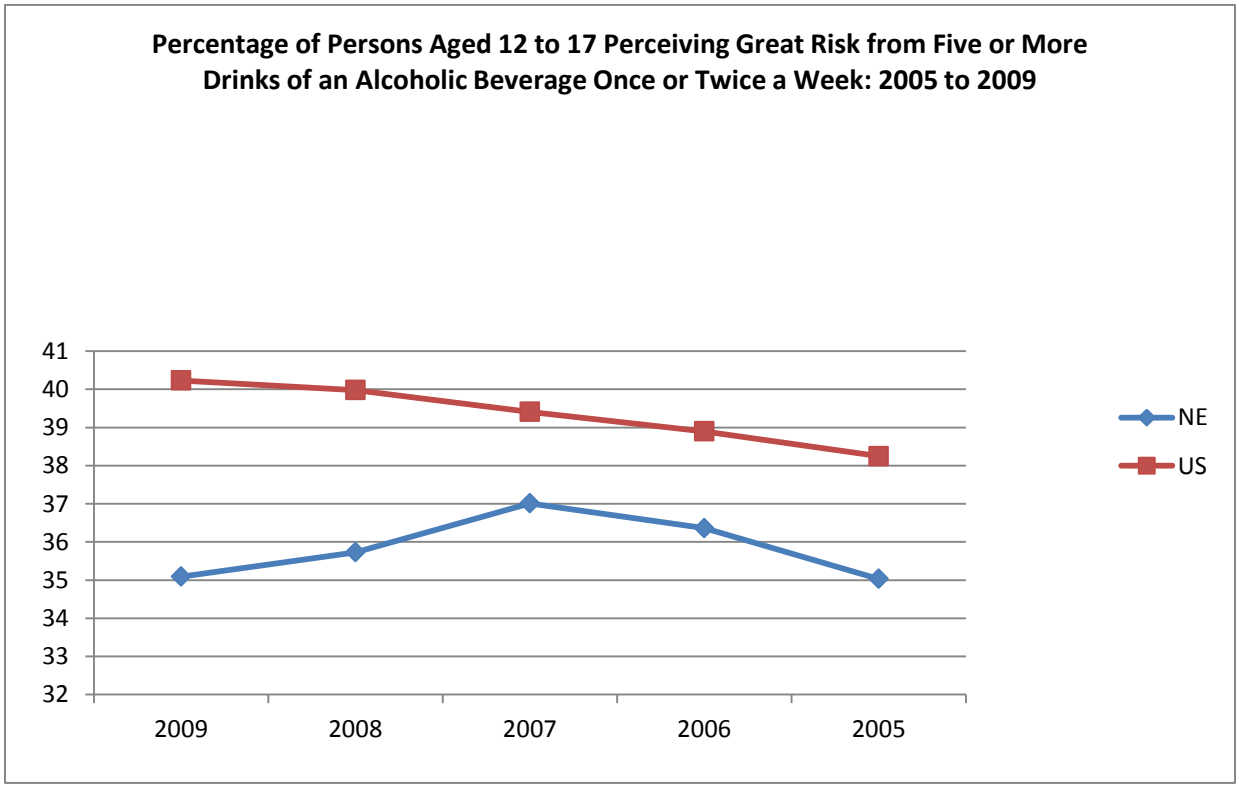
Table 3: Perception of Risk



Youth and Family Functioning

The Professional Partner Program (PPP) is based on the wraparound approach for services and has been recognized as a key component in access to systems of care for Nebraska children with mental health disorders and their families. There is a PPP in each of the six Regional Behavioral Health Authorities. The program embraces a family-centered philosophy and acknowledges families as equal partners. Below is the PPP unduplicated number of persons served in FY2012 by Region.

Professional Partner Program (PPP) / Persons Served FY2012

Region	# of persons served
1	81
2	99
3	201
4	128
5	160
6	438
Total	1107

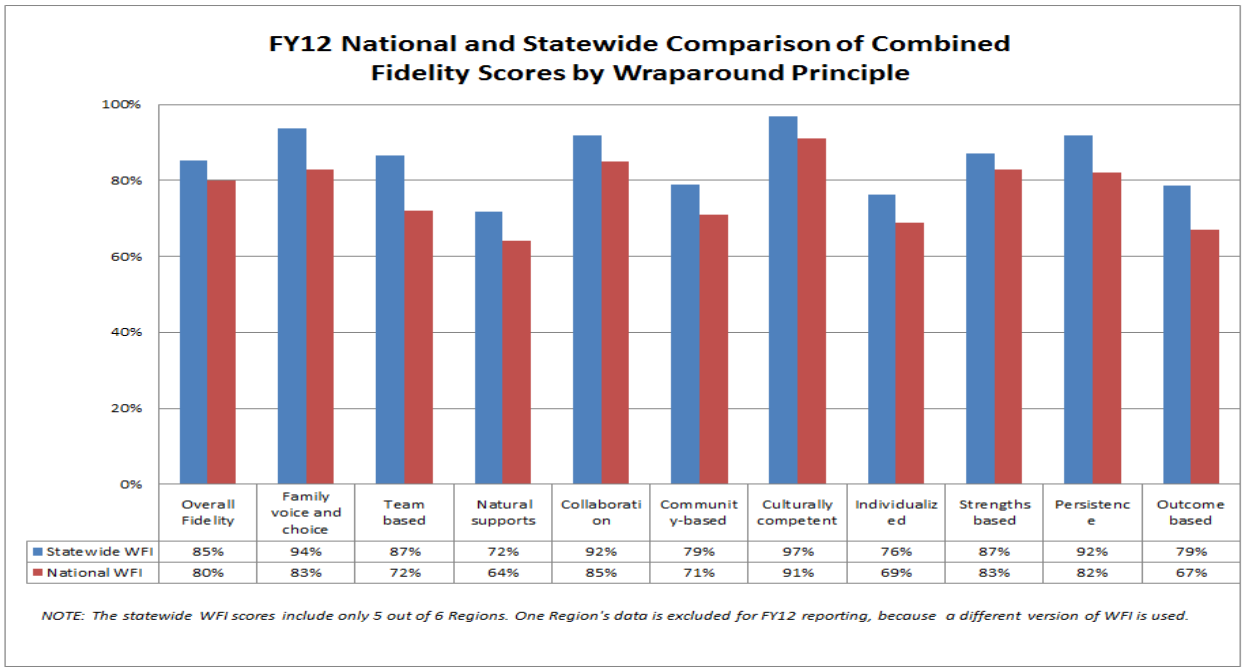
Source: 2012 July PPP data submitted by the Regional Behavioral Health Authorities.

According to the 2012 SAMHSA/CMHS Uniform Reporting System result, the DBH served 1,340 youth with Serious Emotional Disorder. Approximately 83% of the youth the DBH served in FY2012 also received services in the Professional Partners Program, with a small portion of the transitional age youth between 18 and 26 (URS).

FY2012	# of persons served
PPP	1107
Youth with SED	1340

Wraparound is a family-driven, youth-guided, team-based process for planning and implementing services and supports. Through the wraparound process, teams create plans that are geared toward meeting the unique and holistic needs of children and youth with complex needs and their families. The wraparound team members (e.g., the identified youth, his or her parents/caregivers, other family members and community members, mental health professionals, educators, and others) meet regularly to implement and monitor the plan to ensure its success.

The Wraparound Fidelity Assessment System (WFAS) is a multi-method approach to assessing the quality of individualized care planning and management for children and youth with complex needs and their families. WFAS instruments include interviews with multiple stakeholders, a team observation measure, a document review form, and an instrument to assess the level of system support for wraparound. The Regional Behavioral Health Authorities (RBHAs) collect the Wraparound Fidelity Instrument (WFI) version 4 via Access database. The figure below compares Nebraska's state fidelity score against national data by wraparound principle for FY2012, indicating fidelity for this program is high. One RBHAs data is excluded for FY2012 reporting because an older version of the WFI is used. In FY2013, all 6 RBHAs will use version 4 to allow a full picture at the state level.



For the last several years, functioning for youths remain one of the lowest domains of all 7 domains in the annual behavioral health Consumer Survey. Comparing to the U.S. average on the functioning domain, Nebraska's score is below the U.S. average for the last two years.

The functioning domain questions in the annual Consumer Survey are:

- My child is better able to do things he or she wants to do.
- My child is better at handling daily life.
- My child gets along better with family members.
- My child gets along better with friends and other people.
- My child is doing better in school and/or work.
- My child is better able to cope when things go wrong.

Functioning	2009	2010	2011	2012
Nebraska	62%	64%	65%	63%
U.S.	53%	65%	67%	-

Source: CMHS Uniform Reporting System Output Tables

A shift in the Professional Partner Program from measuring youth focused outcomes to family "systems" outcomes is an approach which is expected to guide and inform improvement for youth and family functioning. The tools currently utilized do not support this shift. The DBH is working with the RBHAs Professional Partner Programs to determine an appropriate performance measure related to family functioning. The overall goal is that families and youth receiving services will experience improved family functioning. Specific tools will need to be researched and adopted. Frequency of collection and specific measurement goals will be determined based on the tool selected.

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 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 10% in FY2012. 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).

	Dual ONLY		COMBO		Total Served		Co-Occurring	
FY2012	Youth	Adult	Youth	Adult	Youth	Adult	#	%
# of person served	1	72	27	3360	2174	32764	3460	9.9%

Source: Magellan July 2012 data extract

FY2011 mental health data shows that Nebraska has a higher than national rate of adults served who have co-occurring disorders (26% Nebraska vs. 21% U.S.).

	NE		U.S.	
	FY2010	FY2011	FY2010	FY2011
Adults with Co-Occurring MH/SA Disorders	43.8%	25.6%	20.0%	21.4%
Children with Co-Occurring MH/SA Disorders	7.6%	4.5%	4.7%	5.3%

Source: CMHS Uniform Reporting System Output Tables

It is estimated for Nebraska that approximately 30,000 adults have Serious Psychological Distress (SPD) with Co-Occurring Substance Dependence / Abuse (~2.2% prevalence).

NOTE: The National Survey on Drug Use and Health (NSDUH) includes questions to assess Serious Psychological Distress (SPD). SPD is an overall indicator of nonspecific psychological distress. It is measured by asking questions to respondents on symptoms of psychological distress during the 1 month in the past 12 months when respondents were at their worst emotionally.

State Fiscal Year 2012 (July 1, 2011 to June 30, 2012)

Dual ONLY	COMBO	Total	Estimate of Prevalence SPD with Co-Occurring Substance Dependence / Abuse	Penetration Rate
73	3,387	3,460	30,000	11.5%

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2005, 2006-2010, 2011 (revised March 2012).

According to the estimates, Nebraska served 12.4% of the people with serious psychological disorders and co-occurring substance dependence / abuse. The DBH goal is to increase the number of behavioral health workforce capacity and behavioral health programs/providers able to deliver effective prevention and treatment Recovery Oriented Systems of Care (ROSC) for persons with Co-Occurring Disorders (COD).

Therefore, a tool is needed to measure agency capability to serve persons with Co-Occurring Disorders of Mental Health and Substance Abuse. The COMPASS EZ tool has been selected and is being administered during the late winter and early spring of 2013. It will establish a baseline for the development of training, technical assistance and peer to peer events designed to create an overall co-occurring environment among substance abuse and mental health agencies.

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.

Capabilities measured by the COMPASS EZ include:

- Program philosophy
- Program policies
- Quality improvement and data
- Access
- Screening and identification
- Recovery oriented integrated assessment
- Integrated person centered planning
- Integrated treatment/recovery programming
- Integrated treatment/recovery relationship
- Integrated treatment/recovery program policies
- Psychopharmacology
- Integrated discharge/transition planning
- Program collaboration and partnership

- General staff competencies and training
- Specific staff competencies

Previous work in this area began as a result of the FY2012/2013 Block Grant goals. The goal was to increase the capacity of the public behavioral health workforce to deliver effective prevention and treatment in Recovery Oriented Systems of Care (ROSC) for people with co-occurring disorders through development of a co-occurring disorder system of care. ROSC needs to be consumer driven and consumer centered. It also includes developing strong partnerships across all systems to ensure an expanded continuum of care. Work has begun to increase the total number of behavioral health providers that are dual capable and dual enhanced. Baseline was zero as of January 1, 2012. One hundred percent (100%) of the providers under contract with the six RBHAs completed the COMPASS EZ by January 1, 2013. It is expected that monitoring this data and using it to inform improvement efforts will increase the capability to serve persons with co-occurring disorders and continue to advance efforts initiated with the FY2012/2013 Block Grant goals.

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. 42% of individuals receiving services reported a history of trauma during FY2012 compared to 28% in FY2010. Trauma is now considered to be a near universal experience for those with behavioral health problems.

Table: Number of persons served with Trauma history

Fiscal Year	MH ONLY		SA ONLY		Dual ONLY	COMBO		TOTAL	
	Youth	Adult	Youth	Adult	Adult	Youth	Adult	Youth	Adult
2010	924	5,482	118	2,638	55	30	960	1,072	9,135
2011	845	7,039	111	3,021	66	13	1,339	969	11,465
2012	773	8,154	132	3,893	58	12	1,708	917	13,813

Table: Number of persons served with Trauma history

Fiscal Year	TOTAL Youth and Adult		Total Number of person served
	#	%	
2010	10,207	28.3%	36,011
2011	12,434	35.1%	35,387
2012	14,730	42.2%	34,938

Below is a DBH Trauma History Usage Report [Period: 10/01/2012 - 12/31/2012], which captures positive responses for trauma screened upon admission. In the last quarter of CY2012, 52.8% of admissions to community behavioral health providers contracting with the Regional Behavioral Health Authorities reported a positive trauma history experienced either in adulthood, childhood or both.

	Adult	Child	Both	Neither
Emotional Abuse	528	964	777	1280
Life Threatening Medical Issues	519	101	73	2855
Natural Disasters	129	135	52	3232
Neglect	73	730	152	2595
Physical Abuse	564	967	488	1530
Physical Assault	691	212	328	2318
Prostitution/Sex Trafficking	84	16	21	3428
Sanctuary Trauma	163	43	34	3308
Serious Accident/Injury	615	229	155	2551
Sexual Abuse	226	874	289	2160
Sexual Assault/Rape	327	337	196	2690
Traumatic Loss of a Loved One	1031	397	417	1704
Victim of a Crime	467	124	195	2762
Victim of a Terrorist Act	73	13	13	3449
War/Political Violence/Torture	66	23	18	3441
Witness to Community Violence	341	222	223	2765
Witness to Domestic Abuse	244	757	297	2254
Total Admissions	6726			
Total w/Trauma History = Yes	3555	52.9%		
Total w/at least 1 Trauma selected	3554	100.0%		
Reason for Admission	Both			
Primary Mental Health	1627			
Prim.Mental Hlth/Secondary S/A	197			
Primary Substance Abuse	1288			
Prim.S/A/Secondary Mental Hlth	113			
Dual Diag/Prim.MenHlth/Pri.S/A	240			
Prim.Mental Retardation	0			
Prim.Sex Offender	20			
Unknown	70			
Total	3555			

The next table separates these admissions by gender (male / female). The females reported a Trauma History (at least 1 Trauma selected) at admission 63.1% of the time. The males reported a Trauma History at admission 45.3% 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).

All Regional Behavioral Health Authorities	Male		Female	
Total Admissions	3884		2842	
Total with Trauma History = Yes / at least 1 Trauma selected	1,760	45.3%	1,794	63.1%

Source: Magellan admission trauma summary 2012-10-02 thru 2012-12-31

To develop a service system that understands the effects of trauma and avoids re-traumatizing those who seek services (trauma-informed), the DBH 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 Fallot 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.

The table below shows the number of agencies that completed a trauma informed care self-assessment tool in each Regional Behavioral Health Authority (RBHA). As of August 2012, only 45 DBH funded organizations, from a total of 77, have completed a trauma informed assessment and developed plans for improvement. The DBH is working through the RBHAs to score the TIC tool during FY2013 and asking all providers to complete the TIC tool and supply to the DBH the honest assessment of the agencies' current status. This status report will establish a baseline for training, technical assistance and peer to peer events designed to enhance Trauma Informed Care in agencies funded, and those not funded, by block grant dollars.

RBHA	# completed	# of Agencies	% of completed
Region 1	5	9	55.6%
Region 2	5	6	83.3%
Region 3	11	14	78.6%
Region 4	6	17	35.3%
Region 5	8	13	61.5%
Region 6	9	17	52.9%
DBH	1	1	100.0%
Total	45	77	58.4%

Source: RBHA list of trauma trainings and specific services 2012

A variety of trauma specific services are available but there is not a current repository to evaluate and improve access and distribution across the state. The table below lists all specific models we've surveyed in FY2012. We did a search to find which services various trauma organizations [SAMHSA, National Child Traumatic Stress Network (NCTSN)] support as trauma informed and compared against the list to indicate which on the list are indeed determined to be trauma informed as well as identify potential additional services which are trauma informed. 73.3% of the services on the list are recognized as trauma informed at the Federal level.

Trauma Specific Service from Providers	Presence within NCTCN	Presence within NREPP (SAMHSA)	NREPP (SAMHSA) Trauma/Injuries Outcome
Behavior, Affect, Sensation, and Knowledge (BASK)			
Beyond Trauma		yes	no
Child Parent Psychotherapy (CPP)	yes	yes	yes
Cognitive Behavioral Therapy (CBT)	yes		
Cognitive Processing Therapy			
Dialectic Behavioral Therapy (DBT)	yes	yes	yes
Eye Movement Desensitization and Reprocessing (EMDR)		yes	no
Helping Women Recover		yes	no
Men and Trauma: Dan Griffin - Helping Men Recover			
Parent-Child Interaction Therapy (PCIT)	yes	yes	yes
Real Treatment for Real Kids			
Sanctuary Model	yes		
Seeking Safety		yes	yes
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)	yes	yes	yes
Trauma focused DBT	yes		

Source: http://www.nctsn.org/resources/topics/treatments-that-work/promising-practices
http://www.nrepp.samhsa.gov/Index.aspx

NOTE: SAMHSA supported
- → National Child Traumatic Stress Network (NCTSN)
- → National Registry of Evidence-Based Programs and Practices (NREPP)

Consumers and families are not consistently aware of providers that might specialize in trauma specific services. The DBH needs to increase awareness and publication of this important information to be responsive to the consumers/families.

Peer Support and Wellness Specialists

Peer Support is a priority area in Nebraska. The number of Peer Support and Wellness Specialists has grown. To continue to best utilize this group of individuals, Nebraska seeks to better develop a system to provide Recovery Supports in Nebraska through use of peer support.

The Nebraska Legislature made this a priority for the State Advisory Committee on Mental Health Services under §71-814(2)(c) which states, “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."

This idea was continued within the Division of Behavioral Health Strategic Plan 2011-2015

- Public Behavioral Health System Values: Peer Support
- 2011-2015 Goals: 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).
- Strategy 1: Insist on Accessibility - Partnership Initiatives: 5. Create recovery oriented systems of care that include recovery supports (such as transportation and peer supports) that can ease barriers to accessing care.
- Strategy 2: Demand Quality: Partnership Initiatives: 5. Partner with the Behavioral Health Education Center of Nebraska (BEHCN) to develop and implement a dynamic workforce development plan for all levels of behavioral health professionals including Peer Support Professionals.
- Strategy 3: Require Effectiveness: Leadership Initiatives: 1. Lead a Continuous Quality Improvement process for services funded by the Division of Behavioral Health, focusing on clinical supervision, peer support, co-occurring mental health and addiction services, gender, trauma and cultural competency.

Building on current reform efforts, the DBH wants to continue the Peer Support development that began with the 2009-2010 Transformation Transfer Initiative (TTI) project grant cycle, invest in similar infrastructure for the statewide Family Peer Support system, and keep this workforce focused on trauma informed services. There is a great need system wide to serve the growing number of children and their families. Developing the Family Peer Support system with education on trauma and development will bring the Nebraska Behavioral Health System (NBHS) to a new day, where every family gets the right information at the right time to assist their child in achieving the highest developmental growth potential. Additionally, there will be a common language across the peer service delivery system that is based in trauma informed peer support.

Nearly half (42.2%) of the adult and youth system in Nebraska reports trauma experience in their lifetime, and this number is believed to be an underestimation. Trauma can impact development across the lifespan and addressing this as a lifespan topic to encourage healing will change the conversation in Nebraska. Furthering the trauma informed focus of the adult peer support workforce will bring this workforce to a new day where recovery is also about "uncovery" and empowerment with knowledge versus shame and stigma. Additionally, the DBH will engage in transformational research that will validate a new trauma related health symptom screen that will tell a story about the direct impact of trauma on health and wellness. It could be utilized as a screen for referrals by behavioral health authorities, federally qualified health centers, and primary care practitioners.

One of the FY2012 SAMHSA Block Grant priorities was "Consumer Workforce". The goal was to increase the peer support workforce. The indicator to measure this goal was "count of the total number of trained Peer Support and Wellness Specialists". As of March 31, 2013 there are 124 Certified Peer Support and Wellness Specialists in Nebraska.

Through additional consideration shared at the Office of Consumer Affairs People's Council on February 5, 2013, the Council felt that measuring the number of certified peer specialists was an empty count. The Council preferred counting employment as a more powerful measure. Building upon those ideas, the Office of Consumer Affairs will develop a work plan to help support the use of peer specialists.

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.

Tuberculosis (TB) is a disease caused by a bacterium called Mycobacterium Tuberculosis. The bacteria usually attack the lungs, but TB bacteria can attack any part of the body such as the kidney, spine, and brain. If not treated properly, TB disease can be fatal. Overall, in Calendar Year 2011, Nebraska Department of Health and Human Services - Division of Public Health - Tuberculosis Program reported to the Federal Centers for Disease Control and Prevention (CDC) 23 cases compared to 27 in Calendar Year 2010.

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 Sec.71-502, 71-1626 and 173 NAC Chapters 1-6, which can be found at: 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

Table 1 Step 3,4: -Priority Area and Annual Performance Indicators

Priority #: 1

Priority Area: Prevention: Alcohol Use Among Youth

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 binge drinking among youth up to age 17.

Strategies to attain the goal:

Percentage of students in 9th-12th grade who reported having five or more drinks on at least one occasion in the past 30 days will decrease to 15%.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Prevention: Alcohol Use Among Youth

Baseline Measurement: Percentage of students in 9th-12th grade who reported having five or more drinks on at least one occasion in the past 30 days was 16.4% in 2011.

First-year target/outcome measurement: percentage of students in 9th-12th grade who reported having five or more drinks on at least one occasion in the past 30 days will report 15% in 2013.

Second-year target/outcome measurement: N/A because the survey is conducted every 2 years (see below).

Data Source:

Centers for Disease Control and Prevention (CDC), Youth Risk Behavior Survey (YRBS), 2001–2011.

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. 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).

Priority #: 2

Priority Area: Youth: Improved Family Functioning

Priority Type: MHS

Population (s): SED

Goal of the priority area:

Families and youth receiving services will experience improved family functioning.

Strategies to attain the goal:

% of youth under the age of 18 / Families admitted to the Professional Partner Program (PPP) will be assessed using the designated tool for family functioning to establish a baseline measure of family functioning.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Youth: Improved Family Functioning in the Professional Partner Program (PPP)

Baseline Measurement:	tool is selected; baseline is 0%.
First-year target/outcome measurement:	By June 30, 2014, 25% of the families admitted to the PPP in SFY2014 will receive an assessment of family functioning through the use of the selected tool.
Second-year target/outcome measurement:	By June 30, 2015, 95% of the families admitted to the PPP in SFY2015 will receive an assessment of family functioning through the use of the selected tool.

Data Source:

Data from the selected tool is reported by the six Regional Behavioral Health Authorities to Division of Behavioral Health.

Description of Data:

The Division of Behavioral Health intends to establish a designated tool for family functioning to be used by the Professional Partner Program (PPP) by July 2013. Then the PPP providers will need to be trained on using the tool. The data system for collecting and reporting the tool needs to be established. The intent is to be collecting the data by January 2014. The designated tool for family functioning will be used upon admission to the program.

Data issues/caveats that affect outcome measures::

May encounter issues in tool selection, training of staff, data system development issues, reporting the data, and related implementation issues. The Length of Stay for PPP is less than a year, and Prevention PPP is 90 days or less.

Priority #:	3
Priority Area:	Co-Occurring Disorders
Priority Type:	SAT, MHS
Population (s):	SMI, SED, PWWDC, IVDUs, HIV EIS, TB

Goal of the priority area:

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

Strategies to attain the goal:

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 #:	4
Priority Area:	Trauma-Informed Care
Priority Type:	SAP, SAT, MHP, MHS
Population (s):	SMI, SED, PWWDC, IVDUs, HIV EIS, TB

Goal of the priority area:

Increase the BH workforce education to provide Trauma-Informed Care.

Strategies to attain the goal:

Statewide score on selected sections of the Fallot and Harris Trauma Informed Care (TIC) tool will increase according to the baseline to be developed after June 30, 2013 self-assessment deadline for providers.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Increase the BH workforce education to provide Trauma-Informed Care.
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 score on selected sections of the TIC tool will increase according to the baseline developed after June 30, 2013 self-assessment deadline for providers.
Second-year target/outcome measurement:	Statewide score on selected sections of the TIC tool (to be developed after June 30, 2013 self-assessment deadline for providers) will increase according to the baseline and first year target achieved.

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 first round of effort is to be completed by June 30, 2013. After that work is completed, the new baseline can be established. The intent is to continue the work in order to further improve the trauma informed features of the Nebraska Behavioral Health System.

Priority #: 5

Priority Area: Peer Support

Priority Type: SAP, SAT, MHP, MHS

Population (s): SMI, SED, PWWDC, IVDUs, HIV EIS, TB

Goal of the priority area:

Increase the capacity of the system to use Peer Support

Strategies to attain the goal:

Use of Peer Support to provide Recovery Supports in Nebraska (Year One: develop Plan. Year Two: Implement 25% of Plan)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Peer Support

Baseline Measurement: Increase the capacity of the system to use Peer Support

First-year target/outcome measurement: By June 30, 2014, there is one plan approved by the Director of the Division of Behavioral Health on the Use of Peer Support to provide Recovery Supports in Nebraska.

Second-year target/outcome measurement: By June 30, 2015, the Division of Behavioral Health will implement 25% of Plan.

Data Source:

Office of Consumer Affairs, Division of Behavioral Health

Description of Data:

One plan approved by the Director of the Division of Behavioral Health on the Use of Peer Support to provide Recovery Supports in Nebraska.

Data issues/caveats that affect outcome measures::

- Peer Support has been implemented in one form or another across the State over the last few years. As of March 31, 2013 there are 124 Certified Peer Support and Wellness Specialists in Nebraska.
- The Office of Consumer Affair's People Council on February 5, 2013 clearly indicated the full implementation of peer support in Nebraska was needed. A more focused, organized and systematic approach for using peer support was recommended.
- On March 14, 2013 at a joint meeting of the State Advisory Committee on Mental Health Services and the State Advisory

Committee on Substance Abuse Services, there was support for the idea of this plan.

Priority #: 6

Priority Area: Tuberculosis (TB)

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 NE Division of Public Health provides the overall coordination for the State of Nebraska.

Strategies to attain the goal:

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:

NE 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 NE 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 2014 Region Budget Plan Guidelines and the 2014-2015 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.

Footnotes last updated August 23, 2013

III: Use of Block Grant Dollars for Block Grant Activities

Table 2 State Agency Planned Expenditures [SA]

Planning Period - From 07/01/2013 to 06/30/2015

Activity (See instructions for using Row 1.)	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	$5,256,061		$	$	$25,236,576	$	$
a. Pregnant Women and Women with Dependent Children*	$ 535,401		$	$	$ 1,618,261	$	$
b. All Other	$ 4,720,660		$	$	$ 23,618,315	$	$
2. Substance Abuse Primary Prevention	$ 1,790,451		$	$	$ 355,311	$	$
3. Tuberculosis Services	$		$	$	$	$	$
4. HIV Early Intervention Services	$		$	$	$	$	$
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non -24 Hour Care							
8. Mental Health Primary Prevention							
9. Mental Health Evidenced-based Prevention and Treatment (5% of total award)							
10. Administration (Excluding Program and Provider Level)	$ 370,869		$	$	$	$	$
11. Total	$7,417,381	$	$	$	$25,591,887	$	$

* Prevention other than primary prevention

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 2 State Agency Planned Expenditures [MH]

Planning Period - From 07/01/2013 to 06/30/2015

Activity (See instructions for using Row 1.)	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			$	$	$	$	$
6. Other 24 Hour Care		$ 258,231	$	$	$ 13,757,205	$	$
7. Ambulatory/Community Non -24 Hour Care		$ 1,607,964	$	$ 288,000	$ 44,610,233	$	$
8. Mental Health Primary Prevention		$	$	$	$	$	$
9. Mental Health Evidenced-based Prevention and Treatment (5% of total award)		$	$	$	$	$	$
10. Administration (Excluding Program and Provider Level)		$ 98,221	$	$	$	$	$
11. Total	$	$1,964,416	$	$288,000	$58,367,438	$	$

* Prevention other than primary prevention

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period - From 07/01/2013 to SFY 06/30/2015

Service	Unduplicated Individuals	Units	SABG Expenditures	MHBG Expenditures
Healthcare Home/Physical Health			$	$
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 Dissemination			$	$
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)			$	$
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			$	$
Assessment			$	$
Specialized Evaluations (Psychological and Neurological)			$	$
Service Planning (including crisis planning)			$	$
Consumer/Family Education			$	$
Outreach			$	$
Outpatient Services			$	$
Evidenced-based Therapies			$	$
Group Therapy			$	$
Family Therapy			$	$
Multi-family Therapy			$	$
Consultation to Caregivers			$	$
Medication Services			$	$

Medication Management			$	$
Pharmacotherapy (including MAT)			$	$
Laboratory services			$	$
Community Support (Rehabilitative)			$	$
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			$	$
Peer Support			$	$
Recovery Support Coaching			$	$

Recovery Support Center Services			$	$
Supports for Self-directed Care			$	$
Other Supports (Habilitative)			$	$
Personal Care			$	$
Homemaker			$	$
Respite			$	$
Supported Education			$	$
Transportation			$	$
Assisted Living Services			$	$
Recreational Services			$	$
Trained Behavioral Health Interpreters			$	$
Interactive Communication Technology Devices			$	$
Intensive Support Services			$	$
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			$	$
Children's Mental Health Residential Services			$	$
Crisis Residential/Stabilization			$	$
Clinically Managed 24 Hour Care (SA)			$	$
Clinically Managed Medium Intensity Care (SA)			$	$
Adult Mental Health Residential			$	$
Youth Substance Abuse Residential Services			$	$
Therapeutic Foster Care			$	$
Acute Intensive Services			$	$
Mobile Crisis			$	$
Peer-based Crisis Services			$	$

Urgent Care			$	$
23-hour Observation Bed			$	$
Medically Monitored Intensive Inpatient (SA)			$	$
24/7 Crisis Hotline Services			$	$
Other (please list)			$	$

Footnotes:

The information requested is not available at this time.

III: Use of Block Grant Dollars for Block Grant Activities

Table 4 SABG Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2015

Expenditure Category	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	$ 5,256,061	
2 . Substance Abuse Primary Prevention	$ 1,790,451	
3 . Tuberculosis Services	$	
4 . HIV Early Intervention Services**	$	
5 . Administration (SSA Level Only)	$ 370,869	
6. Total	$7,417,381	

* Prevention other than primary prevention

** HIV Early Intervention Services

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2015

Strategy	IOM Target	FY 2014	FY 2015
		SA Block Grant Award	SA Block Grant Award
Information Dissemination	Universal	$ 78,187	
	Selective	$ 31,836	
	Indicated	$ 15,962	
	Unspecified	$	
	Total	$125,985	
Education	Universal	$ 122,991	
	Selective	$ 67,529	
	Indicated	$ 43,097	
	Unspecified	$	
	Total	$233,617	
Alternatives	Universal	$ 30,534	
	Selective	$ 25,230	
	Indicated	$ 15,993	
	Unspecified	$	
	Total	$71,757	
Problem Identification and Referral	Universal	$ 11,647	
	Selective	$ 128,175	
	Indicated	$ 22,360	
	Unspecified	$	

	Total	$162,182	
Community-Based Process	Universal	$ 444,076	
	Selective	$ 128,854	
	Indicated	$ 27,116	
	Unspecified	$	
	Total	$600,046	
Environmental	Universal	$ 364,644	
	Selective	$ 121,141	
	Indicated	$ 14,976	
	Unspecified	$	
	Total	$500,761	
Section 1926 Tobacco	Universal	$ 96,103	
	Selective	$	
	Indicated	$	
	Unspecified	$	
	Total	$96,103	
Other	Universal	$	
	Selective	$	
	Indicated	$	
	Unspecified	$	
	Total	$	
Total Prevention Expenditures	$1,790,451		
Total SABG Award*	$7,417,381		
Planned Primary Prevention Percentage	24.14 %		

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

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5b SABG Primary Prevention Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2015

Activity	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
Universal Direct	$	
Universal Indirect	$	
Selective	$	
Indicated	$	
Column Total	$	
Total SABG Award*	$7,417,381	
Planned Primary Prevention Percentage	0.00 %	

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

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5c SABG Planned Primary Prevention Targeted Priorities

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

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2015

Activity	FY 2014 SA Block Grant Award				FY 2015 SA Block Grant Award			
	Prevention	Treatment	Combined	Total	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	$ 33,103	$	$	$33,103				
2. Quality Assurance	$ 33,103	$ 33,103	$	$66,206				
3. Training (Post-Employment)	$	$ 94,519	$	$94,519				
4. Education (Pre-Employment)	$	$ 63,013	$	$63,013				
5. Program Development	$ 66,207	$ 33,103	$	$99,310				
6. Research and Evaluation	$	$	$	$				
7. Information Systems	$ 26,331	$ 11,769	$	$38,100				
8. Enrollment and Provider Business Practices (3 percent of BG award)	$	$	$	$				
9. Total	$158,744	$235,507	$	$394,251				

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period - From 07/01/2013 to 06/30/2014

Service	Block Grant
MHA Technical Assistance Activities	$
MHA Planning Council Activities	$
MHA Administration	$ 98,221
MHA Data Collection/Reporting	$
Enrollment and Provider Business Practices (3 percent of total award)	$
MHA Activities Other Than Those Above	$ 79,000
Total Non-Direct Services	$177221
Comments on Data:	

Footnotes:

IV: Narrative Plan

C. Coverage M/SUD Services

Narrative Question:

Beginning in 2014, Block Grant dollars should be used to pay for (1) people who are uninsured and (2) services that are not covered by insurance and Medicaid. Presumably, there will be similar concerns at the state-level that state dollars are being used for people and/or services not otherwise covered. States (or the Federal Marketplace) are currently making plans to implement the benchmark plan chosen for QHPs and their expanded Medicaid programs (if they choose to do so). States should begin to develop strategies that will monitor the implementation of the Affordable Care Act in their states. States should begin to identify whether people have better access to mental and substance use disorder services. In particular, states will need to determine if QHPs and Medicaid are offering mental health and substance abuse services and whether services are offered consistent with the provisions of MHPAEA.

Please answer the following questions:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs on January 1, 2014?
2. Do you have a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who in your state is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe their monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?

Footnotes:

C. Coverage for M/SUD Services

Beginning in 2014, Block Grant dollars should be used to pay for

(1) People who are uninsured and

(2) Services that are not covered by insurance and Medicaid.

Presumably, there will be similar concerns at the state-level that state dollars are being used for people and/or services not otherwise covered. States (or the Federal Exchange) are currently making plans to implement the benchmark plan chosen for QHPs and their expanded Medicaid programs (if they choose to do so). States should begin to develop strategies that will **monitor the implementation of the Affordable Care Act in their states**. States should begin to identify whether people have better access to mental and substance use disorder services. In particular, states will need to determine if QHPs and Medicaid are offering mental health and substance abuse services and whether services are offered consistent with the provisions of MHPAEA.

August 8, 2013

Key Terms:

- Essential Health Benefits (EHBs) are health care service categories that must be covered by all health plans being sold in a state, starting in 2014. Essential Health Benefits must include at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Source: Press Release from Governor Dave Heineman (October 1, 2012) http://www.governor.nebraska.gov/news/2012/10/01_ne_option.html
- Qualified Health Plans (QHPs)
- Mental Health Parity and Addiction Equity Act (MHPAEA)
- Mental and Substance Use Disorder (M/SUD) services
- Affordable Care Act (ACA)
- Nebraska Behavioral Health System (NBHS) is the publicly funded, non-Medicaid program.
- Community Mental Health Services Block Grant (MHBG)
- Substance Abuse Prevention and Treatment Block Grant (SABG)

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs on January 1, 2014?

There are three complicated factors on what will be covered after January 1, 2014.

1. potential Medicaid expansion or non-expansion
2. The implementation of Medicaid Managed Care in Nebraska
3. The affordability of the qualified health plan

Potential Medicaid Expansion or Non-Expansion

On July 11, 2012, Governor Dave Heineman said Nebraska Can't Afford Medicaid Expansion. (http://www.governor.nebraska.gov/news/2012/07/11_medicaid.html). He sent a letter to Nebraska's State Senators outlining the potentially devastating impact to education funding and the progress made to lower taxes on Nebraska's hard-working, middle class families. However, the Nebraska Legislature is discussing the option of Medicaid expansion with debate on LB 577. This debate influences the populations and services to be covered by Medicaid after January 1, 2014.

C. Coverage for M/SUD Services | page 2

The Supreme Court of the United States decision on the Affordable Care Act [June 28, 2012] made the expansion of Medicaid a genuine choice of a State. The choice is to:

- Expand Medicaid coverage by 2014 to virtually all adults with incomes up to 133 percent of the federal poverty level, or
- Continue to cover certain low income persons including persons who are aged, blind, disabled, children, and others who meet eligibility requirements. Kids Connection is part of Nebraska Medicaid and provides medical assistance to children age 18 and younger [Children's Health Insurance Program (CHIP)].

LB577

The Nebraska Legislature continues to discuss the option of full coverage under the federal medical assistance program with debate on Legislative Bill 577. If enacted into law, this option would require Nebraska to participate in the Medicaid expansion offered by the federal Affordable Care Act. According to State Senator Kathy Campbell, the bill's sponsor, LB577 would expand Medicaid coverage for low-income adults ages 19 to 65 with incomes of up to $15,856. The public hearing on LB577 was held by the Health and Human Services Committee on February 28, 2013. Testifying in support of this bill included Nebraska Medical Association, the Nebraska Hospital Association, and the Center for Rural Affairs. DHHS Medicaid director Vivianne Chaumont testified in opposition. She said an expansion that could add 55,000 individuals to the state's Medicaid program would increase pressure on financing and infrastructure.

The bill stalled in floor debate due to a filibuster by opponents. State senators who would vote no on LB577 or no on ending the filibuster indicated they were willing to listen to information coming from the interim study. The interim study is called Legislative Resolution (LR) 22. In discussing LR22, it was noted 25 percent of Nebraska's budget is spent on issues related to health care and the percentage is growing. As a result, the state needs to be more aggressive about long-term planning and public health. LR22 designates the Nebraska Legislature's Health and Human Services Committee, in cooperation with the Banking, Commerce and Insurance Committee, to bring together policymakers and stakeholders at all levels to work toward the following goals:

→ providing a comprehensive review of Nebraska's health care delivery, cost and coverage demands;
→ engaging partners in dialogue, roundtable discussions and public policy discourse;
→ developing a framework for health care system transformation to meet public health, workforce, delivery and budgetary responsibilities; and
→ developing cooperative strategies and initiatives for the design, implementation and accountability of services to improve care, quality and value while advancing the overall health of Nebraskans.

The Health and Human Services Committee may conduct public hearings and, in conjunction with the Banking, Commerce and Insurance Committee, undertake communication, outreach and educational activities. A joint hearing will be held prior to November 1, 2013 to brief the committees on information obtained by the partnership.

Source: http://update.legislature.ne.gov/?p=12164

Meanwhile, the Nebraska Medicaid Program is preparing for the implementation of the Affordable Care Act [see http://dhhs.ne.gov/medicaid/Pages/Medicaid-Eligibility.aspx], including changes in the application beginning October 1, 2013. This application can be used to apply for Medicaid benefits or for other insurance affordability programs such as Qualified Health Plans or Advanced Premium Tax Credits.

2. The implementation of Medicaid Managed Care in Nebraska

In 2013 Nebraska Medicaid Program implemented managed care for behavioral health services by contracting with Magellan Behavioral Health, an Administrative Service Organization (ASO). On January 29, 2013, the State Purchasing Bureau notified those who responded to Request for Proposal Number 4166Z1 that the State of Nebraska awarded the contract for the Division of Medicaid and Long-Term Care Full-Risk Capitated Rate Medicaid Managed Care Program for Mental Health and Substance Use Disorder Services to Magellan Behavioral Health of Nebraska. For details see http://das.nebraska.gov/materiel/purchasing/4166.htm

Under this contract, Magellan coordinates, manages and provides access to mental health and substance abuse services to Medicaid eligible clients. This is a Full-Risk Capitated Rate Medicaid Managed Care Program for Mental Health and Substance Use Disorder Services needs to include the following.

1. MEDICAID COVERED SERVICES

Mental Health (MH) and Substance Abuse (SA) Services for Individuals Age 21 and Older. Unless noted, the following are MH only:

- **a.** Acute Inpatient Hospital
- **b.** Sub-acute Hospital
- **c.** Partial Hospitalization
- **d.** Crisis Assessment
- **e.** Social Detox
- **f.** Dual Disorder Residential
- **g.** Psychiatric Residential Rehabilitation
- **h.** Secure Residential Rehabilitation
- **i.** Intermediate Residential – substance abuse
- **j.** Short-Term Residential
- **k.** Halfway House
- **l.** Therapeutic Community – (SA only)
- **m.** Assertive Community Treatment (ACT) and Alternative ACT (Alt. ACT)
- **n.** Assessment
- **o.** Community Support (MH and SA)
- **p.** Day Rehabilitation
- **q.** Day Treatment (MH and SA)
- **r.** Intensive Outpatient (MH and SA)
- **s.** Medication Management
- **t.** Medication Assisted Treatment (SA)
- **u.** Outpatient (Individual, Family, Group) (MH, SA, or Dual MH/SA)
- **v.** Injectable Psychotropic Medications
- **w.** Substance Abuse Assessment
- **x.** Psychological Evaluation
- **y.** ECT
- **z.** Initial Diagnostic Interviews
- **aa.** Mental Health and Substance Abuse Services for Children and Adolescents (ages 0-20)
- **bb.** Inpatient Hospitalization
- **cc.** Psychiatric Residential Treatment Facility (through age 21)
- **dd.** Therapeutic Group Home (ThGH)
- **ee.** Professional Resource Family Care
- **ff.** Day Treatment (MH and SA)
- **gg.** Partial Hospitalization
- **hh.** Intensive Outpatient (MH and SA)
- **ii.** Home-based MST
- **jj.** Biopsychosocial Assessment and Addendum
- **kk.** Psychological Evaluation and Testing
- **ll.** Substance Abuse Assessment
- **mm.** Sex Offender Risk Assessment

nn. Community Treatment Aide
oo. Outpatient Treatment (Individual, Family, Group) MH, SA, Dual
pp. Interpreter Services for MH/SA services
qq. Initial Diagnostic Interviews

Mental health and substance abuse services for children who are state wards also have an array of supportive services that impact health care delivery and require intensive coordination with a managed care entity – particularly for those requiring residential treatment or intensive community services.

An additional factor relating to this Medicaid Managed Care contract is the role of medical necessity and value added services. These value added services will be funded from managed care savings and are targeted for recovery based services (non-medically necessary services, such as peer services).

3. The Affordability of the Qualified Health Plan

On November 15, 2012, Governor Dave Heineman announced Nebraska's affirmative election to participate in the federal health insurance exchange.
Source: http://www.governor.nebraska.gov/news/2012/11/15_health_care.html

The Nebraska Essential Health Benefits (EHB) Benchmark Plan for the Qualified Health Plan (QHP) is designated as Blue Cross and Blue Shield of Nebraska (Product Name: Blue Pride). Upon initial review of this QHP, it appears to be out of date given the provisions of the ACA. However, there is the following clause:

D. CONFORMITY WITH STATUTES: Any Contract provision which does not conform with the laws of Nebraska or the United States is hereby amended to conform to their minimum requirements.

Source: Blue*Pride* is a Preferred Provider health benefits plan offered by Blue Cross and Blue Shield of Nebraska (BCBSNE), a mutual insurance company, licensed by the State of Nebraska [PART XVIII. D. under GENERAL PROVISIONS pg 48)].

Key Elements of QHP Insurance Coverage
Nebraska's Benchmark Plan – Blue Pride Option 5

Deductible[4]

- In Network: $1,000 individual Deductible/$2,000 Family
- Out of Network: $2,000 individual Deductible/$4,000 Family

Copayments and co-insurance do not count toward deductible.

Maximum Out of Pocket[4]

- In Network: $1,000 individual Deductible/$2,000 Family
- Out of Network: $2,000 individual Deductible/$4,000 Family

Following are not included in maximum out of pocket: copayments, deductibles, prescription drugs, penalties, premiums, balance-billed charges, and services this plan does not cover.

Mental Illness, Substance Dependence and Abuse Benefits[2]

Benefits are payable for covered Hospital and Physician Services, including Mental Health services, Psychological, or Alcoholism and Drug counseling services by and within the scope of practice of a:

- Qualified Physician or Licensed Psychologist;

- Licensed Special Psychologist, Licensed Clinical Social Worker, Licensed Professional Counselor or Licensed Mental Health Practitioner; or
- Auxiliary providers who are supervised, and billed for, by a qualified Physician or Licensed Psychologist or as otherwise permitted by state law.

Inpatient Services[2]

A person is considered to be receiving Inpatient treatment if he or she is confined to a Hospital or a Substance Dependence and Abuse treatment center that provides medical management including 24-hour nursing care. Services provided by a facility that does not meet these criteria are considered part of a Residential Treatment Program, and are not covered.

Inpatient Covered Services include[2]

- Room and board, including covered ancillary services; and
- Services listed under Outpatient Covered Services, when performed in an inpatient setting.

Outpatient Services[2]

A person who is not admitted for Inpatient care, but is receiving treatment in the Outpatient department of a Hospital, Observation Room, Ambulatory Surgical Facility, Urgent Care Facility or Physician's office shall be conserved to be receiving outpatient care.

Outpatient Covered Services include[2]:

- Psychological therapy and/or substance dependence abuse counseling/rehabilitation provided by an approved Provider;
- Office visit or clinic visit, consultation, or emergency room visit;
- Evaluation and assessments;
- Medicine checks;
- Outpatient day, or partial hospitalization program for Mental Illness or a Substance Dependence and Abuse treatment program, that offers all-inclusive Services for each Outpatient treatment day;
- Biofeedback training for treatment of Mental Illness;
- Ambulance Services provided for the treatment of Mental Illness and Substance Dependence and Abuse;
- Laboratory and diagnostic Services; and
- Psychiatric/psychological testing.

Non-covered Services[3]

- Programs for co-dependency, employee assistance, probation, prevention, education or self help
- Programs that treat obesity, gambling or nicotine addiction
- Residential Treatment Programs for Mental Illness
- Residential Treatment Programs, halfway house or methadone maintenance programs that treat Substance Abuse
- Programs ordered by the Court determined by [insurance company] to be not Medically Necessary

2 – from email correspondence with BCBS and Department of Insurance

C. Coverage for M/SUD Services | page 6

3 - from "Blue Cross Blue Shield Blue Pride Preferred Provider Organization master Group Standard Health Benefit Contract for Small Employers"
4 – BluePride Option 5 Summary of Benefits and Coverage

Based on this analysis and applied to the currently funded Division of Behavioral Health community based services, below are the services most likely to be covered by health insurance after January 1, 2014:

Mental Health	**Substance Abuse**[1]
Acute	Community Support
Sub-Acute	Outpatient
Crisis Inpatient Youth	Assessment
Assessments	Intensive Outpatient
Outpatient	
Assertive Community Treatment	
Community Support	
Day Treatment	
Intensive Outpatient	
Medication Management	
Indigent Drug (LB95)	

The following community based services will not be covered by health insurance after Jan. 1, 2014

Mental Health	**Substance Abuse**[1]
Secure Residential	Dual Residential
Psych Res Rehab	Halfway House
Dual Residential	Intermediate Residential
Therapeutic Consultation	Short Term Residential
	Therapeutic Community
	Methadone Maintenance

Mental Health	**Substance Abuse**[1]
24 hour Crisis lines	24 hour Crisis lines
Day Support	Social Detox/CPC
Day Rehabilitation	Peer involved services
Respite Care	Recovery Housing alternatives
Peer Involved services	Flex funding
Supported Employment	Emergency Community Support
Supported Housing	Prevention activities
Flex funding	Other similar recovery services
Crisis Response Teams	
Crisis Respite	
Emergency Protective Custody (?)	
Professional Partner	
Emergency Community Support	
Hospital Diversion	
Other similar recovery services	

C. Coverage for M/SUD Services | page 7

[1] There is conflicting information in the Nebraska's Benchmark Plan documents if 'alcoholism' is covered. At this time, appears coverage limited to amount required by law (30 days inpatient/year; 2 inpatient events per lifetime; 60 outpatient sessions during lifetime of policy)

What is not clear at this time is the affordability of the insurance coverage should Medicaid expansion not occur. There is a probability of individuals between 100% and 133% of federal poverty levels not being able to afford health insurance and not being covered by Medicaid. It is this same population that Division of Behavioral Health is currently funding services.

Based on all of this analysis, it is unclear what services will be funded using SAMHSA Block Grant funds. However, the Division of Behavioral Health will direct the use of these funds for Federal Fiscal Year (FFY) 2014 and 2015 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.
  Source: Federal Register /Vol. 77, No. 196 /Wednesday, October 10, 2012

With that said, Federal Fiscal Year 2013 Block Grant funds support the following services:

Community Mental Health Block Grant (MHBG)	**Substance Abuse Prevention & Treatment Block Grant (SAPTBG)**
**Community Support	Social Detox
Day Rehabilitation	Short Term Residential
Dual Residential	Therapeutic Community
Psych Residental Rehab	Halfway House
**Outpatient	Dual Residential
**Day Treatment	Intermediate Residential
Day Support	**Community Support
Supported Employment	**Outpatient
**Medication Management	Methadone Maintenance
Professional Partner	**Intensive Outpatient
**Child/Youth Outpatient	**Child/Youth Outpatient
**Multi-Systemic Therapy (Home Based)	**Child/Youth Community Support
**Child/Youth Intensive Outpatient	**Child/Youth Assessment
Therapeutic Consultation	Prevention/Synar activities
Peer reviews	Regional Prevention Coordination
Training	Peer Reviews
	Training

NOTE: The ** indicates services to be paid by health insurance or Medicaid in the future. As a result, fewer SAMHSA Block Grant dollars **MAY** be needed to support these services in the future depending on Medicaid expansion or the cost of health insurance.

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

DBH policy already has a Payer of Last Resort expectation. Under the DBH Financial Eligibility Policy (revised November 20, 2012). Thus, DBH is currently monitors whether individuals and families have access to M/SUD services funded through QHPs, Medicaid and other sources.

On July 11, 2012, Governor Dave Heineman assigned responsibility to the Department of Insurance for the implementation of the ACA. The Department of Insurance will review complaints made against QHPs if there is an allegation of a violation of the insurance contract and will also perform market conduct examinations to review whether or not the QHP has properly adhered to state law.

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

The Nebraska Department of Insurance is responsible for monitoring access to M/SUD services by the QHPs. The Department of Insurance is responsible for evaluating and approving or disapproving life, health, and annuity products marketed to Nebraska residents, as well as reviewing rate filings.

The Nebraska Legislature passed bills to facilitate implementation of the Affordable Care Act (ACA). The Department of Insurance is the designated state agency for approving insurance plans, monitoring health insurance exchanges, navigators registered to help people sign up for insurance and an appeals process is in place if someone is denied.

- LB147 (2013) was approved by Governor on March 7, 2013. This law adopts a process for external review of internal decision-making by health insurance carriers. The purpose of Health Carrier External Review Act is to provide standards for external review procedures that assure covered persons an independent review of an adverse determination. The cost of independent reviews would be paid by health insurance carriers.
- LB336 was approved by Governor on March 7, 2013 – This requires state regulation of all health insurance rates for policies issued in Nebraska subject to the federal Patient Protection and Affordable Care Act (ACA). LB336 will ensure Nebraska compliance with the ACA.
- LB568 was approved by the Governor June 5, 2013 - Insurance navigator bill will register individuals and entities applying for and acting as navigators for the state's health benefit exchange. The Affordable Care Act (ACA) requires all exchanges include programs to assist individuals in navigating the new system.

Specifically, the Department of Insurance issued CB-130 on March 21, 2013, describing the work involved in filing individual and small employer health and dental plans in Nebraska as part of the implementation of the Patient Protection and Affordable Care Act (PPACA). The bulletin also outlines Department rating decisions allowed for under PPACA and subsequent regulations issued by the federal government. Filings will be reviewed on a first-in, first-out basis. A copy of CB-130 can be found on the Department's website at www.doi.ne.gov/bulletin/cb130.pdf.

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

The Department of Insurance will review any complaints in regards to insurance as required by state statute.

5. What specific changes will the state make in what is bought given the coverage offered in the state's EHB package?

As indicated in question 1, it is unclear what changes are needed at this time.

C. Coverage for M/SUD Services | page 9

More specific changes to what DBH will cover based on experience in implementing the ACA to date will be made for the State Fiscal Year 2015 contracts (July 1, 2014 – June 30, 2015) for the Regional Budget Plan released in February 2014.

IV: Narrative Plan

D. Health Insurance Marketplaces

Narrative Question:

Health Insurance Marketplaces (Marketplaces) will be responsible for performing a variety of critical functions to ensure access to desperately needed behavioral health services. Outreach and education regarding enrollment in QHPs or expanded Medicaid will be critical. SMHAs and SSAs should understand their state's new eligibility determination and enrollment system, as well as how insurers (commercial, Medicaid, and Medicare plans) will be making decisions regarding their provider networks. States should consider developing benchmarks regarding the expected number of individuals in their publicly-funded behavioral health system that should be insured by the end of FY 2015. In addition, states should set similar benchmarks for the number of providers who will be participating in insurers' networks that are currently not billing third party insurance.

QHPs must maintain a network of providers that is sufficient in the number and types of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be accessible without unreasonable delay. Mental health and substance abuse providers were specifically highlighted in the rule to encourage QHP issuers to provide sufficient access to a broad range of mental health and substance abuse services, particularly in low-income and underserved communities.

Please answer the following questions:

1. How will the state evaluate the impact that its outreach, eligibility determination, enrollment, and re-enrollment systems will have on eligible individuals with behavioral health conditions?

2. How will the state work with its partners to ensure that the Navigator program is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled?

3. How will the state ensure that providers are screening for eligibility, assisting with enrollment, and billing Medicaid, CHIP, QHPs, or other insurance prior to drawing down Block Grant dollars for individuals and/or services?

4. How will the state ensure that there is adequate community behavioral health provider participation in the networks of the QHPs, and how will the state assist its providers in enrolling in the networks?

5. Please provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.

6. Please provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY 2014 and CY 2015. Please provide the assumptions and methodology used to develop the estimate.

7. For the providers identified in Table 8 -Statewide Entity Inventory of the FY 2013 MHBG and SABG Reporting Section, please provide an estimate of the number of these providers that are currently enrolled in your state's Medicaid program. Please provide the assumptions and methodology used to develop the estimate.

8. Please provide an estimate of the number of providers estimated in Question 7 that will be enrolled in Medicaid or participating in a QHP. Provide this estimate for FY 2014 and a separate estimate for FY 2015, including the assumptions and methodology used to develop the estimate.

Footnotes:

D. Affordable Insurance Exchange | pg 1

Affordable Insurance Exchanges (Exchanges) will be responsible for performing a variety of critical functions to ensure access to desperately needed behavioral health services. Outreach and education regarding enrollment in QHPs or expanded Medicaid will be critical. SMHAs and SSAs should understand their state‘s new eligibility determination and enrollment system, as well as how insurers (commercial, Medicaid, and Medicare plans) will be making decisions regarding their provider networks. States should consider developing benchmarks regarding the expected number of individuals in their publicly-funded behavioral health system that should be insured by the end of FY 2015. In addition, states should set similar benchmarks for the number of providers who will be participating in insurers' networks that are currently not billing third party insurance.
QHPs must maintain a network of providers that is sufficient in the number and types of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be accessible without unreasonable delay. Mental health and substance abuse providers were specifically highlighted in the rule to encourage QHP issuers to provide sufficient access to a broad range of mental health and substance abuse services, particularly in low-income and underserved communities.

August 28, 2013

Key Terms:

- Patient Protection and Affordable Care Act (ACA)
- Federally-facilitated Exchange (FFE)
- Essential Health Benefits (EHBs)
- Qualified Health Plans (QHPs)
- Mental Health Parity and Addiction Equity Act (MHPAEA)
- Children‘s Health Insurance Program (CHIP)
- U.S. Department of Health & Human Services (HHS)
- Centers for Medicare & Medicaid Services (CMS)
- Nebraska Department of Health & Human Services (DHHS)
- Note: Division of Behavioral Health (DBH) is the chief behavioral health authority for the State of Nebraska [§71-806 (1)]. Thus, DBH is both the State Mental Health Authority (SMHA) & the State Substance Abuse Authority (SSA).

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- The rule delineates exemptions to the mandate and outlines federal agencies' enforcement roles.
- In particular, the rule clarifies that individuals eligible for the ACA's Medicaid expansion but living in states that do not expand Medicaid are exempt from the law's penalty.

- **Employer mandate delayed to 2015 –** on July 2, 2013, the Internal Revenue Service (IRS) announced plans to provide an additional year (until 2015) before the ACA mandatory employer and insurer reporting requirements begin. Beginning in 2015, the mandate will require companies with more than 50 full-time-equivalent employees to provide health insurance or pay a penalty.

On August 15, 2013, U.S. Department of Health and Human Services (HHS) Secretary Kathleen Sebelius announced the new resources to help consumers navigate the Health Insurance Marketplace. These Navigator grantees and their staff will serve as an in-person resource for people who want additional assistance in shopping for and enrolling in plans via the Health Insurance Marketplace beginning the Fall of 2013.

http://www.cms.gov/Newsroom/Newsroom-Center.html

Two grants were awarded in Nebraska:

- Community Action of Nebraska, Inc. (Anticipated grant amount: $562,457) – They serve community service organizations and non-profits across the state of Nebraska. The organization will build upon existing statewide infrastructure to provide assistance to nearly 40,000 Nebraskans in need of health coverage through the Marketplace.
- Ponca Tribe of Nebraska (Anticipated grant amount: $37,543) – They will use funds to provide outreach, education, and enrollment services to American Indians residing in the fifteen counties that constitute the Ponca Service Delivery Area. Funds will be used to hire Ponca Navigators, and assistance will be delivered through their five office locations, in person, and via videoconferencing.

http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/navigator-list-8-15-2013.pdf

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D. Affordable Insurance Exchange | pg 4

5. Please provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.

According to the Nebraska Department of Insurance, there are currently close to 220,000 uninsured Nebraskans. [source: John Paul Sabby, Nebraska Department of Insurance. January 16, 2013]

It is unclear at this time how many of these individuals will be served under the MHBG and SABG in CY 2013.

6. Please provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY 2014 and CY 2015. Please provide the assumptions and methodology used to develop the estimate.

As documented under Section C (Coverage for M/SUD Services) many questions remain on how the Affordable Care Act will impact and be implemented in Nebraska. In addition, the implications of the delays related to the employer and individual mandates noted under question 1 are yet to be determined.

As such, it is unclear how many individuals will remain uninsured in CY 2014 and CY 2015.

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c. Native American Treatment programs

All six of the Regions are Medicaid registered providers.

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IV: Narrative Plan

E. Program Integrity

Narrative Question:

The Affordable Care Act directs the Secretary of HHS to define EHBs. Non-grandfathered plans in the individual and small group markets both inside and outside of the Marketplaces, Medicaid benchmark and benchmark-equivalent plans, and basic health programs must cover these EHBs beginning in 2014. On December 16, 2011, HHS released a bulletin indicating the Secretary's intent to propose that EHBs be defined by benchmarks selected by each state. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a "typical employer plan" in that state as required by the Affordable Care Act.

SMHAs and SSAs should now be focused on two main areas related to EHBs: monitoring what is covered and aligning Block Grant and state funds to compensate for what is not covered. There are various activities that will ensure that mental and substance use disorder services are covered. These include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including EHBs as per the state benchmark; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring utilization of behavioral health benefits in light of utilization review, medical necessity, etc.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. SAMHSA expects states to implement policies and procedures that are designed to ensure that Block Grant funds are used in accordance with the four priority categories identified above. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment. States should describe their efforts to ensure that Block Grant funds are expended efficiently and effectively in accordance with program goals. In particular, states should address how they will accomplish the following:

1. Does the state have a program integrity plan regarding the SABG and MHBG?
2. Does the state have a specific staff person that is responsible for the state agency's program integrity activities?
3. What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices:
   a. Budget review;
   b. Claims/payment adjudication;
   c. Expenditure report analysis;
   d. Compliance reviews;
   e. Encounter/utilization/performance analysis; and
   f. Audits.
4. How does the state ensure that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered?
5. How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How will the state ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid?

SAMHSA will review this information to assess the progress that states have made in addressing program integrity issues and determine if additional guidance and/or technical assistance is appropriate.

Footnotes:

FY 2014-2015 SAMHSA Block Grant Application
- Community Mental Health Services Plan and Report
- Substance Abuse Prevention and Treatment Plan and Report

August 26, 2013

E. Program Integrity: States should describe their efforts to ensure that Block Grant funds are expended efficiently and effectively in accordance with program goals. In particular, states should address how they will accomplish the following:

1. Does the state have a program integrity plan regarding the SABG and MHBG?
Yes. 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) 2014 RBP Guidelines were provided to the Regions on January 29, 2013. The product of the RBP goes into the development of the contract between the DBH and the Regions.

Under the FY2014 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, specifically added for the next contract year, the Regions are expected to adjust the use of the MHBG and SABG per the direction of SAMHSA as described in the Federal Register (Vol. 77, No. 196 /Wednesday, October 10, 2012). SAMHSA expects the FY2014/2015 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 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.

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 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.

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 Block Grant 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.

2. Does the state have a specific staff person that is responsible for the state agency's program integrity activities?

Sheri Dawson (Director Appointee) is the DBH Deputy Director for Community Services. She reports directly to DBH Director Scot Adams (Gubernatorial Appointee). 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 and contracts.
- Heather Wood is the Quality Improvement and Data Performance Administrator whose responsibilities include data collection, analysis and reporting.

3. What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices:
a. Budget review – yes.

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 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.

b. Claims/payment adjudication and c. Expenditure report analysis – yes

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.

d. Compliance reviews – yes.

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.

e. Encounter/utilization/performance analysis – yes.

f. Audits – yes – (see above).

4. How does the state ensure that the payment methodologies used to disburse 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 develop and maintain the appropriate types and quantities of services delivered within their designated geographic area.

5. How 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 serve as standards of care. The services are reviewed by the Regions or the DBH every three years 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 National Accreditation for most providers to ensure quality and safety infrastructure within their organizations.

6. How will the state ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid?

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 Federal Fiscal Year 2014/2015 block grant funds to be directed toward four purposes as specified in the Federal Register (Vol. 77, No. 196 /Wednesday, October 10, 2012) and discussed in #1 above.

IV: Narrative Plan

F. Use of Evidence in Purchasing Decisions

Narrative Question:

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers decisions regarding mental health and substance abuse services. SAMHSA is requesting that states respond to the following questions:

1) Does your state have specific staff that are responsible for tracking and disseminating information regarding evidence-based or promising practices?

2) Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?

   a) What information did you use?

   b) What information was most useful?

3) How have you used information regarding evidence-based practices?

   a) Educating State Medicaid agencies and other purchasers regarding this information?

   b) Making decisions about what you buy with funds that are under your control?

Footnotes:

FY 2014-2015 SAMHSA Block Grant Application
- Community Mental Health Services Plan and Report
- Substance Abuse Prevention and Treatment Plan and Report

August 2, 2013

F. Use of Evidence in Purchasing Decisions
SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers decisions regarding mental health and substance abuse services. **SAMHSA is requesting** that states respond to the following questions:

1) Does your state have specific staff that are responsible for tracking and disseminating information regarding evidence-based or promising practices?
Blaine Shaffer, MD, Chief Clinical Officer and Sheri Dawson, RN, Deputy Director of the Division of Behavioral Health (DBH) – Nebraska Department of Health and Human Services (NDHHS) track developments regarding evidence-based or promising practices.

- DBH sends out information to the Regional Behavioral Health Authorities (RBHAs) and network providers by list serve.
- DBH is also discussing with BHECN on ways to develop a better approach to information sharing.
- DBH, BHECN and the ATTC have had joint meetings to discuss information sharing especially as it relates to medication assisted treatment.

The Behavioral Health Education Center of Nebraska (BHECN) at the University of Nebraska Medical Center works to improve the numbers, accessibility and competence of the Nebraska Behavioral Health Workforce. see: http://www.unmc.edu/bhecn/about.htm

The Mid-America Addiction Technology Transfer Center (ATTC) in Kansas City is committed to a science-to-service agenda. The ATTC serves to foster collaboration across service systems, bridging the gap between current research and those working the front lines of addiction and mental health treatment. see: http://www.attcnetwork.org/regcenters/index_midamerica.asp

2) Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?
Yes

a) What information did you use?
Many different elements of information are used in the purchasing and policy decisions involving evidence-based or promising practices. The following Evidence-Based Practices (EBPs) are in various phases of development in Nebraska:

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

Included in the consideration is the endorsement of SAMHSA. Two sources are consulted:

1. The SAMHSA website showing the Evidence-Based Practices tool kits http://store.samhsa.gov/facet/Professional-Research-Topics/term/Evidence-Based-Practices?filterToAdd=Kit
2. SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP) is an online registry of more than 280 interventions, as of February 19, 2013, supporting mental health promotion, substance abuse prevention, and mental health and substance abuse treatment. http://www.nrepp.samhsa.gov

b) What information was most useful?

The specific tool kits for the five EBPs being implemented in Nebraska [Assertive Community Treatment (ACT); Integrated Treatment for Co-Occurring Disorders (COD); Medication Treatment, Evaluation, and Management (MedTEAM); Permanent Supportive Housing; and Supported Employment] plus the information from NREPP about the International Center for Clubhouse Development (ICCD) Clubhouse Model http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=189.

3) How have you used information regarding evidence-based practices?

There are many challenges in the development and implementation of Evidence-Based Practices. To address the many complex issues, Blaine Shaffer, MD, Chief Clinical Officer, chartered an Evidence-Based Practices Workgroup (EBP Workgroup) under the Statewide Quality Improvement Team (SQIT). The Charge of the EBP Workgroup was to provide recommendations to the DBH leadership on a consistent and sustainable way of doing fidelity monitoring linked to outcomes on Evidence-Based Practices (EBPs). The DBH is working to determine the level of fidelity in selected practices (see above). The goal is to improve the use of EBPs to achieve more effective use of limited community resources.

a) Educating State Medicaid agencies and other purchasers regarding this information?

The EBP Workgroup was used to educate everyone on the options in this area. Membership on 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.

b) Making decisions about what you buy with funds that are under your control?

Evidence-Based Practices are part of the considerations taken into account on purchasing services. Much 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 area based on a comprehensive needs assessment/strategic plan. The RBHA needs 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.
- 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.

IV: Narrative Plan

G. Quality

Narrative Question:

Up to 25 data elements, including those listed in the table below, will be available through the Behavioral Health Barometer which SAMHSA will prepare annually to share with states for purposes of informing the planning process. The intention of the Barometer is to provide information to states to improve their planning process, not for evaluative purposes. Using this information, states will select specific priority areas and develop milestones and plans for addressing each of their priority areas. States will receive feedback on an annual basis in terms of national, regional, and state performance and will be expected to provide information on the additional measures they have identified outside of the core measures and state barometer. Reports on progress will serve to highlight the impact of the Block Grant-funded services and thus allow SAMHSA to collaborate with the states and other HHS Operating Divisions in providing technical assistance to improve behavioral health and related outcomes.

	Prevention	Substance Abuse Treatment	Mental Health Services
Health	Youth and Adult Heavy Alcohol Use - Past 30 Day	Reduction/No Change in substance use past 30 days	Level of Functioning
Home	Parental Disapproval Of Drug Use	Stability in Housing	Stability in Housing
Community	Environmental Risks/Exposure to prevention Messages and/or Friends Disapproval	Involvement in Self-Help	Improvement/Increase in quality/number of supportive relationships among SMI population
Purpose	Pro-Social Connections Community Connections	Percent in TX employed, in school, etc - TEDS	Clients w/ SMI or SED who are employed, or in school

1) What additional measures will your state focus on in developing your State BG Plan (up to three)?

2) Please provide information on any additional measures identified outside of the core measures and state barometer.

3) What are your states specific priority areas to address the issues identified by the data?

4) What are the milestones and plans for addressing each of your priority areas?

Footnotes:

FY 2014-2015 SAMHSA Block Grant Application
- Community Mental Health Services Plan and Report
- Substance Abuse Prevention and Treatment Plan and Report

August 22, 2013

G. Quality
Up to 25 data elements, including those listed in the table below, will be available through the **Behavioral Health Barometer** which **SAMHSA will prepare annually** to share with states for purposes of informing the planning process. Using this information, states will select specific priority areas and develop milestones and plans for addressing each of their priority areas. States will receive feedback on an annual basis in terms of national, regional, and state performance and will be expected to provide information on the additional measures they have identified outside of the core measures and state barometer. Reports on progress will serve to highlight the impact of the Block Grant-funded services and thus allow SAMHSA to collaborate with the states and other HHS Operating Divisions in providing technical assistance to improve behavioral health and related outcomes.

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	Prevention	Substance Abuse Treatment	Mental Health Services
Health	Youth and Adult Heavy Alcohol Use-Past 30 Day	Reduction/No Change in substance use past 30 days	Level of Functioning
Home	Parental Disapproval Of Drug Use	Stability in Housing	Stability in Housing
Community	Environmental Risks/Exposure to prevention Messages and/or Friends Disapproval	Involvement in Self-Help	Improvement/Increase in quality/number of supportive relationships among SMI population
Purpose	Pro-Social Connections–Community Connections	Percent in TX employed, in school, etc. (TEDS)	Clients w/ SMI or SED who are employed, or in school

1) What additional measures will your state focus on in developing your State BG Plan (up to three)?
   a) Trauma Informed Care (TIC) Tool
   b) Compass EZ
   c) PPP Family Functioning Tool

2) Please provide information on any additional measures identified outside of the core measures and state barometer.
   a) Trauma Informed Care – the Division of Behavioral Health (DBH) is working through the Regional Behavioral Health Authorities (RBHAs) to score the TIC tool during FY2013, asking all providers to complete the TIC tool and supply to DBH the honest assessment of the agencies' current status. This status report will establish a baseline for training, technical assistance, and peer to peer events designed to enhance TIC in agencies funded, and those not funded, by block grant dollars. TIC baseline data will be established after the June, 30, 2013 collection deadline. All provider information has been received and is currently being reviewed. Sections for improvement will be identified by January 15, 2014. Follow-up assessment scores will be collected using the 2015 Regional Budget Planning process and results reported in July, 2014. The complete self-assessment, using the TIC tool, will be repeated in spring, 2015.

b) Compass EZ is a tool used to measure agency capability to serve persons with co-occurring disorders of mental health and substance abuse. The tool was administered during the late winter and early spring of 2013 to establish a baseline for the development of training, technical assistance, and peer to peer events designed to create an overall co-occurring environment among substance abuse and mental health agencies. 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. Using the Compass EZ baseline, established in 2013, sections for improvement will be identified by January 15, 2014. Follow-up assessment scores will be collected using the 2015 Regional Budget Planning process and results reported in July, 2014. The complete self-assessment, using the Compass EZ, will be repeated in spring, 2015.

c) The DBH is working with a Professional Partner Program specialist for each RBHA and the consulting firm, TriWest Group, to evaluate the Professional Partner Program and to select a measure for family functioning. Currently the RBHAs are using several tools, and the DBH is unable to compare and contrast between tools. During the first year of the biennium, it is anticipated the tool will be selected and initial measures recommended by the consulting firm to strengthen the program.

3) What are your states' specific priority areas to address the issues identified by the data?

In the FY2014-2015 Block Grant Application - b. Planning Steps | Step 3: Prioritize State Planning Activities, the DBH Priority Areas are:

#1 – Prevention: Alcohol Use among Youth
#2 – Youth: Improved Family Functioning
#3 – Co-Occurring Disorders
#4 – Trauma-Informed Care
#5 – Peer Support
#6 – Tuberculosis (TB)

4) What are the milestones and plans for addressing each of your priority areas?

The Division of Behavioral Health milestones and plans for addressing the priority areas are specified under the Annual Performance Indicators to measure goal success – Planning Steps 3 & 4 – Priority Areas | 2014 – 2015 (see Section b. planning steps | Step 3 and 4 for the details).

Priority #: 1 From the DBH FY2014 Region Budget Plan Guidelines – Statewide Goals
Priority Area: Prevention: Alcohol Use Among Youth
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)

Priority #: 2 From the DBH FY2014 Region Budget Plan Guidelines – Statewide Goals
Priority Area: Youth: Improved Family Functioning
Priority Type: MHS
Population(s): SED

Priority #: 3 From the DBH FY2014 Region Budget Plan Guidelines – Statewide Goals
Priority Area: Co-Occurring Disorders
Priority Type: SAT, MHS

Population(s): SMI, SED, PWWDC, IVDUs, HIV EIS, TB

Priority #: 4 From the DBH FY2014 Region Budget Plan Guidelines – Statewide Goals
Priority Area: Trauma-Informed Care
Priority Type: SAP, SAT, MHP, MHS
Population(s): SMI, SED, PWWDC, IVDUs, HIV EIS, TB

Priority #: 5 From the DBH Office of Consumer Affairs | DBH Strategic Plan 2011-2015
Priority Area: Peer Support
Priority Type: SAP, SAT, MHP, MHS
Population(s): SMI, SED, PWWDC, IVDUs, HIV EIS, TB

Priority #: 6 From the SAPTBG Core Requirement
Priority Area: Tuberculosis (TB)
Priority Type: SAT
Population(s): TB

Note:

- 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 2014 Region Budget Plan Guidelines and the 2014-2015 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.

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IV: Narrative Plan

H. Trauma

Narrative Question:

In order to better meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed care approach consistent with SAMHSA's trauma-informed care definition and principles. This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate so that these services and programs can be more supportive and avoid being traumatized again.

Please answer the following questions:

1. Does your state have any policies directing providers to screen clients for a personal history of trauma?
2. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?
3. Does your state have any policies that promote the provision of trauma-informed care?
4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?
5. What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?

Footnotes:

FY 2014-2015 SAMHSA Block Grant Application
- Community Mental Health Services Plan and Report
- Substance Abuse Prevention and Treatment Plan and Report

August 2, 2013

H. Trauma
In order to better meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a **trauma-informed care approach** consistent with SAMHSA's trauma-informed care definition and principles. This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate so that these services and programs can be more supportive and avoid being traumatized again.

Please answer the following questions:

1. Does your state have any policies directing providers to screen clients for a personal history of trauma?

Yes. The Division of Behavioral Health (DBH) directs providers to screen clients for a personal history of trauma. The requirement is identified via contracts. 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 regionally funded 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. Many individuals may not feel safe to disclose information initially and can periodically be screened during the treatment process. However, there are many other individuals who are relieved to address these concerns and have not been asked to do so previously. It is also important to allow time for the individual's responses for discussion and provide referrals as necessary.

Additionally, the information from the screening is entered into the Magellan data system. Data collection is required at admission and discharge and is updated at the time of the annual registration. The Provider Data Collection Manual states:

> In order to support Trauma Informed Care the consumer's experience with trauma is to be screened. If the Provider clicks 'Yes' to the Trauma History field, an accordion view of several Trauma types will display. Providers then are to enter at least one type of trauma the consumer reports experiencing, as well as when it occurred i.e., either as a Child or as an Adult. Any traumas not reported by the consumer are entered as 'No'. The default setting on all trauma types is no, so click on the adult or child box or both for the type of trauma experienced to move the check mark.

The Trauma Variables are:

1	Emotional Abuse
2	life Threatening Medical Issues
3	Natural Disasters

4	Neglect
5	Physical Abuse
6	Physical Assault
7	Prostitution/Sex Trafficking
8	Sanctuary Trauma
9	Serious Accident/injury
10	Sexual Abuse
11	Sexual Assault/Rape
12	Traumatic Loss of a Loved One
13	Victim of a Terrorist Act
14	War/Political violence/Torture
15	Witness to community Violence
16	Witness to Domestic Abuse

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. A sample of a summary data report from the Nebraska Behavioral Health Services (NBHS) data system is included below. This reflects trauma screening data for the Reporting Period of 04/01/2012 - 06/30/2012. Overall, the total persons admitted with a Trauma History (yes to one or more of the categories) in the three month period ending June 30, 2012 was 50.3% (41.3% of males and 62.7% of females).

	Both Genders				Male				Female			
	Adult	Child	Both	Neither	Adult	Child	Both	Neither	Adult	Child	Both	Neither
Emotional Abuse	529	1,020	735	1,268	106	592	177	806	423	428	558	462
Life Threatening Medical Issues	433	92	83	2,942	206	51	38	1,386	227	41	45	1,556
Natural Disasters	111	107	29	3,303	42	60	16	1,563	69	47	13	1,740
Neglect	82	702	139	2,627	19	300	34	1,328	63	402	105	1,299
Physical Abuse	576	949	458	1,569	91	574	83	933	485	375	375	636
Physical Assault	633	201	305	2,412	231	127	126	1,198	402	74	179	1,214
Prostitution/Sex Trafficking	67	17	12	3,454	9	3	2	1,667	58	14	10	1,787
Sanctuary Trauma	139	47	12	3,352	69	22	9	1,581	70	25	3	1,771
Serious Accident/Injury	547	196	118	2,689	285	116	67	1,213	262	80	51	1,476
Sexual Abuse	182	905	274	2,191	17	316	23	1,325	165	589	251	866
Sexual Assault/Rape	312	309	203	2,726	27	80	10	1,564	285	229	193	1,162
Traumatic Loss of a Loved One	984	371	333	1,864	452	209	149	872	532	162	184	992
Victim of a Crime	328	58	156	3,008	149	30	64	1,438	179	28	92	1,570
Victim of a Terrorist Act	77	7	5	3,461	29	6	4	1,642	48	1	1	1,819
War/Political Violence/Torture	67	11	14	3,458	47	8	8	1,618	20	3	6	1,840
Witness to Community Violence	319	164	200	2,867	151	93	121	1,316	168	71	79	1,551
Witness to Domestic Abuse	241	675	277	2,358	63	352	75	1,191	178	323	202	1,167
Total Admissions	7,073				4,082				2,991			

At this time, the Division of Behavioral Health Office of Consumer Affairs is working to implement evidence-based trauma-specific interventions. In the FY2013-14 Transformation Transfer Initiative (TTI) project, Nebraska proposes to work towards several goals under the general premise of *Trauma Informed Peer Support within Family Systems*. The focus of this initiative is on how trauma impacts consumers of mental health services across the lifespan, and to promote healing that is developmentally specific. One specific goal includes validation of a trauma-related health

symptom screen that can be utilized by peer support providers. It may have larger system implications and the DBH looks forward to the final work product and recommendations.

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The specific Trauma-Informed Services policy is below.

Subject: Trauma-Informed Services

Purpose: To describe the Division of Behavioral Health (DBH) expectations in the provision of trauma-informed services to consumers accessing state-funded behavioral health services.

Rationale: Trauma-Informed services are informed about, and sensitive to trauma-related issues present in survivors. DBH is committed to a trauma-informed behavioral health system. All components of the system include services that accommodate the vulnerabilities of trauma survivors. The DBH system also delivers services in a way that avoids re-traumatization and facilitates consumer participation in treatment.

Policy: It is the policy of DBH that all state-funded 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; develop services that are recovery-oriented and trauma-sensitive; and understand that re-traumatization may occur if safe, effective, and responsive services are not available.

DBH is in the process of updating and promulgating new regulations, referred to as the Nebraska Administrative Code (NAC). Definitions and language in the regulations support trauma informed care. The definitions are as follows:

From NAC 206 Chapters 1-2 (Definitions)

Psychological Trauma means events or experiences that confront the person directly or as a witness where there exists an immediate perceived threat of death, extreme human suffering, severe bodily harm or injury, coercive exploitation or harassment, or sexual violation. Response to traumatic event involves intense fear, helplessness, or horror. Psychological trauma has a direct impact on the brain, body, and stress response system. This disrupts the cognitive, emotional, physical, spiritual, and relational functioning. Persons with severe and persistent behavioral health problems, including mental illness, and/or substance use disorders, often have experienced trauma. Many suffer from post-traumatic symptoms which exacerbate their other behavioral health problems, impair their psychosocial functioning, and interfere with the quality of their lives. Traumatic events may include rape, physical, emotional, or sexual abuse, war combat, urban street violence, torture, motor vehicle accidents, natural disasters and violence associated with crime.

Trauma-Informed Services means services that are informed about, and sensitive to, trauma-related issues present in survivors; but they need not be specifically designed to treat symptoms or syndromes related to sexual or physical abuse or other trauma. Trauma-informed services are provided based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization. Trauma-informed services are designed to include a basic understanding of how trauma impacts the life of an individual seeking service.

Trauma-Informed System means one in which all components of a given service system have been considered and evaluated in the light of a basic understanding of the role that violence plays in the lives of people seeking mental health and addictions services. A 'trauma informed' system uses that understanding to design service systems that accommodate the vulnerabilities of trauma survivors and allows services to be delivered in a way that will avoid re-traumatization and will facilitate consumer participation in treatment. It also requires, to the extent possible, closely knit collaborative

> relationships with other public sector service systems serving these clients and the local network of private practitioners with particular clinical expertise in traumatology" (Harris & Fallot, 2001).

Additionally, the DBH Strategic Plan requires effectiveness and specifies a continuous quality improvement (QI) process for services funded by the DBH, focusing on a number of factors including trauma. Strategic planning work to improve access to a trauma-informed service delivery system includes increasing the number of behavioral health providers who have completed a Trauma Informed Care (TIC) self-assessment or peer assessment tool. Providers were trained on the Harris and Fallot TIC tool. The DBH contracted with a trauma survivor to complete the tool for the DBH central office. RBHAs and providers are required to complete the self, or peer, assessment by June 30, 2013. Results will be aggregated and a system development plan will be identified.

Lastly, the DBH promotes Trauma Informed Care through Trauma Informed Nebraska (TIN). Led by the DBH Chief Clinical Officer, Dr. Blaine Shaffer, TIN's mission is to oversee the development and implementation of a statewide, consumer-driven, recovery-oriented, trauma-informed project. Goals include:

- The utilization of consumers/survivors in all aspects of trauma improvements and practices;
- Administrative commitment and capacity to become a trauma-informed system;
- Service provision that is aware of the origins of trauma, effects of trauma on survivors and their loved ones, and the possibility that re-traumatization may occur if safe, effective, sensitive services are not available;
- Brief, focused, non-threatening screening for trauma conducted as early as possible;
- Consistent, ongoing trauma assessment as an integral part of the clinical picture and used as part of the treatment and discharge planning;
- Decreasing the stigma surrounding survivors of trauma;
- Policy and procedures that incorporate trauma awareness and use the "Expectation, not the exception" guideline in daily treatment practices, and;
- The hiring and development of "trauma champions" in behavioral health services.

Stakeholders from across Nebraska join the quarterly meeting. A welcome packet full of history and resources is available to any stakeholder.

4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?

Each May, via the Regional Budget Plan (RBP), RBHAs submit an updated list of trauma specific services by provider. Over the last two years, the DBH noted a range of services listed as trauma specific; however the DBH Chief Clinical Officer questioned some on the list. As a result, TIN reviewed the definition of trauma specific and a number of EBP registries for trauma services (referenced in step 2 of this document). The DBH adopted a list of approved trauma specific registries and services, and guidance was included in this year's RBP. Following the receipt and aggregation of the regional budget plans this spring, a repository will be developed and placed on our Network of Care website. DBH will strive to increase the awareness of consumers and families requesting access to trauma specific services, such as Cognitive Behavioral Therapy (CBT), Trauma- Focused Dialectical Behavior Therapy (DBT), Eye Movement Desensitization and

Reprocessing (EMDR), Parent-Child Interaction Therapy (PCIT), Helping Women Recover, Sanctuary Model, and Seeking Safety.

5. What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?

Through TIN, the DBH, and the 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.

TIN has an educational component at each of its meetings. At the most recent TIN meeting (February 7, 2013), Dr. Kristin Yeoman, MD, MPH, from the Nebraska Department of Health and Human Services (NDHHS) Division of Public Health, presented "Adverse Childhood Experiences – Nebraska, 2011." This was a report on the Nebraska specific ACE module from the Behavioral Risk Factor Surveillance System (BRFSS) data collected in 2011. TIN also reviewed the definition of trauma specific and a variety of trauma specific registries.

The DBH has established a TIN and provider listserv. 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.

RBHAs have sponsored and funded training for provider EBP training for PCIT and TF-CBT which are trauma specific services. In June of this year, the DBH and the Lasting Hope Recovery Center will sponsor an Intergenerational Trauma conference from which trauma specific interventions can be identified and developed.

IV: Narrative Plan

I. Justice

Narrative Question:

The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance abuse disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas. [42,43] Rottman described the therapeutic value of problem-solving courts: Specialized courts provide a forum in which the adversarial process can be relaxed and problem solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs. Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient utilization of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; and therefore, risk factors remain unaddressed.[44]

A true diversion program takes youth who would ordinarily be processed within the juvenile justice system and places them instead into an alternative program. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as lack of identification needed for enrollment; loss of eligibility resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention

Please answer the following questions:

1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions?

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

3. Are your SMHA and SSA coordinating 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?

4. Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?

5. What cross-trainings do you provide 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?

42 The American Prospect: In the history of American mental hospitals and prisons, The Rehabilitation of the Asylum. David Rottman,2000.

43 A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs U.S. Department of Justice, Renee L. Bender, 2001.

44 Journal of Research in Crime and Delinquency: Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. OJJDP Model Programs Guide.

Footnotes:

FY 2014-2015 SAMHSA Block Grant Application
- Community Mental Health Services Plan and Report
- Substance Abuse Prevention and Treatment Plan and Report

August 2, 2013

Please answer the following questions:

1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions?
Governor Dave Heineman says Nebraska cannot afford Medicaid expansion. For more details, see Section C. Coverage for Mental and Substance Use Disorder (M/SUD) Services. In addition, see the Governor's press release from July 11, 2012. (http://www.governor.nebraska.gov/news/2012/07/11_medicaid.html).

2. What 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: Criminal Justice to provide context on organizing these services.

Intercept 1 - Law Enforcement/ Emergency services
Intercept 2 - Initial detention/Initial court hearings

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.

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

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 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
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

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

Intercept 1 – **Nebraska Mental Health Commitment Act**

Nebraska Revised Statute §§71-901 to 71-962 provides a form of screening by law enforcement leading to diversion from arrest for individuals with mental and/or substance use disorders who are mentally ill and dangerous. The purpose of the Nebraska Mental Health Commitment Act is to provide for the treatment of persons who are mentally ill and dangerous. State policy indicates mentally ill and dangerous persons shall be encouraged to obtain voluntary treatment. If voluntary treatment is not obtained, such persons shall be subject to involuntary custody and treatment only after Mental Health Board proceedings are completed as provided by this Act. Such persons can be held under an Emergency Protective Custody (EPC) for a limited period of time. For more details on the Nebraska Mental Health Commitment Act see:
http://dhhs.ne.gov/behavioral_health/Documents/NE_MentalHealthCommitmentActReferenceManual2011.pdf

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 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 jails. 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 jail the staff can call upon the psychiatrist 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, and at the end of the 2010-2011 Biennium, received $2 million annually from each source for a total budget of $4 million per year. 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. Are your SMHA and SSA coordinating 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. Section 2 (above) outlines a number of these efforts.

Regional Behavioral Health Authority

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 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 Doulas 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 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.

Rate of Diagnosed Mental Illness at Intake Made By NDCS

This table shows the rates of mental illness diagnosed at NDCS intake facilities. The table reports all Axis I diagnoses exclusive of sole substance-related diagnoses for adult males, adult females, youth offenders, county safe keepers and ninety day evaluators.

	FY2005		FY2006		FY2007		FY2008		FY 2009	
Number of inmates with mental illness	341	16%	645	25%	768	31%	949	40%	656	29%
Total Intakes	2,121		2583		2,447		2,379		2,289	
	FY2010		FY2011		FY 2012		FY 2013			
Number of inmates with mental illness	843	35%	824	32%	851	30%	944	33%		
Total Intakes	2,418		2,573		2,794		2,819			

Prescribed Psychiatric Medications on One Day (Point in Time)

Another indicator of the high rate of persons with mental illness in the state prison system is the number of inmates who are prescribed psychiatric medication. The following table shows the NDCS Inmate Population with Prescribed Psychiatric Medications on one day, June 30, of each reported year.

On June 30, 2005		Of June 30, 2006		on June 30, 2007		On June 30, 2008		On June 30, 2009	
854	20.20%	871	19.40%	858	19.70%	817	18.70%	1,080	24.10%
On June 30, 2010		On June 30, 2011		On June 30, 2012		On June 30, 2013			
907	20%	1191	26.50%	1,295	28%	1,401	28%		

Substance Related Diagnosis Made By NDCS Substance Abuse Staff at Intake

The rate of individuals diagnosed with substance-related disorders at intake in the NDCS state prison system is significant.

	FY2005		FY2006		FY2007		FY2008		FY 2009	
Inmate population with a substance abuse or dependence diagnosis	1,743	82%	1,372	89%	1,782	86%	1,741	89%	1,496	78.6%
Number of inmates screened	2,121		1,538		2,081		1,967		1,903	
	FY2010		FY2011		FY2012		FY2013			
Inmate population with a substance abuse or dependence diagnosis	1,477	76%	1,666	77%	1,430	76%	1,613	76%		
Number of inmates screened	1,955		2,175		1,874		2,131			

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.

4. Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?

Regional Behavioral Health Authority

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.

Region 5 – Lancaster County

This program is continually ensuring care coordination and follows 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.

Region 6 – Douglas, Sarpy, and Washington Counties

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

5. What cross-trainings do you provide 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?

Regional Behavioral Health Authority

Region 3 – Adams and Buffalo Counties

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

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

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.

IV: Narrative Plan

J. Parity Education

Narrative Question:

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action states can develop communication plans to provide and address key issues. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position.

Please answer the following questions:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness about parity?
2. How will or can states coordinate across public and private sector entities to increase awareness and understanding about benefits (e.g., service benefits, cost benefits, etc.?
3. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that are directly impacted by parity?

Footnotes:

FY 2014-2015 SAMHSA Block Grant Application
- Community Mental Health Services Plan and Report
- Substance Abuse Prevention and Treatment Plan and Report

August 27, 2013

J. Parity Education

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action states can develop communication plans to provide and address key issues. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position.
Please answer the following questions:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness about parity?

The Nebraska Department of Insurance and the Division of Behavioral Health (DBH) will work closely with internal and external stakeholders to educate and raise awareness about parity.

2. How will or can states coordinate across public and private sector entities to increase awareness and understanding about benefits (e.g., service benefits, cost benefits, etc.?

The Federally Facilitated Exchange will be doing the majority of the outreach. The applicability of this effort in Nebraska is undetermined at this time (see section C).

3. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that are directly impacted by parity?

The DBH will work with internal and external stakeholders to provide outreach to the appropriate and relevant audiences that are directly impacted by parity.

IV: Narrative Plan

K. Primary and Behavioral Health Care Integration Activities

Narrative Question:

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be rewarded to coordinate care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please answer the following questions:

1. Describe your involvement in the various coordinated care initiatives that your state is pursuing?

2. Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?

3. Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?

4. Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.

5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.

6. Describe how your behavioral health providers are screening and referring for:

   a. heart disease,

   b. hypertension,

   c. high cholesterol, and/or

   d. diabetes.

Footnotes:

FY 2014-2015 SAMHSA Block Grant Application
- Community Mental Health Services Plan and Report
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August 27, 2013

K. Primary and Behavioral Health Care Integration Activities
Numerous provisions in the **Affordable Care Act** and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be rewarded to coordinate care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please answer the following questions:
1. Describe your involvement in the various coordinated care initiatives that your state is pursuing?
The Division of Behavioral Health (DBH), the Division of Public Health, and other local partners have been involved in the development of the Nebraska Public Health Quality Improvement Plan. In this process, there are programs and activities being implemented that are moving the system toward integration. Although these programs and activities do not yet provide a clear pathway toward integration, they do provide several opportunities to focus on the health of the population and provide new opportunities for partnerships between primary care, mental health and substance abuse, and public health.

As part of the assessment of the need for coordinated service, DBH added health questions to the admission, yearly update, and discharge form in the community data system. These data elements include height and weight – to calculate BMI, medication information; mental and general health assessment as well as indicators of tobacco usage and last physician visits. These questions were added to enhance the health information of the service providers, to gather data on the service populations' access to, or knowledge of the relationship of mental and physical health, as well as to provide local and statewide data for coordination efforts.

2012 Consumer Survey
DBH conducts the annual Behavioral Health Consumer Survey. This survey solicits input from adult and youth consumers receiving mental health and/or substance abuse (substance use disorder) services from the publicly funded, community-based behavioral health system in Nebraska.

The adult behavioral health consumers were asked about their physical health status. Their responses to the health questions on the consumer survey were compared to responses to the 2011 Behavioral Health Risk Factor Surveillance System (BRFSS) for the general adult population in Nebraska. Those comparisons are shown in Table 5. To measure the presence of chronic physical health conditions among behavioral health consumers, four questions from the BRFSS were included on the consumer survey in 2012.

The findings indicated mental health consumers were about twice as likely as the general population to report having diabetes, and over one and a half times more likely to be obese. While mental health consumers tend to have higher rates of poor health status and lower rates of very good and

excellent health status compared to the general population, substance abuse consumers tend to have rates reported in-between those of mental health consumers and the general population.

TABLE 5: Differences on BRFSS Questions between Consumers Receiving Mental Health Versus Substance Abuse Services and the General Adult Population in Nebraska

	Primary Reason for Admission		2011 Nebraska General Population
	MH	SA	
Physical Health Conditions:			
Heart Attack or Myocardial Infarction	5.0%	3.1%	**4.3%**
Angina or Coronary Heart Disease	4.9%	2.0%	**3.9%**
Stroke	4.5%	3.5%	**2.6%**
Diabetes	16.1%	6.8%	**8.4%**
General Health Status:			
Excellent	7.5%	15.3%	**18.0%**
Very Good	19.2%	24.7%	**36.0%**
Good	37.2%	37.1%	**32.0%**
Fair	26.0%	17.3%	**11.0%**
Poor	10.1%	5.6%	**3.0%**
In the Past 30 Days:			
Average Days Physical Health Not Good	7.8	5.5	**NA**
Average Days Mental Health Not Good	10.4	5.8	**NA**
Average Days Poor Health Prevented Usual Activities	8.8	6.7	**NA**
Average Days of Binge Drinking	0.7	1.3	**NA**
Body Mass Index Category:			
Obese	45.9%	26.4%	**28.0%**
Overweight	27.7%	37.7%	**37.0%**
Normal Weight/Underweight	26.4%	35.9%	**36.0%**

Note: Most recent data for Nebraska general population is from 2011.

Source: DHHS-DBH 2012 Behavioral Health Consumer Survey Results / page 12
http://dhhs.ne.gov/behavioral_health/Documents/Nebraska2012BehavioralHealthConsumerSurvey.pdf

One of the opportunities for building this integrated model is a new federal requirement in the Affordable Care Act that all non-profit hospitals must conduct a Community Health Needs Assessment (CHNA) and develop an implementation plan to address the high priority health problems. This requirement provides an opportunity for local health departments to partner with the non-profit hospitals in their area to develop the CHNA and the implementation plan. Currently, several local health departments in Nebraska are working with their local hospitals to conduct the CHNA using a comprehensive planning model called Mobilizing for Action through Planning and Partnerships (MAPP) to assess the needs of the population, set priorities, and determine the most appropriate evidence-based strategies. The CHNA must be completed by the end of the hospital's fiscal year in 2013 and every three years after this date. Although all non-profit hospitals are required to conduct the CHNA, several government-owned facilities are also participating in the process. As a result, this process provides a unique opportunity to establish strong partnerships between local public health agencies and both urban and rural hospitals. Once the priorities are established, the hospitals must demonstrate that they are working to address the high priorities that are included in their implementation plans. Although hospitals are likely to finance some of the key strategies directly, it is also an opportunity to leverage additional resources from both hospitals and other partners to implement key strategies. This collaboration between hospitals and public health is directly focused on assessing needs and implementing programs and policies to improve the health of the population. It also has the potential to build a long-term partnership between these two entities and engage several additional partners.

Health Care Home Model

In Nebraska, the Health Care Home (HCH) model is rapidly spreading across the state. In 2011, Blue Cross Blue Shield of Nebraska initiated a medical home model in nine cities by focusing on management of diabetes, using test results for the patient's blood sugar, blood pressure, and cholesterol levels. In 2012, this model was expanded to 33 clinics and about 42,000 Blue Cross subscribers.

In 2010, the State Legislature appropriated funds for two medical home pilot projects for Medicaid patients. In 2011, two pilot projects were launched in clinics located in Lexington and Kearney. Also, as part of the Medicaid managed care contract, Coventry and Arbor Health are expected to develop medical home models in 12 new communities over a three-year period.

Blue Cross Blue Shield of Nebraska has experienced early success with this model and the Medicaid program is rigorously evaluating the results of the pilot projects.

One of the important features of the HCH is the integration of primary care and mental health services. This feature has become an important part of the model because the diagnosis of mental disorders and substance abuse problems has shifted to primary care practitioners due to the shortage of mental health providers and limited insurance coverage.

In the HCHs, it should be possible to address mental health and substance abuse problems in a more timely manner. Individuals with severe mental disorders will continue to be referred to mental health physician specialists, but all of the referrals will be tracked and monitored. Individuals with less severe mental disorders or substance abuse problems should be able to receive more timely counseling, medications, or other treatments either on-site or at a nearby location.

2. Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?

Two pilot programs within the state of Nebraska, based in FQHC clinics (One World Health Center in Omaha and People's Health Center in Lincoln), ensure access to behavioral health services by promoting "warm handoffs" to therapists located within the facility for individuals presenting with physical ailments but screening positive for behavioral health disorders.

Program of All-inclusive Care for the Elderly (PACE): Immanuel Health Systems, in cooperation with the Division of Medicaid and Long-Term Care has developed a PACE program in Omaha and Lincoln. PACE provides a continuum of support services for persons over the age of 55 with chronic care needs who are able to live safely within the community. The continuum ranges from primary medical care to specialists, home care such as home health, personal care and respite services to hospital and nursing home services, as well as a wide variety of services including behavioral health within an adult day care setting.

3. Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?

No, not at this time.

4. Describe how your behavioral health facilities are moving towards addressing **nicotine dependence** on par with other substance use disorders.

The three Nebraska Regional Centers (public psychiatric hospitals) in Lincoln, Hastings, and Norfolk have been smoke-free campuses for a number of years. Nicotine patches are offered when people are admitted to help them with the withdrawal. While in treatment there are a variety of groups/treatment interventions that are offered. At discharge, they are given the tobacco free information and education on staying smoke free. Below is a listing of the groups/treatment interventions that are offered:

- Smoking Cessation – This group focuses on understanding tobacco addiction, tobacco and mental illness, what helps people quit smoking, and tobacco and peer support.
- Strength Training – Strength training sessions consist of instruction and consultation in individualized exercise programs to assist group participants in the use of muscular contraction to build strength, anaerobic endurance, improve overall physical fitness, and develop coping and social skills.
- Sleep Habits and Health – This group includes a one-hour education-based class AND a one-hour hands-on "lab." Group members will receive education regarding common healthy/unhealthy sleep habits and discuss how those habits can affect mood, concentration and general health. The group also provides education and tips regarding the importance of developing a healthy sleep routine and/or hygiene. Lab opportunities allow patients to practice relaxation and stress reduction strategies taught, in order to identify their personal preferences and promote better sleep.
- Stress Management – Stress Management consists of instructional sessions that explore cognitive and behavioral components dealing with stressors. Sessions discuss how behavior can affect stress and also includes instruction on methods for identifying stressors, how stress affects physical and mental health, effective strategies in coping with stressors, and various types of relaxation exercises.
- Health Awareness – Health Awareness consists of education and skills to enhance health via physical movement and health education.
- Healthy Lifestyles – Reinforces skills previously learned in core classes and new skills to develop and implement a healthy lifestyle to ease transition into the community and a component in the patient's relapse prevention plan.
- Moving Toward Recovery – Designed to introduce and explore the concept of recovery, to encourage and motivate toward personal change, to deal with unresolved emotional issues that interfere with recovery choices, and to aid in maintaining a healthy, sober and safe recovery lifestyle.
- Peer Support Whole Health & Resiliency: A Person-Centered Planning Process (Peer Whole Health) – Focuses on health and resiliency lifestyle domains that are vital to the overall mental and physical wellness using a person-centered planning process to look at current patterns, interests, and strengths in each domain. Process will help prioritize and focus on one health or resiliency domain in which individual's set goals and create weekly action plans to achieve while providing peer support.
- Responsible Lifestyles Group – To provide education on the importance of making responsible lifestyle choices to decrease health risk factors related to poor nutrition and exercise.

On the community side of this question, the 2012 Consumer Survey provided some interesting findings. When asked whether they smoke cigarettes, more than a third (39.8%) of mental health consumers indicated that they smoke every day, and 52.6% reported not smoking. Likewise, over half (55.8%) of substance abuse consumers reported smoking every day and 35.8% reported not

smoking. However, only 15% of the general population reported smoking every day, while 80.0% reported that they do not smoke.

TABLE 5: Differences on BRFSS Questions between Consumers Receiving Mental Health Versus Substance Abuse Services and the General Adult Population in Nebraska.

Cigarette Smoking	Primary Reason for Admission		2011 Nebraska General Population
	MH	SA	
Every Day	39.80%	55.80%	15.00%
Some Days	7.60%	8.40%	5.00%
Does Not Smoke	52.60%	35.80%	80.00%

Source: DHHS-DBH 2012 Behavioral Health Consumer Survey Results / page 12
http://dhhs.ne.gov/behavioral_health/Documents/Nebraska2012BehavioralHealthConsumerSurvey.pdf

Behavioral health consumers, especially those receiving substance abuse services, were much more likely than the general population to report smoking cigarettes on a daily basis. As a result of these consumer survey findings, DBH added a new data element in July 2012 to the Community Services Data System to measure the degree of nicotine dependence. The first questions was "Tobacco Use?" with the options to answer either Yes or No. If yes, additional questions were asked. Table below is a duplicated count of admission summary for consumers admitted between October 1, 2012 and December 31, 2012.

Tobacco use	MH		SA		Dual		Total	
Yes	1,790	31.7%	2,156	46.0%	58	60.4%	4,004	38.4%
No	3,833	67.9%	2,506	53.5%	38	39.6%	6,377	61.2%
Unknown	19	0.3%	23	0.5%	.		42	0.4%
Total	5,642	100.0%	4,685	100.0%	96	100.0%	10,423	100.0%

These preliminary findings from the DBH Community Services Data System suggest contracted community based providers are in a position to respond to this issue. Over 38% of those consumers admitted to services in the Fall of 2012 reported some form of tobacco use. The DBH has no authority to regulate service agencies to require nicotine dependency training. However, many community-based service providers work to connect consumers to resources such as the Division of Public Health's Tobacco Free Nebraska and related programs.

5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking

Consumers are asking about nicotine use at admission to treatment. When requested, the consumer would have access to the following information:

The Office of Consumer Affairs has coordinated with Magellan (Whole Health) and Public Health (Living Well) to have Certified Peer Support and Wellness Specialists trained in creating health goals and supporting people with their health goals. Attending these are equivalent to 6 CEU credits or the whole year's requirement for CEU's.

Also we publish this smoke free guide:
http://dhhs.ne.gov/behavioral_health/Documents/SmokingCessationGuide.pdf

Additionally, the DBH Prevention program has created educational materials directed at youth smoking cessation as well as for those in the treatment community. This information has been shared with the six Behavioral Health Regions – specifically with Regional Prevention Centers as well as Lincoln Medical Education Program and School Community Intervention and Prevention Program to be shared with local teams.

6. Describe how your behavioral health providers are screening and referring for:
a. heart disease, b. hypertension, c. high cholesterol, and/or d. diabetes

The behavioral health providers are screening and referring for based on their own initiatives. For example, Region 5 network providers have implemented strategies to refer consumers suspected of having heart disease, hypertension, high cholesterol, and/or diabetes to the People's Health Center in Lincoln.

Other than for tuberculosis (TB) screening (per the Federal Block Grant Requirements) and what national accreditation requires, there are no policy directives from the Division of Behavioral Health requiring behavioral health providers do these screening and referring for those medical conditions.

IV: Narrative Plan

L. Health Disparities

Narrative Question:

In the Block Grant application, states are routinely asked to define the population they intend to serve (e.g., adults with SMI at risk for chronic health conditions, young adults engaged in underage drinking, populations living with or at risk for contracting HIV/AIDS). Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, Latino adults with SMI may be at heightened risk for metabolic disorder due to lack of appropriate in-language primary care services, American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community, and African American women may be at greater risk for contracting HIV/AIDS due to lack of access to education on risky sexual behaviors in urban low-income communities.

While these factors might not be pervasive among the general population served by the Block Grant, they may be predominant among subpopulations or groups vulnerable to disparities. To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. In order for states to address the potentially disparate impact of their Block Grant funded efforts, they will be asked to address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

In the space below please answer the following questions:

1. How will you track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?
2. How will you identify, address and track the language needs of disparity-vulnerable subpopulations?
3. How will you develop plans to address and eventually reduce disparities in access, service use, and outcomes for the above disparity-vulnerable subpopulations?
4. How will you use Block Grant funds to measure, track and respond to these disparities?

Footnotes:

FY 2014-2015 SAMHSA Block Grant Application
- Community Mental Health Services Plan and Report
- Substance Abuse Prevention and Treatment Plan and Report

August 2, 2013

L. Health Disparities
In the Block Grant application, states are routinely asked to define the population they intend to serve (e.g., adults with SMI at risk for chronic health conditions, young adults engaged in underage drinking, populations living with or at risk for contracting HIV/AIDS). Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, Latino adults with SMI may be at heightened risk for metabolic disorder due to lack of appropriate in-language primary care services, American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community, and African American women may be at greater risk for contracting HIV/AIDS due to lack of access to education on risky sexual behaviors in urban low-income communities.

While these factors might not be pervasive among the general population served by the Block Grant, they may be predominant among subpopulations or groups vulnerable to disparities. To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. In order for states to address the potentially disparate impact of their Block Grant funded efforts, they will be asked to address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

In the space below please answer the following questions:

1. How will you track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?
All community level data are collected at admission, annual re-registration, annual re-authorization and discharge. Annual re-registration is a concept developed to measure progress of individuals whose service stays extend beyond a single year. At or near the anniversary data of admission to the service, individual records are updated to measure progress toward the national outcome measures. Individual records are updated and classified by service type, race, ethnicity, gender, age and other variable to report state, region or agency performance toward recovery as outlined in national outcome goals. The DBH data system doesn’t specify the language services, but on the Mental Health capacity report submitted by all six Regional Behavioral Health Authorities (RBHAs) each month, we track the capacity used for bilingual/bicultural services. The current Magellan data system does not capture LGBTQ information.

2. How will you identify, address and track the language needs of disparity-vulnerable subpopulations?
Consumer preferred language is captured at admission. Interpreters are employed at the provider level. The Regional Budget Plan (RBP) states the RBHAs will 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. In the Division of Behavioral Health (DBH) annual Consumer Survey, consumers are asked whether staff are sensitive to their cultural background, including race, religion, and language, etc.

3. How will you develop plans to address and eventually reduce disparities in access, service use, and outcomes for the above disparity-vulnerable subpopulations?

The DBH will seek opportunities to share data across the Nebraska Department of Health and Human Services (NDHHS) Divisions including the Medicaid at-risk vendor to develop plans for disparities.

The DBH measures progress toward the National Outcome Measures (NOMS) by service type, race, ethnicity, gender, age and other variables on a quarterly basis. The DBH shares the information with RBHAs, and the RBHAs share the information with their contracted providers. The DBH also monitors the capacity used for Mental Health and Substance Abuse services each week through the DBH's waiting list and capacity reporting.

4. How will you use Block Grant funds to measure, track and respond to these disparities?

Based on the identification of needs and the development of planned strategies noted above, quality improvement initiatives will be considered to look at adjusting the RBP guidelines and related DBH policy. For example, the DBH staff will measure these disparities using National Outcome Measures (NOMS) reports, capacity and waiting list reports, Mental Health client level data, and the Treatment Episode Data Set (TEDs). This data is tracked through the Magellan data system. To respond, DBH will share the information with the RBHAs, providers, consumers (Consumer Survey results) through the use of ongoing Tuesday Data Calls, Quality Improvement workgroups, and State Advisory Committees to reduce disparities in access, service use and outcomes.

IV: Narrative Plan

M. Recovery

Narrative Question:

SAMHSA encourages states to take proactive steps to implement recovery support services. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Indicators/Measures

Please answer yes or no to the following questions:

1. Has the state has developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?

2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?

3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?

4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).

5. 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?

6. 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?

7. Does the state have an accreditation program, certification program, or standards for peer-run services?

8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

Involvement of Individuals and Families

Recovery is based on the involvement of consumers/peers and their family members. States must work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system. In completing this response, state should consider the following questions:

1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?

2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?

3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?

4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Housing

1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?

2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a

supportive community?

Footnotes:

FY 2014-2015 SAMHSA Block Grant Application
- Community Mental Health Services Plan and Report
- Substance Abuse Prevention and Treatment Plan and Report

August 2, 2013

M. Recovery: SAMHSA encourages states to take proactive steps to implement recovery support services. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Indicators/Measures: Please answer yes or no to the following questions:

1. Has the state developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?

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 will:

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

For more details on the DBH Strategic Plan, see
http://dhhs.ne.gov/behavioral_health/Pages/2010BHStrategicPlan.aspx

The Division of Behavioral Health 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, under Chapter 2 – Definitions are the following two terms:

→ Recovery means a process of healing the mind, body, and spirit; inclusive of transformation of individuals with behavioral health conditions (consumers), family and friends, communities, and care systems to equip the person to exercise their choices and rights. This transformation or change can influence individual goals, roles, skills, attitudes that result in moving from hopelessness to hopeful life, dysfunctional relationships to quality relationships, and from illness to wellness.

→ Recovery-Oriented System of Care (ROSC) means a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resilience of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life.

Of key importance for the implementation of the strategic plan is the development of a recovery-oriented system of care model framework which shall include further clarification of standards and principles as well as service delivery components. Moving these into practice is of central focus for the next few years.

2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?

YES.

→ Carol Coussons de Reyes is a Certified Peer Specialist. She is the Administrator for the DBH Office of Consumer Affairs (OCA).

→ 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

→ Several Recovery Specialists have been hired by the Lincoln Regional Center. They are people in recovery that report directly to the CEO of Lincoln Regional Center.

→ DBH contracts directly with 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.

3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?

Yes. The Division of Behavioral Health supports the concepts involved in the use of person-centered planning, self-direction and participant-directed care as evidenced within the Strategic Plan and within contracts for peer/family peer support services. Person centered planning was implemented in the Regional Centers. The DBH Office of Consumer Affairs actively promotes Consumer Involvement. These efforts include the OCA Facilitators Circle, OCA Peer Support and Wellness Specialist Certification training, Peer Support and Wellness Specialist Co-Supervision, the OCA People's Council, the OCA Open Door Calls and the Statewide Behavioral Health Conference. Peer Support and Wellness Specialist certification (CPSWS) training has a module on Person Centered Recovery

Planning that encourages person centered planning, self-direction, and participant directed care. The code of ethics of CPSWS's promotes self-advocacy also.
For more details see the Office of Consumer Affairs web site:
http://dhhs.ne.gov/behavioral_health/Pages/beh_mh_mhadvo.aspx

In addition, the Family Navigator service model rests solely on the concept of family-centered and directed care. This service, new to Nebraska in the last couple years, was designed purposely to utilize the strength of family peer support specialists in assisting and empowering other families to develop family plans and identify community services and support to achieve their goals. This service has proven successful not only in outcomes but also in further formalizing the standards by which family peer services are implemented and recognized in Nebraska.

4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).

The Division of Behavioral Health Strategic Plan is designed to move the system in Nebraska in these directions.

→ 206 Draft Regulations include a definition of peer support and peer support staff to support this growing workforce in Nebraska. There is even a chapter title being inserted to include peer support in the next iteration of regulations for peer support services. Strategic Planning around peer support is ongoing and current work includes building the infrastructure to support a peer workforce with a service definition.

→ Also, as noted above, the Family Navigator service is designed specifically to utilize peers in assisting families to connect to services and in some instance play a key role in interim crisis or intervention support when a family is referred from a statewide family helpline. This has resulted in a significant reduction of families utilizing hospital based care or seeking police intervention for care when otherwise not most appropriate.

→ Housing Related Assistance is provided in all six Regions.

→ Supported Employment is provided in all six Regions. DBH has been working in partnership with State Vocational Rehabilitation to update the program.

→ One of the DBH state priorities for the Block Grant is the further development of Peer Support.

→ Diversion Services provided by Mental Health Association of Nebraska include Keya House (a crisis diversion house for adults providing a safe location to work on maintaining wellness and recovery); Hospital Peer Support (to individuals seeking assistance with psychological issues at the BryanLGH emergency department, and to adults receiving in-patient services); and Lincoln Police Department Referral (trained peers providing follow-up services to individuals identified by LPD during routine mental health investigations). For more information see:
http://www.mha-ne.org/

→ Safe Harbor Peer Services was opened in 2012 by Community Alliance (CARF Accredited) as an alternative to going to the hospital or emergency room for those in crisis but not needing psychiatric or medical care. The program is comprised totally of individuals who are self-identified as having a personal life experience with mental illness. These individuals, trained Peer Specialists, staff the Safe Harbor center where guests may stay for up to 24 hours. Peers

also answer a "warm line", designed to offer non-crisis support via telephone. See: http://www.community-alliance.org/www/index.php?option=com_content&view=article&id=55&Itemid=55

5. 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 Division of Behavioral Health Strategic Plan is designed to move the system to improve services for these populations.

The model of peer support utilized by Peer Support and Wellness Specialists is Intentional Peer Support that is a trauma informed and culturally competent model of peer support, inclusive of tools to understand all worldviews. Several Veterans and member of LGBT communities have participated in the CPSWS training, though no formal records have been collected of this information.

The Family Navigator/Family Peer Support services are provided by 40 trained family peer specialists in Nebraska that are actively connected with a statewide helpline for family members. All staff are trained to utilize a standard suicide screening process as a result of the Garret Lee Smith grant, and are currently imbedding trauma informed training into workforce competencies as well. Current plans through a NASMHPD managed SAMHSA TTI Grant are working to hone these competencies to be inclusive of trauma informed language and concepts utilized by the Adult Peer Support Providers trained in Intentional Peer Support. We will host a Facilitator's Training in August of this year and hope to train a CPSWS from the VA and a Family Member in delivering the Intentional Peer Support curriculum.

Within the framework of recovery-oriented systems of care, the person centered approach allows for greater flexibility for cultural adaptations within service delivery. Special initiatives regarding trauma and returning military are in planning.

6. 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?

YES, through the DBH Office of Consumer Affairs (OCA), a contract with a workforce development vendor (Lincoln Medical Education Partnership), and the six Regional Behavioral Health Authorities. There is also the Nebraska Statewide Conference 'Success, Hopes & Dreams for the Future' scheduled for May 13th - 15th, 2013 in Lincoln, Nebraska.

Keynote Speakers are:
Monday, May 13 (12:45-1:45)

→ Gina Calhoun – It's a Beautiful Day for a Neighbor: Won't You Be Mine?
Description: This keynote will address Ms. Calhoun's story of mental health recovery after 17 years of back-to-back institutionalization and escaping from Harrisburg State Hospital to live on the streets. She will use the ABC's of whole health to help us understand that wellness matters.

Tuesday, May 14 (8:15-9:15)

→ LaVerne Miller, JD – The Road Less Traveled: Opportunities for Collaboration Between Consumer and Family Organizations
Description: Recent events have highlighted the often fractured relationship between consumer and family organizations. Recent headlines about gun violence and involuntary

treatment detract from the real issues facing family members, transitional age youth, and adult consumers. There are potentially many areas where common ground can and must be found. Whether it's the integration of primary and behavioral health care, early prevention, or trauma informed care, there is far much more that unites us than divides us. This keynote will focus on creating a new and dynamic narrative that prepares us all for the challenges that we must confront and overcome in the future.

Tuesday, May 14 (12:30-1:30)

Charles Curie – Behavioral Health: Impacting the Future of Health Care

Description: We know today, more than ever, what works when it comes to effective behavioral health treatment and how to facilitate and sustain recovery in the lives of people with mental illnesses and addictive disorders. The challenge today is to "do what we know." The year 2013 marks the 50th Anniversary of President Kennedy signing the CMHC Act of 1963 and gives us an opportunity to take stock of the progress we have made and the future we must seek in assuring access to effective behavioral health services and supports. This keynote address will focus on what behavioral health services can and should look like in the future. There will be a special emphasis on behavioral health's part in the evolution of health care reform. The impact of the concept of recovery in policy and finance development will also be considered. The concept of "health homes" as a means to realize effective integration of behavioral health and physical health care will be addressed.

For more information see: http://www.nebraskastateconference.org

Training of Providers in Intentional Peer Support is a goal of many of the consumer leaders in Nebraska that are members of the OCA People's Council and the OCA Facilitator's Circle. A Webinar has been written and is being recorded to increase understanding of the Adult Peer Workforce, their use of Intentional Peer Support as a Trauma Informed Approach, and the Code of Ethics.

7. 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 attachment. 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 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 Intentional Peer Support model and certification process facilitated by OCA includes standards and competencies. In addition, the contract requirements for the delivery of the Family Navigator/Family Peer Support services include standards and competencies. The Federation of Families for Children's Mental Health who delivers this service, are formalizing their workforce competencies and standards of care with the expectation of contribution towards a regulated credential in the future.

8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, 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)

→ The Office of Consumer Affairs 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 also works with the Nebraska Network of Care Website to provide information for consumers. http://dhhs.ne.gov/behavioral_health/Pages/networkofcare_index.aspx

→ Peer Support and Wellness Specialists

→ Picture Recovery: http://youtu.be/UBDi3wKRPnw

→ Artists of the Arboretum: Page 7- http://dhhs.ne.gov/Connections%20Newsletters/March2013.pdf

OCA has a Transformation Transfer Initiative (TTI) Grant from SAMHSA (administered by National Association of State Mental Health Program Directors (NASMHPD) focused on Trauma. The goals of the grant activities include the following:

a) Family Peer Support Competencies creation that includes emphasis on creating a common language around Intentional Peer Support between the Adult Peer Support and Family Peer Support systems. Cross learning opportunities are being discovered.
b) Trauma Informed and Culturally Competent Peer Support Facilitator Training for family members, veterans, and adults to be led by Focus on Recovery United/Shery Mead Consulting/Yale University and the OCA Facilitator's Circle.
c) Creating a Health Screening Tool related to Trauma Health Symptoms for Adult and Family Peer Support Workforce.
d) Creating training related to the Impact of Trauma on the Adult and Family Peer Workforce.
e) Creating a Guidebook Related to Trauma so individuals, peer support workers, and family members can understand the causes and symptoms of trauma over the lifespan.

M. Recovery | page 7

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

Involvement of Individuals and Families

Recovery is based on the involvement of consumers/peers and their family members. States must work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system. In completing this response, state should consider the following questions:

1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?

The Division of Behavioral Health believes involvement of consumers/peers and their family members is very important. 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. Here are some examples of how DBH approaches involvement of individuals and families.

Office of Consumer Affairs

Under Neb. Rev. Stat. 71-805(1) the Office of Consumer Affairs (OCA) within the Division was established. Carol Coussons de Reyes is the Administrator for OCA. The OCA Administrator has experience as a consumer or former consumer of mental health, substance abuse or gambling addiction services and must have specialized knowledge, experience or expertise relating to consumer-directed behavioral health services, delivery systems and advocacy on behalf of consumers and their families. The Administrator of the Office of Consumer Affairs is a member of Division of Behavioral Health senior management and acts as a systems change agent in partnership with consumers and families at open forums with Regional Consumer Specialists, statewide consumer organizations, and a circle of peer training facilitators.

OCA is very active in working with people in recovery and the development and implementation of recovery oriented services. OCA organizes meetings to specifically identify consumer issues and needs regarding the behavioral health service system. Consumers are provided with opportunities to proactively engage and participate in a variety of ways within the Nebraska behavioral health service delivery system. For more details see the OCA website http://dhhs.ne.gov/behavioral_health/Pages/beh_mh_mhadvo.aspx.

Regional Behavioral Health Authorities

Each Regional Behavioral Health Authority encourages and facilitates the involvement of consumers in all aspects of service planning and delivery within the region. These efforts are coordinated with the Office of Consumer Affairs. Each Regional Behavioral Health Authority also has a regional advisory committee consisting of consumers, providers, and other interested parties.

Regional Consumer Specialist

In addition, the State of Nebraska funds Consumer Specialist positions in the Regional Behavioral Health Authority offices across the state. At the Regional level, the Consumer Specialist serve on the management team working in a wide variety of areas such as policy development (e.g., needs assessment, program planning, training, technical support, financial planning, trauma-informed services, gather feedback regarding the service delivery system, participate meetings to raise awareness of the levels of consumer involvement, and recovery-oriented services) as well as

connecting with consumers in a wide variety of areas (such as handling grievances, linking to services, and advocacy).

Family Organizations

Nebraska is home to the Nebraska Federation of Families for Children's Mental Health (herein referred to as the Federation), a chapter of the National Federation of Families for Children's Mental Health. There are seven local Family Organizations statewide, at least one within each of the six Regional Behavioral Health Authorities, and six of whom are affiliates to the Federation. Their role is to advocate for families with youth experiencing mental/emotional disorders, support the family voice and offer supportive services such as Family Navigator, parent education, support groups for parents and youth, advocacy and mentoring. In 2011, the Division of Behavioral Health established a contract thru the competitive bidding process, to the Federation to provide Family Navigator Service (a time limited family peer service designed to assist families navigating the behavioral health system) and the Family Peer Support Service (an array of family supportive services as described earlier). These services are available statewide at no cost to the families, contribute to the family's stability and the youth's recovery, and play a vital role in preventing unnecessary family involvement with the Child Welfare System. Although these services are eligible for families not involved in the Child Welfare System, the Federation provides similar services for Child Welfare involved families thru a contract with the DHHS Division of Children and Family Services. The partnership between the Division of Behavioral Health and the Division of Children and Family Services has resulted in consistency in family peer support system development, support and service delivery collaboration for the Federation with ultimate benefit of uninterrupted service to Nebraska families.

In addition, the Nebraska chapter of National Alliance on Mental Illness (NAMI) branch also provides some support services to youth and families.

State Advisory Committees

Within Nebraska, the State Advisory Committee on Mental Health Services (§ 71-814), the State Advisory Committee on Substance Abuse Services (§ 71-815), and the State Committee on Problem Gambling (§71-816) advise the Division of Behavioral Health. These Committees are authorized under State Statute and are appointed by the Governor. These Committees provide advice and assistance to the Division of Behavioral Health on the provision of behavioral health services in the State of Nebraska. By state statute, these Committees hold public meetings.

The State Advisory Committee on Mental Health Services members need to have a demonstrated interest and commitment and specialized knowledge, experience, or expertise relating to the provision of mental health services in the State of Nebraska. The committee membership includes twelve consumers of behavioral health services or their family members. This committee serves as the state's mental health planning council as required by Public Law 102-321.

The State Advisory Committee on Substance Abuse Services members includes at least three consumers of substance abuse services. The committee members need to have demonstrated interest and commitment and specialized knowledge, experience, or expertise relating to the provision of substance abuse services in the State of Nebraska.

The State Committee on Problem Gambling members includes at least three consumers of problem gambling services. The committee members need to have a demonstrated interest and commitment and specialized knowledge, experience, or expertise relating to problem gambling in the State of Nebraska.

Statewide Success, Hopes, and Dreams Conference Planning Committee

The Annual Success, Hopes, and Dreams Conference Planning Committee consists of an open conference call line that meets weekly to plan the conference. Any Nebraskan can join this call and it is largely consumer-run. The Planning Committee also reviews awards nominations that showcase the best recovery-oriented leadership, advocacy, service, administration, recovery-muses, and intentional peers in Nebraska.

2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?

The DBH Office of Consumer Affairs (OCA) holds meetings to provide opportunities for individuals and family members issues and needs. Here are some examples of how the DBH Office of Consumer Affairs (OCA) sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system.

- The OCA People's Council: The OCA hosts a council to advise the OCA on its agenda and occasionally the Division on Division agenda. Information from the council is collected by the director of the Office of Consumer Affairs, Carol Coussons de Reyes. The members were selected by an open public invitation to apply to the council membership. For example, one special topic involved the Cemetery Restoration Park plans:

  The Cemetery Restoration Park plans were reviewed at the Office of Consumer Affairs People's Council meeting on March 15, 2012. The three Regional Centers (public psychiatric hospitals) in Lincoln, Hastings, and Norfolk have cemeteries with most of the graves dug between the late 1800s and the 1950s. For decades, some people with mental illness who lived at one of the Regional Centers died and were buried anonymously. Under the leadership of William Gibson, the Regional Centers Chief Executive Officer, the State Hospital Cemetery Gardens were developed.
- OCA Open Door Calls: The Office of Consumer Affairs hosts open door calls for anyone that would like to learn more about the OCA or share information and resources. These calls are hosted monthly and the schedule is posted on the OCA website.
- The Statewide Behavioral Health Conference: The Office of Consumer Affairs began the Statewide Behavioral Health Conference by contracting with the Nebraska Mental Health Association annually to host the event. There are workshop presenter and scholarship opportunities offered by open public invitation. See applications when available at www.nebraskastateconference.org
- The FY 2013-14 Transformation Transfer Initiative (TTI) project is working towards several goals under the general premise of *Trauma Informed Peer Support within Family Systems*. This project will include focus groups.
- The DBH Statewide Quality Improvement Team (SQIT) involves consumers directly in meetings. This group recently drafted a consumer authored guidebook to participation as a member in the Statewide Quality Improvement Team.

For more information see:
http://dhhs.ne.gov/behavioral_health/Pages/DBHOCAConsumers.aspx

3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?

In addition to the Division of Behavioral Health opportunities noted above, individuals and family members are presented with opportunities to proactively engage the behavioral health service delivery system as follows:

→ Consumers and family members participate on the DBH Statewide Quality Improvement Team. 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. http://dhhs.ne.gov/behavioral_health/Pages/beh_sqit_sqit.aspx

→ Through the six Regional Behavioral Health Authorities. 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 [Neb. Rev. Stat. §71-808 (2)].

The idea of participation in treatment and recovery planning, shared decision making; and directing one's own ongoing care and support is part of the Nebraska Behavioral Health System expectations. DBH measures the degree of consumer reported participation using the annual consumer survey. The complete results of the DHHS-DBH 2012 Behavioral Health Consumer Survey is posted online at: http://dhhs.ne.gov/behavioral_health/Documents/Nebraska2012BehavioralHealthConsumerSurvey.pdf

One of the domains of questions are "Participation in Treatment Planning".

1. I felt comfortable asking questions about my treatment and medication.
2. I, not staff, decided my treatment goals.

These responses are combined into a single measure of "Participation in Treatment Planning". The percentages of positive responses are listed below in several categories.

Type of Services Received Last 12 Months:

MH Only	77.2%
SA Only	75.1%

Length of Time Receiving Services:

Less Than One Year	76.1%
More Than One Year	77.3%

Participation in Treatment Planning

By Region	Number of responses	percentage positive
Region 1	170	82.5%
Region 2	250	82.5%
Region 3	270	78.1%
Region 4	396	77.5%
Region 5	527	73.3%
Region 6	540	74.3%

4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

As noted above, this is the work of the DBH Office of Consumer Affairs (OCA) and note the awards at the Success, Hopes, and Dreams Conference.

The OCA People's Council recently recommended use of the Recovery Self-Assessment Tool (RSA), after carefully reviewing recovery instruments for a year, to assist DBH is assessing system wide recovery-orientation and implementation is being discussed currently.

The DBH Office of Consumer Affairs (OCA) contracts with the Nebraska Recovery Network for Recovery Jams, Film Festivals, and Art Shows. Additionally, the OCA contracts with Nebraska NAMI to provide NAMI basics support groups and to train peers in using the Network of Care Website.

Additionally, the 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.

Housing

1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?

The Division of Behavioral Health works with the six Regional Behavioral Health Authorities to address housing needs of persons served so that they are not served in settings more restrictive than necessary. The expectations to address housing needs are included within the Fiscal Year 2014 Region Budget Plan Guidelines (January 29, 2013). Regions appoint a Regional Housing Coordinator to do things including:

- Provide leadership, planning activities and system problem solving for regional housing issues for persons with extremely low incomes who have Behavioral Health disorders.
- Coordinate the State Housing Related Assistance Program consistent with Division Policy.
- Develop and implement of strategies to ensure the Housing Related Assistance Program is culturally and linguistically competent, and represents the ethnic and gender needs of the community.
- Use State and Federal dollars addition to Housing Related Assistance dollars to increase service capacity in the Housing Related Assistance program or to expand services to BH populations not currently eligible for services through this program (i.e. consumers with SA needs only).

Recovery homes, also known as Oxford House, are available in Nebraska. These are self-supporting, self-run recovery homes for substance abusers. These homes are located in residential areas for individuals in recovery. No treatment or prevention services are offered in the Oxford house. For more details see Recovery Homes for Substance Abusers http://dhhs.ne.gov/publichealth/Pages/hew_sua_recvyexp.aspx

M. Recovery | page 13

2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a supportive community?

DBH expects the six Regional Behavioral Health Authorities to demonstrate progress in achieving the Statewide Housing Coordination goal in FY2014. The Housing Goal and Indicator is:

Goal: Behavioral health consumers will experience an increase in stability of housing.

Indicator: The overall percentage of consumers discharging from care as "homeless" will decrease by 2%.

IV: Narrative Plan

N.1. Evidence Based Prevention and Treatment Approaches for the SABG

Narrative Question:

As specified in 45 C.F.R. §96.125(b), states shall use a variety of evidence-based programs, policies, and practices to develop prevention, including primary prevention strategies (45 CFR §96.125). Strategies should be consistent with the IOM Report on Preventing Mental Emotional and Behavioral Disorders, the Surgeon General's Call to Action to Prevent and Reduce Underage Drinking, the NREPP or other materials documenting their effectiveness. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance abuse prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SABG statute directs states to implement strategies including : (1) information dissemination: providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities; (2) education aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities; (3) alternative programs that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use; (4) problem identification and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use; (5) community-based processes that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and (6) environmental strategies that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population. In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

States should provide responses to the following questions:

1. How did 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 (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?

2. What specific primary prevention programs, practices, and strategies does the state intend to fund with SABG prevention set-aside dollars, and why were these services selected? What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?

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

4. What outcome data 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?

5. How is the state's budget supportive of implementing the Strategic Prevention Framework?

6. How much of the SABG prevention set-aside goes to the state, versus community organizations? (A community is a group of individuals who share common characteristics and/or interests.)

7. How much of the prevention set-aside goes to evidence-based practices and environmental strategies? List each program.

Footnotes:

FY 2014-2015 SAMHSA Block Grant Application
- Community Mental Health Services Plan and Report
- Substance Abuse Prevention and Treatment Plan and Report

August 5, 2013

N. Prevention
As specified in 45 C.F.R. §96.125(b), states shall use a variety of evidence-based programs, policies, and practices to develop prevention, including primary prevention strategies (45 CFR §96.125). Strategies should be consistent with the IOM Report on Preventing Mental Emotional and Behavioral Disorders, the Surgeon General's Call to Action to Prevent and Reduce Underage Drinking, the NREPP or other materials documenting their effectiveness. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance abuse prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

States should provide responses to the following questions:

1. How did 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 (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?

The Division of Behavioral Health (DBH) Prevention System is a standing agenda item for the State Advisory Joint Committee as well as the State Advisory Committee on Substance Abuse. This allows the continuous opportunity to provide updates on substance use consumption patterns and discuss recommendations for state level planning. With strong stakeholder feedback considered, DBH has developed their overarching statewide strategic goals and focus of 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. Data sources that have been taken into consideration for planning efforts include but are not limited to the following highlights from the states most recent Substance Abuse Epidemiological Profile and DBH's 2013 Needs Assessment:

Substance use is common in Nebraska with alcohol being the primary substance of choice. In 2011, more than 1 in every 4 Nebraska high school students (26.6%) drank alcohol during the past month, about 1 in every 7 smoked cigarettes (15%), and approximately 1 in every 8 used marijuana (12.7%). In 2010, nearly 3 out of 5 Nebraska adults (59%) drank alcohol in the past month, a percentage that has remained relatively unchanged over the past 15 years. In addition, about one-quarter of adults over 18 (24.5%) smoked cigarettes and approximately 1 in every 15 used illicit drugs (6.5%).

Binge drinking among Nebraska residents was higher than residents nationally across the National Survey on Drug Use and Health (NSDUH) and the Behavioral Risk Factor Surveillance System (BRFSS) data sources that contained information on self-reported binge drinking. High school students are reporting lower binge drinking rates than their national counterparts. (Source: YRBS).

Alcohol is the primary drug of choice in substance abuse treatment admissions. In fiscal year 2011, alcohol was listed as the primary drug of choice during 7 in every 10 substance abuse treatment admissions (68%) in Nebraska, followed by marijuana (10%), methamphetamine (9%), and other opiates (e.g., morphine, heroin, codeine, methadone) at 4 percent.

Therefore, DBH has committed to a Five Year Plan for Prevention that seeks to prevent and reduce a wide range of substance use behaviors, including:

- Underage drinking
- Binge drinking
- Prescription drug abuse
- Marijuana use
- Illegal sale of tobacco products to minors

2. What specific primary prevention programs, practices, and strategies does the state intend to fund with SABG prevention set-aside dollars?

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. Stick shock campaigns have also been utilized and currently we have a statewide media campaign in place.

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:

- Protecting You/Protecting Me
- PRIME For Life
- CASASTART - Striving Together to Achieve Rewarding Tomorrows
- Slick Tracy
- Too Good for Drugs
- Too Smart to Start Drugs
- 7 Habits of Successful Teens
- Healthy Alternatives for Little Ones (HALO)
- Character Counts
- All Stars
- LifeSkills Training Program
- Mentoring programs
- W.A.I.T. (Abstinence Education)
- Parent and Family Skills Training
- Materials in support of Red Ribbon Week

DBH funds **alternative** programs such as Health Rocks is a healthy living program commonly used program to target young people ages 8 to 14. Teen and adult facilitators share hands-on activities

that educate youth on the consequences of tobacco, alcohol and drug use. Additionally we sponsor a variety of youth trainings and/or summits throughout the school year and summer breaks designed to develop youth leadership within their home communities. There are a handful of community drop-in centers that SABG dollars help ensure availability of this service for at risk youth. Another frequently used strategy is partnerships with law enforcement to host drug free dances/parties and 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; provide positive alternatives to our youth.

DBH has a service contract with Lincoln Medical Education Partnership – School Community Intervention and Prevention (SCIP) statewide program to provide **problem identification and referral** services. This program is focused on providing support and assistance to families in need, ensuring all youth have access to the appropriate services. SCIP provides prevention, education, and early intervention services and trains teams within the school 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. SCIP applies a multi-layered approach to at-risk behaviors in youth. 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.

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 team-building 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. Across Ages is also used as a school and community-based substance abuse prevention program for youth ages 9 to 13.

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). CMCA is a community organizing effort designed to change policies and practices of major community institutions in ways that reduce access to alcohol by teenagers. Other environmental strategies implemented each 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, we have focused much of energy towards the prevention the sale and use of alcoholic beverages products to minors, which includes regular provision of Responsible Beverage Server Training (RBST) and Training for Intervention Procedures (TIPS). Technical assistance to schools in review of use policies and procedures are also occurring throughout the state.

- Why were these services 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 (SPF). By following this framework, we've chosen to promote youth development, reduce risk-taking behaviors, strengthen assets and resiliency, and prevent problem behaviors across the life span.

- What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?

DBH consistently provides guidelines for use of SABG dollars through a number of methods. The first has been to ensure the language within our State to Region/community coalitions mirrors the federal register and SABG application instructions. Thus, it has become a 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 RFP process. Additionally, DBH performs a variety of audits with their providers, including a Programmatic Review for an entity receiving SABG dollars for prevention. A Programmatic Review for all community coalitions funded by the SABG is conducted in partnership with Regional Prevention Coordinators. Lastly, a Division policy is in development to provider further guidance on the use of these funds.

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 has identified a capacity goal to enhance leadership, infrastructure and workforce at the State and Regional levels to support strong prevention coalitions and their volunteer members. This 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. This involves multiple objectives such as defining and contracting for Regional leadership competencies, developing a plan by to create and sustain a professionalized workforce within each Region, developing minimum standards for coalition and other prevention organizations and building Regional approaches to link existing intervention and treatment services to existing problem identification and referral mechanisms.

4. What outcome data 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 intends to standardize outcome-based Regional action plans that are reviewed and reported upon semi-annually. Regional Prevention Coordinators will provide updates to State Prevention staff at quarterly meetings. We also intend to collaborate and create joint action plans with the Division of Public Health, and the Division of Children and Families that integrate funding,

workforce, strategies and outcome measurement for initiatives that focus on substance abuse prevention and risk factor reduction/protective factor enhancement.

Much of our analytic strategy uses substance use as an illustrative dependent variable, but it is important to note that we applied this strategy to both outcome and process measures. The outcome evaluations typically focus on assessing the effectiveness of selected prevention strategies in terms of intended goals and objectives. We would propose to examine the impact of our efforts by using selected indicators of substance use and related risk and protective factors for the identified priority areas. Historically, data has been 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) participant-level National Outcome Measures for youth; (4) Community-Level Instrument information on intervention implementation; (5) Quarterly reports from Regional Prevention Coordinators (6) the Nebraska Risk and Protective Factor Student Survey; (7) the Nebraska Young Adult Alcohol Opinion Survey and (8) the BRFSS.

5. How is the state's budget supportive of implementing the Strategic Prevention Framework?

Any entity receiving SABG funds is required to follow the Strategic Prevention Framework (SPF) model. The SPF shall also be comprehensively utilized for all planning and decision making processes at the State level. DBH leverages funds whenever possible and has placed greater emphasis on the use of data-driven processes to identify, select, and implement evidence-based prevention strategies appropriate for various target populations.

6. How much of the SABG prevention set-aside goes to the state, versus community organizations? (A community is a group of individuals who share common characteristics and/or interests.)

DBH requires that not less than 50 percent of the SABG set-aside funds designated for prevention services be made available to community coalitions through a regionally developed grant process. These funds must support the communities' implementation of identified prevention strategies through evidence, scientific or promising program based activities identified by the community coalitions through the use of the SPF planning process.

7. How much of the prevention set-aside goes to evidence-based practices and environmental strategies? List each program.

DBH requires that at least 50 percent of the SABG Primary Prevention dollars received by community coalitions be used to fund **community based** and **environmental** strategies. Use of environmental strategies is highly encouraged and is considered those that focus on altering societal influences rather than focusing on the individual. Examples of key strategies selected by coalitions often involve activities that seek to:

- Increase the perception of risk,
- Increase positive norms and policies associated with drug and alcohol free life choices, social norms campaign;
- Increase positive attachments to family, school, neighborhood and community,
- Reduce parental and peer group attitudes favorable toward the problem behavior or use;

- Control the availability of substances, or create/strengthen enforcement of laws and regulations affecting their use;
- Establish a social hosting ordinances via public policy campaigns;
- Establish consistent school use policies and procedures.

Specific environmental strategies funded include: CMCA, RBST, TIPS, Community Trials Intervention To Reduce High-Risk Drinking, and Prevention through Alternative Learning Styles.

Broken out by Regional Behavioral Health Authorities, the following table demonstrates current (State FY13) contracted SABG Prevention set-aside dollars and the percentage each Region dedicates to Environmental strategies.

Region	Total SABG Prevention Contracted	Total Contracted for Environmental	% SABG Contracted for Environmental
1	$134,307.00	$84,258.00	62.74%
2	$297,789.00	$76,901.00	25.82%
3	$257,406.60	$60,280.00	23.42%
4	$207,854.40	$51,498.00	24.78%
5	$357,803.60	$48,324.00	13.51%
6	$271,641.23	$66,631.81	24.53%
All Region (Misc)	$39,809.97	N/A	N/A
	$1,566,611.80	**$387,892.81**	**24.76%**

Other funded evidence-based practices include: Across Ages, All Stars, Big Brothers Big Sisters Mentoring Program, Brief Alcohol Screening and Intervention for College Students, HALO, LifeSkills Training, PRIME For Life, Protecting You/Protecting Me, and Too Good for Drugs.

IV: Narrative Plan

N.2. Evidence Based Prevention and Treatment Approaches for the MHBG (5 percent)

Narrative Question:

States are being asked to utilize at least five percent of their MHBG funds to award competitive grants to implement the most effective evidence-based prevention and treatment approaches focusing on promotion, prevention and early intervention. States that receive two percent or more of the total FY 2014 state allotment will be required to implement a competitive sub award process. States should describe how they intend to implement the competitive grants and/or sub award process.

Footnotes:

IV: Narrative Plan
N. Prevention
2. Evidence Based Prevention and Treatment Approaches for the MHBG (5 percent)

States are being asked to utilize at least five percent of their MHBG funds to award competitive grants to implement the most effective evidence-based prevention and treatment approaches focusing on promotion, prevention and early intervention. States that receive two percent or more of the total FY 2014 state allotment will be required to implement a competitive sub award process. States should describe how they intend to implement the competitive grants and/or sub award process.

In FY 2014, states should take the scientific developments of the last 25 years into account and prioritize proven mental illness prevention, emotional health promotion, and treatment/recovery support approaches as they develop comprehensive and coordinated plans to address mental disorders. Treatment approaches and system designs can help to prevent and/or mitigate the disabilities caused by serious and persistent mental illness and severe emotional disturbances. Five percent of the MHBG funds [are for] competitive grants to implement the most effective evidence-based prevention and treatment approaches, focusing on promotion, prevention and early intervention.

States may use some of their current MHBG to support services that are preventative in nature for adults with serious mental illness (SMI) and children with serious emotional disorders (SED) and their families.

The Division of Behavioral Health (DBH) acknowledges SAMHSA's interest in the development of Evidence Based Prevention and Treatment Approaches in proven mental illness prevention, emotional health promotion, and treatment/recovery support approaches to be part of the comprehensive and coordinated plans to address mental disorders. SAMHSA has asked states to set-aside five percent of the MHBG for implementation of evidence based practices in the FY14-15 Application.

Using the final 2013 allocations for the MHBG ($1,964,456), the five percent set-aside in Nebraska represents an estimated $98,223. The request for this 5% set aside will apply to the Federal Fiscal Year 2014 allocation. The expenditure of the Federal Fiscal Year 2014 allocation is estimated to start approximately July 2014.

Community Mental Health Services Block Grant Award FY2013

5% of FY13 for prevention	$98,223
FY2013 final (100%)	$1,964,456

The Federal Community Mental Health Services Block Grant (MHBG) is for adults with Serious Mental Illness (SMI) and youth with Serious Emotional Disturbance (SED). DBH will use State Fiscal Year 2014 (ending June 30, 2014) for planning a reasonable approach to addressing the SAMHSA request and prioritizing the best use of the $98,223 in Community Mental Health Block Grant funds. This planning phase will explore how to develop the most appropriate Evidence Based Prevention and Treatment Approaches in proven mental illness prevention, emotional health promotion, and treatment/recovery support approaches for adults with SMI and youth with SED in the state of Nebraska with the most efficient and least administrative burden.

DBH's Prevention System

DBH has already established a solid foundation for behavioral health prevention strategies via the implementation of the requirements under the Substance Abuse Prevention and Treatment Block Grant (SAPTBG). A comprehensive approach to behavioral health also means seeing prevention as part of an overall continuum of care. The Behavioral Health Continuum of Care Model helps us recognize that there are multiple opportunities for addressing behavioral health problems and disorders. Utilizing a Continuum of Care model will guide our planning processes to think, more explicitly, about the relationships between promotion, prevention, and treatment.

The prevention field understands that behavioral health issues are influenced by underlying conditions (e.g. the presence of risk factors and absence of protective factors). Thus, underlying community conditions are complex and intertwined and require a coordinated, comprehensive plan to identify linkages and target root causes. Additionally, knowing that integration leads to better health outcomes at all levels, it is important to understand the factors that have contributed to the lack of integration. The focus and membership of Nebraska's State Epidemiological Outcomes Workgroup (SEOW) is broadening in order take a more comprehensive approach to addressing health by identifying strengths and weaknesses and by incorporating such collaborations into a strategic plan. The DBH Prevention System Coordinator is Renee Faber. Under her leadership A Five Year Strategic Plan for Prevention was developed in October of 2012.

The effort here is to align a shared focus of preventing mental and substance use disorders with this Five Year Strategic Plan for Prevention. The idea is to consider promoting healthy lifestyles by working collaboratively across disciplines and communicating strong prevention messages and demonstrating prevention's role in mental health promotion throughout the continuum of care. This plan is posted on the DBH web site.
[see: http://dhhs.ne.gov/behavioral_health/Documents/DBH-PreventionStrategicPlan2013-17.pdf].

Below are from the draft Title 206 Behavioral Health Services [206 NAC 6 (Draft 6/27/13)] which were subject to public hearing on August 1, 2013.

Chapter 6: Standards of Care

6-017 PREVENTION SERVICES

6-017.01 Administration of Funded Community-Based Prevention Initiatives: The Department provides leadership and oversight to prevention systems by distributing funds received from the state and the federal government to Regional Behavioral Health Authorities. Prevention initiatives funded through the State of Nebraska must follow the Strategic Prevention Framework and include the following:

a. Universal Prevention: activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk;
b. Selective Prevention: activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average;
c. Indicated Prevention: activities targeted to individuals in high-risk environments, identified as having minimal but detectable signs symptoms foreshadowing disorder or having biological markers indicating predisposition for disorder but not yet meeting diagnostic levels.

DBH has a long history of working in the substance abuse prevention area. DBH is open to working on developing the mental health side of this picture.

June 27, 2013 Omaha Workshop on MH Promotion \ MI Prevention

On June 27, 2013, supported by Substance Abuse Prevention and Treatment Block Grant funding from DBH, Region 6 Behavioral Healthcare hosted a day long workshop on Prevention in Mental Health Workshop featuring by Michael Compton and Ruth Shim.

→ Michael Compton, M.D., M.P.H.is Professor and Director of Research Initiatives in the Department of Psychiatry and Behavioral Sciences at The George Washington University School of Medicine and Health Sciences, in Washington, D.C.

→ Dr. Ruth Shim is an Assistant Professor, Department of Psychiatry and Behavioral Sciences at Morehouse School of Medicine in Atlanta, GA.

Sixty-two professionals attended the workshop, with state-wide representation, including the DHHS-Division of Behavioral Health and five of the six Behavioral Health Regions. Community sectors in attendance included prevention coalition professionals, mental health providers, school counselors and social workers, and juvenile justice professionals.

The one-day workshop was designed as a first step in the planning process to incorporate the concepts of mental health promotion and mental illness prevention into existing substance abuse prevention practice and programs. Drs. Compton and Shim presented many ideas including:

Mental Health Promotion – The enhancement of the capacity of individuals, families, groups, or communities to strengthen or support positive emotional, cognitive, and related experiences

- Any action taken to maximize mental health and well-being among populations and individuals
- The operation by which we improve the place which mental health occupies on the scale of values of individuals, families, or societies
- When mental health is valued more, people tend to be more motivated to improve it

Health Promotion = Mental Health Promotion

- Mental health promotion involves actions to create living conditions and environments that support mental health and allow people to adopt and maintain healthy lifestyles
- These include a range of actions to increase the chances of people experiencing better overall health

Physical and Mental Health – Promoting positive mental health is significant to overall health (both physical and mental disorders)

- Mental health can influence the onset, course, and outcomes of both physical and mental illnesses
- Poor general health is 3 times more common among people who report significant emotional distress

The training provided attendees the opportunity to work in small groups to identify needs and areas for capacity building in regard to implementation of strategies. Issues discussed in the break out groups covered a wide range of topics including:

→ Need to look at all systems integration (mind, body, spirit)

→ Community outreach/education (awareness and education for youth, schools, parents, law enforcement, behavioral health providers, physical health services) using a variety of media to change perception and social norms.

→ Capacity-building (human and financial resource development, community support and buy-in, mentoring/training of providers)

SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP)
http://www.nrepp.samhsa.gov/Index.aspx
The NREPP is a searchable online database of mental health and substance abuse interventions. All interventions in the registry have met NREPP's minimum requirements for review and have been independently assessed and rated for Quality of Research and Readiness for Dissemination. NREPP has 300 interventions listed as of July 22, 2013.

SAMHSA's Good and Modern System
SAMHSA included prevention in the Good and Modern System paper. The vision for a good and modern mental health and addiction system is grounded in a public health model that addresses the determinants of health, system and service coordination, health promotion, prevention, screening and early intervention, treatment, resilience and recovery support to promote social integration and optimal health and productivity. Prevention programs should be made available to all individuals through appropriate channels including healthcare providers, media, employers, public agencies, communities, and schools. SAMHSA should continue efforts to identify prevention services that can be clearly defined, coded and reimbursed. "Prevention and Wellness Services" are one of the nine domains on SAMHSA's proposed continuum.

Source: SAMHSA (Draft – April 18, 2011) "Description of a Good and Modern Addictions and Mental Health Service System," Pages 6-8
http://www.samhsa.gov/healthreform/docs/good_and_modern_4_18_2011_508.pdf

EBP Work Group and Recommendations
DBH recognizes there is great interface between both Mental Health Prevention, Substance Abuse Prevention and Promotion in Mental Health, based on the following principles:

- Prevention and promotion are overlapping and complementary activities
- Preventive and promotional elements can be present within the same program and hold different meanings for two groups of the targeted population.
- Two approaches may involve similar activities but produce different outcomes

DBH chartered an Evidence Based Practices (EBP) Workgroup to bring stakeholders together to discuss EBP funded services and needs for enhancement. The EBP workgroup reviewed SAMHSA Tool Kits for fidelity. The services reviewed were MedTEAM (Medication Treatment, Evaluation, and Management), Assertive Community Treatment (ACT), Permanent Supportive Housing and Supported Employment. Recommendations were provided to DBH pertaining fidelity monitoring toolkits, frequency of evaluation, potential people involved and overall recommendations. Additional work included readiness assessments and preliminary fidelity evaluation on MedTEAM.

NEXT STEPS
The challenge is how best to move forward with this limited amount of funds, and the variety of changes coming with the implementation of the Affordable Care Act. There are many options and few resources. Time is needed to consider next steps. Taking the time to carefully develop this area was encouraged by the SAMHSA during the August 7, 2013 Center for Substance Abuse Prevention (CSAP) webinar on preparing content for the Block Grant. During the webinar CSAP officials encouraged States to think through the plan using sound approaches in a collaborative way to best align proposals with other funding and resources.

DBH will start work on this area including steps such as:

1. Discuss this request in a joint session of the State Advisory Committee on Mental Health Services and State Advisory Committee on Substance Abuse Services on September 19, 2013.
2. DBH identify current effective evidence-based prevention and treatment approaches focusing on promotion, prevention and early intervention.
3. DBH will inventory current practices being purchased by the six Regional Behavioral Health Authorities in the area of effective evidence-based prevention and treatment approaches.

This information and more will be collected and reviewed by DBH. By June 30, 2014 DBH will make a decision on the best way to move forward. Options include:

1. The full or partial implementation of the five percent set-aside to award competitive grants to implement the most effective evidence-based prevention and treatment approaches focusing on promotion, prevention and early intervention; OR
2. This is a requested area, meaning the State has the option to not conduct this activity. If this is done, then the MHBG funds will be used to purchase community based behavioral health services for adults with SMI and youth with SED.

IV: Narrative Plan

O. Children and Adolescents Behavioral Health Services

Narrative Question:

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with over 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

SAMHSA expects that states will build on this well-documented, effective system of care approach to serving children and youth with 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.

Please answer the following questions:

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?

2. What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?

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.)?

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?

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?

Footnotes:

FY 2014-2015 SAMHSA Block Grant Application
- Community Mental Health Services Plan and Report
- Substance Abuse Prevention and Treatment Plan and Report

August 5, 2013

O. Children and Adolescents Behavioral Health Services

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Please answer the following questions:

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 Behavioral Health System includes six Regional Behavioral Health Authorities (RBHAs), local behavioral health providers, and the Division of Behavioral Health (DBH). Through contractual agreements with the DBH, each RBHA braids funding from state, federal and county resources to maintain local provider networks which provide an array of traditional treatment and non-traditional supports to non-Medicaid eligible children and their families. These services range from emergency to resiliency oriented supports to wraparound.

Each RBHA Network includes a Youth Systems coordination function, responsible for the children's behavioral health system within their respective Region. Expectations of the Youth System Coordinator include the development and maintenance of a System of Care (SOC) environment throughout the RBHA by hosting education/training opportunities that create workforce expertise on System of Care principles, participation in larger SOC initiatives, and providing Leadership in initiatives that promote the assessment of Family Centered Practice (FCP). 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 FCP and SOC principles into their practices. Each RBHA has multi-stakeholder collaborative structures to coordinate efforts in formal functional areas for youth consumers, family involvement and inclusion, and the Youth SOC.

Through conference call and live meeting, the DBH Youth Systems Team provides leadership via the Statewide Youth Systems Team. The members represent the DBH, the Nebraska Department of Health and Human Services - Division of Child and Family Services [NDHHS-DCFS) (child welfare)], Family Organizations, Juvenile Justice, and Youth Specialists from the six RBHAs. With the DBH coordination, the team identifies needs and develops recommendations for an overall plan to enhance and improve services available to youth and their families.

In 2009, a System of Care Primer Training was held in Lincoln, Nebraska. This training provided an opportunity to learn about systems of care and to plan for enhancing the children's behavioral health systems of care at both the state and regional levels. Each RBHA was allotted 10 slots for this training, and invited representatives from the NDHHS-DCFS Service Areas, families and family organizations, youth and youth organizations, service providers, and other system partners including schools, probation, law enforcement, vocational rehabilitation, public health, primary healthcare, and developmental disabilities. Eventually, SOC trainers were identified and continue to hold SOC trainings within their respective RBHAs.

On the individual service level, each RBHA directly provides wraparound services to children and their families. Since its implementation in 1995, the Professional Partner Program (PPP) has used a fidelity based version of the wraparound care coordination model to coordinate support services to families with a youth with Serious Emotional Disturbance (SED), and to ensure that youth and families have a voice and ownership in developing an accessible, comprehensive, and individualized family support plan. Using a data driven approach, the PPP collects outcomes and fidelity data to ensure positive results for children and their families. To insure reliability of data, the RBHA Region 5 (in Lincoln) contracts with Families Inspiring Families (family organization) to conduct fidelity monitoring of all wraparound programs. The DBH recently contracted with the nationally recognized consulting firm, TriWest Group, to revitalize the PPP. This work will be accomplished through the TriWest Group's knowledge on wraparound evaluation and pricing, augmented with information gathered from national experts, as well as investigating the implementation of case rate reimbursement. Outcomes of this collaboration include recommendation of the proper tools and data to evaluate the PPP, as well as identification of fidelity and increased family functioning measures. Specialty wraparound programs have developed within each RBHA, including Transition Age Youth wraparound teams for children aging out of the youth behavioral health system and "Rapid Response" wraparound teams for youth who are at risk of entering the child welfare system. The Rapid Response programs were developed as a proactive strategy to reduce the number of youth/young adults and families seeking out of home care and services by way of County Attorneys. The DCFS has identified the Prevention PPP as part of its Alternative Response strategy to reduce the number of youth who receive out of home care.

The Youth Systems Team and the PPP infrastructure facilitate the involvement of youth, families and system partners at the regional (Youth Systems Team) and individual family (Professional Partner Program) levels.

A dynamic environment surrounding services for children and families currently exists in Nebraska. The collaborative relationship between the DBH and the DCFS is strengthened through monthly on-site meetings of the DBH Deputy Director and Section Administrators, the RBHA Administrators, and the DCFS 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. With the Nebraska Medicaid program moving to an at-risk environment , as well as looking at ways to serve children and families more effectively and with better outcomes, it is anticipated that the Youth System of Care infrastructure will provide an efficient and effective approach in support of resilience and recovery for children and youth with mental and substance abuse disorders.

2. What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?

In collaboration with family organization representatives and the RBHA staff, the DBH developed and implemented guidelines as outlined in the PPP manual for children with Serious Emotional Disturbance and their families. With seven wraparound components at its core, an individualized service plan is developed for each youth/young adult and his/her family. The service plan is based on the strengths and concerns of the youth/young adult and his/her family across live domains, including mental health, substance abuse, residential, family, education, vocational, financial, social/recreational, medical, legal, safety and cultural.

The four sets of data are submitted and reviewed at least quarterly are:

- 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); and
- a review of the effects and costs of the services and supports.

In collaboration with its users, the PPP manual is reviewed at least annually, with updates identified and incorporated as needed.

As the Division of Behavioral Health Professional Partner Program is adopted within the Division of Child and Family Services and the Office of Juvenile Justice, joint collaboration among all three Divisions will result in the development, implementation and monitoring of additional guidelines specific to the respective agencies. Ongoing collaboration will occur throughout the life of each Professional Partner Program, regardless of agency ownership.

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.)?

The DBH has demonstrated a solid commitment to the use of stakeholder collaboration as an effective strategy in the design of systems and services to meet the growing needs of our youth.

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 May 2012, the Directors of the DBH and the DCFS issued Administrative Memo #17-2012 that defined a process for the two divisions to collaborate in new ways to improve outcomes for every child welfare system involved youth with a mental health and/or substance abuse disorder. The Transition Aged Youth Referral and Coordination process was developed through this memo and set into motion a renewed spirit of shared responsibility in helping youth with behavioral health challenges access the full array of services and supports available to them. Administrators from both divisions meet monthly to identify and remove systems barriers standing in the way of successful transitions from youth to adulthood.

The DBH maintains active involvement in the Title IV-E Foster Care Workgroup by providing guidance and direction in the provision of safe and stable out-of-home care for children until the children are safely returned home, placed permanently with adoptive families, or placed in other planned arrangements for permanency.

Together for Kids and Families, a two-year planning grant awarded to the former Nebraska Health and Human Services System (currently NDHHS) in 2003 and funded through the State Early Childhood Comprehensive Systems (SECCS) Grant Program administered by the Maternal and Child Health Bureau, U.S. Department of Health and Human Services continues its mission in support of children and youth. This project is designed to achieve optimum outcomes for children and their families through comprehensive system planning and collaborative effort among stakeholders. Planning projects must address comprehensive early childhood systems, including at a minimum: (1) access to medical homes, (2) mental health and social-emotional development, (3) early care and education, (4) parent education, and (5) family support. Additionally, this project was required to address the sustainability of the Healthy Child Care America (HCCA) objectives, which Nebraska implemented through the HCCA grant from 1996 to 2005. The goals developed by the workgroups integrate and interface with the HCCA objectives.

On March 1, 2013, the NDHHS submitted an application for a System of Care (SOC) planning grant for the expansion of comprehensive community mental health services for children and their families. On July 29, 2013 Sheri Dawson (Deputy Director of the Division of Behavioral Health) reported the Federal Substance Abuse and Mental Health Services Administration (SAMHSA) awarded $504,413 to the Nebraska Department of Health and Human Services, Division of Behavioral Health for a system-of-care expansion planning grant. She noted the purpose of the grant is to develop a comprehensive strategic plan to expand and sustain the system-of-care approach to providing services for children and youth with serious emotional disturbances and their

families. Systems of care help coordinate resources and supports in communities to improve all aspects of a young person's health and well-being, which includes their emotional and behavioral health. The planning that will occur through these grants will improve services and systems intended to meet the behavioral health needs of families and entire communities.

This project will bring together as equal partners Nebraska youth, families, child-serving systems and providers, and Nebraska leaders to develop a statewide comprehensive strategic plan for prevention oriented, culturally and linguistically appropriate, family driven, and youth guided SOC for children and youth with Serious Emotional Disturbance and their families. This plan will include health equity quality improvement plans in support of the statewide goal to reduce overall and disproportionate involvement of youth of color in the child welfare and juvenile justice systems and out of home placements. The plan will build on the current Trauma Informed Care framework, and ensure that decisions related to the implementation of the new at-risk Medicaid behavioral health benefit, provisions of the Accountable Care Act, and federal parity requirements for Medicaid are made in the contexts of the SOC values and practices.

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 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.

Trainings are made available for statewide participation for all interested parties, and are announced locally and throughout the state via regional and statewide meetings, by way of widely distributed emails and through the quarterly Youth Systems Team conference calls and live meetings. Trainings are documented at the organizational, regional and state level through follow-up reports, meeting notes, and conference calls.

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 NDHHS-DCFS, Juvenile Justice, school districts and other interested parties. One training is reserved to update partners' and others' skills in wraparound services with the second training suggested by ongoing needs assessments, reviews of data collection for trends, and current literature. To this end, in partnership with the Heartland Juvenile Justice Association of Nebraska, the RBHA Professional Partner Programs are sponsoring an April 2013 training with wraparound expert Karl Dennis who's reputation is based on the fundamental principles which he brought to life and seeded: that children can be best served in their families and in their communities; that the assets and strengths of their situation are best known to those closest to the child; and that wrapping the youngster and family with individual human care, supervision, and concern is safer, better and cheaper than tearing apart child, family, community, and

systems. Using the program content of wraparound and working with hostile and violent families and youth, the training will provide instruction in:

- Philosophy of the Wraparound Process
- Developing Partnerships with Families, Providers and Community
- Nuts & Bolts of Working with Families – how to deal with resistance, crisis & conflict resolution and crisis planning exercise.
- Working with Potentially Violent Youth and/or Family Members – early identification, violence prevention versus violent behaviors, relationships, relationships and relationships.
- Treatment Interventions – community, wraparound and mental health
- Worker and Caregiver Safety

To equip the Professional Partners with knowledge and skills in support of youth within the transitional age range, in collaboration with Magellan Managed Care, the Division of Behavioral Health recruited Hewitt B. "Rusty" Clark, Ph.D., BCBA, for a three day hands-on training in the use of the evidence based practice, Transition to Independence Process (TIP) Model. One hundred participants representing Professional Partners and supervisors, family organizations, Children and Family Service workers and supervisors, service providers, administrative staff and youth participated in the statewide October, 2012 training and are actively using strategies and techniques learned. TIP follow-up resource calls, conferences, and advanced trainings are routinely offered through contract with the Region 3 Behavioral Health Authority (Kearney) and the National Network on Youth Transition TIP Stars Academy, and are open to everyone interested in expanding knowledge and skills in the use of the TIP Model. In spring, 2013, the Professional Partner supervisors will identify potential TIP strategies for statewide data collection.

The DBH contracts with the RBHAs includes the Prevention System Coordination Network's expectation of the promotion of a comprehensive prevention approach, including a mix of evidence based programs, policies, and/or practices that best address the selected prevention priorities. The reasons youth and young adults begin to drink alcohol and other substances are varied and often complex. They include the physical and emotional feelings that can come from using, as well as social influences and the easy availability. Much of the Prevention System work involves providing education to parents, community members, school faculty, as well as youth, to strengthen their understanding of how and why, while also working to delay the onset of use. Many of the strategies to reduce underage drinking have focused on decreasing the availability of alcohol to underage drinkers, reducing opportunities and occasions for underage drinking, and diminishing the demand for alcohol among youth.

As a statewide resource and sponsored by the NDHHS, the 2013 annual Prevention Summit will provide participants the opportunity to learn more about evidence based strategies designed to prevent child maltreatment, and encourage participants to think about new strategies to implement within their communities.

Offered annually, Nebraska's Statewide Behavioral Health Conference, "Success, Hopes and Dreams 2013" provides training opportunities in seven focus areas:

- 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

Facilitated by the DBH, the Evidence Based Workgroup conducted a multi-dimensional review of Evidence Based Practices (EBPs) and, in September, 2012, presented recommendations to the DBH leadership in regard to a consistent and sustainable method of doing fidelity monitoring linked to outcomes of EBPs. The workgroup's goal is to improve the use of EBPs in order to achieve more effective use of limited resources. Adult services reviewed included Supported Housing, Supported Employment, Integrated Treatment for Co-occurring Disorders, Medication Management, and Illness Self-Management. Phase II, the review of children's services remains underway. The DBH is currently awaiting final approval of the Title 206 Behavioral Health Services Regulations, including new, as well as updated Service Definitions for adult services. Within the next two years, regulations and updated Children's Service Definitions will be added to the Title 206 Behavioral Health Regulations. Integrated training on the findings of the EBP Workgroup and the Title 206 Regulations will be presented upon final approval of the Title 206 Regulations.

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?

The DBH utilizes a variety of methods of monitoring and tracking service utilization, costs, and outcomes using several means.

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 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. To this end, the NDHHS has contracted with Tri-West Group, to identify the proper tools/data to evaluate the Professional Partner Program,

including outcomes, fidelity, and increased family functioning, as well as to develop comparisons of cost methodology on wraparound versus determination of a case rate.

Youth outcomes are reviewed by the respective Regional Behavioral Health Authorities 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 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.

IV: Narrative Plan

P. Consultation with Tribes

Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinions between parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues.

For the context of the Block Grants awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees. SAMHSA is requesting that states provide a description of how they consulted with tribes in their state, which should indicate how concerns of the tribes were addressed in the State Block Grant plan(s). States shall not require any tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for tribal members on tribal lands. If a state does not have any federally-recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect. For states that are currently working with tribes, a description of these activities must be provided in the area below. States seeking technical assistance for conducting tribal consultation may contact the SAMHSA project officer prior to or during the Block Grant planning cycle.

Footnotes:

P. Consultation with Tribes | page 1

FY 2014-2015 SAMHSA Block Grant Application
- Community Mental Health Services Plan and Report
- Substance Abuse Prevention and Treatment Plan and Report

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinions between parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues.

For the context of the Block Grants awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees. SAMHSA is requesting that states provide a description of how they consulted with tribes in their state, which should indicate how concerns of the tribes were addressed in the State Block Grant plan(s). States shall not require any tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for tribal members on tribal lands. If a state does not have any federally-recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect. For states that are currently working with tribes, a description of these activities must be provided in the area below. States seeking technical assistance for conducting tribal consultation may contact the SAMHSA project officer prior to or during the Block Grant planning cycle.

August 5, 2013

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.

- How Tribes are currently included in the planning process?

The four federally recognized tribes with whom the Division of Behavioral Health awards $1.4 million of general funds in contracts, are invited to participate in advisory committees, local and statewide meetings regarding services, trainings on behavioral health topics as requested by the tribes, and other state activities.

When appropriate, the Division of Behavioral Health Director and/or other designees work with the Nebraska Commission on Indian Affairs to address behavioral health needs for American Indians residing in Nebraska.

- How are the needs of the tribes assessed and addressed in last year's plan?

The tribes conduct their own needs assessment and work plans and communicate these to the Division of Behavioral Health.

- How is specific information on Tribes collected and reported?

The tribes utilize some combination of the federal Resource and Patient Management System (RPMS) and other private patient information management systems to collect information on the individuals served. The Division of Behavioral Health requires the tribes to report information on persons served annually and with contract billings.

- What are your State's plans to consult with each Tribe in your State to ensure their involvement in the needs assessment, planning and service delivery process?

The Division of Behavioral Health will continue its efforts to engage tribal representatives in statewide and regional planning teams and will contract with each of the four tribes for needs assessment and provision of services to their tribal members.

IV: Narrative Plan

Q. Data and Information Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked each state to:

- Describe its plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data;
- List and briefly describe all unique information technology systems maintained and/or utilized by the state agency;
- Provide information regarding its current efforts to assist providers with developing and using EHRs;
- Identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment; and
- Identify the specific technical assistance needs the state may have regarding data and information technology.

Please provide an update of your progress since that time.

Footnotes:

FY 2014-2015 SAMHSA Block Grant Application
- Community Mental Health Services Plan and Report
- Substance Abuse Prevention and Treatment Plan and Report
August 19, 2013

Q. Data and Information Technology - Please provide an update of your progress since that time.

The Division of Behavioral Health (DBH) data sources used for unique client level data for any part of its behavioral health service system are detailed below.

→ **Addiction Severity Index/Child and Adolescence Security Index (ASI/CASI) Training and Certification** - DBH maintains a database of individuals who have received Addiction Severity Index/Child and Adolescence Security Index (ASI/CASI) training and certification in conjunction with the Criminal Justice System and the standardized assessment model. This assessment assists judges in deciding the outcome of cases, especially substance abuse. For DBH and Medicaid funded services, the assessment must be performed by an individual trained in the application of the model.

→ **Assertive Community Treatment (ACT) outcomes and fidelity measurement** - ACT provides comprehensive, evidence-based practice and locally based treatment to people with serious and persistent mental illnesses. Patients receive multidisciplinary, round-the-clock in-home staffing of a multi-disciplinary team. Outcome reports are provided bi-annually directly from the provider to DBH. The data are a series of spreadsheets from ACT providers.

→ **Avatar** - State Psychiatric Hospital data is collected using software called Avatar. It is a practice management system for Nebraska's three psychiatric hospitals - Lincoln Regional Center, Hastings Regional Center, and Norfolk Regional Center.

→ **Community Services (CS) Data System** - DBH contracts with Magellan Behavioral Health for data collection and management of data relating to DBH-funded community behavioral health treatment programs including Mental Health and Substance Abuse. Magellan Behavioral Health contract has been extended to June 30, 2014, and there continues to be discussion as to the best approach for a new data system owned and operated by the Division. Summer 2013 has seen a draft RFP for a new data system for the Division developed. That draft is undergoing review and is anticipated to be released in early Fall 2013 for implementation in July 2014. The Governor did not forward the budget request for additional funds to build a state-owned and operated behavioral health system to the Legislature. DBH and other Nebraska Department of Health and Human Services (NDHHS) staff are exploring a variety of alternatives, including extending the current Magellan contract, Request For Proposals for a data system using AVATAR as a base, utilizing a paper based system of client information, and having no data system at all. For a basic orientation on the DBH CS data, see web page Magellan Partnership Quality Improvement Team (MQIT) http://dhhs.ne.gov/behavioral_health/Pages/beh_mqit.aspx.

→ **Emergency** - tracking of individuals in the DBH Emergency System to comply with LB1083 reporting and DBH Network planning. Not all emergency services are entered into the CS Data System and those that are not must be tracked by DBH. Each Region has an Emergency Coordinator who oversees the process and provides aggregate numbers to DBH each Wednesday, and DBH consolidates the reports. Series of spreadsheets designed to track individuals in the DBH Emergency System to comply with LB1083 reporting and DBH Network planning.

→ **Fiscal Database** - consists of several spreadsheets and Access databases designed to augment and delineate the paper-based billing system. DBH receives paper-based requests

for reimbursement from the Regions on a monthly basis and enters the data into the State accounting system. DBH spreadsheets and Access datasets break out the funding sources between Mental Health and Substance Abuse as well as rate and expense reimbursement types. These spreadsheets and datasets also provide compliance with Mental Health and Substance Abuse Block grant reporting requirements. Currently, development is underway to provide an alternative automated data entry system to replace this labor-intensive system.

→ **Housing Related Assistance -** this database supports the Housing Related Assistance program for individuals with Serious Mental Illness. The program provides subsidies for housing-related expenses. Each Region has a Housing Coordinator who completes monthly reports and submits to DBH on a quarterly basis.

→ **Mental Health Commitments & Handgun Database -** in 2012, the DBH, working with the Office of the Chief Information Officer and District Court Clerks, initiated an Electronic Reporting Commitment Application. Sponsored in part with the Nebraska State Patrol and under the auspices of LB 512-2011, DBH worked to facilitate the "simultaneous reporting" of Mental Health Commitments to the Nebraska State Patrol and NDHHS and the enhancement of the State's reporting responsibilities under the Brady Handgun Act. This reporting application eliminates multiple data entry points in the old paper stream that included District Court Clerks and DBH Staff. It also reduces the delay in the reporting process to the Nebraska Mental Health database at the State Patrol of undesirables for firearm permit/possession per federal legislation. This internet-based application is maintained on a secure server to preserve confidentiality of information as mental health commitments are not a matter of public court records. The reporting system feeds the Nebraska State Patrol and National Instant Criminal Background Check System (NICS) databases for handgun purchases. The process is on the DBH website at: http://dhhs.ne.gov/behavioral_health/Pages/FirearmRestoration.aspx

→ **Nebraska Prevention Information Reporting System (NPIRS)** – NPIRS underwent programmatic and structural changes in FY 2012, including a realignment of the names and regions of reporting entities, new variables designed to facilitate reporting of Institute of Medicine (IOM) classifications of prevention efforts in coordination with the SAMHSA strategies, and inclusion of mental health promotion as a reportable activity. Additionally, the consulting firm strengthened the programming of the application through rewrite of the software and background application along with a review of how the application reports out information to community groups, regions and the state. Developments for new and revised reports are a part of the state's response to federal and community requests for information. Community coalitions report prevention activities funded by a variety of sources including Block Grant, Strategic Prevention Framework, Department of Education, Department of Roads, Tobacco Free fund distributions.

→ **Professional Partners Program (PPP) -** the PPP program provides a wraparound, or coordinated care, for children and young adults (youth) with serious emotional/behavioral problems. The youth involved is registered in the CS Data System and DBH requires collection of further data that is clinical in nature. The State provides a case rate with flexibility for purchases. A monthly billing report is provided on paper to the State for case rate utilization as well as expenses and an extern enters the data into a database. An additional database is maintained at the Regional level. This information is provided on a quarterly basis and summarized into a yearly report by DBH. Additionally, Regions are required to use a Wraparound Fidelity (WFI) Index tool to assess the quality of individualized care planning and management for the youth and family. DBH receives the WFI report and summarizes the results on an annual basis. This is the database of individuals receiving PPP services.

→ **SYNAR Data Collection Reporting -** tobacco retailer compliance reporting in terms of the sale of tobacco products to minors is federally required as a part of the Substance Abuse Block Grant. DBH is responsible for compiling a list of the State's tobacco retailers with the retailers randomly selected for compliance checks/monitoring by the Peace Officers regarding selling tobacco to youths. The Peace Officers mail a separate sheet of paper with the results of each monitoring episode to DBH and this information is entered into a spreadsheet and converted into a standard CSV (Comma-Separated Value) file. DBH loads this into a federal web site, and also enters other data into the site manually. Annual reporting is required. A violation rate on the sale of tobacco to minors exceeding 20% will result in an impact to Nebraska's substance abuse funding.

→ **Weekly Capacity and Wait List -** this reporting process is required by the Substance Abuse Block Grant and addresses the need for individuals to be admitted for substance abuse treatment and mental health services. Each Monday the providers send data to Regions who manually consolidate the data and send it to DBH. Included is a Substance Abuse Report, a Substance Abuse Interim Waiting List and a Mental Health Monthly report. DBH staff then review the information for the week and report summary information on the number of open beds or those individuals whose length of stay on the waiting list is approaching critical time intervals. This weekly list is rolled up into a quarterly list. Series of spreadsheets from agencies and Regions designed to facilitate block grant reporting requirements for special populations.

Characteristics	AVATAR System (State Psychiatric Hospitals)	Magellan Data System (Community Based Programs)
Provider characteristics	YES	Magellan (Provider Enrollment)
Client enrollment, demographics, and characteristics	YES	YES
Admission, assessment, and discharge	Avatar	Magellan (managed care)
Services provided, including type, amount, and individual service provider	Avatar	Magellan Turn Around Documents
Prescription drug utilization	Avatar	None – but a part of concurrent review – free form text
Unique Client ID	Yes	Yes

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The Nebraska Information Technology Commission (NITC) is a nine-member, governor-appointed commission. The members of the Commission are approved by a majority of the Legislature, serve four-year terms, and are limited to two consecutive terms.

The NITC report "Digital Nebraska Envisioning Our Future - Nebraska's Statewide Technology Plan 2012" [http://www.nitc.nebraska.gov/stp/stp.pdf] provides an update in this important area.

The NITC has identified eight strategic initiatives. These action items guide the work of the NITC and its advisory groups. One of them is eHealth.

The eHealth Council is composed of representatives from public health, consumers, state and federal government, employers, eHealth initiative groups, health care providers, and other resource providers. It was formed to identify, prioritize, and coordinate issues within the realm of healthcare and technology.

eHealth technologies include telehealth, electronic health records, e-prescribing, computerized physician order entry, and health information exchange. The widespread adoption of electronic health records and other eHealth technologies is expected to reduce medical errors, improve quality of care, and reduce health care costs for payers. The Nebraska Information Technology Commission formed an eHealth Council in 2007 to make recommendations on how the State of Nebraska can effectively and efficiently promote the adoption of interoperable health technologies. On March 15, 2010, the State of Nebraska received $6.8 million in funding from the Office of the National Coordinator's State Health Information Exchange Cooperative Agreement program, which was created as part of the HITECH ACT in the American Recovery and Reinvestment Act. The eHealth Council has developed strategic and operational eHealth plans which guide the implementation of Nebraska's State HIE Cooperative Agreement funding.

eHealth Council's objective is to foster the collaborative and innovative use of eHealth technologies through partnerships between public and private sectors, and to encourage communication and coordination among eHealth initiatives in Nebraska.

Health Information Technology (HIT) Update

Two information exchange networks are developing in Nebraska: The Nebraska Health Information Initiative (NeHII) (http://nehii.org/) and the Electronic Behavioral Health Information Network (e-BHIN) (http://www.ebhin.org). Behavioral Health Authority of Region 5 is participating in the E-BHIN system. Additionally, Region 2 has developed a practice management system that promises to be a NeHII certified entity in the future.

IV: Narrative Plan

R. Quality Improvement Plan

Narrative Question:

In the FY 2012/2013 Block Grant application, 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, that will describe the health of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, continue reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements and garner and use stakeholder input, including individuals in 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. In an attachment, states must submit a CQI plan for FY 2014/2015.

Footnotes:

FY 2014-2015 SAMHSA Block Grant Application
- Community Mental Health Services Plan and Report
- Substance Abuse Prevention and Treatment Plan and Report

August 22, 2013

R. Quality Improvement Plan

In the FY 2012/2013 Block Grant application, 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, that will describe the health of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, continue reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements and garner and use stakeholder input, including individuals in 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.

In an attachment, states must submit a CQI plan for FY 2014/2015.

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 FY2014/2015 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 practice, and effective practices;
→ Services are of high quality and provided in a cost-effective manner.

Core Principles

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

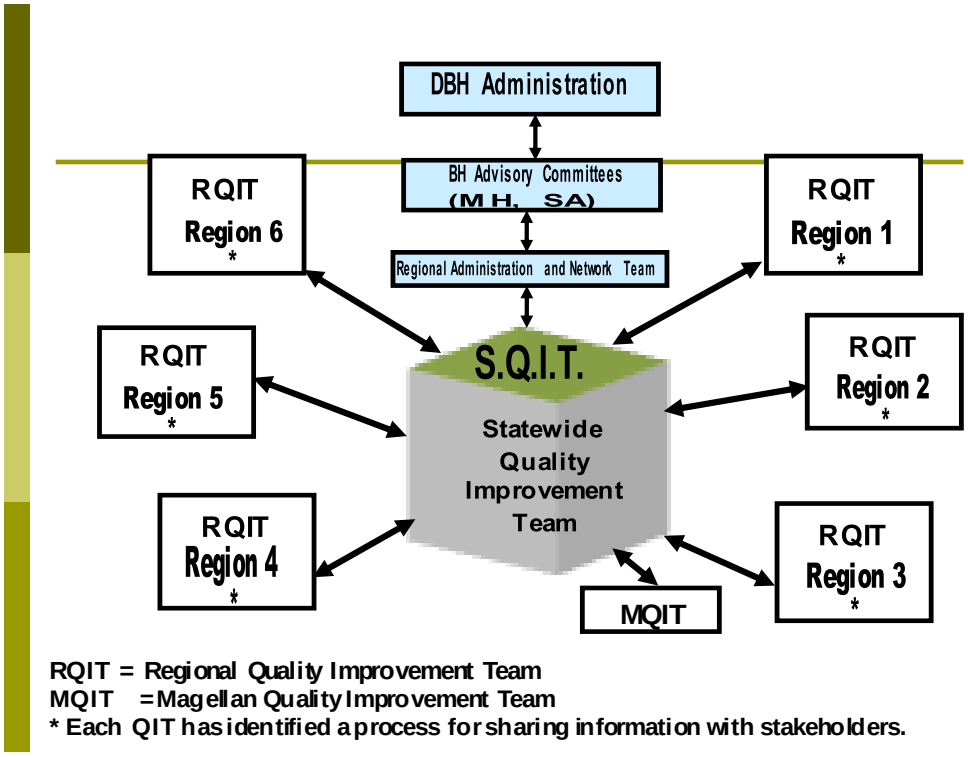
→ Customers Focused. Understanding and respecting needs and requirements of all customers and striving to exceed expectations.
→ Strength Based. Effective growth and change build on the consumer/family and system's strengths.
→ Recovery Oriented. Services are characterized by a commitment to promoting 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. 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.

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, Service Providers, Advocacy Groups and Office of Consumer Affairs Participants, Managed Care Staff, DHHS Partners, etc. Working Relationships are pictured and described below.



Division of Behavioral Health Administration – The DBH Director and Community Services Section Administrator 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.

Regional Administrator and Network Management Team 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.

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.

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.

Magellan Quality Improvement Team (M.Q.I.T.) **-** Primary responsibilities include improvement of data quality utilized in QI processes and activities:

- Improving communication and coordination between the Division, Regions, Providers and Magellan
- Developing an understanding of the work flows, systems and processes related to data and making recommendations for improvement
- Establishing a mechanism for the identification, review and resolution of issues
- Reviewing reports and recommending content and format improvements to ensure the presentation of meaningful data
- Meetings are held monthly

Quality Improvement Program Goals and Initiatives for FY14/15 – Nebraska will enhance the Behavioral Health System through collaboration with consumers, providers, regions, partnering agencies, and system stakeholders to include identification of specific methods to measure and evaluate progress in Behavioral Health System effectiveness.

Focus is placed on supporting a Behavioral Health System which:

1. Provides quality services to meet co-occurring disorder needs
2. Is trauma informed
3. Promotes recovery-oriented care

Examples of Quality Improvement initiatives and measures:

1. System Team Goals:
   - Network Systems

     Goal #1: Increase the number of behavioral health programs/providers able to deliver effective prevention and treatment ROSC for persons with COD.
     Indicator #1: Statewide average score on selected sections of the Compass EZ will increase according to the baseline.
     - Compass EZ scores are currently being received by DBH so a baseline can be established.

     Goal #2: Increase the knowledge of trauma-informed care within the behavioral health workforce.
     Indicator #2: Statewide average score on selected sections of the Fallot and Harris Trauma Informed Care tool will increase according to the baseline.
     - Providers have completed or are in the process of completing the Trauma Informed Care tool (deadline is June 30). Resulting data will assist DBH, in partnership with the Regions, look at how providers can be supported and how the Division and Regions can help them become more Trauma Informed.
     - This is an area of focus for a UNMC Nursing Students project with DBH.

– Emergency Systems

Goal: Consumers experiencing a BH crisis will be served at the most appropriate and least restrictive Level of Care (LOC).

Indicator: The percentage of consumers served by crisis response programs taken into custody by law enforcement will decrease by 2%.

- The intended result is to see Crisis Response Teams provide service alternatives to law enforcement. This will reflect success in efforts to make Crisis Response Teams as effective as possible.
- Some Regions have begun to create and commence plans to address this goal.
- Baselines are being established by the Division.

– Prevention Systems

Goal: Increase the perception of risk related to alcohol use among all age groups.

Indicator #1: The percentage of persons aged 18 or older reporting binge alcohol use will decrease to 20%.

Indicator #2: Percentage of students in 9th-12th grade who reported having five or more drinks on at least one occasion in the past 30 days will decrease to 15%.

- Youth drinking will be measured using the Youth Risk and Behavior Survey (YRBS).
- Adult drinking will be measured using the Behavioral Risk Factor Surveillance System (BRFSS).

– Youth Systems

Goal: Families and youth receiving services will experience improved family functioning.

Indicator: The number of youth in the PPP under the age of 18 will be assessed using the designated tool for family functioning to establish a baseline measure of family functioning.

- Regions contract with DBH for Wraparound Care as well as with Children and Family Services (in different models of Wraparound). Due to the short term aspect of some Wraparound programs, an improved outcome for youth may not be seen; however, improvement might be attained in family functioning.
- DBH is contracting with TriWest who will work to identify, based on input from Regions and others, an appropriate tool to measure improved family functioning. Once the tool to be used is chosen (by the end of April), the language for the measure can be fully defined.
- A full understanding of and training on the tool will precede its use to assess family in their functioning. The process for delivering the assessment is forthcoming.

– Housing Systems

Goal: Behavioral health consumers will experience an increase in stability of housing.

Indicator: The overall percentage of consumers discharging from care as "homeless" will decrease by 2%.

- A measure from the Magellan Database will be used to look at the status of living situation when an individual is discharged from care.
- Because people define "homeless" differently, data integrity is uncertain, which has led to conversations regarding the definition of "homeless," and the importance of agreement on what is and is not considered homeless.

- This will be a focus of Housing Coordinators and also of Networks. DBH will work with Regions to drill down on data if needed.

SAMHSA Block Grant Performance Indicators

For more details see
II: Planning Steps - Table 1 Step 3, 4: -Priority Area and Annual Performance Indicators

Priority #: 1 From the DBH FY2014 Region Budget Plan Guidelines – Statewide Goals
Priority Area: Prevention: Alcohol Use Among Youth
Goal of the priority area: Reduce binge drinking among youth up to age 17.

Priority #: 2 From the DBH FY2014 Region Budget Plan Guidelines – Statewide Goals
Priority Area: Youth: Improved Family Functioning
Goal of the priority area: Families and youth receiving services will experience improved family functioning.

Priority #: 3 From the DBH FY2014 Region Budget Plan Guidelines – Statewide Goals
Priority Area: Co-Occurring Disorders
Goal of the priority area: Providers demonstrate better ability to understand persons with Co-Occurring Disorders (COD) in order to improve the treatment and recovery services.

Priority #: 4 From the DBH FY2014 Region Budget Plan Guidelines – Statewide Goals
Priority Area: Trauma-Informed Care
Goal of the priority area: Increase the BH workforce education to provide Trauma-Informed Care.

Priority #: 5 From the DBH Office of Consumer Affairs | DBH Strategic Plan 2011-2015
Priority Area: Peer Support
Goal of the priority area: Increase the capacity of the system to use Peer Support

Priority #: 6 From the SAPTBG Core Requirement
Priority Area: Tuberculosis (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 NE Division of Public Health provides the overall coordination for the State of Nebraska.

The CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints and grievances.

DBH has a process for responding to emergencies, critical incidents, complaints and grievances.

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. This plan was formally adopted by the Nebraska Department of Health and Human Services on April 6, 2012. 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.

The Nebraska Disaster Behavioral Health All-All Hazards Disaster Response and Recovery Plan includes many areas for both DBH and the six Regional Behavioral Health Authorities:

- → Emergencies, critical incidents and other high profile events may or may not be considered a "disaster." However, the all-hazards 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.
- → 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.
- → The Division of Behavioral Health has developed and maintained relationships with other state officials who have disaster duties, a hotline provider and Behavioral Health Regions' disaster coordinators.
- → The Division of Behavioral Health 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.

Complaints & Grievances

The Mental Health Commitment Act provides for the individual rights of persons subject to a Mental Health Board (MHB) hearing. For more details see the Nebraska Mental Health Commitment Act Reference Manual (Revised January 2012). The manual is in compliance with NEB. Rev. Stat. §71-916. This manual includes sections on:

Individual Procedural Rights 30
Rights in Custody or While Receiving Treatment 33
Appendix V. Individual Rights 137

The complete document is posted on line at:
http://dhhs.ne.gov/behavioral_health/Pages/beh_commit_commit.aspx

The Department 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.

In addition, the Division of Behavioral Health has included procedures for complaints and grievances within the proposed Nebraska Administrative Code (NAC) draft Title 206 regulations. These proposed regulations outline consumer rights under Chapter 6-001 (as of February 2011). The proposed Rules & Regulations Docket is posted on the Nebraska Secretary of State web site:
http://www.sos.ne.gov/rules-and-regs/regtrack/index.cgi

Click on Title: 206 Chapter(s): 001-009 NEW
Then go to: TITLE 206 BEHAVIORAL HEALTH SERVICES
CHAPTER 6-000 STANDARDS OF CARE
http://www.sos.ne.gov/rules-and-regs/regtrack/proposals/0000000000000965.pdf

6-001 CONSUMER RIGHTS:
6-002 COMPLAINTS:
6-003 CONSUMER GRIEVANCES:

The proposed Title 206 regulations include the following rights. These apply to consumers receiving behavioral health services through Nebraska's public behavioral health system. All consumers have the right to:

1. Be treated respectfully, impartially, and with dignity.
2. Communicate freely with individuals of their choice, including (but not limited to) family, friends, legal counsel, and their private physician.
3. Have clinical records made available to themselves and individuals of their choice by written request.
4. Actively and directly participate in decisions that incorporate independence, individuality, privacy, and dignity and to make decisions regarding care and treatment.
5. Refuse treatment or therapy, unless treatment or therapy was authorized by the consumer's legal guardian or was ordered by a Mental Health Board (MHB) or court.
6. Have privacy and confidentiality related to all aspects of care.
7. Be protected from neglect; physical, emotional, or verbal abuse; and exploitation of any kind.
8. Actively and directly participate in developing an individual treatment, rehabilitation, and recovery plan and decision making regarding their behavioral health care.
9. Receive care from providers who adhere to a strict policy of nondiscrimination in the provision of services.
10. Be free of sexual exploitation, harassment, or re-traumatization.

11. Voice complaints and file grievances without discrimination or reprisal and to have those complaints and grievances addressed in a timely manner.
12. Receive behavioral health services in the most integrated setting appropriate for each consumer, based on an individualized and person-centered assessment.

The NAC also ensures that 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.

The NAC requires each provider to establish a written consumer grievance policy with the following components:

1. Consumers and their families must be informed of and given a copy of the written procedures for addressing and resolving grievances established by each provider.
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 DBH OCA, the Division of Public Health, Facility Complaint Intake and the Investigations Sections, the Consumer Specialist of the RBHA, the Office of the Ombudsman, the DHHS System Advocate, or the vendor who is contracted for system management.

IV: Narrative Plan

S. Suicide Prevention

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to:

- Provide the most recent copy of your state's suicide prevention plan; or
- Describe when your state will create or update your plan.

States shall include a new plan as an attachment to the Block Grant Application(s) to provide a progress update since that time. Please follow the format outlined in the new SAMHSA document Guidance for State Suicide Prevention Leadership and Plans available on the SAMHSA website at here.

Footnotes:

S. Suicide Prevention
In the FY 2012/2013 Block Grant application, SAMHSA asked states to:
Provide the most recent copy of your state's suicide prevention plan; or
Describe when your state will create or update your plan.

States shall include a new plan as an attachment to the Block Grant Application(s) to provide a progress update since that time. Please follow the format outlined in the new SAMHSA document Guidance for State Suicide Prevention Leadership and Plans available on the SAMHSA website at http://www.samhsa.gov/grants/blockGrant/docs/SAMHSA_State_Suicide_Prevention_Plans_Guide_Final.pdf.

Revised August 7, 2013

Nebraska's State Suicide Prevention Goals are drawn from multiple sources including a statewide summit and a strategic planning process led by the Nebraska State Suicide Prevention Coalition (NSSPC). The NSSPC is an all-volunteer coalition with an open membership policy that is recognized as the group with primary responsibility for development of recommendations related to suicide prevention for the Nebraska Department of Health and Human Services. The NSSPC works throughout the year to promote suicide prevention activities statewide via local coalitions and other grassroots initiatives. More information about the NSSPC can be found on its website at http://www.suicideprevention.nebraska.edu.

Nebraska State Suicide Prevention Plan mission: *Decreasing the rates of suicide in Nebraska will signal success for the state's suicide prevention efforts*

Three goals are identified for suicide prevention in Nebraska during 2011-2015:
Goal 1: Nebraskans will view suicide as a preventable public health problem

Goal 2: Empirically supported suicide prevention programs are implemented across Nebraska.

Goal 3: Data is collected and reported across systems to evaluate effectiveness and cost efficiency of suicide prevention efforts in Nebraska.

These goals were initially implemented with specific objectives for the period of 2011-2012, in coordination with Nebraska's Garret Lee Smith (GLS) Grant award. The objectives were intended to guide and inform NSSPC activities; youth suicide prevention work associated with implementation of this federal youth suicide prevention grant directed by the DHHS Division of Behavioral Health (http://www.youthsuicideprevention.nebraska.edu); and surveillance activities directed by the Division of Public Health.

Nebraska DHHS enjoyed a successful partnership during the implementation of the GLS grant to include the NSSPC, Interchurch Ministries and the University of Nebraska-Lincoln Public Policy Center. The purpose of the Nebraska Youth Suicide Prevention Project was to decrease the suicide rate among young people in Nebraska. Three cross-cutting system needs were identified through statewide planning efforts related to children's behavioral health and suicide prevention:

1. A need to increase suicide prevention awareness about the signs of suicide, available resources, and restriction of firearms access.
2. A need to enhance expertise among professionals for screening and treatment of underlying causes of suicide.
3. A need to increase collaboration among child-serving systems for suicide prevention.

The Nebraska Youth Suicide Prevention Project targeted the entire state of Nebraska for awareness and training, but prioritized high-risk groups for intervention activities such as outreach and screening. Three high risk groups were of particular concern in Nebraska:

1. Children and youth involved in multiple systems are at high risk for suicide
    - 1,282 children and youth served in "wraparound" programs for high risk youth were screened for suicide risk during the project
    - 4,059 adult gatekeepers and 447 youth in contact with high risk youth were trained in QPR (Question, Persuade, Refer ©)
2. Minority youth in Nebraska are at high risk for suicide
    - 8.4% of Gatekeepers trained reported they were of minority races
    - 5.5% of Gatekeepers trained reported they were Hispanic
3. Youth in transition to adulthood (ages 19-24), are at high risk for suicide; of particular concern are individuals who have served in the Global War on Terror and their families
    - 12,304 Nebraskans were touched by the military outreach
    - Youth in transition were touched through outreach on social media and seed grants in local communities and campuses

Here are some additional grant successes as reported in the DHHS Final GLS 2012 Report:

Goal 1	Nebraska youth suicide prevention activities will produce measureable outcomes.	
	Obj.1.1	**By 2012 every child engaged with Professional Partners Program (PPP) will be regularly screened for suicide (600-700/year).** • All Professional Partners Program staff were trained in screening and data collection (March 24-25, 2010). Screening began in April 2010, and screening is now routinely done and captured in a state reporting system. A total of 1,203 children and youth were screened in years one, two and three.
	Obj.1.2	**By 2012 minority youth in Nebraska will report via the Youth Risk Behavior Survey (YRBS) a rate of attempting suicide at or below the rate for Caucasian youth.** • Data for minority youth was not available for analysis at the time of this writing. However, the YRBS rates declined from 2005 to 2011 for Nebraska youth reporting depression (- 4%), considering suicide (-3%), and attempting suicide (- 1%).

	Obj.1.3	**By 2012 evidence-based suicide screening protocols will be adopted for use with youth in transition to adulthood by behavioral health systems serving youth and adults.** • Youth in transition who are in PPP are now routinely screened and data reported to the State Department of Health and Human Services. • In Year Two, the process to add the Family Navigator Service begun. The service assists families in finding community-based services for youth in transition and also provides peer support to families who experience children's behavioral health challenges and/or child welfare system involvement. In the fourth quarter of Year Two, Family Navigators began to utilize a database to track their identification, referral, and follow-up data. • In Year Three, the Family Navigators regularly screened and adopted reporting requirements. During the last three quarters of Year Three, 79 children and youth were screened.
	Obj.1.4	**By 2012 evidence-based suicide prevention practices appropriate for use with returning military and their families will be adopted by behavioral health, faith communities, healthcare, and veteran's services in Nebraska.** • Outreach to military families included QPR and dissemination of prevention materials (e.g., dvd's, books, etc.) to military families and churches (for use in their resource libraries). National Guard family support group facilitators agreed to use QPR while the Office of Veteran's Affairs (VA) promotes a similar adapted version for military. ASSIST training was also offered by the Nebraska National Guard as a regular part of their work with returning military.
Goal 2	**Nebraskans will view suicide as a preventable public health problem.**	
	Obj. 2.1	**By 2012 Public health districts and behavioral health regions will incorporate suicide awareness benchmarks in regular reports.** • Division of Public Health routinely tracks suicide data via hospital discharge data. • Behavioral health regions now collect and report PPP and Family Navigator screening data routinely.
	Obj. 2.2	**By 2012 suicide by firearm in Nebraska youth will decrease by 25%.** • The number of suicides by gunshot in youth (ages 10-24) decreased from 21 (2009) to 9 (2010).
	Obj. 2.3	**By 2012, 100% of Level 1, 2 & 3 and 50% of Level 4 Nebraska Trauma Centers will incorporate means restriction protocols in emergency rooms.** • Means restriction material for emergency rooms and families was approved for distribution by the Nebraska State Trauma board and distributed to all of the trauma centers in Nebraska. • While protocols within individual hospitals vary, one large medical center and affiliated hospitals have incorporated the material for routine distribution to all patients.

	Obj. 2.4	**By 2012 support for returning military and their families will be available within 60 miles of their homes.** • Outreach in conjunction with the VA and National Guard included distribution of resource materials at deployment and demobilization. QPR was made available to family support groups run in conjunction with the VA and National Guard close to each town containing deployed soldiers' families. A total of 12,304 people have been touched directly by military outreach efforts.
Goal 3	**Gatekeepers and clinicians will competently screen, assess, and treat children and youth at risk for suicide.**	
	Obj. 3.1	**By 2011, a minimum cadre of 24 trainers (4 in each Region) will be prepared to provide appropriate, evidence-based gatekeeper training.** • 24 QPR trainers were trained (12 in 2010 and 12 in early 2011) • 21 QPR trainers currently are active
	Obj. 3.2	**By 2012 Gatekeeper training will be delivered to 600 people/year across the state** • 4,509 people were trained in QPR with 3,094 reporting data on the Training Exit Survey (TES) after completing QPR (TES submitted: Yr One – 250; Yr Two – 1,325; Yr Three – 1,519).
	Obj. 3.3	**By 2011 Nebraska will prepare a cadre of 12 trainers (2 in each Region) to provide clinician training in assessment and interventions that are culturally and linguistically appropriate for Nebraska children and youth.** • Four (4) trainers were accepted and trained as trainers in the "Assessing and Managing Suicide Risk" (AMSR) curriculum in August 2010. These four trainers provided training in each of the behavioral health regions in Nebraska.
	Obj. 3.4	**By 2012, 25% of licensed behavioral health clinicians will receive training in youth suicide assessments and interventions.** • 252 Clinicians were trained in AMSR (approximately 12% of the 4,520 licensed mental health practitioners and social workers). • Additionally, 1,132 trained Gatekeepers identified themselves as Clinicians (25% of total Gatekeepers).

	Obj. 3.5	**Results of suicide screening, assessment, and intervention will be routinely collected and tracked across child-serving systems.**
		
		• **Screening and reporting was institutionalized in behavioral health regions via the Professional Partners Program.**
		  o SBQ-R administered – 1,203; SBQ-R Positive – 433;
		  o Early Identification, Referral and Follow-up (EIRF) forms filed – 413; mental health service referrals made – 249; mental health services received within 3 months of referral – 124
		  o The main reasons youth did not receive mental services within three months were: youth was already receiving mental health services (28%); an appointment for mental health services was made but the youth did not attend the appointment (28%); and/or no action was taken following the referral (23%).
		• **Screening and reporting was institutionalized in the Child Welfare system via the Family Navigator/Peer Support Service.**
		  o SBQ-R administered – 79; SPQ-R Positive – 30; EIRF forms filed – 28; mental health service referrals made – 20; no data received to date on mental health services received.

Goal 4	**Sustain Nebraska youth suicide prevention efforts by enhancing infrastructure for public/private collaboration.**	
	Obj. 4.1	**State-level suicide prevention activities will be integrated with the cross-system infrastructure development underway in Nebraska.** • The project management team had representatives from State Divisions of Public Health and Behavioral Health, the University of Nebraska Public Policy Center, Interchurch Ministries and the State Suicide Prevention Coalition who worked together on grant implementation. Further coordination with the statewide family peer support network facilitated integration at a grass roots level as well as impacting the child welfare system. The State's strategic plan for behavioral health was completed during the project period with updated suicide prevention goals and a work plan for the State Suicide Prevention Coalition. In addition, information from the project was communicated with the State mental health and substance abuse advisory committees to help inform their activities including SAMHSA Block Grant applications.
	Obj. 4.2	**The Nebraska State Suicide Prevention Coalition will expand membership to include youth, family organizations, and more representatives from minority and at-risk populations.** • Membership has expanded, and off-site coalitions in three locations are now joining regular meetings via video conferencing.

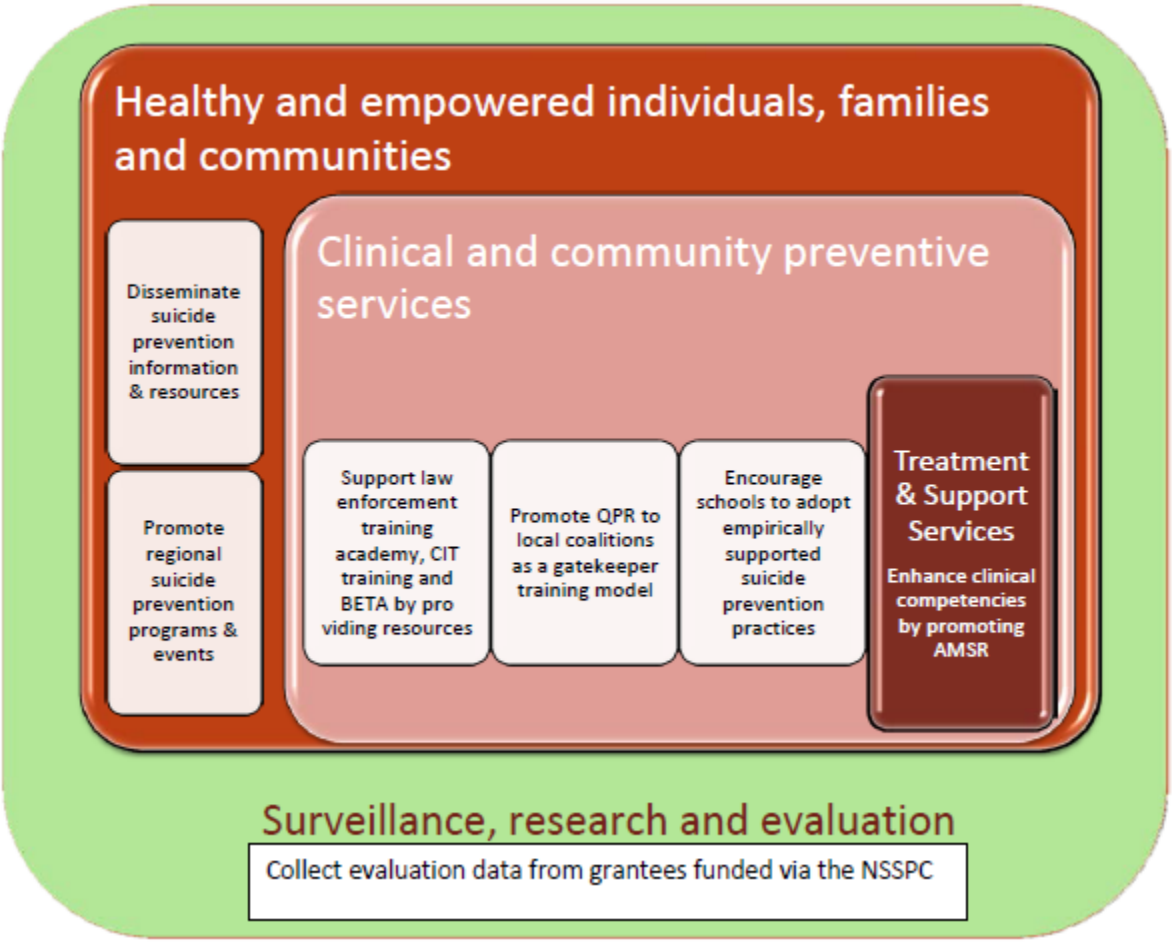
Obj. 4.3	**Local communities and prevention coalitions will establish active suicide prevention goals and activities that are culturally and linguistically appropriate for children and youth.** • Seed grants have strengthened a large western prevention coalition by adding suicide prevention activities and added three new community coalitions focusing on suicide prevention. Local coalitions and grantees included a tribal group, a Hispanic-focused, federally-qualified health center; two Universities, several faith-based groups, and frontier/rural coalitions.
Obj. 4.4	**By 2012 the Division of Behavioral Health will dedicate .3 FTE to continue coordination of statewide suicide prevention efforts.** • The Division has identified .3 FTE for ongoing suicide prevention coordination with current work effort varying between .15 and .30.

Original State Plan objectives were designed to be reviewed annually to align with grant goals and to compliment achievements. The GLS Grant was finalized in September 2012 thus planning for sustainability and next steps began last summer. Several initiatives from this grant will continue as appropriate. The QPR trainers are still available to facilitate workshops throughout the state. While these events may occur without coordination from the State or NSSPC, it is anticipated that an additional state partner (BHECN) will absorb some of the effort to ensure QPR training is a continued resource for behavioral health professionals statewide. Two youth/family programs (Professional Partner Program and the Family Navigator/Family Peer Support Services) shall continue to perform routine suicide risk screenings and provide data for analysis. This work has provided extended opportunity to review the role of peer support specialists, especially those working with high risk populations, and has led to work within the State's workforce development efforts and trauma initiatives. The work of identifying competencies for peer support specialists will also include consideration given to the inclusion of evidence based suicide prevention training. Partnership with agencies serving military and veterans groups has strengthened as a result of the grant.

As an outcome of our efforts, a suicide prevention specialist was placed from the grant within the National Guard unit in Nebraska and has allowed for further collaboration of trainings and community awareness activities among military and veterans organizations statewide. Related, on March 22, 2012 Governor Dave Heineman was joined by veteran and military leaders to kick-off Nebraska's "Not One More Life" campaign to bring public awareness for help that is available to at risk veterans. The "Not One More Life" campaign is specifically focused on the risk of emotional issues that could result in suicide. The campaign will include bumper stickers promoting crisis line, 1-800-273-TALK, and radio public service announcements. The "Not One More Life" campaign is made possible through a partnership between Nebraska Chapter 7 of the Disabled American Veterans (DAV) and The Nebraska Department of Veterans Affairs.

Additional mini-grant opportunities will be extended to community coalitions/agencies to facilitate suicide prevention strategies such as awareness events, trainings and community capacity development. These mini-grants will be managed thru the NSSPC. NSSPC, with support from State leadership and stakeholders, has updated their goal activities for the State Plan 2013-2014 in April 2013. Two contextual changes influenced NSSPC members as they engaged in this process. First, the state of Nebraska completed a grant funded project addressing youth suicide which decreased resources available to NSSPC to carry out activities. Second, the 2012 National strategy for suicide prevention embraced a model of organizing goals and objectives that the NSSPC wished to emulate

as much as possible to be consistent with national goals and objectives. The new strategy organizes activities into four interconnected directions:
1. Healthy and empowered individuals, families and communities
2. Clinical and community preventive services
3. Treatment and support services
4. Surveillance, research and evaluation



Some additional noteworthy recent activities include:

- The NSSCP partnered to host a successful LOSS Conference in 2012 and planning is underway for another event this year as well, scheduled for September 10-11, 2013 in Ohio.
- DHHS developed a 'Strategies for Suicide Care in Systems Framework - Suicide Prevention Self-Assessment Survey' for behavioral health providers. This survey tool, developed based upon the National Action Alliance on Suicide Prevention: Clinical Care & Intervention Task Force "Suicide Care in Systems Framework" and key AMSR competency elements, was implemented at the close of calendar year 2012. The survey was required by all funded mental health, substance abuse and problem gambling (adult and youth) treatment providers funded by DHHS Division of Behavioral Health. The purpose of this project was to measure strategies that minimize the risk of self-injurious and life threatening behaviors of consumers served in the publicly funded system. The desired outcome was to inform of opportunities for quality improvement and training initiatives that could be implemented in the future to improve suicide prevention practices (particularly focusing on the adult population as the GLS focus was youth). Survey data is still being received and analyzed, but some examples of partial, early data results include:

  - 85% of respondents reporting always or usually providing 24-hour clinical coverage for consumers
  - 94% of respondents reporting always or usually providing course of action procedures to all clinical staff for consumers at risk of suicide
  - 88% of respondents reporting always or usually providing training to clinical staff on the development of treatment plans responsive to consumer self-harm and/or suicide risk.
- A legislative resolution (LR533) was proposed during 2012 to provide for a study regarding teen suicide, trauma, bullying and youth mental health. This bill, introduced by Senator McGill, initiated much dialogue with community stakeholders regarding children's mental health including the NSSPC. More on this can be found at: http://nebraskalegislature.gov/bills/view_bill.php?DocumentID=17265
  Legislation was proposed in this 2013 session that addresses access to children's mental health services via schools. This bill (LB556) also includes behavioral health screenings as a part of mandatory health screening required by schools for students. More can be found on this bill at: http://nebraskalegislature.gov/bills/view_bill.php?DocumentID=18827
- In partnership with the DHHS Division of Behavioral Health and made possible by Substance Abuse Prevention and Treatment Block Grant training funds, several Regional Behavioral Health Authorities and prevention providers have sponsored Anti-bullying Program speakers throughout their communities.
  - On March 27, 2013 Lincoln Medical Education Partnership's School Community Intervention & Prevention program (SCIP) will host "Finding light through the darkness" a Suicide Prevention Conference presenting information to improve participant response to youth suicide ideation, completion and its aftermath.
  - Last year SCIP's annual conference featured Kirk and Laura Smalley, parents of Ty Smalley, who was bullied at school and at age 11 took his own life. The Oklahoma couple eventually turned that tragedy into a powerful presentation – dedicating their lives to spreading the message of anti-bullying. The week of February 18, 2013 Nebraska once again welcomed these two very special people to the state to speak with various audiences to share their personal story about the dangers of bullying.
- DHHS recently submitted an application to SAMHSA for the 'Cooperative Agreements for State sponsored Youth Suicide Prevention and Early Intervention' grant opportunity CFDA#93.243.

Abbreviations and Acronyms used in this Document	
AAS	American Association of Suicidology
AFSP	American Foundation for Suicide Prevention
AMSR	Assessing and Managing Suicide Risk (Training tool from SPRC)
BHECN	Behavioral Health Education Center of Nebraska
BH	Behavioral Health
DHHS	Department of Health and Human Services
GLS	Garrett Lee Smith (Grant Act Title)
LOSS	Local Outreach to Suicide Survivors (Outreach Teams)
NSSPC	Nebraska State Suicide Prevention Coalition
PSA	Public Service Announcement
QPR	Question, Persuade, Refer (Suicide Prevention Training Tool)
SPRC	Suicide Prevention Resource Center (National)
YRTC	Youth Rehabilitation and Treatment Center (Kearney, NE)

IV: Narrative Plan

T. Use of Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to describe:

- What strategies the state has deployed to support recovery in ways that leverage ICT;
- What specific application of ICTs the State BG Plans to promote over the next two years;
- What incentives the state is planning to put in place to encourage their use;
- What support system the State BG Plans to provide to encourage their use;
- Whether there are barriers to implementing these strategies and how the State BG Plans to address them;
- How the State BG Plans to work with organizations such as FQHCs, hospitals, community-based organizations, and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine;
- How the state will use ICTs for collecting data for program evaluation at both the client and provider levels; and
- What measures and data collection the state will promote to evaluate use and effectiveness of such ICTs.

States must provide an update of any progress since that time.

Footnotes:

FY 2014-2015 SAMHSA Block Grant Application
- Community Mental Health Services Plan and Report
- Substance Abuse Prevention and Treatment Plan and Report

August 7, 2013

T. Use of Technology
In the FY 2012/2013 Block Grant application, SAMHSA asked states to provide a "Description of the Use of Technology — Interactive Communication Technologies (ICTs)" Section E.
States must provide an update of any progress since that time.

In the Section Q. Data and Information Technology updates are provided on:

- Community Services (CS) Data System (Magellan Behavioral Health Contract)
- Nebraska Prevention Information System
- Mental Health Commitments & Handgun Data Base and
- Health Information Technology (HIT) Update

Here is addition to updates to Use of Technology - Interactive Communication Technologies (ICTs)

Nebraska Information Technology Commission

The "Nebraska Strategic eHealth Plan" [August 2012 - Version 6] provides a good overview of use of technology. To see the full report go to:
http://nitc.nebraska.gov/nitc/meetings/documents/20121029/NebStrategiceHealthPlanV6Aug2012.pdf

page 2 - This edition of Nebraska's Strategic eHealth Plan lays out the state's vision, goals, and objectives, and strategies for implementing statewide health information exchange and supporting the meaningful use of health information technology. The plan focuses on the domains of adoption, governance, finance, technical infrastructure, business and technical operations. Key considerations and recommendations are also included. As the eHealth Council continues to address the development of health information exchange and the adoption of health IT, the plan will be updated. Frequent revisions are anticipated due the quickly changing health IT environment. Please check the Nebraska Information Technology Commission's website (www.nitc.nebraska.gov) for the most recent edition.

Page 5 - Nebraska also has one of the nation's only health information network exclusively serving behavioral health information exchange providers and clients. The Electronic Behavioral Health Information Network went live with its electronic health record and electronic practice management systems in Southeast Nebraska in the summer of 2011 and in the Panhandle region in the winter of 2011/2012. Health information exchange functionality is expected to go live in the spring and summer of 2012. NeHII and eBHIN have developed an innovative approach to managing consent which will allow for the exchange of behavioral health information with patient consent. NeHII and eBHIN also plan to pilot the use of Direct to exchange behavioral health information with patient consent between providers in each system.

Page 6
Vision: Stakeholders in Nebraska will cooperatively improve the quality and efficiency of patient-centered health care and population health through a statewide, seamless, integrated consumer-centered system of connected health information exchanges. Nebraska will build upon the investments made in the state's health information exchanges and other initiatives which promote the adoption of health IT.

Goals: These goals will be achieved while ensuring the privacy and security of health information, which is an essential requirement in successfully implementing health information technology and exchanging health information:

- Using information technology to continuously improve health care quality and efficiency through the authorized and secure electronic exchange and use of health information.
- Improve patient care and consumer safety;
- Encourage greater consumer involvement in personal health care decisions;
- Enhance public health and disease surveillance efforts;
- Improve consumer access to health care;
- Improve consumer outcomes using evidence-based practices.

Technical Infrastructure (page 8)

Nebraska's technical architecture is based upon a federation of health information exchanges and other providers, following national standards. NeHII is serving as the lead health information exchange, statewide integrator, and health information service provider for Nebraska, providing the technical architecture and creating a statewide health information exchange. NeHII is a hybrid federated model in which providers send data to unique Edge Servers in standard transaction formats through VPN. Providers access the interoperability hub through the Internet to access information using a master patient index and record locator service. This type of architecture is simple and encourages innovation.

eBHIN is using a hybrid federated model, also known as a blended model. The Central Data Repository (CDR) will contain data which is common and relevant to all behavioral healthcare providers in the HIE. The Document Locator Service will be used to share other data and documents among providers for those consumers who have consented to participate. It is an index of the location of documentation held by participating organizations. The CDR proposed for this HIE system will include a centralized data base with the additional capability of maintaining wait list/referral management coordination functionality, easy access to longitudinal consumer data, e-prescribing, medication reconciliation, and lab results.

Summary Care Record Exchange (page 20)

Health care providers in Nebraska have several options for exchanging summary care records, including:

- Summary care record exchange using query. As of March 2012, NeHII has over 700 physician users of the query model exchange. Inquiries to the NeHII system for January 2012 rose to 182,263 compared to 103,215 in January 2011 and 26,294 in January 2010.
- Summary care record exchange using query functionality through eBHIN. The eBHIN HIE is going live in three regions of Nebraska in 2012-2013 and will be expanding to other regions as time and resources allow.
- Summary care record exchange using Direct services with NeHII/HIO Shared Services as the statewide HISP. Physicians participating in NeHII can also send directed care summary exchange through NeHII and can use our HISP offering to send via Direct.

Electronic Behavioral Health Information Network (eBHIN) (page 27-28)

The Electronic Behavioral Health Information Network (eBHIN) is currently developing an eHealth network to exchange behavioral health information among behavioral health providers in the Region 5 in Southeast Nebraska and Region I in the Panhandle. Regions 2, 3 & 4 have received a HRSA planning grant to determine the resources needed to participate. Region 6 in Omaha is also planning to join the HIE Network. Phase I participants in Region 5 include Blue Valley Behavioral Health Center, Bryan Health Systems, CenterPointe, Child Guidance Center, Community Mental Health Center, Cornhusker Place, Family Services, Houses of Hope, Lincoln Medical Education Partnership, Lutheran Family Services, Mental Health Association, Region V Systems, and St. Monica's Home. The Region I deployment has begun with EPM deployment at Panhandle Mental Health Center and will continue to the following seven additional sites: Box Butte General Hospital,

Cirrus House, CrossRoads Resources, Human Services, Inc., North East Panhandle Substance Abuse Center, Regional West Medical Center, and Western Community Health Resources. eBHIN partners have received several grants including a planning grant from the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality (AHRQ) in 2004, an AHRQ Ambulatory Care Grant in 2008, a three-year Rural Health Network Development Grant from the U.S. Department of Health and Human Services' Health Resources and Services Administration in 2008, Region V Systems, and a grant from the Nebraska Information Technology Commission, a HRSA – Rural Health Information Technology Network Development Grant for the Region I expansion, ONC – RTI Grant for participation in the Behavioral Health Consortium and most recently, a HRSA Planning Grant for HIE Deployment in Regions 2,3 & 4 of the State.

eBHIN will utilize Direct secure messaging to exchange patient information with consent outside of the eBHIN exchange. eBHIN is utilizing the NextGen EMR application to order lab results and e-prescribe.

eBHIN (page 132)

The Electronic Behavioral Health Information Network (eBHIN) connects publicly funded behavioral health providers in Nebraska.

Governance. eBHIN is a tax exempt 501(c)3 private, non-profit corporation that serves as a Regional Health Information Organization (RHIO) for providers of Behavioral Health services in southeast Nebraska. The governing Board of Directors is made up of stakeholder representatives who have been working together since 2003 to promote health information exchange as a means to improve patient care, integrate with primary care and improve efficiency of behavioral health care service delivery. eBHIN serves as the primary governing body providing oversight for the financing, development, and implementation of a Health Information Exchange (HIE) among member behavioral health providers and organizations in Nebraska. Currently services are being deployed in three regions in Nebraska, representing more than 75% of the publicly funded organizations in the state. The additional three regions will be added as resources and readiness allow.

Nebraska Medicaid Telehealth

The regulations for coverage criteria and reimbursement of Medicaid telehealth services are in the Nebraska Administrative Code 471 NAC 1-006. Each service covered as a Medicaid telehealth service must otherwise be covered as a face-to-face service, and all other Medicaid policies and regulations in addition to 471 NAC 1-006 apply to telehealth services. Each telehealth site must meet the definition in regulations and must enroll independently prior to billing for services. Both sites on a telehealth transmission must be enrolled as a Medicaid telehealth site. http://dhhs.ne.gov/medicaid/Pages/med_telehealth.aspx (Last Updated: 8/21/2012)

BHECN (Behavioral Health Education Center of Nebraska at the University of Nebraska Medical Center) has had several telehealth summits which the DBH Chief Clinical Officers attended. DBH is working with BHECN to begin discussions for connecting the Regional Behavioral Health Authorities and network providers through a telehealth capability.

University of Nebraska Medical Center Department of Psychiatry

- To greater serve the mental health care needs of rural Nebraskans, the University of Nebraska Medical Center's Department of Psychiatry recently initiated a Telepsychiatry Consultation Service. As one of the most effective ways to increase access to psychiatric care for individuals living in underserved areas, the service began in Nebraska Behavioral Region 4 (Columbus, Wayne, and Norfolk) and currently serves 19 rural Nebraska locations. Telepsychiatry provides opportunities for consultative services and second opinions between psychiatrists, primary care physicians and other healthcare providers. We expect to continue extending critically needed psychiatric care to other areas of Nebraska in the very near future. For further information, please contact: Carl Greiner, MD

[email: cgreiner@unmc.edu] http://www.unmc.edu/psychiatry/telepsychiatry.htm

- Telepsychiatry Consultation Service, under the direction of Dr Thomas Magnuson (tmagnuson@unmc.edu), enables patients in nursing homes and long-term care facilities across rural Nebraska to be evaluated and treated for mental health problems. This clinical service (Dementia in Long Term Care) is especially targeted toward the development of non-pharmacologic interventions for residents, but it also recognizes the prudent use of medications. http://www.unmc.edu/psychiatry/geriatric.htm

IV: Narrative Plan

U. Technical Assistance Needs

Narrative Question:

States shall describe the data and technical assistance needs identified during the process of developing this plan that will facilitate the implementation of the proposed plan. The technical assistance needs identified may include the needs of the state, providers, other systems, persons receiving services, persons in recovery, or their families. Technical assistance includes, but is not limited to, assistance with assessing needs; capacity building at the state, community and provider level; planning; implementation of programs, policies, practices, services, and/or activities; evaluation of programs, policies, practices, services, and/or activities; cultural competence and sensitivity including how to consult with tribes; and sustainability, especially in the area of sustaining positive outcomes. The state should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

1. What areas of technical assistance is the state currently receiving?
2. What are the sources of technical assistance?
3. What technical assistance is most needed by state staff?
4. What technical assistance is most needed by behavioral health providers?

Footnotes:

FY 2014-2015 SAMHSA Block Grant Application
- Community Mental Health Services Plan and Report
- Substance Abuse Prevention and Treatment Plan and Report

August 27, 2013

U. Technical Assistance Needs
States shall describe the data and technical assistance needs identified during the process of developing this plan that will facilitate the implementation of the proposed plan. The technical assistance needs identified may include the needs of the state, providers, other systems, persons receiving services, persons in recovery, or their families. Technical assistance includes, but is not limited to, assistance with assessing needs; capacity building at the state, community and provider level; planning; implementation of programs, policies, practices, services, and/or activities; evaluation of programs, policies, practices, services, and/or activities; cultural competence and sensitivity including how to consult with tribes; and sustainability, especially in the area of sustaining positive outcomes. The state should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

1. What areas of technical assistance is the state currently receiving? … and … 2. What are the sources of technical assistance?

Prevention System Consultation: Nebraska state-to-state mentoring –
State Priority Area #1 is Prevention: Alcohol Use Among Youth (Goal: Reduce binge drinking among youth up to age 17). For more details see: Table 1 Step 3,4: -Priority Area and Annual Performance Indicators. This is one of the Priority Areas from the FY2014 Region Budget Plan Guidelines – Statewide Goals.

Michael Langer, Office of Program Services Behavioral Health Administrator, for Washington State Division of Behavioral Health and Recovery, is providing technical assistance in the form of State-to-State consultation to "coach/mentor" as the Nebraska State Substance Abuse Authority (SSA) implements their Strategic Plan for Prevention.

a. Michael has many years of experience working with the Washington State substance abuse prevention and treatment programs, as well as current efforts to integrate integrating mental health promotion/mental illness prevention, the Affordable Care Act requirements, and other national initiatives with substance abuse services in Washington State.
b. Washington State recently began a prevention redesign initiative which will influence how the Washington SSA "rolls out" substance abuse efforts at the community level.
c. The purpose of the coaching/mentoring will be to use examples and lessons from Washington State and Michael's specific knowledge and experience, to maximize Nebraska's success in integrating mental health promotion/mental illness prevention, the Affordable Care Act requirements, and other national initiatives relating to behavioral health planning and services, with Nebraska's Strategic Prevention Plan implementation.
d. The coaching/mentoring technical assistance is being provided via conference calls and electronic communication (emails, document sharing) on an "as needed" basis requested by Nebraska SSA staff.

DBH Prevention Team & SEOW

DBH Prevention team and State Epidemiological Outcomes Workgroup (SEOW) are currently working with the Training and TA Coordinator (Wanda West) from SAMHSA's Center for the

Application of Prevention Technologies (CAPT) Southwest Resource Team as well as their EPI consultant, Beverly Tremain, to receive additional guidance on identifying and analyzing Behavioral Health Indicators in Nebraska. Much of this is follow up from their webinar ***Using Epidemiological Data to Support Substance Abuse Prevention and Mental Health Promotion*** conducted on January 30, 2013. They will be presenting a condensed version of this to the SEOW via webinar on March 26, 2013 and then will also walk the workgroup through next steps with how to use this information.

This TA will help in accomplishing DBH's SEOW grant deliverable which is to revise the State's Epidemiological profile by expanding the substance abuse prevention focus to align prevention of mental disorders as they relate to substance abuse. This also supports the DBH efforts to meet SAMHSA's expectation that SEOWs move toward better understanding the shared or common risk and protective factors that impact both substance abuse and mental disorders and incorporate them in their products and prevention planning.

Professional Partner Program

State Priority Area #2: Youth: Improved Family Functioning (Goal: Families and youth receiving services will experience improved family functioning). For more details see: Table 1 Step 3,4: - Priority Area and Annual Performance Indicators. This is one of the Priority Areas from the FY2014 Region Budget Plan Guidelines – Statewide Goals.

In the Fiscal Year 2014 Region Budget Plan Guidelines under the section on Youth System Coordination and Professional Partner Program are the following expectations:

- Ensure children and youth with behavioral health disorders receive the most appropriate services located within their community whenever possible.
- Regions are expected to provide technical assistance as needed and as appropriate to providers to increase their ability to incorporate Family Centered Practice and System of Care principles into their practices.

Continued use of High Fidelity Wraparound is the cornerstone of Nebraska's statewide Professional Partner Program. The statewide program is coordinated through the Division of Behavioral Health with comprehensive services provided in local communities through established programs located within each of the state's six Regional Behavioral Health Authorities. The statewide Professional Partner Program has been in place for over ten years, and as part of the Division's continuous quality reviews of established programs, the need to examine the most appropriate and effective methods of High Fidelity Wraparound service delivery, as well as corresponding best practices, was identified.

To achieve the objective is to assist providers in implementing best practices in wraparound assessment and improve the outcomes for youth and families receiving wraparound services through the Professional Partner Program. To accomplish this, the Division of Behavioral Health's Community Based Services entered into partnership with Peter Selby, PhD, and Andrew Keller, PhD of the TriWest Corporation, Boulder, Colorado, to review the Professional Partner Program (PPP) in terms of best practices for the overall Program itself, specifically addressing best practices in High Fidelity Wraparound, recommendation of an assessment of family functioning, and, development of associated cost models.

Working in a collaborative relationship with DBH and each of the six statewide Regional Behavioral Health Authorities, Dr.'s Selby and Keller gained insight from a statewide perspective into current PPP implementation, an understanding of the current regional differences regarding

history and development of the Professional Partner Programs, and a greater awareness of what works well and what works less well across the state.

Dr.'s Selby and Keller concluded:

- that family centered practice is a core value that is demonstrated across the State.
- that there is a strong commitment to a data-driven culture in which outcome data, fidelity data and satisfaction data are routinely used to support decisions and to communicate about programs with multiple stakeholders.
- that Regions are implementing PPP with attention to quality and in keeping with High Fidelity Wraparound's core values in service planning and delivery; and,
- that most Region's prefer the current reimbursement case rate approach.

In conjunction with Dr.'s Selby and Keller, as well as each of the Regional Behavioral Health Authorities, the Division of Behavioral Health will evaluate report recommendations and considerations, and develop next step action plans to address:

- A tiered approach for eligibility, with staff/case ratio rigorously defined in expectations to exceed no greater than 1:15;
- For core fidelity and ongoing program improvement, replacement of the WFI-4 with the new WFI-EZ;
- Utilization of the Child And Adolescent Needs and Strengths (CANS) as an assessment tool and quality management process to capture:
    - Measurements of the targeted health and human service needs and strengths of children and their families;
    - Supports in planning the individualized services for children and adolescents; and,
    - Documentation of the level of care (services) needed by the child and family.
- A formal rate review, with special attention given to establishing a fixed flexible High Fidelity Wraparound funding amount per child/family.

The Division will continue partnership with Dr.'s Selby and K ller in the recently awarded SAMHSA System of Care Grant, with its purpose to expand and sustain the system-of-care approach to providing services for children and youth with serious emotional disturbances and their families. High Fidelity Wraparound is a System of Care component and will be addressed with other stakeholders as a core strategy team workgroup in the grant structure.

Trauma-Informed Care & Peer Support

State Priority Area #4: Trauma-Informed Care (Goal: Increase the BH workforce capacity to provide trauma-informed care). This is one of the Priority Areas from the FY2014 Region Budget Plan Guidelines – Statewide Goals.

State Priority Area Priority Area #5: Peer Support. This is under the DBH Office of Consumer Affairs and is part of the DBH Strategic Plan 2011-2015 implementation (Goal: Increase the capacity of the system to use Peer Support).

NOTE: For more details see: Table 1 Step 3,4: -Priority Area and Annual Performance Indicators.

Technical assistance needed to help facilitate the implementation of the proposed plan is part of the Trauma Across the Lifespan Conference on September 12-13, 2013. The Nebraska Department of Health and Human Services, Division of Behavioral Health and the Division of Children and Family Services plus the University of Nebraska Public Policy Center are sponsoring this conference at the Cornhusker Hotel Conference Center [333 S 13th Street, Lincoln, NE 68508]. The funding to support the program is from the Transformation Transfer Initiative (TTI) Grant from

Substance Abuse Mental Health Service Administration and administered by National Association of State Mental Health Program Directors. The Target Audience includes Children and Family Services Case Managers, Adult and Family Peer Support Specialists, Consumers and Family Members, Service Providers, Administrators, Child and Adult Service Providers, Judges, and County Attorneys.

Featuring Guest Speakers: Dr. Bruce Perry, Sharon D. Wise, and Nathan Ross

- Bruce Perry, M.D., Ph.D. is the Senior Fellow of The Child Trauma Academy, a not-for-profit organization based in Houston, TX (www.ChildTrauma.org), and adjunct Professor in the Department of Psychiatry and Behavioral Sciences at the Feinberg School of Medicine at Northwestern University in Chicago. He serves as the inaugural Senior Fellow of the Berry Street Childhood Institute, an Australian based center of excellence focusing on the translation of theory into practice to improve the lives of children (www.berrystreet.org.au). Dr. Perry is the author, with Maia Szalavitz, of The Boy Who Was Raised As A Dog, a bestselling book based on his work with maltreated children and Born For Love: Why Empathy is Essential and Endangered.
- Sharon D. Wise is a Certified Wellness Recovery Action Plan Facilitator located in Washington, D.C. Sharon has over fifteen years in the mental health consumer movement and has operated the first 100% consumer-run organization in the Washington DC metropolitan area. She was successful in winning one of the first major contracts from the D.C. Department of Mental Health in consumer-run history. Sharon is an artist-in residence for the St. Elizabeths Hospital and performs at major conferences that support mental health recovery for consumers all over the world. She recently completed an Alternatives to Seclusion and Restraint documentary entitled, "Leaving the Door Open" and a cable show "The Great Hip-Hop Debate".
- Nathan Ross, went into the foster care system at the age of 10 after witnessing the murder of two of his brothers by his birth mother. Nathan was in the foster care system with his remaining brother and sister for two years before he was adopted. Nathan currently runs the youth mentoring program for Midwest Foster Care and Adoption Association. As a person who was in foster care and later went on to be adopted, he knows the struggles that children go through in looking for their forever families and hopes to provide support and resources to youth in their times of need by matching them with a support system that will help guide them through various trials while allowing for self-discovery.

Sharon Wise - Keynote speaker

On May 15, 2013, Sharon Wise was the keynote at the Success, Hopes, and Dreams 2013, Nebraska's Statewide Behavioral Health Conference (May 13-15, 2013, at the Cornhusker Hotel in Lincoln, Nebraska. The Title of her address was: "What is Trauma and Why Must We Address it? Creating Trauma Informed Systems of Care for Human Services Settings."

The Center for Mental Health Services' (CMHS) National Center for Trauma-Informed Care (NCTIC) promotes trauma-informed practices in the delivery of services to people who have experienced violence and trauma and are seeking support for recovery and healing. CMHS's NCTIC is guided by the following fundamental beliefs: People with lived experience of trauma can and do recover and heal. Trauma-informed care is the hallmark of effective programs to promote recovery and healing through support from peers, consumers, survivors, ex-patients, and recovering persons and mentoring by providers. Finally, leadership teams of peers and providers charting the course for the implementation of Trauma-Informed Care are essential. This presentation will address the prevalence of trauma and suggest techniques to reduce the

likelihood of re-traumatization. Participants will learn what trauma is, how it affects individuals psychologically, developmentally, and neurobiologically.

Data System and Ikaso Consulting

The Division of Behavioral Health (DBH) faces substantial obstacles in collecting, organizing and accessing data, from behavioral health regions and providers. The data is necessary for DBH to efficiently, accurately and completely fulfill its obligations for reporting, monitoring and managing care in the Nebraska Behavioral Health System. Data is held in multiple different forms, systems and data bases, causing data aggregation to be an ever increasing difficulty for DBH and necessitating multiple verification processes that result in delays discharging its responsibilities. Personnel at DBH and in the behavioral health regions spend many hours combing data from paper reports, spreadsheets and disparate databases and lack quick, reliable access to information. In addition to its planned reporting, a wide variety of requirements and report breakdowns for various funders and stakeholders are often requested on an ad-hoc basis.

A new centralized data system (CDS) is necessary to overcome these immediate challenges in data access and reporting compliance while also providing DBH, behavioral health regions and providers with data necessary to improve the NE public behavioral health system, especially in an environment of health information exchange and performance monitoring.

The NE DHHS Division of Behavioral Health (DBH) Centralized Data System (CDS) will track outcomes of managed care, measure performance of managed care (in real time), measure funding for managed care, provide for greater fiscal accountability for managed care, meet reporting needs of DBH to Federal and State entities, unify existing databases and technology, fill data gaps for improved management of care and utilize health information exchange efficiencies by interfacing with the State Health Information Exchange (HIE). An example of improvement: data driven, evidence-based, incentives to providers for improved performance.

DBH Community Based Services Section has contracted with Ikaso Consulting to write a Request for Proposal for contracting the development and creation of a DHHS data system. The consultation is funded by the State Mental Health Data Infrastructure Grants for Quality Improvement (State DIG) from the Center for Mental Health Services (CMHS) in the U.S. Department of Health and Human Services.

Ikaso consulting will draft a RFP for DHHS to competitively procure a centralized, integrated management information system to securely transmit and retrieve data on behalf of DBH's contracted providers, Regional Behavioral Health Authorities, and other DBH information systems. This information system shall eliminate unnecessary or duplicative data elements and consolidate information technology platforms and software within DBH to better meet the payment, analytical, and data needs of DBH and its stakeholders.

As part of the information gathering process required to write the RFP, Ikaso Consulting will utilize the following as the four (4) key written sources of information for the RFP and shall review these materials with DBH to gather feedback, validate accuracy, solicit updates, and identify information gaps:

a. The Business Requirements Report for the Development and Maintenance of a Centralized Data System delivered by Orion Healthcare Technology,
b. The Implementation Roadmap for a Centralized Data System delivered by Orion Healthcare Technology,
c. The previously issued Request for Information (RFI DBH28), and

d. The RFI responses for the three (3) solutions (InfoMC, NetSmart and Siemens Healthcare).

In addition to the draft RFP, Ikaso has performed research on similar procurement processes in other states and has provided the information to DBH for review. They have drafted the RFP with performance metrics and sanctions conforming to applicable State of Nebraska policy, procedure(s), and statute(s). This draft is undergoing review and is anticipated to be released in early Fall 2013 for implementation in July 2014.

Performance Contracting

DBH Community Services staff attended Results-Based Accountability™ Administrator Training on April 2, 2013. The training was provided by Karen Finn, M.Ed, Partner/Senior Consultant with the Results Leadership Group. She has extensive experience in using Results Accountability particularly in the areas of children, youth and family policy. [see: http://resultsleadership.org/]. This is an initiative in collaboration with the Division of Children and Family Service to move towards performance contracting. DBH will be seeking consultation to begin utilizing RBA for performance contracting with behavioral health community based services.

This workshop introduced the Results-Based Accountability™ (also known as RBA) framework. RBA is a disciplined way of thinking and taking action communities can use to improve the lives of children, youth, families, adults and the community as a whole. RBA is also used by organizations to improve the performance of their programs. RBA was developed by Mark Friedman and described in his book Trying Hard is Not Good Enough.

RBA uses a data-driven, decision-making process to help an organization get beyond talking about problems to taking action to solve problems. RBA starts with ends and works backward, towards means. The "end" refers to the difference one is trying to make. An organization can only be held accountable for the customers they serve. RBA helps organizations identify the role they play by identifying specific customers who benefit from the services provided. The performance measures focus on whether customers are better off as a result of the services. These performance measures also look at the quality and efficiency of these services. RBA asks three simple questions to get at the most important performance measures:

- How much did you to?
- How well did you do it?
- Is anyone better off?

Timeline for DBH implementation is expected to include preliminary conversations and introductions to the RBA framework and concepts will be held with Regional Behavioral Health Authorities throughout the Fall of 2013. Preliminary intentions are to use this to develop a process for performance contracting.

Olmstead & ROSC

Olmstead refers to Olmstead v. L.C., the 1999 Supreme Court decision affirming unjustified segregation of individuals with disabilities living in institutions and other segregated settings is an illegal form of discrimination. Recovery Oriented Systems of Care (ROSC) refer to coordinated network of community-based services and supports which are person centered, building on the strengths and resilience of individuals, families, and communities in order to achieve abstinence and improve health, wellness, and quality of life for people with or at risk of behavioral health disorder problems. [see: http://partnersforrecovery.samhsa.gov/docs/rosc_resource_guide_book.pdf]

Technical Assistance Collaboration (TAC) is currently assisting DBH to expand efforts to support persons with behavioral health challenges in integrated community based settings. A series of meetings were held with multiple stakeholders during the Nebraska's Statewide Behavioral Health Conference (May 13-15, 2013) lead by Kevin Martone, the Executive Director of the Technical Assistance Collaborative (Boston, MA). The overall effort is to provide housing to persons with disabilities in the most integrated setting consistent with Olmstead and ROSC.

TAC's report will provide recommendations on the improved use of resources such as the Low Income Housing Tax Credit (LIHTC) for affordable housing for people with low-incomes. Looking for ways improved partnerships between DBH and the Nebraska Investment Finance Authority (NIFA) as well as the Nebraska Department of Economic Development (NEDED) will also be considered.

Supported Employment (SE) Consultations

The DHHS Division of Behavioral Health (DBH) and State Vocational Rehabilitation (VR) are working collaboratively to update Supported Employment in Nebraska. The core SE Update issues are

- → Consistent with the concept of Recovery Oriented Systems of Care:
  - Update Supported Employment services
  - Improve employment assistance as part of each DBH funded community service
- → Only one payment source at a time (braided funding from any funding source such as VR, DBH &/or others).
- → Payments are tied to the consumer.
- → Program meets fidelity consistent with the SE Toolkit from the Substance Abuse & Mental Health Services Administration (SAMHSA).
- → Separate Transitional Employment (TE), as described by the International Center for Clubhouse Development (ICCD), from SE.

To help accomplish this work, DBH is working with two consultants. One consultant is Barbara W. Thomas (Lincoln, NE). She is developing Cost Models for both SE and TE. The other consultant is Virginia Selleck, PhD (Chief Clinical Officer, Places for People, St. Louis, MO). She is providing program consultation and training:

- → Meeting in Lincoln, NE on August 29, 2013 with DBH and VR staff to discuss observations of current practices, and make suggestions for improvement.
- → Final report to DBH by September 28, 2013. Content of the report shall include recommendations and strategies:
  - To aid DBH in improving SE & employment assistance across its service array and
  - To improve coordination between DBH & VR.
- → Conduct Quality Improvement Self-Assessment training using the SAMHSA SE tool kit with providers. Training shall be held in Lincoln, NE (date to be determined) from 9:00 a.m. to noon and from 1:00 p.m. to 4:00 p.m.
- → May include formal review of proposed SE service update.
- → Seven SE providers, Regional Staff, DBH staff, and others invited.

Tuberculosis

There is no technical assistance needed to facilitate the implementation of State Priority Area Priority Area #6 Tuberculosis (TB). This is a SAPTBG Core Requirement. For more details see: Table 1 Step 3,4: -Priority Area and Annual Performance Indicators.

3. What technical assistance is most needed by state staff? … and …
4. What technical assistance is most needed by behavioral health providers?

DBH sees the technical assistance most needed by state staff and behavioral health providers as the same. Thus, a combined list is presented below.

A. Affordable Care Act (ACA) –
   i. As the Affordable Care Act is implemented, adjusting the role of the Division of Behavioral Health in the non-Medicaid public behavioral health system is key to moving forward with an integrated, recovery oriented, community-based system of care and identifying options for best practice models;
   ii. Improving mental and substance use service providers' capacity to bill public and private insurance as well as to support enrollment into health insurance for eligible individuals. By June 30, 2014, DBH will make some decisions on the best way to move forward. The decisions may include the full or partial implementation of the three percent set-aside as well as the option to not conduct this activity.

B. Implementation of Recovery Oriented Systems of Care [ROSC] using a person-centered planning and self-direction and participant-directed care approach. This includes: the emerging role of the DBH in housing and other supports in the new healthcare environment; as well as Person-centered planning and self-direction and participant-directed care.

C. Engagement of Tribes – Consulting regarding engagement of tribes;

D. Data System – With the development of the DBH Centralized Data System (CDS), technical assistance and training on the use of integrated data exchange techniques would be useful. The new secure data exchange is expected to include the ability to access and integrate with other service entities, as well as health information exchanges. Training on confidentiality regulations as they relate to integrated health information exchanges.

IV: Narrative Plan

V. Support of State Partners

Narrative Question:

The success of a state's MHBG and SABG 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. States should identify these partners in the space below and describe how the partners will support them in implementing the priorities identified in the planning process. In addition, the state should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the state education authority(ies), the State Medicaid Agency, entity(ies) responsible for health insurance and health information marketplaces (if applicable), adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan.[45] This could include, but is not limited to:

- The State Medicaid Agency agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.
- The state justice system authorities that will work with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment.
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system. Specific service issues, such as the appropriate use of psychotropic medication, can also be addressed for children and youth involved in child welfare.
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities.

45 SAMHSA will inform the federal agencies that are responsible for other health, social services, and education

Footnotes:

FY 2014-2015 SAMHSA Block Grant Application
- Community Mental Health Services Plan and Report
- Substance Abuse Prevention and Treatment Plan and Report

August 7, 2013

V. Support of State Partners
The success of a state's MHBG and SABG 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. States should identify these partners in the space below and describe how the partners will support them in implementing the priorities identified in the planning process. In addition, the state should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the state education authority(ies), the State Medicaid Agency, entity(ies) responsible for health insurance and health information exchanges (if applicable), adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan. This could include, but is not limited to:

- The State Medicaid Agency agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.

In 2010, the State Legislature appropriated funds for two medical home pilot projects for Medicaid patients. In Nebraska, a patient-centered medical home for the Medicaid Medical Home pilot is defined as a health care delivery model in which a patient establishes an ongoing relationship with a physician in a physician-directed team, to provide comprehensive, accessible, and continuous evidence-based primary and preventive care, and to coordinate the patient's health care needs across the health care system in order to improve quality, safety, access, and health outcomes in a cost effective manner. The Medicaid State Plan Amendment was approved in 2011, and subsequently, two pilot projects were launched in clinics located in Lexington and Kearney. Also, as part of the Medicaid managed care contract, Coventry and Arbor Health are expected to develop medical home models in twelve new communities over a three-year period.

- The state justice system authorities that will work with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment.

The Justice Behavioral Health Committee (JBHC) was created to improve communication and collaboration between the criminal justice and treatment systems. JBHC consists of 34 members representing the Executive and Judicial branches as well as behavioral health treatment providers and consumers. JBHC's mission is to ensure integration, cooperation, and active communication between the criminal justice system and treatment systems, substance abuse and mental health. JBHC develops and implements standards for the criminal justice population for mental health and substance abuse evaluations and treatment. JBHC strives for a collaborative working relationship between criminal justice and treatment providers in order to meet the ultimate goal of effective and

competent client care. The vision involves educational endeavors, data monitoring, provider competency, and strategic planning.
Expected outcomes include safer communities, recidivism reduction, risk reduction, and effective and competent client care. JBHC seeks to ensure adherence to and expansion of the Nebraska Standardized Model. The work continues today and most recently, standardized program plan guidelines and standards of care for treatment providers have been developed.

- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.

The Nebraska Department of Education (NDE) received a Building State Capacity for Preventing Youth Substance Abuse and Violence grant from the Office of Safe and Drug-Free Schools in 2010. The purpose of the grant was to help states maintain an infrastructure to prevent drug use and violence among children and youth. A priority of the program was to support collaboration between the state education agency and other state agencies which typically are involved in prevention efforts. NDE entered into partnership agreements with the Department of Health and Human Services (DHHS) Division of Behavioral Health (DBH) and the Division of Public Health. As a condition of the grant, the project developed a plan for sustaining the state's infrastructure to support the implementation of effective drug and violence prevention activities at the state and local levels. Each school district/school is encouraged to form a School Health Council that develops and implements a comprehensive plan that includes evidence-based strategies based on the eight components of The Coordinated School Health Program Model. NDE will take the lead in implementing these activities, but strong partnerships have been formed with DHHS, local community prevention coalitions, the University of Nebraska-Lincoln, the Parent Training and Information Center and Educational Service Units across the state.

Building on this initial work, DBH is engaged in a Five Year Strategic Plan for Prevention that includes an initiative to collaborate and create joint action plans with the Division of Public Health, and the Division of Children and Family Services (DCFS) that integrate funding, workforce, strategies and outcome measurement for initiatives that focus on substance abuse prevention and risk factor reduction/protective factor enhancement. This work involves creating a strategic collaboration with educational and research institutions to identify and divert youth who are at risk of addiction or substance-related delinquency into programs that can successfully intervene, thereby reducing their risk of further involvement with addiction or law enforcement.

- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system. Specific service issues, such as the appropriate use of psychotropic medication, can also be addressed for children and youth involved in child welfare.

In 2012, Nebraska Legislature passed LB821, creating the 24-member Nebraska Children's Commission. This Commission is comprised of stakeholders, child welfare advocates, and DHHS staff dedicated to ensuring system reform. The Commission has created a strategic plan for child welfare services and made recommendations on possible administrative restructuring of child

welfare services. Areas examined included a policy for prescribing psychotropic drugs to state wards, the role and responsibilities for the Office of Juvenile Services, Title IVE waivers, and foster care reimbursements. Based on examination of the system, legislation was proposed to continue to reform the child welfare system in Nebraska. LB 502 provides a demonstration project to allow for "Alternative Response" to child abuse and neglect reports. These projects would be planned in consultation with the Nebraska Children's Commission. Following planning, DHHS could use Alternative Response in up to five designated locations, with a report due to the Legislature on December 15, 2014. Through the Alternative Response initiative, Nebraska expects to change its culture in regards to thinking safety of a child can only be achieved through removal from the family home, and to enhance the family's protective factors while maintaining the child's safety. This includes having a system that allows families to access needed services and supports without the formal involvement of the court system. Nebraska is in a time of great change in regards to the transparency and collaboration between DBH and stakeholders.

The Governor appointed Blaine Shaffer, M.D., DBH Chief Clinical Officer to serve on the Psychotropic Medication Committee of the Nebraska Children's Commission. The Committee provided recommendations for state policy regarding the prescription and administration of psychotropic drugs for state wards. To see the recommendations, go to Appendix C of the Strategic Plan (December 11, 2012 Meeting Handouts):
http://dhhs.ne.gov/ChildrensCommission/Documents/CC-Draft%20Strategic%20Plan%20121012.pdf

Nebraska is examining a cross divisional effort focused on trauma and understanding its effects on the entire system and the children and families served. DBH and 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. DCFS is currently working on a Trauma Informed Care Self-Assessment in order to develop a strategic plan moving forward

Also, DHHS was required by recent state legislation to apply for a Title VI-E waiver on or before September, 2013. Title IV-E waivers allow states greater flexibility in the use of federal Title-IV-E funds. Title-IV-E funds are restricted to paying for out-of-home care and some training and administrative costs. The waivers allow states to cover a broader population such as children at risk of abuse and neglect and those remaining in their homes. It also allows for a broader range of services such as prevention services and a wide range of intervention, support and therapy services. The intent of the flexibility provided for in the waiver is to improve the delivery of child welfare services by designing programs to keep children out of the system, to maintain children in their family homes, to accelerate the movement toward permanency and to provide aftercare services that help to stabilize situations after existing the system. In the long range, there should be general fund savings from enhanced preventative services and improvements in the child welfare system. This waiver application was completed and submitted.

DCFS has recently implemented the structured decision-making model in all five Services Areas. Structured decision-making is an approach to child protective services that uses clearly defined and consistently applied decision-making criteria for screening for investigation, determining response priority, identifying immediate threatened harm, and estimating the risk of future abuse and neglect. Child and family needs and strengths are identified and considered when developing and monitoring progress toward a case plan. DCFS has also

recently contracted with Regional Behavioral Health Authorities (RBHAs) in Nebraska to implement a wraparound model to assist families whose children are at risk of becoming state wards, providing assistance for families to promote children's well-being in their current home. In an additional collaborative effort, the NDHHS (Division of Children and Families, Behavioral Health, and Public Health) will host a Prevention Summit in April 2013. The Summit will provide participants the opportunity to learn more about evidence-based strategies designed to prevent child maltreatment and encourage participants to think about new strategies to implement within their communities. Included in the summit will be sessions on trauma, with information on how to more readily identify children and youth who may be affected by trauma and to provide recommendations for coping strategies that support those served in succeeding in life. The presentation will include a definition of trauma using a developmental perspective to discuss the prevalence and impact of traumatic experiences on young children and adolescents. This will include emerging clinical and research findings about the keys times of development and the primary functions of the brain as it relates to trauma.

The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities.

- In order to better address substance abuse prevention in Nebraska, DHHS applied for and was awarded a 5-year substance abuse prevention grant, entitled the Strategic Prevention Framework State Incentive Grant (SPF SIG), from the Center for Substance Abuse Prevention of the Substance Abuse and Mental Health Services Administration (SAMHSA) in October of 2006. This effort was a collaborative effort and involved the Division of Public Health and the DBH. As part of the SPF SIG, the Nebraska Substance Abuse Prevention Program was required to establish an epidemiology workgroup to develop an epidemiological profile of substance abuse in the state which was published in December 2007 and most recently updated in 2012. Its primary purpose was to present the epidemiological profile to identify substance abuse needs and select statewide priorities and to increase awareness of substance abuse problems among key decision makers to assist them in future activities. The reports examine data on alcohol, tobacco, and illicit drug use and associated consequences in Nebraska. In addition, it identifies gaps in existing substance abuse data within Nebraska that will help guide future data collection and analysis.
- At the time of this report the NSAEW consisted of 25 members, with 20 being stakeholders to the Nebraska Substance Abuse Prevention Program and 5 being Substance Abuse Prevention Program staff. Organizations represented on the NSAEW include Native American Tribal Representatives, Nebraska Crime Commission, Nebraska Department of Correctional Services, Nebraska Department of Education, Nebraska Local Public Health Departments, Nebraska Office of Highway Safety, Nebraska Substance Abuse Regional Prevention Centers, University of Nebraska-Lincoln, University of Nebraska Medical Center, Non-profit Agencies, and Divisions/programs within the DHHS including maternal and child health, behavioral health, tobacco prevention, epidemiology, and minority health. The first NSAEW meeting was held on March 20, 2007 in Lincoln, Nebraska. The NSAEW remained active throughout the 6 years of SPF SIG and will continue to enhance substance abuse data collection, reporting, and utilization within Nebraska. DBH currently is the recipient of State Epidemiological Workgroup grant to maintain and further develop infrastructure to ensure this work continues.

IV: Narrative Plan

W. State Behavioral Health Advisory Council

Narrative Question:

Each state is required to establish and maintain a state Behavioral Health Advisory Council (Council) for services for individuals with a mental disorder. While many states have established a similar Council for individuals with a substance use disorders, that is not required. SAMHSA encourages states to expand their required Council's comprehensive approach by designing and use the same Council to review issues and services for persons with, or at risk of, substance abuse and substance use disorders. In addition to the duties specified under the MHBG statute, a primary duty of this newly formed Council will be to advise, consult with, and make recommendations to SMHAs and SSAs regarding their activities. The Council must participate in the development of the MHBG state plan and is encouraged to participate in monitoring, reviewing, and evaluating the adequacy of services for individuals with substance abuse and mental disorders within the state. SAMHSA's expectation is that the State will provide adequate guidance to the Council to perform their review consistent with the expertise of the members on the Council. States are strongly encouraged to include American Indians and/or Alaska Natives in the Council; however, their inclusion does not suffice as tribal consultation. In the space below describe how the state's Council was actively involved in the plan. Provide supporting documentation regarding this involvement (e.g., meeting minutes, letters of support, etc.)

Additionally, please complete the following forms regarding the membership of your state's Council. The first form is a list of the Council members for the state and second form is a description of each member of the Council.

There are strict state Council membership guidelines. States must demonstrate (1) that the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council and (2) that no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services. States must consider the following questions:

- What planning mechanism does the state use to plan and implement substance abuse services?
- How do these efforts coordinate with the SMHA and its advisory body for substance abuse prevention and treatment services?
- Was the Council actively involved in developing the State BG Plan? If so, please describe how it was involved.
- Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council?
- Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
- Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders.

Footnotes:

W. State Behavioral Health Advisory Council

August 7, 2013

Each state is **required** to establish and maintain a state Behavioral Health Advisory Council (Council) for services for individuals with a mental disorder.
SAMHSA **encourages** states to expand and use the same Council to review issues and services for persons with, or at risk of, substance abuse and substance use disorders.

- What planning mechanism does the state use to plan and implement substance abuse services?

Behavioral Health strategic planning process – Director Scot Adams lead the planning process resulting in a Strategic Plan which is serving as to guide the Division of Behavioral Health (DBH) while providing flexibility to react to changes in the environment. The DBH strategic plan is posted on the web site.

- August 2012 Strategic Plan Progress Report
  Strategic Planning for Nebraska Behavioral Health System, February 2011
  http://dhhs.ne.gov/behavioral_health/Pages/2010BHStrategicPlan.aspx
- Five-Year Prevention Statewide Strategic Plan FY13-FY17 has also been prepared. It is posted on the web at:
  http://dhhs.ne.gov/behavioral_health/Documents/DBH-PreventionStrategicPlan2013-17.pdf

Thus, substance abuse services planning and implementation is part of the ongoing work of DBH and includes:

- Routinely meeting with Regional Behavioral Health Authorities (RBHAs) [Director/Regional Administrators call on Monday, Tuesday Data Call, Network Management Team (eight meetings each year), quarterly Regional Administrator meetings, and more].
- Annual Regional Budget Planning: DBH implements community based behavioral health services via the Regional Budget Plan Guidelines. Fiscal Year 2014 included the DBH expectations. Each of the six RBHAs is expected to address these issues.
- Development of a separate strategic plan for Substance Abuse Prevention.
- Each RBHA has planning mechanisms and is responsible for comprehensive planning for the provision of an appropriate array of community-based behavioral health services and continuum of care for their assigned area [§71-809(c)]. Each RBHA is also expected to involve consumers in all aspects of service planning and delivery. Each RBHA has a Regional Advisory Committee consisting of consumers, providers, and other interested parties to assist in carrying out these duties [§71-808(2)].
- Linking the planning efforts between DBH and the six RBHAs are several system teams. These include NETWORK (priority issues for 2014 include prevention and treatment Recovery Oriented System of Care for persons with co-occurring disorders, and trauma-informed care]; EMERGENCY (priority issues for 2014 include serving consumers experiencing a BH crisis in the most appropriate and least restrictive level of care); PREVENTION (priority issues for 2014 include increasing the perception of risk related to alcohol use among all age groups as well as students in 9th-12th grade who reported having five or more drinks on at least one occasion in the past 30 days); YOUTH (priority issues for 2014 include families and youth receiving services will experience improved family functioning); and HOUSING (priority issues for 2014 include consumers discharging from care as “homeless” will decrease).

- Collaborating with DHHS Divisions of Children & Family Services, Public Health, and Medicaid & Long-Term Care on issues such as standards of care, service definitions, prevention, emergency management preparedness, and more.

The Nebraska Behavioral Health Services Act defines "Behavioral Health Disorder" as Behavioral health disorder means mental illness or alcoholism, drug abuse, or other addictive disorder [Neb. Rev. Stat. §71-804(1)]. This statute also establishes the State Advisory Committee on Mental Health Services (§71-814) and the State Advisory Committee on Substance Abuse Services (§71-815). Both of these State Advisory Committees are used to provide advice and assistance to the DBH relating to the provision of behavioral health services. Starting on May 6, 2010, DBH started holding joint meetings of the committees. In 2011, with the first combined SAMHSA Block Grant application, there were joint meetings on May 3, August 18 and November 3. In 2012, there were joint meetings May 3 and November 8. In 2013, there was a joint meeting on March 14 and one is scheduled for September 19. There was a joint morning session on June 11 with afternoon separate meetings. November 14, 2013 is scheduled to be a joint morning session with afternoon separate meetings.

When meeting in a joint session, the two advisory committees serve as the state Behavioral Health Advisory Council. The meeting documentation shows these two advisory committees, meeting jointly or separately, review issues and make recommendations to DBH regarding services for persons with behavioral health disorders to. All of this meaningful input is used in a variety of ways, including the development of the SAMHSA Block Grant 2014-2015 application (the combined MHBG and SABG). DBH is responsible for both the Community Mental Health Services Block Grant (MHBG) as the State Mental Health Authority and Substance Abuse Prevention and Treatment Block Grant (SABG) as the Single State Authority.

At the May 3, 2012 Joint Committee Meeting of the State Advisory Committee on Mental Health Services, State Advisory Committee on Substance Abuse Services, and State Committee on Problem Gambling, a DBH State Advisory Committee Feedback Survey was handed to members of each Committee. Each member was asked to respond in accordance with their experience in participating on their respective Committee and was anonymous. Those members not present were e-mailed a survey. The results from the survey were provided at the next meeting of each Committee.

Feedback Survey Results:

- August 7, 2012 – State Advisory Committee on Mental Health Services – The results showed overall positive responses. The Committee comments included: suggestions that the survey be conducted annually and that an exit interview with similar questions be conducted when members leave the committee.
- September 6, 2012 – State Advisory Committee on Substance Abuse Services – The results showed overall positive responses. The Committee comments included: consider including committee members that match the changing population of Nebraska, such as growing Hispanic population; balancing urban, rural, and frontier backgrounds; more clearly defining the role of the committee and committee members; provide more cross-education between all three State Advisory Committees; holding Joint Advisory Committee meetings, while maintaining the identity of each committee.

How do these efforts coordinate with the SMHA and its advisory body for substance abuse prevention and treatment services?

The Behavioral Health Services Act designates the DBH as the chief behavioral health authority for the State of Nebraska [§71-806 (1)]. That means DBH is both the State Mental Health Authority (SMHA) and the State Substance Abuse Authority (SSA). These efforts to coordinate with the

SMHA and its advisory body for substance abuse prevention and treatment services are addressed by the staff of the DBH.

- The duties of the State Advisory Committee on Mental Health Services includes providing advice and assistance to DBH relating to the provision of mental health services in the State of Nebraska [(§71-814)(c)]. The membership, agendas, and minutes of their meetings are posted on the web at: http://dhhs.ne.gov/behavioral_health/Pages/beh_mh_sacmhs.aspx.
- The duties of the State Advisory Committee on Substance Abuse Services includes providing advice and assistance to DBH relating to the provision of substance abuse services in the State of Nebraska [(§ 71-815)(b)]. The membership, agendas, and minutes of their meetings are posted on the web at: http://dhhs.ne.gov/publichealth/Pages/hew_sua_sacsa.aspx.

- Was the Council actively involved in developing the State BG Plan?

Yes.

- If so, please describe how it was involved.

State Block Grant Plan was the topic of discussion for both state advisory committees. Here are several examples.

→ May 3, 2012-Joint Meeting MH/SA/Problem Gambling. This meeting included members of the State Committee on Problem Gambling (§71-816). The topics included: Returning Veterans Resource Network, Consumer Workforce & Peer Recovery Supports, Sex Offender Issues, Primary & BH Care Integration, SA Counselor Education, and working session on Access under the DBH Strategic Plan.

→ August 7, 2012-MH Committee. The topics discussed included: DBH Strategic Plan and Issues from NASMHPD, Behavioral Health Inmates in the State Correctional System, Peer Support roles (paid versus not paid), Children's Behavioral Health (Bringing the Committee up to date on Children's BH issues from the point of view of the Division of Children and Family Services; work on the IV-E waiver; better prevention and promote early intervention), a SAMHSA Block Grant review of the Priority Indicators, as well as Community Mental Health Services Block Grant Application for 2013 funds.

→ September 6, 2012-SA Committee. The topics discussed included DBH Strategic Plan, BH Inmates in State Correctional System, Peer Support roles (paid versus not paid), Substance Abuse Prevention, and a SAMHSA Block Grant review of the Priority Indicators.

→ November 8, 2012-Joint Meeting MH & SA. The meeting included a review of the SAMHSA Block Grant implementation reports. In addition, there was time focused on the 2014 SAMHSA Block Grant Application including a review of the SAMHSA Priorities, DBH Strategic Plan, needs assessment data followed by Committee Input on Priorities for 2014-2015 application.

→ March 14, 2013–Joint Meeting MH/SA. This meeting included a public review of the draft SAMHSA Block Grant 2014-2015 application.

For more details, see the Division of Behavioral Health web pages for

- State Advisory Committee on Mental Health Services
  http://dhhs.ne.gov/behavioral_health/Pages/beh_mh_sacmhs.aspx
- State Advisory Committee on Substance Abuse Services
  http://dhhs.ne.gov/publichealth/Pages/hew_sua_sacsa.aspx

- Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council?

Yes. The response above demonstrates the integration of these two State Advisory Committees. This started in 2010 and continued in 2011 and 2012. Integration will continue with the 2013 meetings. The 2013 schedule includes meeting time as a Joint State Advisory Committees on

Mental Health & Substance Abuse Services. The meeting schedule is intended to address the bigger questions, common concerns, and major issues needing shared conversations. For example:

→ Improving community behavioral health services capacity to work as Recovery Oriented Systems of Care.
→ Promoting integrated services for people with co-occurring mental health and substance use disorders.
→ Understanding fundamental concepts of a trauma informed system of care for serving people in all behavioral health services.
→ Reducing tobacco use by people served in behavioral health services.
→ Integrating primary and behavioral health services as effective approaches to caring for people with multiple healthcare needs.

- Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?

Yes. The membership is appointed by the Governor according to State Statute.

- 71-814 (1) State Advisory Committee on Mental Health Services members shall have a demonstrated interest and commitment and specialized knowledge, experience, or expertise relating to the provision of mental health services in the State of Nebraska. The committee shall consist of twenty-three members appointed by the Governor as follows: (a) One regional governing board member, (b) one regional administrator, (c) twelve consumers of behavioral health services or their family members, (d) two providers of behavioral health services, (e) two representatives from the State Department of Education, including one representative from the Division of Vocational Rehabilitation of the State Department of Education, (f) three representatives from the Department of Health and Human Services representing mental health, social services, and Medicaid, (g) one representative from the Nebraska Commission on Law Enforcement and Criminal Justice, and (h) one representative from the Housing Office of the Community and Rural Development Division of the Department of Economic Development.
- 71-815 (1) State Advisory Committee on Substance Abuse Services members shall have a demonstrated interest and commitment and specialized knowledge, experience, or expertise relating to the provision of substance abuse services in the State of Nebraska. The committee shall consist of twelve members appointed by the Governor and shall include at least three consumers of substance abuse services.

The membership for both State Advisory Committees is posted on:
http://dhhs.ne.gov/behavioral_health/Pages/beh_mh_sacmhs.aspx.
http://dhhs.ne.gov/publichealth/Pages/hew_sua_sacsa.aspx.

- Please describe the duties and responsibilities of the Council.

71-814 (2) State Advisory Committee on Mental Health Services 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.

71-815 (2) State Advisory Committee on Substance Abuse Services 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.

IV: Narrative Plan

Behavioral Health Advisory Council Members

Start Year: 2014

End Year: 2015

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Jerry McCallum (MH)	Others (Not State employees or providers)	Region 4 - Governing Board Member	55717 831 Road Madison, NE 68748 PH: 402-454-3735	jejamc@telebeep.com
Ann Ebsen (SA)	Others (Not State employees or providers)		309 Oakridge Court Papillion, NE 68005 PH: 402-331-8830	aebsen@aol.com
Adria Bace (MH)	State Employees	Education	301 Centennian Mall So Lincoln, NE 68509 PH: 402-471-2471 FAX: 402-471-5022	adria.bace@nebraska.gov
Cameron White (MH)	State Employees	Dept of Correctional Services	PO Box 94661 Lincoln, NE 68509 PH: 402-479-5971	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
Jill Schreck (MH)	State Employees		Division of Children and Family Services (Social Services), 301 Centennial Mall So Lincoln, NE 68508 PH: 402-471-9243	Jill.schreck@nebraska.gov
Randy See (SA)	State Employees	Dept of Correctional Services	529 Hermitage Court Grand Island, NE 68801 PH: 308-381-8721	randy.see@nebraska.gov
Sheri Dawson (MH & SA)	State Employees		DHHS- Division of Behavioral Health, 301 Centennial Mall So Lincoln, NE 68508 PH: 402-471-7818 FAX: 402-471-7859	sheri.dawson@nebraska.gov
Cynthia Brammeier (MH)	State Employees		301 Centennial Mall So Lincoln, NE 68508 PH: 402-471-9224	cynthia.brammeier@nebraska.gov
Lara Huskey (MH)	State Employees		P.O. Box 64666 Lincoln, NE PH: 402-471-7359	lara.huskey@nebraska.gov
Janet Johnson (SA)	Providers		Choices Treatment Center, 2737 No. 49th Street, Lincoln, NE 68504 PH: 402-476-2300	janet.l.johnson09@gmail.com
DeLinda Mercer (SA)	Providers		Regional West Med Center, 2 West 42nd Street, #3200 Scottsbluff, NE 69361 PH: 308-635-3888	mercerd@rwmc.net

Ingrid Gansebom (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	mikep@ccomaha.org
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
Robert Donlan (MH)	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	1013 So. 35th Avenue Omaha, NE 68105 PH: 402-714-3222	donlanrobert@yahoo.com
Kasey Moyer (MH)	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	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
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
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: 402-261-3756	Khanson1757@msn.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: 402-359-1082	bradhoefs@yahoo.com
Paige Hruza (SA)	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	3801 Harney Street Omaha, NE 68131 PH: 402-591-5000	phruza@regionsix.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
Jette Hogenmiller (MH)	Family Members of Individuals in Recovery (to include family members of adults with SMI)	8686 Tranquility Loop Fort Calhoun, NE 68023 PH: 402-426-5645	jetteh@huntel.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: 402-891-6960	dwaggoner@thekimfoundation.org
Jorge Rodriguez-Sierra (SA)	Family Members of Individuals in Recovery (to include family members of adults with SMI)	2706 No. 99th Street Omaha, NE 68134 PH: 402-559-6259	jrodrigu@inmc.edu
Rachel Pinkerton (MH)	Family Members of Individuals in Recovery (to include family members of adults with SMI)	16 Ginger Cove Road Valley, NE 68064 PH: 402-763-8352	rachelpinkerton@hotmail.com
Karla Bennetts (MH)	Parents of children with SED	301 No. Briggs Street Wilcox, NE 68982 PH: 308-991-6099	kbennetts@familiescares.org
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	2219 Rodeo Road North Platte, NE 69101 PH: 308-352-6720	ashleypankonin@gmail.com

Footnotes:

There are 23 members of the State Advisory Committee on Mental Health Services (MH) and 12 members of the State Advisory Committee on Substance Abuse Services (SA).
- Sheri Dawson, Deputy Director of the Division of Behavioral Health is appointed to both committees represinting the Division. She is listed one time.
- As of August 7, 2013, there is one vacancy for a consumer of substance abuse services.
- As a result, there are a total of 34 members including the one vacancy for the combined advisory committees listed.

IV: Narrative Plan

Behavioral Health Council Composition by Member Type

Start Year: 2014

End Year: 2015

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)	8	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	4	
Parents of children with SED*	4	
Vacancies (Individuals and Family Members)	1	
Others (Not State employees or providers)	2	
Total Individuals in Recovery, Family Members & Others	19	55.88%
State Employees	9	
Providers	6	
Federally Recognized Tribe Representatives	0	
Vacancies	0	
Total State Employees & Providers	15	44.12%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	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	11	

* 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 draft Priority Areas for the SAMHSA 2014-2015 Block Grant application were presented for discussion at the Joint Advisory Committee meeting on March 14, 2013. In addition, Advisory Committee members were invited to comment upon the complete draft application posted on DBH website from April 16, 2013 to May 1, 2013. For more details see Section Y. Comment on the State BG Plan.

Footnotes:

* The information on DBH Advisory Committee membership regarding racial, ethnic, or LGBTQ status is not collected.

IV: Narrative Plan

X. Enrollment and Provider Business Practices, Including Billing Systems

Narrative Question:

Each state is asked to set-aside three percent each of their SABG and MHBG allocations to support mental and substance use service providers in improving their capacity to bill public and private insurance and to support enrollment into health insurance for eligible individuals served in the public mental and substance use disorder service system. The state should indicate how it intends to utilize the three percent to impact enrollment and business practices taking into account the identified needs, including:

- Outreach and enrollment support for individuals in need of behavioral health services.
- Business plan redesign responsive to the changing market under the Affordable Care Act and MHPAEA.
- Development, redesign and/or implementation of practice management and accounts receivable systems that address billing, collection, risk management and compliance.
- Third-party contract negotiation.
- Coordination of benefits among multiple funding sources.
- Adoption of health information technology that meets meaningful use standards.

Footnotes:

FY 2014-2015 SAMHSA Block Grant Application
- Community Mental Health Services Block Grant (MHBG)
- Substance Abuse Prevention and Treatment Block Grant (SABG)
August 21, 2013

Narrative Question:
Each state is "asked" (meaning: not required) to set-aside three percent each of their SABG and MHBG allocations to support mental and substance use service providers in improving their capacity to bill public and private insurance and to support enrollment into health insurance for eligible individuals served in the public mental and substance use disorder service system. The state should indicate how it intends to utilize the three percent to impact enrollment and business practices taking into account the identified needs, including:

- Outreach and enrollment support for individuals in need of behavioral health services.
- Business plan redesign responsive to the changing market under the Affordable Care Act and MHPAEA.
- Development, redesign and/or implementation of practice management and accounts receivable systems that address billing, collection, risk management and compliance.
- Third-party contract negotiation.
- Coordination of benefits among multiple funding sources.
- Adoption of health information technology that meets meaningful use standards.

Beginning in January 2014, the Affordable Care Act (ACA) should provide improved access to behavioral health services to people in Nebraska. There are many, including the Legislature, monitoring the impact of increased health insurance coverage on the Nebraska population under the ACA. The Legislature will continue the debate on Medicaid expansion in the 2014 session (Legislative Bill 577). As noted in other sections of this application, the Nebraska Department of Insurance is the lead State Agency for implementation of the ACA, and will be using the Federal Exchange

The Division of Behavioral Health (DBH) acknowledges SAMHSA's interest in improving mental and substance use service providers' capacity to bill public and private insurance as well as to support enrollment into health insurance for eligible individuals. DBH in partnership with the six Regional Behavioral Health Authorities continues to successfully and responsibly manage the available community based financial resources. As noted in Section C (Coverage for M/SUD Services), DBH Financial Eligibility Policy is to be the payer of last resort. Thus, community based behavioral health providers enrolled under the Regional Behavioral Health Authorities are already strongly encouraged to improve their capacity to bill public and private insurance as well as support consumers to properly enroll into health insurance.

Between September 2013 and June 2014, under the leadership of Karen Harker, Fiscal & Federal Performance Administrator, DBH will engage in a planning process. The planning will include a review the following issues:

- Outreach and enrollment support for individuals in need of behavioral health services.
- Business plan redesign responsive to the changing market under the Affordable Care Act and MHPAEA.
- Development, redesign and/or implementation of practice management and accounts receivable systems that address billing, collection, risk management and compliance.
- Third-party contract negotiation.
- Coordination of benefits among multiple funding sources.

- Adoption of health information technology that meets meaningful use standards.
- Best use of decreasing SAMHSA Block Grant funds

By June 30, 2014, DBH will determine the best way to move forward. The decisions may include the full or partial implementation of the three percent set-aside as well as the option to not conduct this activity.

IV: Narrative Plan

Y. Comment on the State BG Plan

Narrative Question:

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the State BG Plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to the Secretary of HHS.

Footnotes:

FY 2014-2015 SAMHSA Block Grant Application
- Community Mental Health Services Plan and Report
- Substance Abuse Prevention and Treatment Plan and Report

August 8, 2013

Y. Comment on the State BG Plan
Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the State BG Plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to the Secretary of HHS.

SAMHSA Uniform Block Grant

The Substance Abuse Mental Health Services Administration (SAMHSA) has combined the previously separate Community Mental Health Services Block Grant (MHBG) and the Substance Abuse Prevention and Treatment Block Grant (SABG) into one application.

The Division of Behavioral Health (DBH) within the Nebraska Department of Health and Human Services welcomes Public Comments on NE State Application for SAMHSA Uniform Block Grant (BG) Application.

NE State Application FY 2012-2013

The SAMHSA-approved application from 2012-2013 is posted on the DBH Web site (Submitted September 1, 2011 | Revised January 13, 2012) … see …
http://dhhs.ne.gov/behavioral_health/Documents/NE-FINAL-SAMHSA-UniformBlockGrantApplication2012-13-Revision13Jan2012.pdf

NE State Application FY 2014-2015 - Public Comments on State Plan

Public Comments were requested and welcomed on NE State Application for SAMHSA Uniform Block Grant FY 2014-2015. Several approaches were used:

The Joint State Advisory Committee on Mental Health and State Advisory Committee Substance Abuse Services.

- The State of Nebraska draft priorities for the SAMHSA Block Grant application were reviewed at the meeting on **March 14, 2013** at the Country Inn and Suites, 5353 No 27th Street, Lincoln, NE.
- Notice for the meeting was posted on the Public Meeting Calendar - http://www.nebraska.gov/calendar/.
- For the implementation report, the **Review Meeting is on November 14, 2013**. Specific meeting arrangements are yet to be determined.
- At each meeting of the DBH Advisory Committees there are two designated times to receive public comments. To make public comments at the meetings:
    - Each person wishing to comment on the NE State Application for FY 2014-2015 Federal SAMHSA Uniform Block Grant at the meeting needs to sign up on the Public Comment Sign-in List.

- Each person will be called on from the Public Comment Sign-in List in order of sign-in. **Each person may have 5 minutes** (unless the chair grants more time) to provide comments.
- Public comments not provided verbally at the meeting may be sent to - Attention: Jim Harvey (see address below).

Send written comments by US Mail or e-mail to the Nebraska Department of Health and Human Services, Division of Behavioral Health:

Jim Harvey – Federal Resources Manager
Jim.Harvey@nebraska.gov
Nebraska Department of Health and Human Services
Division of Behavioral Health
301 Centennial Mall South, 3rd Floor
PO Box 95026
Lincoln, NE 68509-5026

Complete draft 2014-2015 SAMHSA Block Grant application posted on line for two weeks:

- On April 15, 2013 – the complete draft of the Nebraska application for the SAMHSA 2014-2015 Uniform Block Grant Application will be posted on DBH website.
- An email notice will be sent to DBH Advisory Committee Members, Regional Behavioral Health Authorities, Office of Consumer Affairs contact list, Behavioral Health Providers, press release and other interested parties.
- Comment period will be open for two weeks. Email comments strongly encouraged.
- On May 1, 2013 – DBH will submit the final and complete application using the designated SAMHSA website.
- Final application will be posted on DBH website after submission is completed.

Comments from Joint Committee Meeting March 14, 2013

State Advisory Committee on Mental Health Services
State Advisory Committee on Substance Abuse Services

This Joint Committee Meeting minutes are posted at:
http://dhhs.ne.gov/behavioral_health/Documents/MHandSA-MtsAndAttach03-14-13.pdf

Much of the meeting time was used to review the six Priority Areas selected for the SAMHSA 2014-2015 Block Grant Application for Planning Steps b. 3 and 4. The six areas are:

#1. Prevention: Alcohol Use Among Youth
#2. Youth: Improved Family Functioning
#3. Co-Occurring Disorders
#4. Trauma-Informed Care
#5. Peer Support
#6. Tuberculosis (TB)

Agenda Item: Adverse Childhood Experience (ACE) presentation
(Priority Area #4. Trauma-Informed Care)

Committee comments included:

- Groups in the education and justice systems need to work together to determine how intrusive measures need to be. Awareness, education, and family support services are necessary.

- The removal of a child from their home often causes additional trauma. Education on ACE may provide additional information to help the child and family.
- Ten or eleven other states opted to participate in the ACE study, so hopefully as more states participate in the future better information can be shared among states and interested groups.
- Surveillance and privacy can be delicate to carry out effectively.

Agenda Item: Youth: Improved Family Functioning
(Priority Area #2. Youth: Improved Family Functioning)

Committee comments included:

- Providers have used a related tool to assist with developing the Individual Family Service Plan (IFSP).
- Evidence-Based Practices are effective.

Agenda Item: Peer Support
(Priority Area #5. Peer Support)

Committee comments included:

- Request that the Office of Consumer Affairs (OCA) consider integrating the Transition to Independence Process (TIP) System, which is a community-based model for improving the outcomes of youth and young adults with Emotional/Behavioral Difficulties (EBD). For more information on the TIP System, please refer to the following website: http://www.tipstars.org/OverviewofTIPModel.asp.
- There is some confusion on the requirements for certification of Peer Specialists at the Veterans Administration, and is what is required for re-certification.
- Is Nebraska utilizing the correct model for peer support? Is there a national consensus on the certification requirements for peer support?

Agenda Item: Projects for Assistance in Transition from Homelessness (PATH)

Committee comments included:

Perhaps DBH will consider providing similar services for individuals diagnosed with Substance Use Disorder, as it is often difficult for these individuals to rent due to their diagnosis.

Agenda Item: Prevention: Alcohol Use Among Youth
(Priority Area #1. Prevention: Alcohol Use Among Youth)

Committee comments included:

- Recommend the Prevention data be correlated with declines in alcohol-related traffic accidents to determine if there is a relationship.
- The decline in drinking and driving data is encouraging, but we can't sit back and rest—the prevention work needs to continue.
- Although the prevention focus is on youth, there is also a concern about the next age group showing an increase; education still needed because this age group may be thinking that prevention no longer applies since I am now of legal age to drink.
- Parents and educators need to open lines of communication with youth to start asking questions and change expectations from previous generations; also promote resilience and learn life skills.
- Consider how the data is reported (in reference to the slide "Binge Drinking among Nebraska Residents compared to US Rates')—did alcohol use increase from age 17 and older, or did it increase from 10 years ago?

Agenda Item: Impact of Affordable Care Act on Behavioral Health Services

Committee comments included:

- Invite a State Senator, perhaps from the Health and Human Services Committee, to attend an Advisory Committee meeting.
- Karen did a good job of laying out this complicated situation, including the Sequester. Appreciate being able to better understand the challenges and opportunities.
- Providers will need to be creative and think outside of the box to determine future services.

Agenda Item: Committee Recommendations

In the last part of the meeting, Committee members were specifically asked a series of questions on these Priority Areas and Ideas for Annual Performance Indicators. The questions were:

Question #1: Is it realistic to expect that these priorities will help move the system in the right direction?

Question #2: Is it realistic to expect we can accomplish these priorities by end of SFY2015?

Question #3: What might be reasonable mid-point goals (June 30, 2014)?

Question #4: What other recommendations do you have?

Committee responses are as follows:

- Question #1: Is it realistic to expect that these priorities will help move the system in the right direction? – Unanimous "Yes".
- Question #2: Is it realistic to expect we can accomplish these priorities by the end of SFY2015? – "Yes", with hard work and partnerships.
- Question #3: What might be reasonable mid-point goals (June 30, 2014)? – Discussion on the definition of capacity for Priority #3 (Co-Occurring Disorders) was held—does it mean volume or ability?
    - If capacity is determined through self-assessment, does that indicate the provider is capable of service delivery?
    - Suggest re-word the Goal to read: Increase Behavioral Health workforce efficiency to deliver effective treatment and recovery services for persons with COD.
    - The Goal and Indicator don't match—the capability of providers to deliver services can't be determined by the score of the Compass EZ.
    - Suggest use capability instead of capacity in the Goal. Suggest the Indicator read 'Providers demonstrate better ability to understand COD' so it indicates the score will not improve but the provider is better in providing services.
    - Suggest capacity be changed to ability or proficiency or capability in the Goal.
    - Suggest change Goal to read 'Increase the BH workforce education to provide trauma-informed care.
- Discussion on Priority #4 (Trauma-Informed Care) was held—the same question about capacity was raised.
    - Suggest the number of providers using the tool will increase instead of the number of people responding to TIC.
    - As the scores increase, it will reflect the ability to provide TIC.
    - The TIC Tool will be used to establish baseline data, and other information from self-assessments, etc. will become the focus for the Block Grant priority.
    - Suggest change capacity to ability in the Goal.
    - Understands the intention of this Indicator is to increase the use of the TIC tool and to utilize the information gathered to increase success.
    - Recognize that development of care includes results of the TIC Tool.

    - Priority #4 is moving DBH from a process outcome to a performance outcome. The appropriate assessment tool is the process to move to performance.
- Discussion on Priority #5 (Peer Support) was held—the same question about capacity was raised.
    - Is capacity the number of providers, or increased knowledge?
    - The priority reflects not only increasing the number of individuals providing Peer Support, but also increasing the use of Peer Support.
    - What is 25% of Plan? Is it 25% of a number or 25% of the plan in place, but we don't know what the plan is? It is 25% of the plan.
    - Suggest add to the Indicator that 25% of the plan include the number of Peer Support allocated to individuals or families.
- Discussion on Priority #1 (Prevention: Alcohol Use Among Youth) was held.
    - Like the focus on the perception of risk.
- Discussion on Priority #2 (Youth: Improved Family Functioning) was held.
    - By June 30, 2015, the family functioning tool will be fully implemented and utilized.
    - This is a good, understandable measure?

Question #4: What other recommendations do you have?

Other Committee recommendations/comments included:

- The Intentional Peer Support model is appropriate and should be used solely for training Peer Support staff.
- Although much of the information is overwhelming, the expertise of presenters is appreciated to help understand.
- Peer Support volunteers have been very beneficial to the Veterans' Administration and recommend this workforce be included in DBH.
- The Block Grant Priorities and Goals are good; understand DBH is doing the best they can with changes they are facing.
- Appreciate the Sequester presentation and explanation.
- Peer Support is and will be a huge part of future DBH services.
- There are three parts of healing—Therapy-Medication-Peer Support—want to see Peer Support valued and promoted.
- Believe in Recovery services because they relate more to the quality of life of an individual.
- It is scary to not know where are going with behavioral health services.
- The community-based providers and DBH must collaborate to look at the funding challenges so providers know who to call with questions and suggestions.
- Appreciate the relationships being built in the Committees and with DBH. These meetings are a safe place to express questions/concerns and to receive information.
- Need to address the gaps and broken parts of the mental health system in Nebraska. Individuals needing care aren't being told what they need to know to access appropriate services, because they have not learned the system, or because clinicians aren't telling them, or because clinicians aren't sharing information about the individual. Where and how do the broken pieces get addressed?
- Agree with the emphasis on the Youth Priority, but suggest that 100% of youth will be assessed be changed to 99% or a range to allow some flexibility in meeting the goal.
- Request a glossary of acronyms used to help understand the discussions.
- Excited to serve on the Committee as a parent and an employee of an agency. As a parent, it can get frustrating because the system affects daily life.

- The ACE study is interesting and provides information we need to do our work. Suggest funding be established to support the Home Visitation program.
- Although some new members may be feeling frustrated about how long it takes to change the DBH system, as a long-term member it is satisfying to see how far the system has come in the past fourteen years starting with mental health reform and the closing of the Regional Centers to move individuals to community-based services. Hopefully, more individuals will receive appropriate services with the implementation of increased Peer Support.
- It is helpful to have open discussions because things get done when people can talk through issues.
- This has been a very informative meeting. Appreciate having the Mental Health and Substance Abuse Committees meet together. Hopefully all of the comments made today will move forward to improve the quality of services for individuals.

Comments Received from On-Line Posting of Draft Application.

On April 4, 2013, the following email was sent to the members of the State Advisory Committee on Mental Health Services and the State Advisory Committee on Substance Abuse Services.

~*~*~*

NE Department of Health and Human Services
Jim.Harvey@nebraska.gov

… and ... thank you for serving on our State Advisory Committees …

~*~*~*

Y. Comment on the State BG Plan | page 8

If you answered "No" to any of the items above, please explain:

No Responses Here

What are possible midpoint goals to have accomplished by June 30, 2014 for each priority?

No Responses Here

Are there any other outcome measures that will help us to know the system is improving?

No Responses Here

What other comments, concerns, recommendations, or suggestions do you have for our consideration (1 comment – see below)?

"eBHIN is currently deploying HIE applications is Regions 5 & ^. The Region 2 system is seeking federal certification, not NeHII certification."