Nebraska

UNIFORM APPLICATION
FY 2016/2017 - STATE BEHAVORIAL HEALTH ASSESSMENT AND PLAN

SUBSTANCE ABUSE PREVENTION AND TREATMENT
and
COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 06/30/2018
(generated on 08/31/2015 11.20.54 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

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

State Information

State Information

Plan Year

Start Year	2016
End Year	2017

State SAPT DUNS Number

Number	808819957
Expiration Date	

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

Agency Name	Nebraska Department of Health and Human Services
Organizational Unit	Division of Behavioral Health
Mailing Address	301 Centennial Mall South, Third Floor, PO Box 95026
City	Lincoln
Zip Code	68509-5026

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

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

State CMHS DUNS Number

Number	808819957
Expiration Date	

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

Agency Name	Nebraska Department of Health and Human Services
Organizational Unit	Division of Behavioral Health
Mailing Address	301 Centennial Mall South, Third Floor, PO Box 95026
City	Lincoln
Zip Code	68509-5026

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

First Name	Sheri
Last Name	Dawson
Agency Name	Nebraska Department of Health and Human Services
Mailing Address	301 Centennial Mall South, Third Floor, PO Box 95026

City	Lincoln
Zip Code	68509-5026
Telephone	402-471-7856
Fax	402-471-7859
Email Address	Sheri.Dawson@nebraska.gov

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

From	
To	

IV. Date Submitted

Submission Date	8/31/2015 11:19:46 PM
Revision Date	

V. Contact Person Responsible for Application Submission

First Name	Karen
Last Name	Harker
Telephone	402-471-7796
Fax	402-471-7859
Email Address	karen.harker@nebraska.gov

Footnotes:

State Information

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

Fiscal Year 2016

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
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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**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPMâ€™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.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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

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

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

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

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

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

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

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

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

Signature of CEO or Designee[1]: _____

Title: Director Division of Behavioral Health

Date Signed: _____

mm/dd/yyyy

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

State Information

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

Fiscal Year 2016

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

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

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

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

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

Signature of CEO or Designee[1]: Sheri Dawson

Title: Director Division of Behavioral Health

Date Signed: 8-19-15

mm/dd/yyyy

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

STATE OF NEBRASKA

Pete Ricketts
Governor

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

August 14, 2015

Ms. Barbara Orlando, M.S.
Grants Management Specialist
Office of Program Services, Division of Grants Managements
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 Courtney N. Phillips, MPA, Chief Executive Officer of the Department of Health and Human Services, to make all required applications, agreements, certifications and reports related to the Community Mental Health Services Block Grant (CFDA 93.958); the Substance Abuse Prevention and Treatment Block Grant (CFDA 93.959); and the PATH Grant (Projects for Assistance in Transition from Homelessness) (CFDA 93.150):

Courtney N. Phillips, MPA
Chief Executive Officer
Nebraska Department of Health and Human Services
P.O. Box 9506
Lincoln, NE 68509-5026

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

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

Thank you for your attention to this matter.

Sincerely,

Pete Ricketts
Governor

Department of Health & Human Services
DHHS
NEBRASKA

State of Nebraska
Pete Ricketts, Governor

August 14, 2015

Ms. Barbara Orlando, M.S.
Grants Management Specialist
Office of Program Services, Division of Grants Managements
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 Sheri Dawson, RN, Director, Division of Behavioral Health of the Department of Health and Human Services, to make all required applications, agreements, certifications and reports related to the Community Mental Health Services Block Grant (CFDA 93.958); the Substance Abuse Prevention and Treatment Block grant (CFDA 93.959); and the PATH Grant (Projects for Assistance in Transition from Homelessness) (CFDA 93.150):

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

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

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

Thank you for your attention to this matter.

Sincerely,

Courtney N. Phillips, MPA
Chief Executive Officer
Department of Health and Human Services

Helping People Live Better Lives
An Equal Opportunity Employer

Footnotes:

State Information

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

Fiscal Year 2016

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

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

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (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.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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

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

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

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

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

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

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

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

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

Signature of CEO or Designee[1]: Sheri Dawson

Title: Director Division of Behavioral Health

Date Signed: 8-19-15

mm/dd/yyyy

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

STATE OF NEBRASKA

Pete Ricketts
Governor

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

August 14, 2015

Ms. Barbara Orlando, M.S.
Grants Management Specialist
Office of Program Services, Division of Grants Managements
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 Courtney N. Phillips, MPA, Chief Executive Officer of the Department of Health and Human Services, to make all required applications, agreements, certifications and reports related to the Community Mental Health Services Block Grant (CFDA 93.958); the Substance Abuse Prevention and Treatment Block Grant (CFDA 93.959); and the PATH Grant (Projects for Assistance in Transition from Homelessness) (CFDA 93.150):

Courtney N. Phillips, MPA
Chief Executive Officer
Nebraska Department of Health and Human Services
P.O. Box 9506
Lincoln, NE 68509-5026

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

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

Thank you for your attention to this matter.

Sincerely,

Pete Ricketts
Governor

Department of Health & Human Services
DHHS
NEBRASKA

State of Nebraska
Pete Ricketts, Governor

August 14, 2015

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

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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,

Courtney N. Phillips, MPA
Chief Executive Officer
Department of Health and Human Services

Helping People Live Better Lives
An Equal Opportunity Employer

State Information

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

Fiscal Year 2016

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
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2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
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16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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

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

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

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

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

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

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

Signature of CEO or Designee[1]: _____

Title: Director Division of Behavioral Health

Date Signed: _____

mm/dd/yyyy

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

Footnotes:

State Information

Disclosure of Lobbying Activities

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

Standard Form LLL (click here)

Name

Title

Organization

Signature: _____ Date: _____

Footnotes:

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, as well as American Indian/Alaskan Native populations in the states.

Footnotes:

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

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 Single State Substance Abuse Authority (SSA). It is important to note that the authority does not extend to DMLTC policy decisions. The DBH administers, oversees, and coordinates the state's public behavioral health system to address the prevention and treatment of mental health and substance use disorders. The primary goal is to develop a behavioral health system that is co-occurring capable, trauma-informed, recovery-oriented, and person-centered. The DBH is responsible for managing both the Community Mental Health Services Block Grant (CMHSBG) and the Substance Abuse Prevention and Treatment Block Grant (SAPTBG). DBH is excited about the opportunity for system transformation in the next few years. New leadership at the DHHS CEO level expects a collaborative system of care approach in behavioral health.

Strategic Planning

The tasks of incorporating consumer voice, reviewing prior planning documents, and suggesting key areas of focus were given to a joint strategic planning workgroup made up of representatives from both Advisory Committees guiding the DBH (Mental Health and Substance Abuse), the

Regional Behavioral Health Authorities, and the DBH administration. The work of this group was augmented by consultation with national experts in behavioral health, as well as opportunities for public review and comment. The process was facilitated by the University of Nebraska Public Policy Center.

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

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

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

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

2011-2015 Goals:

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

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

»» The first relates to the role of the Division of Behavioral Health as a *leader* in the public behavioral health system.
»» The second proposes key *partnerships* the Division of Behavioral Health should focus on as part of the strategy.
»» The third proposes suggests *joint initiatives*.

DBH continues to use the 2011-2015 Behavioral Health Strategic Plan as a guide. The process for establishing the next overall strategic plan for DBH is underway; a "bridger" plan is in place for use after December 2015 until the newly appointed Director of DBH engages system partners, a consultant, and consumers in updating the strategic plan.

The DBH Strategic Plan includes an overall behavioral healthcare system focus by integrating a Substance Abuse Prevention Statewide Strategic Plan into the document. http://dhhs.ne.gov/behavioral_health/Pages/2010BHStrategicPlan.aspx and http://dhhs.ne.gov/behavioral_health/Documents/DBH-PreventionStrategicPlan2013-17.pdf

The Co-Occurring Disorders Services Delivery Quality Initiative Workgroup crafted a roadmap which is guiding the transformation of the current system of care. Nebraska has moved the roadmap forward by offering providers and system partners the opportunity to participate in multiple webinars and onsite trainings conducted over FY14 and FY15 with national consultants having expertise in Co-Occurring Disorders. These training opportunities provided technical assistance related to creating a welcoming environment and how to improve integrated treatment by refining organizational procedures and policies. Providers were also required in FY15 to complete a second round of assessments using the COMPASS EZ to describe their capability for meeting co-occurring needs. More on the COMPASS EZ is available in Planning Step 2 of this Block Grant application.

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

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

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

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

- Psychiatric Services: These are services for people with severe and persistent mental illness who have been committed by a mental health board due to mental illness and dangerous behaviors and cannot be served at a community-based hospital facility. The primary mission of the programs is to help individuals stabilize and return to live in the community. Interdisciplinary treatment teams develop individualized treatment plans based upon assessments completed at the time of admission. Discharge planning is part of the treatment plan, and starts when an individual is admitted.
- Forensic Services: Psychiatric Services provide evaluation, assessments, and treatment for individuals as ordered by the Nebraska legal system. The Forensic Program serves individuals who need competency evaluation, competency restoration, and who are found Not Responsible by Reason of Insanity. The program offers a structured treatment approach which is tailored to the specific needs of the individual patient.
- Sex Offender Service: This service provides treatment for individuals with a history of sexually harmful behavior. The population includes convicted sex offenders who have been committed under an inpatient mental health board order for sex offender treatment. Additionally, a residential level transition program works to release the patients with the necessary structure to allow them the opportunity to successfully return to the community.
- Whitehall Campus: This service is a Psychiatric Residential Treatment Facility (PRTF) that addresses the treatment needs of male adolescents who have sexually harmed. Each youth has his own room. The program is family-centered and has its own school on the campus. Youth who complete treatment at Whitehall have a low incidence of reoffending sexually based on an independent study that followed the youth over seven years from completion of treatment.

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

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

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 DBH is organized into three teams – Network 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 directly contracts with entities for recovery and support services. Some examples include:

- Trilogy Integrated Services to provide a web portal for consumers to access: a comprehensive directory of behavioral health resources in their area, a databank of articles, factsheets and reports about behavioral health conditions, recovery and treatment, and recovery tools for their personal use;
- Father Flanagan's Boystown to operate the Nebraska Family Helpline (888-866-8660) where families can obtain assistance and provide a single contact point 24 hours a day, seven days a week; to connect callers with family organizations to advocate for families with youth experiencing mental/emotional disorders, support the family voice and offer supportive services such as education, support groups, advocacy and mentoring; and,
- Four federally recognized Native American Tribes in the state for the provision of culturally specific mental health and substance use disorder treatment services as well as relapse prevention activities.

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 for 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 service planning and an integral part of decisions at all levels.

The OCA People's Council is designated to advise the Office of Consumer Affairs around consumer involvement in all aspects of service planning and delivery. The members are appointed by the NDHHS Director of the DBH. In the next year DBH looks to strengthen and formalize the reporting relationship to the Planning Councils.

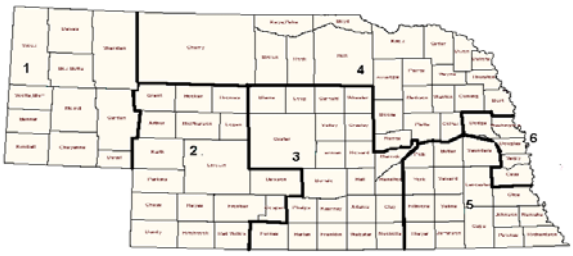
For more information about the Office of Consumer Affairs, see the NDHHS Division of Behavioral Health web site at: http://dhhs.ne.gov/behavioral_health/Pages/beh_mh_mhadvo.aspx

DBH is strengthening its commitment to peer support by partnering with the University of Nebraska-Lincoln Public Policy Center in developing the *Office of Facilitation of Recovery* at the Lincoln Regional Center (LRC). An administrator with lived experience will lead the office and be solely assigned to the state hospital. The DBH Community-Based Section is also strengthening the peer support commitment by reorganizing staff to lead peer support and other recovery initiatives.

DBH has a new initiative underway – the Peer Bridger Program at LRC, the state hospital. LRC will develop and implement a "Peer Bridger Pilot Program" that will provide peer support to LRC general psychiatric patients as they transition to the community. The Peer Bridger Pilot Program will develop relationships with patients during their stay at the hospital and continue to provide peer support after discharge.

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.



By state statute, 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 NDHHS. Each RBHA is governed by a Regional Governing Board consisting of one county

board member (locally elected official) from each county in the Region. The administrator of the RBHA is appointed by the Regional Governing Board.

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

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

Each RBHA is under contract 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 (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 (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 financial audits, monitor all funding for compliance with state and federal requirements, compliance with the DBH policy regarding financial eligibility, ensure the DBH funding is used as payment of last resort, monitor all contracts for the purchase of services and related duties.

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

The DBH Title 206 regulations requires nationally recognized accreditation in order to receive funds administered by the DBH for service delivery. A copy of the Title 206 regulations can be found here: http://dhhs.ne.gov/Pages/reg_t206.aspx

Independent Peer Review

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

Prevention System Organization

The DBH is charged with the development of prevention, treatment and recovery services for the State of Nebraska. The focus of DBH's Prevention System is to develop a sustainable and effective prevention system that is committed to the reduction of substance abuse and its related consequences. This is accomplished by promoting safe and healthy environments that foster youth, family, and community development through the implementation of early intervention and substance abuse prevention best practices.

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

Nebraska's Five-Year Strategic Prevention Plan (2011-2015) supports the DBH's overarching strategic goals and will focus statewide prevention efforts on a prioritized set of behaviors – this selection was data driven, and results of activities can be measured over time to demonstrate the success of state initiatives. These priorities are aligned with those of the Substance Abuse Prevention and Treatment Block Grant. This plan guides prevention prioritization, decision-making, and policy development at the State, Region and community level. In cooperation and partnership with Regional Prevention System Coordinators, training events are funded

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

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

The PAC objectives are as follows:

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

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

Youth and Adult Services

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

List of Funded Services

Service	Mental Health	Substance Abuse
Emergency Services & Inpatient 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	
Hospital Diversion	x	
Acute Inpatient Hospitalization	x	x
Subacute Inpatient Hospitalization	x	x
Respite	x	x
Social Detox		x
Residential Based Services:		
Dual Disorder Residential	x	x
Halfway House		x
Intermediate Residential-Substance Abuse		x
Psychiatric Residential Rehabilitation	x	
Secure Residential	x	
Short Term Residential		x
Therapeutic Community		x
Outpatient Services:		
Assertive Community Treatment/Alternative Act	x	
Assessments / Evaluations	x	x
Community Support	x	x
Day Rehabilitation	x	
Day Support	x	
Day Treatment	x	

Service	Mental Health	Substance Abuse
Housing Related Assistance	x	x
Intensive Case Management/Community Services	x	x
Intensive Outpatient		x
Medication Management	x	
Methadone Maintenance		x
Outpatient Psychotherapy (Individual/Family/Group)	x	x
Recovery Support	x	x
Supported Employment	x	
Children/Youth Services:		
Therapeutic Community		x
Wraparound	x	
Assessment/Evaluation	x	x
Intensive Outpatient	x	x
Outpatient Psychotherapy (Individual/Family/Group)	x	x
Medication Management	x	
Therapeutic Consultation	x	
Crisis Inpatient	x	
Home Based Multi-Systemic Therapy	x	
Supported Employment	x	x
Crisis Response Team	x	

Public Behavioral Health System Organization: NDHHS Division Partners

Other Division partners within the NDHHS agency include the following:

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 continues to work with the DBH to standardize service delivery expectations (service definitions) to ensure that Medicaid and non-Medicaid individuals are receiving similar services. 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.

In September 2013, the DMLTC moved to an at risk environment for behavioral health treatment and rehabilitative services and is in contract with Magellan Behavioral Health. Continued

cooperation between the DBH, the DMLTC, and the vendor is a key area of interest and coordination efforts.

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

In summer of 2015, DBH and DMLTC entered into a Memorandum of Understanding to facilitate the sharing of data related to eligibility, expenditures and utilization for Medicaid eligible individuals to facilitate DBH's duties as the chief behavioral health authority for the State of Nebraska and directing the administration and coordination of the public behavioral health system.

The Division of Public Health

This Division of Public Health (DPH) is responsible for preventive and community health programs and services. It is also responsible for the regulation and licensure of health-related professions and occupations, as well as the regulation and licensure of health care facilities and services. DPH and DBH work collaboratively on mental health and substance use provider agency issues which may impact both quality of care and consumer accessibility in order to promote positive outcomes for consumers and public safety.

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

Division of Children and Family Services

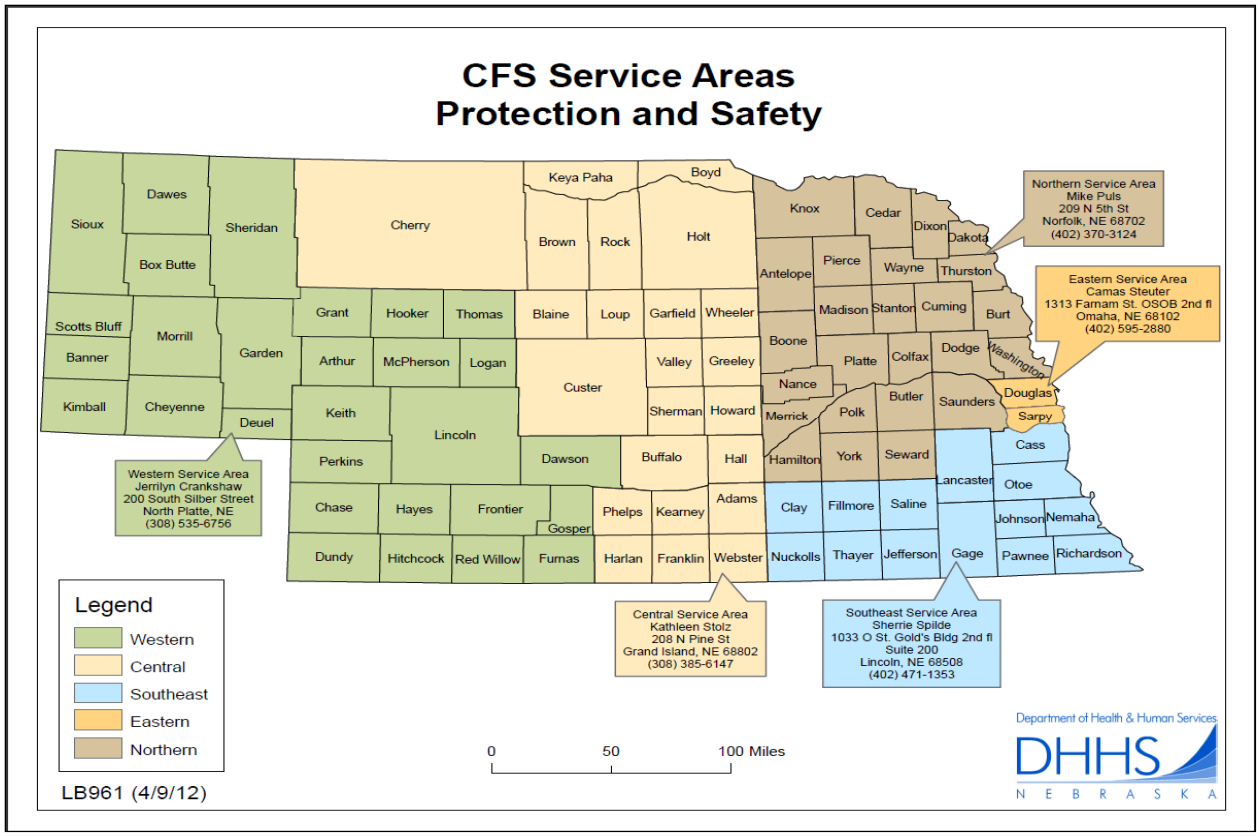
The Division of Children and Family Services (DCFS) is comprised of three sections— the Office of Juvenile Services, Economic Assistance and Protection and Safety. The Director's leadership team includes Deputy Directors for each section; a Fiscal Administrator; a Research, Planning and Evaluation Administrator; and a Legislative Coordination / Project Development Administrator. This organizational structure allows DCFS to focus attention on and support the priorities identified by the division.

The DCFS Office of Juvenile Services (OJS) oversees the operation of two Youth Rehabilitation and Treatment Centers (YRTC). The YRTCs serve youth between 12 and 18 years that have been adjudicated as a juvenile offender and committed to the Office of Juvenile Services. The DCFS Economic Assistance Unit is responsible for the administration of the Supplemental

Nutrition Assistance Program (SNAP), Aid to Dependent Children, refugee resettlement, energy assistance, child care subsidies and child support enforcement.

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

Case management functions are state-administered in the Western Service Area (WSA), Central Service Area (CSA), Northern Service Area (NSA) and Southeast Service Area (SESA). DCFS contracts for case management and service coordination in the largest service area, the Eastern Service Area (ESA), with the Nebraska Families Collaborative (NFC) http://www.nebraskafc.org/. The structure of the Service Areas are aligned with the Judicial Districts as set forth by the Supreme Court to allow for greater coordination of service delivery between DCFS and the Judicial Branch. A map of the DCFS Service Areas is below:



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

The Division of Developmental Disabilities

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

The DDD is involved in an array of planning and implementation activities to ensure that quality developmental services are provided at the Beatrice State Developmental Center (ICF-ID) Bridges and in community based services throughout Nebraska. The Division of Behavioral Health and the Division of Developmental disabilities work collaboratively to provide services for individuals who have been diagnosed with both and intellectual disability and a behavioral health disorder.

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

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

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

Nebraska Department of Correctional Services

Pursuant to Legislation, Nebraska Department of Correctional Services has formed a workgroup focused on re-entry into the community for inmates completing their sentences. The DBH has been asked to participate to ensure timely access to mental health and substance use disorders for inmates leaving corrections facilities.

In addition, prison social workers continue to work directly with Region Transition Coordinators directly to ensure access to services following their release.

Addressing the Needs of a Diverse Population

The DBH is dedicated to providing excellent behavioral health services that are accessible to all members of the community, including racial/ethnic minorities, Native Americans, refugees, and newly-arrived immigrant groups. The DBH functions in accordance with the NDHHS Office of Health Disparities & Health Equity (OHDHE), striving for appropriate cultural and linguistic specificity for all recipients of behavioral health services. All RBHAs and their contractors are required to provide services that are culturally and linguistically appropriate. The DBH also contracts directly with the four federally recognized tribes of Nebraska (Ponca, Winnebago,

Omaha and Santee Sioux) for behavioral health services and provides staff assistance to the tribes as needed, and works to promote cultural awareness and diversity in the workforce through leadership, training, and direct funding of continuing education classes for providers. Each RBHA is also expected to address the needs of the diverse populations within their designated geographic area based on a comprehensive needs assessment/strategic plan. Each RBHA has an advisory committee consisting of consumers, providers, and other interested parties.

Although Nebraska is often viewed as having a homogenous population, it is becoming increasingly diverse with African American, Hispanic, Native Americans, and immigrants from the continents of Africa and Asia. This being said, the consumer population remains nearly universal when it comes to language preference. In fiscal year 2014, 98% of individuals receiving Behavioral Health services funded through the DBH indicated English as their preferred language.

Nebraska 2013 Estimates for Race Populations

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

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

Division of Behavioral Health Community Based Services Consumer Race Categories

	TOTAL	
Race of Persons Served	Number	Percent of Total
Asian	241	0.8%
Native Hawaiian/Other Pacific Islander	308	1.0%
Native American/Alaska Native	1,213	3.8%
Black/African American	2,816	8.8%
White	26,803	83.8%
Multiracial	302	0.9%
Unknown	311	1.0%
Total	31,994	100.0%

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

the total numbers of persons by race present in the State of Nebraska. The current data system does not capture LGBTQ information. The DBH continues to work toward a new centralized data system and is reviewing policy on the collection of data pertaining to gender affiliation.

System Strengths Summary

While many strengths exist across the state, some of the greatest strengths the DBH has to leverage for continuous improvement include behavioral health consumer involvement at numerous if not all levels of decision making, a wide variety of behavioral health services in state hospitals and community settings, a workforce dedicated to meeting consumers' complex needs, and engaged system partners who play a vital role in supporting an effective behavioral health system. Development of a new centralized data system will continue to enhance opportunities to review data trends and assess changing service needs. Continued training for providers will further develop and maintain a system that is co-occurring capable, trauma-informed, recovery-oriented, and person-centered. As previously mentioned, it is expected that collaboration will only improve under the new leadership at the DHHS CEO position and across DHHS Divisions and partnering state agencies.

Planning Steps

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

Narrative Question:

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

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, the annual State and National Behavioral Health Barometers, and the Uniform Reporting System (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance abuse prevention, 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 report presents 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) and other relevant data sets. 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 National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the Behavioral Health Barometers. 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.

Through the Healthy People Initiative[18] HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

[18] http://www.healthypeople.gov/2020/default.aspx

Footnotes:

Identifying Unmet Needs and Critical Gaps within Current System

Nebraska understands how important a data driven approach is to understand the dynamic needs of our state as well as to make informed decisions about the services funded for individuals dependent upon the Division of Behavioral Health (DBH) for treatment and recovery. Nebraska has evaluated data from a variety of internal sources on treatment data collected in addition to external resources that have historically been used to monitor and inform decision making such as the National Survey on Drug Use and Health (NSDUH), the Treatment Episode Data Set (TEDS), and the Uniform Reporting System (URS). The 2014 Behavioral Health Barometer report for Nebraska was also used to identify specific areas of need related to alcohol use with emphasis among youth and young adults. Data from this report also presented gaps in treatment need for both mental health and substance use disorders when reviewing the rates of those receiving behavioral health services.

Through review of the aforementioned data sources and reports, the DBH put together an initial needs assessment which was reviewed in January 2015 with both of the state Advisory Committees. This meeting was followed by a posting of the draft Block Grant Application sections which again covered identification of service system gaps and consumer needs. A second meeting with both committees was held in August of 2015. The draft application was also posted on the DBH website for public review and comment. Each of these provided opportunity for feedback and suggestions on which areas of need should be prioritized for FY16/FY17.

Note on Community Behavioral Health Data

The DBH does not own a data or billing system though both are currently under development and are expected to offer a variety of evaluation and process improvements. Until development of a centralized data system is complete, Magellan Behavioral Health, as Administrative Service Organization (ASO) contractor, provides the data 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 is 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.
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

In Fiscal Year 2014 (FY14), the DBH funded community-based services for 31,994 individuals. When considering service breakdown, 13,518 received treatment for substance use disorders and, including state hospital services, there were 22,579 individuals who received treatment for mental health disorders. There were 13,777 adults served with SMI and 1,674 youth with SED.

Data sources: Magellan FY14 Treatment Data MH: FY2014 URS table 2A, 14A;SA: FY2014 SABG Behavioral Health Report Table 11

Adults with Serious Mental Illness (SMI)

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

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

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

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

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

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

SMI means that:

- The person is 18 years old or older AND
- 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].

Youth with Serious Emotional Disturbance (SED)

The DBH through the six Regional Behavioral Health Authorities serves Youth with SED. SED means that:

- The person is 17 years old or younger **AND**
- The person has an Axis I or Axis II diagnosis of conditions 295.0 to 298.9 (as referenced with SMI), 300.30, 300.01, 300.21, 301.13, 307.1, 307.23, 307.51, 309.81, 312.34, 314.00, 314.01, 314.9 [Cyclothymic Disorder, Obsessive-Compulsive Disorder, Panic Disorder with or without Agoraphobia, Anorexia Nervosa, Bulimia Nervosa, Post Traumatic Stress Disorder, Tourette's Disorder, Intermittent Explosive Disorder, Attention Deficit/Hyperactivity Disorders] **AND**
- SSI/SSDI eligible **OR**
- The persons has been admitted to Professional Partner Services, Special Education Services, Day Treatment Mental Health Services, Intensive Outpatient Mental Health Services, Therapeutic Consultation/School Wrap, Respite Care Mental Health Services

The data tables below are from the Nebraska FY2014 Uniform Reporting System (URS).

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

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

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

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

Capacity Management and Waiting List System for Priority Populations

The DBH 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) establishes these reporting requirements.

Priority populations are determined by federal and state statutes and/or regulations. Persons in this population require priority admission into treatment services. Contracted providers receiving Substance Abuse Block Grant Funds must offer priority populations immediate admission into the appropriate recommended treatment or offer priority placement on the waiting list and interim services within 48 hours of the request for treatment. Interim services must be provided until they are admitted into appropriate recommended treatment. There are four priority populations:

- Priority Population 1 - Pregnant and current intravenous drug using women

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

During fiscal year 2014:

- There were 590 priority persons waiting for services in FY2014.
- The majority of identified priority persons waiting for substance abuse services were women with dependent children (39%, n=229).
- Most people identified as priority persons waiting for substance abuse services were waiting for admission into Short-Term Residential services (63%, n=347).

Priority Population 1 - Pregnant and Current Intravenous Drug Using Women

The DBH through the six RBHAs 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.

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
FY2013	0	41
FY2014	0	39

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

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

FY2014 Average Wait Days for Pregnant Injecting (IV) Drug Users

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

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

Priority Population 2 - Pregnant Substance Abusing Women

The DBH through the six RBHAs serves Youth and Adults who are Pregnant Substance Abusing Women. Generally, less than one percent of the persons served are Pregnant Substance Abusing Women.

Pregnant Substance Abusers - Number of Persons Served

	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%
FY2013	0	226	0	27	0	253	253	0.8%
FY2014	1	173	0	15	1	188	189	0.6%

Total Youth & Adult All Services who are Pregnant Substance Abusers

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

FY2014 Average Wait Days for Pregnant Substance Abusers

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

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

Priority Population 3 - Persons who are Intravenous Drug Users

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

Injecting Drug Users – Number of Persons Served

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

Total Youth & Adult All Services who are Injecting Drug Users

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

FY2014 Average Wait Days for IV Drug Users

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

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

Priority Population 4 - Women with Dependent Children

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

FY2014 Average Wait Days for Women with Dependent Children

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

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 an urban areas and urban clusters as "densely developed territory, [which] encompass residential, commercial, and other non-residential urban land uses (2010 Census Urban and Rural Classification and Urban Area Criteria). Urban areas have populations of 50,000 or more people; urban clusters have populations of at least 2,500 but less than 50,000 people. All areas that are not urban are considered rural.
Source: https://www.census.gov/geo/reference/ua/urban-rural-2010.html

The following are the Metropolitan Statistical Areas in Nebraska:

Lincoln, NE Area

- Lancaster County, NE
- Seward County, NE

Omaha-Council Bluffs, NE-IA Area

- Cass County, NE

- Douglas County, NE
- Sarpy County, NE
- Saunders County, NE
- Washington County, NE

Sioux City, IA-NE-SD Area

- Dakota County, NE
- Dixon County, NE

Source: U.S. Census Bureau, Population Division

In 2013, the U.S. Census estimated that Nebraska's total population was 1,868,516, with approximately 40% (n≈754,460) of persons living in rural counties. Data from persons served indicates that between 40-44% of the persons served each year live in rural areas.

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

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

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

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

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

State Epidemiological Outcomes Workgroup (SEOW)

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

One of the main functions of the SEOW is data review. The SEOW works collectively to identify the availability of data, utilization of data and prioritization of substance abuse data gaps, including missing or incomplete data. In December of 2007, the *Substance Abuse and Associated Consequences in Nebraska –An Epidemiological Profile* was published. 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 leads the workgroup in its efforts to identify priority substance use disorder issues and problems associated with related mental health disorders to maximize use of resources at the state and community level. In many areas, the state has a wealth of data available from which the SEOW will be able to draw assessment information. For example, the Nebraska Young Adult Alcohol Opinion Survey, the Nebraska Risk and Protective Factor 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 minimal. Often, data drives decisions about resources; absence of data impacts the attention directed toward major public health issues. Therefore, ensuring sustainability and ongoing operation of a SEOW is vital to coordinate a public health surveillance system that is capable of providing a comprehensive, focused assessment and analysis.

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

Priority Areas for FY2016/2017

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

- Prevention of underage and binge drinking among youth and young adults

- Persons with co-occurring mental health and substance use disorders
- Persons with a history of trauma
- Persons experiencing first-episode psychosis
- Persons with tuberculosis.

Data in support of each of these areas is provided below.

Alcohol Use among Youth and Young Adults

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

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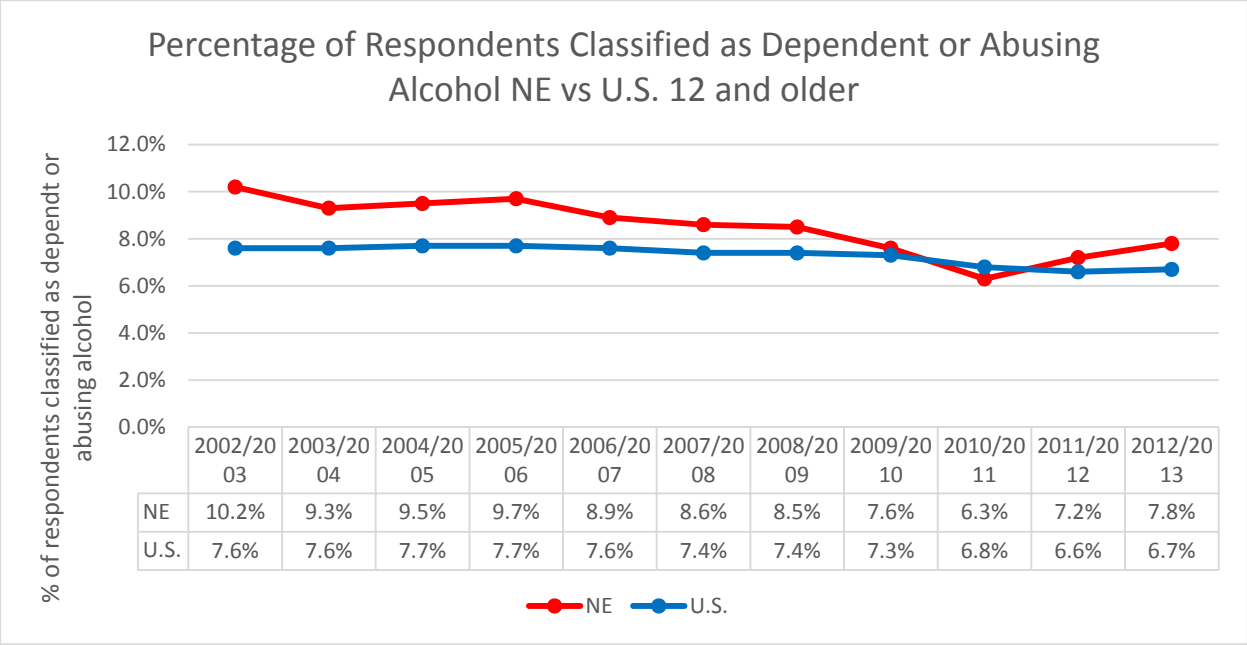
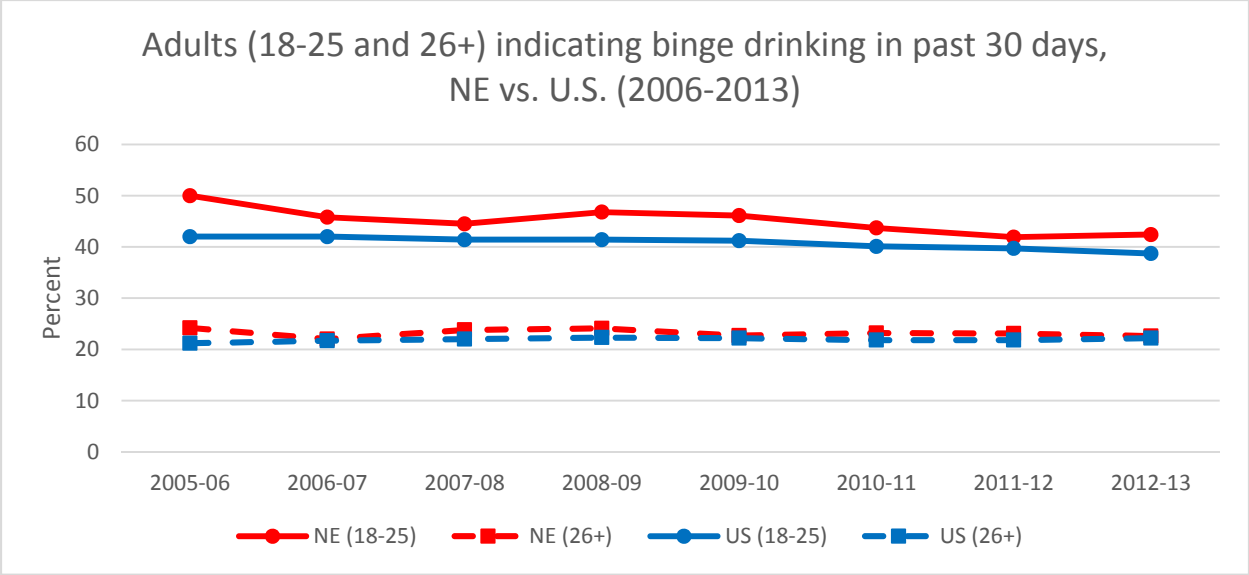


	2002/2003	2003/2004	2004/2005	2005/2006	2006/2007	2007/2008	2008/2009	2009/2010	2010/2011	2011/2012	2012/2013
NE	10.2%	9.3%	9.5%	9.7%	8.9%	8.6%	8.5%	7.6%	6.3%	7.2%	7.8%
U.S.	7.6%	7.6%	7.7%	7.7%	7.6%	7.4%	7.4%	7.3%	6.8%	6.6%	6.7%



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." 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 if the person exhibits disorders of different types that are diagnosable as being exclusive of one another and are not symptoms caused by a single condition or disorder.

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.

As identified in the DBH's co-occurring road map, the DBH has determined that all agencies should be better able to meet the complexities of behavioral health consumers.

The number of individuals served in both a mental health and substance abuse or dual service has risen to nearly 11%. It is quite likely this percentage underestimates actual co-occurring treatment needs. The National Alliance on Mental Illness (NAMI) reports that approximately 50% of individuals with severe mental disorders are affected by substance abuse while 37% of alcohol abusers and 53% of drug abusers also have at least one serious mental illness (NAMI, 2012).

Number of person served who received services for both
Substance Abuse and Mental Health Disorders

	Dual ONLY		COMBO		Co-Occurring		
	Youth	Adult	Youth	Adult	Total # Receiving BH Services	# Receiving Dual Services or Combination of MH and SUD Services	%
FY2012	1	72	27	3360	34,938	3,460	9.9%
FY2013	3	88	30	3303	31,974	3,424	10.7%
FY2014	1	61	38	3311	31,994	3,411	10.7%

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

FY2014 mental health data shows that Nebraska has a higher percentage of adults served who have identified co-occurring disorders than the nation (29% Nebraska vs. 22% U.S.).

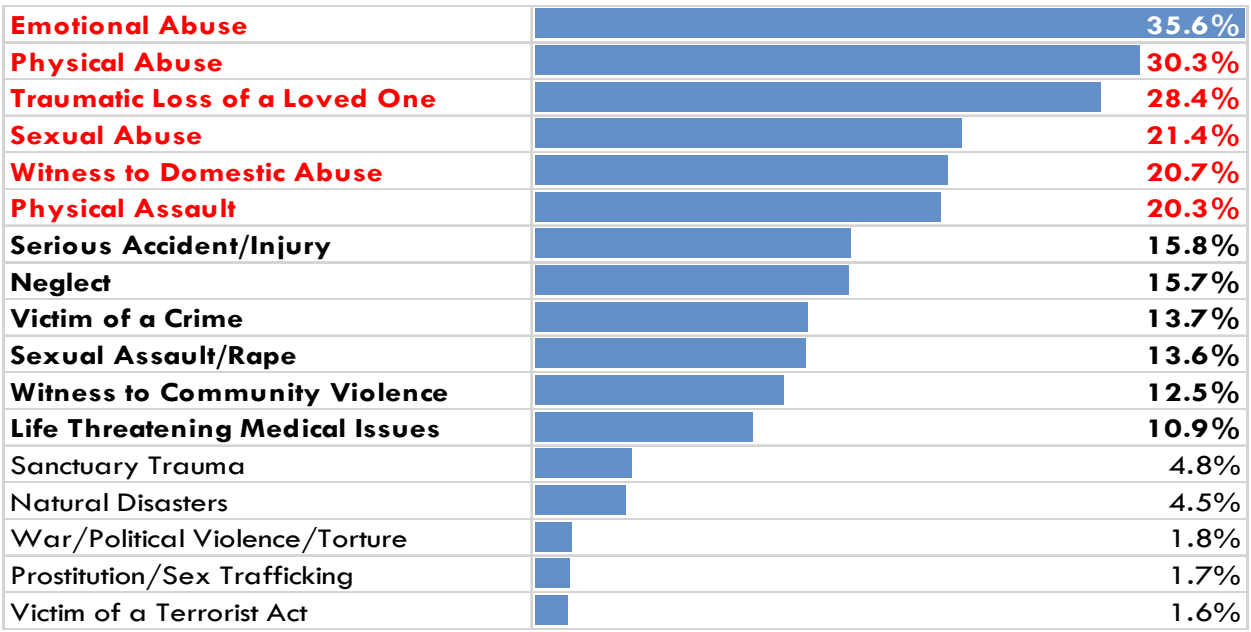
	NE		U.S.	
	FY2013	FY2014	FY2013	FY2014
Adults with Co-Occurring MH/SA Disorders	28.9%	29.3%	21.2%	21.6%
Children with Co-Occurring MH/SA Disorders	5.5%	5.3%	5.1%	4.4%

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

The COMPASS EZ tool has been selected to help equip providers with the knowledge necessary to address the complexities of co-occurring disorders. In FY2013 an initial assessment using the COMPASS EZ was completed by each provider agency under contract with the RBHAs. A second assessment took place in FY2015 and review of the data is underway to determine areas for improvement. The COMPASS EZ measures 15 areas of readiness and performance including an understanding of the agency and staff readiness to become either a dual enhanced or dual capable provider which may result in increased reimbursements to agencies, especially those persons who are Medicaid eligible.

Trauma Informed Services

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



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

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

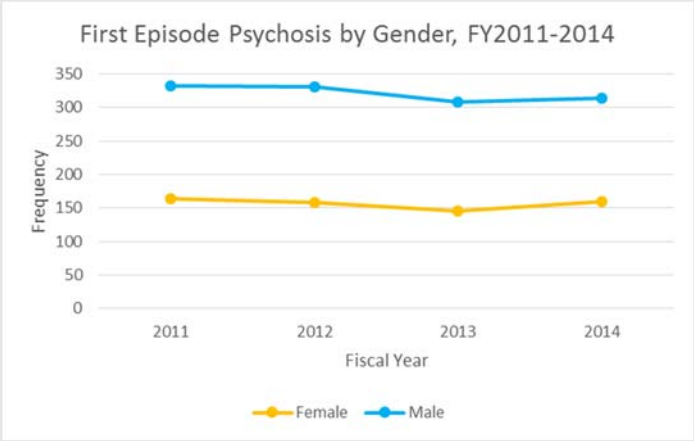
First Episode Psychosis

Psychosis is treatable and recovery, particularly from related problematic symptoms is possible. Research suggests early intervention can improve treatment outcomes. Psychosis in the early stages may not be detected right away. Although the majority of services funded through the DBH are for adults, many youth and young adults benefit from the DBH substance use and mental health service array.

Review of recent treatment data shows a fairly consistent group of both males and females between the ages of 12 to 26 who have a psychotic diagnosis. In FY2014 there were 473 meeting this criteria, 159 were female and 314 were male.

First Episode Psychosis by Gender, FY2011-2014

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



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

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

The DBH First Episode Psychosis Program criteria are:

- Person is 15 to 25 years old
- Person has a diagnosis of Schizophrenia/Schizophreniform and Schizoaffective Disorder, Delusional Disorder, Brief Psychotic Disorder, or Psychotic Disorder Not Otherwise Specified
- Antipsychotic medication was taken for a cumulative period of no longer than 12 months regardless of the duration of the first episode

- Person has not been diagnosed with Intellectual Disability, Psychotic Disorder Due to a General Medical Condition, Substance-Induced Psychotic Disorder (Substance Use Disorder as a secondary diagnosis is not excluded.), Depressive and Bipolar Disorders

Next Steps in Addressing Unmet Service Needs

The DBH works with RBHAs to address unmet needs in a variety of ways. It should be noted that unmet needs may be based on lack of training for providers, lack of funding within the system, or lack of providers in the system with certain expertise.

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

The DBH asks Regions to conduct needs assessments to better designate Regional allocated funding for areas where the unmet need exists, shifting funding away from areas where needs are adequately met by Medicaid or where funding was unexpended within their contract. The DBH is currently contracting for consultation in maximizing the use of behavioral health dollars, with consideration going to allocation of funding and other strategies to use dollars efficiently.

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

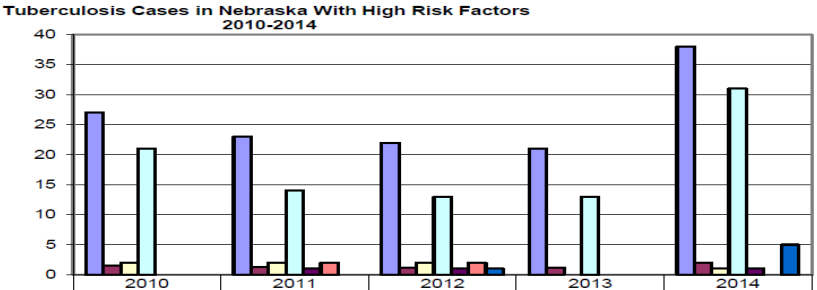
Within the Prevention system, the DBH continues to work with Regions to support community coalitions in using funding for areas of need for Substance Abuse prevention. Using data from a variety of surveys regarding alcohol and drug use, communities are able to evaluate the effectiveness of current prevention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

Additional Considerations

Requirements Regarding Tuberculosis

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

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



	2010	2011	2012	2013	2014
Reported cases	27	23	22	21	38
Statewide Rate/100,000	1.5	1.3	1.2	1.2	2
Homeless	2	2	2	0	1
Foreign Born	21	14	13	13	31
Related to institutions	0	1	1	0	1
HIV +	0	2	2	0	0
Resistant to => 1 drug	0	0	1	0	5

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

The DBH has no specific financial set aside for TB services. The Division of Public Health supports TB testing, education and treatment. The DBH contract with the six RBHAs requires 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
FY2016 Region Budget Plan Guidelines

Services for HIV/AIDS

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

Summary of System Needs and Priorities

Through a comprehensive review of data sources and reports, followed by discussion and review with advisory groups, the DBH has identified four priority areas to add to the priority area which addresses Tuberculosis. Each identified priority area has been determined as necessary to best address priority and target population needs. Concentration on identified priority areas throughout FY16/FY17 is expected to bring about overall behavioral health system improvements to support the treatment and recovery needs of consumers while working to prevent harmful substance use behaviors. The DBH has selected the following 5 priority areas for FY16/FY17:

1. Prevention: Alcohol Use Among Youth and Young Adults to address underage drinking by high school students and binge drinking by young adults.
2. Co-Occurring Disorders Services (COD) to better meet the complexity of consumer needs through continued improvement of treatment and recovery services.

3. Trauma-Informed Care to increase the percentage of programs which are trauma informed to meet the needs of consumers with a history of trauma.
4. First Episode Psychosis to improve functioning for youth and young adults who have experienced a first episode of psychosis.
5. Tuberculosis (TB) in order to screen for individuals who are at high risk for TB.

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

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

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

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

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

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

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

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

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

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

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

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

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

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

B. Planning Steps

1. Quality and Data Collection Readiness

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

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

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

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

Current data system structure and the system under development allows for collection of treatment data from contracted behavioral health providers and offers reporting capability at the client, program, provider, regional, and state levels. Data is only available for individuals not eligible for or funded through Medicaid, private insurance or other payer sources. The system(s) are focused on TEDS type basis of reporting.

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

Data collection and reporting is limited to data for substance use disorder and mental health treatment services but does not include treatment data for those funded through Medicaid, private insurance, self pay, child welfare systems or other state or federally funded sources such as Veterans or Medicare. Prevention data collection is primarily at a population and/or strategy level and does not capture the draft measures proposed.

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

None of the proposed measures are currently collected at the individual level for both treatment and prevention. A limited number are available from individuals in treatment; however, we are

uncertain if the question and response wording is an exact match which could require significant work to change across our treatment provider network. We also do not have a claims system that can track proposed measures through this type of system. Most existing systems do not capture primary health measures such as A1c or blood pressure screening, nor are many treatments centers licensed to do such care.

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

See above. In addition, there are significant challenges in collecting data from Medicaid and Commercial Adult populations within our state system. There would also be **significant costs** to add the measures not currently collected. There are significant barriers for any type of post discharge data collection due to having to "track" down clients, potential confidentiality barriers as well as increased staffing needs to perform these functions. Providers are already burdened by data collection and varying requirements for data reporting and billing, and this will only add to the burden unnecessarily and likely negatively impact overall data integrity.

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

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Prevention: Alcohol use Among Youth and Young Adults

Priority Type: SAP

Population(s): Other (Adolescents w/SA and/or MH, LGBTQ, Rural, Criminal/Juvenile Justice, Children/Youth at Risk for BH Disorder, Homeless, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities, Under age youth who drink alcohol)

Goal of the priority area:

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

Objective:

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

Strategies to attain the objective:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Reduce the prevalence of underage drinking by high school students.

Baseline Measurement: Percentage of students in 9th-12th grade who reported drinking in the past month was 26.6% in 2011.

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

Second-year target/outcome measurement: Reduce underage drinking by high school studens to less than 25% by June 30, 2017.

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures::

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

Indicator #: 2

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

Baseline Measurement:	Percentage of young adults who reported having more than five drink for males and more than four drinks for females on one occassion was 47.1 % in 2012.
First-year target/outcome measurement:	N/A because the survey is conducted every 2 years (see below)
Second-year target/outcome measurement:	Reduce the prevalence of binge drinking by young adults to less than 43% by June 30, 2017.

Data Source:

Nebraska Youth Adult Alcohol Opinion Survey (NYAAOS)

Description of Data:

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

Data issues/caveats that affect outcome measures::

The survey is conduct every other year and is scheduled for 2017.

Priority #:	2
Priority Area:	Co-Occurring Disorders
Priority Type:	SAT, MHS
Population(s):	SMI, SED, PWWDC, IVDUs, HIV EIS, TB

Goal of the priority area:

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

Objective:

Increase or maintain statewide average score on COMPASS-EZ.

Strategies to attain the objective:

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

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Providers demonstrate better ability to understand persons with Co-Occurring Disorders (COD) in order to improve the treatment and recovery services.
Baseline Measurement:	Statewide scores on COMPASS-EZ as collected in 2013 resulted in a domain average total score of 57.3 across 15 distinct domains. The overall average item score was 3.8 out of 5.
First-year target/outcome measurement:	N/A
Second-year target/outcome measurement:	Statewide total score will maintain or increase according to the baseline.

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures::

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

Priority #: 3

Priority Area: Trauma-Informed Care

Priority Type: SAT, MHS

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

Goal of the priority area:

Increase the percentage of programs which are trauma informed.

Objective:

Statewide score on the Fallot and Harris Trauma Informed Care (TIC) tool will be maintained or increase.

Strategies to attain the objective:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Statewide scores on the Fallot and Harris Trauma Informed Care (TIC) self-assessment tool.

Baseline Measurement: Statewide scores on TIC tool as collected in 2013 resulted in a domain average total score of 20.3 across 6 distinct domains. The overall average item score was 3.4 out of 5.

First-year target/outcome measurement: N/A

Second-year target/outcome measurement: Statewide total score will maintain or increase according to baseline.

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures::

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

Priority #: 4

Priority Area: First Episode Psychosis

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

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

Objective:

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

Strategies to attain the objective:

Continue to develop recovery-oriented services and increase use of evidence-based practices which help individuals stabilize and maintain stabilization

in community settings. Support Mental Health trainings to improve early intervention and support, particularly for youth having a first episode of psychosis (FEP). Establish pilot programs using the OnTrackNY system for FEP.

Annual Performance Indicators to measure goal success

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

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures::

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

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

Goal of the priority area:

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

Objective:

Strategies to attain the objective:

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

Annual Performance Indicators to measure goal success

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

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures::

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

Footnotes:

-- The Division of Behavioral Health Priorities, expressed as goals and performance indicators, are based on the 2011-2015 Strategic Plan. These DBH Priorities are used to prepare the SFY 2016 Region Budget Plan Guidelines and the 2016-2017 SAMHSA Block Grant application. They are all connected and help move the system forward.

-- The Priority Areas of Co-Occurring Disorders, Trauma-Informed Care, and Peer Support are intended to make a positive difference for all persons served including SMI, SED, PWWDC, IVDUs, HIV EIS, TB, and Others.

-- Nebraska is not a HIV EIS designated state. HIV EIS means persons with or at risk of Human Immunodeficiency Virus infection / Acquired Immunodeficiency Syndrome (HIV/AIDS) who are in treatment for substance abuse.

-- TIC and COD self-assessment tools were conducted in calendar year 2015 by providers. Results are being analyzed and were not available for this application.

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

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

Activity	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	$5,490,689		$0	$0	$23,286,705	$0	$0
a. Pregnant Women and Women with Dependent Children*	$463,637		$0	$0	$1,754,446	$0	$0
b. All Other	$5,027,052		$0	$0	$21,532,259	$0	$0
2. Substance Abuse Primary Prevention	$1,721,791		$0	$1,294,910	$319,139	$0	$0
3. Tuberculosis Services	$0		$0	$0	$0	$0	$0
4. HIV Early Intervention Services	$0		$0	$0	$0	$0	$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary Prevention**							
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)							
10. Administration (Excluding Program and Provider Level)	$379,604		$0	$0	$0	$0	$0
13. Total	$7,592,084	$0	$0	$1,294,910	$23,605,844	$0	$0

* Prevention other than primary prevention

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

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

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

Activity	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			$0	$0	$0	$0	$0
6. Other 24 Hour Care		$15,000	$0	$0	$1,564,450	$0	$0
7. Ambulatory/Community Non-24 Hour Care		$1,880,570	$0	$1,021,556	$54,476,222	$0	$0
8. Mental Health Primary Prevention**		$0	$0	$0	$0	$0	$0
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)		$106,000	$0	$0	$0	$0	$0
10. Administration (Excluding Program and Provider Level)		$105,345	$0	$0	$0	$0	$0
13. Total	$0	$2,106,915	$0	$1,021,556	$56,040,672	$0	$0

* Prevention other than primary prevention

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

Footnotes:

Planning Tables

Table 3 State Agency Planned Block Grant Expenditures by Service

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

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

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

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

Consultation to Caregivers;		
Medication Services	$1,013,811	$59,213
Medication Management;		
Pharmacotherapy (including MAT);		
Laboratory services;		
Community Support (Rehabilitative)	$247,590	$829,745
Parent/Caregiver Support;		
Skill Building (social, daily living, cognitive);		
Case Management;		
Behavior Management;		
Supported Employment;		
Permanent Supported Housing;		
Recovery Housing;		
Therapeutic Mentoring;		
Traditional Healing Services;		

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

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

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

Footnotes:
Amounts do not include 5% allowable for Administrative expenses

Planning Tables

Table 4 SABG Planned Expenditures

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

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

* Prevention other than primary prevention

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

Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

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

Strategy	IOM Target	FY 2016
		SA Block Grant Award
Information Dissemination	Universal	$85,465
	Selective	$8,147
	Indicated	
	Unspecified	
	Total	$93,612
Education	Universal	$117,395
	Selective	$90,118
	Indicated	
	Unspecified	
	Total	$207,513
Alternatives	Universal	$47,113
	Selective	
	Indicated	
	Unspecified	
	Total	$47,113
Problem Identification and Referral	Universal	$17,898
	Selective	$45,975
	Indicated	$65,200
	Unspecified	
	Total	$129,073

Community-Based Process	Universal	$659,911
	Selective	$86,053
	Indicated	
	Unspecified	
	Total	$745,964
Environmental	Universal	$386,671
	Selective	$59,295
	Indicated	
	Unspecified	
	Total	$445,966
Section 1926 Tobacco	Universal	$52,550
	Selective	
	Indicated	
	Unspecified	
	Total	$52,550
Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	
Total Prevention Expenditures		$1,721,791
Total SABG Award*		$7,592,084
Planned Primary Prevention Percentage		22.68 %

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

Footnotes:

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

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

Activity	FY 2016 SA Block Grant Award	
Universal Direct	$361,555	
Universal Indirect	$1,005,450	
Selective	$289,586	
Indicated	$65,200	
Column Total	$1,721,791	
Total SABG Award*	$7,592,084	
Planned Primary Prevention Percentage	22.68 %	

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

Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

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

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

Footnotes:

Planning Tables

Table 6a SABG Resource Development Activities Planned Expenditures

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

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

Footnotes:

Planning Tables

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

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

Service	Block Grant
MHA Technical Assistance Activities	
MHA Planning Council Activities	
MHA Administration	$105,345
MHA Data Collection/Reporting	
MHA Activities Other Than Those Above	
Total Non-Direct Services	$105345
Comments on Data:	

Footnotes:

Environmental Factors and Plan

1. The Health Care System and Integration

Narrative Question:

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[26] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but “[h]ealth system factors” such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[27] It has been acknowledged that there is a high rate of co- occurring mental illness and substance abuse, with appropriate treatment required for both conditions.[28] Overall, America has reduced its heart disease risk based on lessons from a 50-year research project on the town of Framingham, MA, outside Boston, where researchers followed thousands of residents to help understand what causes heart disease. The Framingham Heart Study produced the idea of "risk factors" and helped to make many connections for predicting and preventing heart disease.

There are five major preventable risks identified in the Framingham Heart Study that may impact people who live with mental illness. These risks are smoking, obesity, diabetes, elevated cholesterol, and hypertension. These risk factors can be appropriately modified by implementing well-known evidence–based practices[29] [30] that will ensure a higher quality of life.

Currently, 50 states have organizationally consolidated their mental and substance abuse authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[31] Specific to children, many children and youth with mental illness and substance use issues are more likely to be seen in a health care setting than in the specialty mental health and substance abuse system. In addition, children with chronic medical conditions have more than two times the likelihood of having a mental disorder. In the U.S., more than 50 percent of adults with mental illness had symptoms by age 14, and three-fourths by age 24. It is important to address the full range of needs of children, youth and adults through integrated health care approaches across prevention, early identification, treatment, and recovery.

It is vital that SMHAs' and SSAs' programming and planning reflect the strong connection between behavioral, physical and population/public health, with careful consideration to maximizing impact across multiple payers including Medicaid, exchange products, and commercial coverages. Behavioral health disorders are true physical disorders that often exhibit diagnostic criteria through behavior and patient reports rather than biomarkers. Fragmented or discontinuous care may result in inadequate diagnosis and treatment of both physical and behavioral conditions, including co-occurring disorders. For instance, persons receiving behavioral health treatment may be at risk for developing diabetes and experiencing complications if not provided the full range of necessary care.[32] In some cases, unrecognized or undertreated physical conditions may exacerbate or cause psychiatric conditions.[33] Persons with physical conditions may have unrecognized mental challenges or be at increased risk for such challenges.[34] Some patients may seek to self-medicate due to their chronic physical pain or become addicted to prescribed medications or illicit drugs.[35] In all these and many other ways, an individual's mental and physical health are inextricably linked and so too must their health care be integrated and coordinated among providers and programs.

Health care professionals and consumers of mental illness and substance abuse treatment recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[36]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[37] Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between mental and substance abuse treatment providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as federally qualified health centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including electronic health records (EHRs) and telehealth are examples of important strategies to promote integrated care.[38] Use of EHRs – in full compliance with applicable legal requirements – may allow providers to share information, coordinate care and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, care, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[39] and ACOs[40] may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

The Affordable Care Act is an important part of efforts to ensure access to care and better integrate care. Non-grandfathered health plans sold in the individual or the small group health insurance markets offered coverage for mental and substance use disorders as an essential health benefit.

SSAs and SMHAs also may work with Medicaid programs and Insurance Commissioners to encourage development of innovative demonstration projects and waivers that test approaches to providing integrated care for persons with mental illness and substance use disorders and other vulnerable populations.[41] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[42]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[43] Roughly, 30 percent of dually eligible persons have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[44] SMHAs and SSAs also should collaborate with Medicaid, insurers and insurance regulators to develop policies to assist those individuals who experience health coverage eligibility changes due to shifts in income and employment.[45] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or finding a provider.[46] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should ensure access and integrated prevention care and recovery support in all vulnerable populations including, but not limited to college students and transition age youth (especially those at risk of first episodes of mental illness or substance abuse); American Indian/Alaskan Natives; ethnic minorities experiencing health and behavioral health disparities; military families; and, LGBT individuals. SMHAs and SSAs should discuss with Medicaid and other partners, gaps that may exist in services in the post-Affordable Care Act environment and the best uses of block grant funds to fill such gaps. SMHAs and SSAs should work with Medicaid and other stakeholders to facilitate reimbursement for evidence-based and promising practices.[47] It also is important to note CMS has indicated its support for incorporation within Medicaid programs of such approaches as peer support (under the supervision of mental health professionals) and trauma-informed treatment and systems of care. Such practices may play an important role in facilitating integrated, holistic care for adults and children with behavioral health conditions.[48]

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[49] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists and others will need to understand integrated care models, concepts and practices.

Another key part of integration will be defining performance and outcome measures. Following the Affordable Care Act, the Department of Health and Human Services (HHS) and partners have developed the NQS, which includes information and resources to help promote health, good outcomes and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[50]

SAMHSA recognizes that certain jurisdictions receiving block grant funds – including U.S. Territories, tribal entities and those jurisdictions that have signed compacts of free association with the U.S. – may be uniquely impacted by certain Affordable Care Act and Medicaid provisions or ineligible to participate in certain programs.[51] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment and recovery support for persons with, or at risk of, mental illnesses and substance use disorders.

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 charged with coordinating 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 consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?
2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the 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?
6. Is the SSA/SMHA is involved in the various coordinated care initiatives in the state?
7. Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?
8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?
9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?

10. Indicate tools and strategies used that support efforts to address nicotine cessation.
    - Regular screening with a carbon monoxide (CO) monitor
    - Smoking cessation classes
    - Quit Helplines/Peer supports
    - Others_____
11. The behavioral health providers screen and refer for:
    - Prevention and wellness education;
    - Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,
    - Recovery supports

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

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[26] BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care. 2011 Jun;49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, Bulletin of the World Health Organization, 2013;91:102–123

http://www.who.int/bulletin/volumes/91/2/12-108282.pdf; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, World Psychiatry. Feb 2011; 10(1): 52–77

[27] Research Review of Health Promotion Programs for People with SMI, 2012, http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper; About SAMHSA's Wellness Efforts,

http://www.promoteacceptance.samhsa.gov/10by10/default.aspx; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, JAMA; 2007; 298: 1794-1796; Million Hearts, http://www.integration.samhsa.gov/health-wellness/samhsa-10x10 Schizophrenia as a health disparity, http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml

[28] Comorbidity: Addiction and other mental illnesses, http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, *JAMA Psychiatry*. 2014;71(3):248-254. doi:10.1001/jamapsychiatry.2013.3726; http://www.samhsa.gov/co-occurring/

[29] 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults: Report From the Panel Members Appointed to the Eighth Joint National Committee (JNC 8); JAMA. 2014;311(5):507-520.doi:10.1001/jama.2013.284427

[30] A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines: 2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk; http://circ.ahajournals.org/

[31] Social Determinants of Health, Healthy People 2020, http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39;

http://www.cdc.gov/socialdeterminants/Index.html

[32] Depression and Diabetes, NIMH, http://www.nimh.nih.gov/health/publications/depression-and-diabetes/index.shtml#pub5;Diabetes Care for Clients in Behavioral health Treatment, Oct. 2013, SAMHSA, http://store.samhsa.gov/product/Diabetes-Care-for-Clients-in-Behavioral-Health-Treatment/SMA13-4780

[33] J Pollock et al., Mental Disorder or Medical Disorder? Clues for Differential Diagnosis and Treatment Planning, Journal of Clinical Psychology Practice, 2011 (2) 33-40

[34] C. Li et al., Undertreatment of Mental Health Problems in Adults With Diagnosed Diabetes and Serious Psychological Distress, Diabetes Care, 2010; 33(5) 1061-1064

[35] TIP 54: Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders, SAMHSA, 2012, http://store.samhsa.gov/product/TIP-54-Managing-Chronic-Pain-in-Adults-With-or-in-Recovery-From-Substance-Use-Disorders/SMA13-4671

[36] Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. http://www.nami.org/Content/ContentGroups/CAAC/FG-Integrating.pdf; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011,

http://www.nami.org/Content/NavigationMenu/State_Advocacy/About_the_Issue/Integration_MH_And_Primary_Care_2011.pdf;. Abrams, Michael T. (2012, August 30). *Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and challenges.* Baltimore, MD: The Hilltop Institute, UMBC.

http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf; American Psychiatric Association, http://www.psych.org/practice/professional-interests/integrated-care; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, http://books.nap.edu/openbook.php?record_id=11470&page=210; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, http://nasadad.org/nasadad-reports

[37] Health Care Integration, http://samhsa.gov/health-reform/health-care-integration; SAMHSA-HRSA Center for Integrated Health Solutions, (http://www.integration.samhsa.gov/)

[38] Health Information Technology (HIT), http://www.integration.samhsa.gov/operations-administration/hit; Characteristics of State Mental Health Agency Data Systems, SAMHSA, 2009, http://store.samhsa.gov/product/Characteristics-of-State-Mental-Health-Agency-Data-Systems/SMA08-4361; Telebehavioral Health and Technical Assistance Series, http://www.integration.samhsa.gov/operations-administration/telebehavioral-health State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, http://www.americantelemed.org/docs/default-source/policy/ata-best-practice---telemental-and-behavioral-health.pdf?sfvrsn=8; National Telehealth Policy Resource Center, http://telehealthpolicy.us/medicaid; telemedicine, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html

[39] Health homes, http://www.integration.samhsa.gov/integrated-care-models/health-homes

[40] New financing models, http://www.samhsa.gov/co-occurring/topics/primary-care/financing_final.aspx

[41] Waivers, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html;Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS

[42] What are my preventive care benefits? https://www.healthcare.gov/what-are-my-preventive-care-benefits/; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); Preventive services covered under the Affordable Care Act, http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html

[43] Medicare-Medicaid Enrollee State Profiles, http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html; About the Compact of Free Association, http://uscompact.org/about/cofa.php

[44] Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, http://www.cbo.gov/publication/44308

[45] BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707

[46] TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014;71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013;70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218

[47] http://www.nrepp.samhsa.gov/

[48] Clarifying Guidance on Peer Support Services Policy, May 2013, CMS, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Clarifying-Guidance-Support-Policy.pdf; Peer Support Services for Adults with Mental Illness and/or Substance Use Disorder, August 2007, http://www.medicaid.gov/Federal-Policy-guidance/federal-policy-guidance.html; Tri-Agency Letter on Trauma-Informed Treatment, July 2013, http://medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf

[49] Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf; Annapolis Coalition, An Action Plan for Behavioral Health Workforce Development, 2007, http://annapoliscoalition.org/?portfolio=publications; Creating jobs by addressing primary care workforce needs, http://www.hhs.gov/healthcare/facts/factsheets/2013/06/jobs06212012.html

[50] About the National Quality Strategy, http://www.ahrq.gov/workingforquality/about.htm; National Behavioral Health Quality Framework, Draft, August 2013, http://samhsa.gov/data/NBHQF

[51] Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, http://www.cms.gov/cciio/resources/letters/index.html; Affordable Care Act, Indian Health Service, http://www.ihs.gov/ACA/

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

C. Environmental Factors and Plan

1. The Health Care System and Integration

It is vital that SMHAs' and SSAs' programming and planning reflect the strong connection between behavioral, physical and population/public health, with careful consideration to maximizing impact across multiple payers including Medicaid, exchange products, and commercial coverages. Behavioral health disorders are true physical disorders that often exhibit diagnostic criteria through behavior and patient reports rather than biomarkers. Fragmented or discontinuous care may result in inadequate diagnosis and treatment of both physical and behavioral conditions, including co-occurring disorders. For instance, persons receiving behavioral health treatment may be at risk for developing diabetes and experiencing complications if not provided the full range of necessary care. In some cases, unrecognized or undertreated physical conditions may exacerbate or cause psychiatric conditions. Persons with physical conditions may have unrecognized mental challenges or be at increased risk for such challenges. Some patients may seek to self-medicate due to their chronic physical pain or become addicted to prescribed medications or illicit drugs. In all these and many other ways, an individual's mental and physical health are inextricably linked and so too must their health care be integrated and coordinated among providers and programs.

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

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

Nebraska Department of Health & Human Services (NDHHS) Division of Medicaid and Long Term Care (DMLTC) and its at risk managed care vendor Magellan Behavioral Health of Nebraska, Inc. (Magellan of Nebraska), provide the following services for behavioral health consumers:

1. Crisis Stabilization Services
    a. Crisis Assessment;**
    b. Sub-acute Hospital - Adults age 19 & over;**
2. Acute Inpatient Hospital**
3. Residential Services
    a. Psychiatric Residential Treatment Facility (PRTF) - Children under age 19
    b. Therapeutic Group Home (ThGH) - Children under age 19;
    c. Professional Resource Family Care (PRFC) - Children under age 19;
    d. Dual Disorder Residential - Adults age 19 & over;**
    e. Intermediate Residential for substance abuse - Adults age 19 & over;**
    f. Short-Term Residential - Adults age 19 & over;**
    g. Halfway House - Adults age 19 & over;**

h. Therapeutic Community for substance abuse only - Adults age 19 & over;**
i. Community Support for substance abuse - Adults age 19 & over;**

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

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

Services indicated with ** are also provided by the SSA/SMHA to non-Medicaid eligible consumers in the state and are paid for with a combination of SAPTBG, MHBG and state funding. In the fall of 2015, the DMLTC will be issuing a Request for Proposals for integrated physical health and behavioral health care services and upon completion behavioral health will no longer be carved out. The Division of Behavioral Health (DBH) will be partnering with

DMLTC as this initiative moves forward to plan a quality public system of behavioral health care that is seamless and inclusive of all individuals eligible for services.

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

The State of Nebraska is one of 27 States using the Federally-facilitated Marketplaces (FFM). The Nebraska Department of Insurance (DOI) 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. The DOI coordinates with the FFM both individually and through the National Association of Insurance Commissioners to ensure compliance and provide guidance to address frequently asked questions from stakeholders.

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

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

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. The Nebraska Health Carrier External Review Act (2013) provides standards for external review procedures that assure covered persons an independent review of an adverse determination.

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

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

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

The SSA/SMHA provides oversight, direction and assistance to the six Regional Behavioral Health Authorities (Regions). With Behavioral Health Regions 5 and 6, behavioral health providers are partnering with the FQHCs to provide cross site physical and behavioral healthcare. In addition, the SSA/SMHA works collaboratively with the DMLTC, Magellan of Nebraska (the Medicaid at risk vendor), the Division of Children and Family Services and the Division of Developmental Disabilities to coordinate initiatives for individuals included in

their respective populations.

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

The DBH supports and encourages local partnerships with FQHCs and other collaborative efforts with primary care and publicly funded systems. Funding from the block grant along with state dollars pass through from DBH to Regions and are distributed via Subgrants to local providers.

The DBH works with the Regions and the Nebraska Association of Behavioral Health Organizations to identify needs and develop plans for service delivery. Regular meetings by NABHO are often attended by DBH leadership, who present on key issues and receive feedback regarding system issues and barriers. In addition, the DBH has urged Regions to work collaboratively with FQHCs in their catchment areas to provide integrated opportunities to receive behavioral/physical healthcare.

Also, in a collaborative effort to help identify issues early and connect children and teens with services, the Nebraska Legislature created a pilot children's behavioral health screening program in three primary care clinics. Children are screened for common behavioral health challenges and referred to behavioral health specialists for treatment. This work is being spearheaded by the Behavioral Health Education Center of Nebraska. See Section 10 for more information.

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

Yes. Nebraska' Clean Indoor Act (Neb Rev Stat 71-5716 through 71-5735), prohibits smoking in public places and places of employment with limited exceptions for guestrooms and suites, research, tobacco retail outlets, and cigar shops. As such, all publically funded behavioral health provider offices and residential programs must be smoke free. This act does not prohibit smoking outdoors and not all programs have implemented smoke free campus policies. However, data from Magellan of Nebraska indicates that smoking among behavioral health consumers has decreased. We anticipate future work with the Division of Public Health to combine efforts to reduce use of tobacco products.

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

All consumers in the publically funded behavioral health system are screened and assessed for nicotine dependence upon admission to the service.

10. Indicate tools and strategies used that support efforts to address nicotine cessation, e.g., Regular screening with a carbon monoxide (CO) monitor, Smoking cessation classes, Quit Helplines/Peer supports, Others.

NDHHS Division of Public Health's program Tobacco Free Nebraska (TFN) is the state's comprehensive tobacco prevention program that works to help people quit, eliminate exposure to second hand smoke, keep youth from starting, and to reach underserved populations. Local tobacco prevention coalitions, schools, and non-profits like the American Cancer Society, American Lung Association, and American Heart Association often partner with TFN. Health care providers and educators, law enforcement, teachers, and community leaders work as well to address the serious health issues that result from tobacco use and exposure.

TFN funds Nebraska's Quit Line, which provides free access to counseling and support services to individuals who want to quit smoking or chewing tobacco. TFN is working to connect Quit Line information with behavioral health services providers across the state with informational and networking activities, including most recently presenting a the 2015 Nebraska Behavioral Health Conference as part of a panel discussion on tobacco.

DBH works in partnership with TFN on tobacco prevention activities including coordination of merchant compliance checks (SYNAR) and education efforts.

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

Yes all providers work with individuals to provide prevention and wellness education and recovery supports. Some Regional Prevention coalitions work to train healthcare providers on Screening, Brief Intervention and Referral to Treatment (SBIRT) model and gather data on its use and efficacy.

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

Environmental Factors and Plan

2. Health Disparities

Narrative Question:

In accordance with the *HHS Action Plan to Reduce Racial and Ethnic Health Disparities*[52], *Healthy People, 2020*[53], *National Stakeholder Strategy for Achieving Health Equity*[54], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, and people living with HIV/AIDS or other chronic diseases/impairments) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS standards).[55]

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

The top Secretarial priority in the Action Plan is to "[a]ssess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[56]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, in accordance with section 4302 of the Affordable Care Act, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status.[57] This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations.[58] In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

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

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is 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. For states to address the potentially disparate impact of their block grant funded efforts, they will 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).

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

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

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

[52] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[53] http://www.healthypeople.gov/2020/default.aspx

[54] http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf

[55] http://www.ThinkCulturalHealth.hhs.gov

[56] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[57] http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208

[58] http://www.whitehouse.gov/omb/fedreg_race-ethnicity

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

C. Environmental Factors and Plan

2. Health Disparities

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

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

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

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

Although Nebraska is often viewed as having a homogenous population, it is becoming increasingly diverse with African American, Hispanic, Native Americans, and immigrants from the continents of Africa and Asia. Culture in Nebraska is not only related to race/ethnicity but also to geography and economics. Nebraska is largely a rural state and the 9th least-densely populated state of the United States. The more urban areas of the state (Omaha and Lincoln)

have more diverse populations than the rural/frontier areas. All areas of the state are impacted by poverty but the most affected areas are rural and frontier counties in the western and northern areas of the state.

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

The National Center on Immigrant Integration Policy estimates that less than 5 percent of Nebraska's total population is considered as having Limited English proficiency (LEP). Consumer preferred language is captured at admission to behavioral health treatment and interpreters are provided as necessary at the service provider level. In fiscal year 2014, 98% of individuals receiving Behavioral Health services funded through the Division of Behavioral Health indicated English as their preferred language. The current data system does not specifically track language services; however, this is under review for improvement in the new centralized data system under development.

DBH and network partners measure, track, and respond to these disparities through use of NOMs reports, capacity and waiting list reports, Mental Health and Substance Abuse client level data, ongoing admission/discharge reports, and annual reporting at state and regional levels. This information is regularly shared with RBHAs, providers and consumers through use of ongoing Tuesday Data Calls, quality improvement workgroups and state advisory committees. DBH treatment and recovery service system data is collaboratively reviewed in order to create a holistic view of the behavioral health system and identify opportunities to improve access for disparate populations through informed infrastructure and policy as well as service delivery best practices. Ongoing review of analysis provides information to decision makers regarding potential barriers to accessing mental health and related services and the potential for under-identification of risk in some populations. This information can inform strategies and identify the need to seek additional stakeholder involvement from diverse groups. Work is intended to improve the state's capacity to promote integrated approaches, evidenced-based programs and best practices to reduce health disparities in our prevention system as well as providing recommendations to the behavioral health system of care. DBH has recently completed a data

sharing agreement with Nebraska DHHS Division of Medicaid and Long Term Care and will pursue opportunities to share data across other DHHS divisions to further develop plans that address disparities. The expected outcome of improved sensitivity to health disparities includes sharper strategies in prevention and service delivery as well as infrastructure capacity as a result of informed policy and implemented system standards. In addition, our approach to systems of care will result in shared processes that will inform our state's behavioral health treatment and recovery service system, public health system, and child welfare system.

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

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

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

Awarded in 2013, the federal grant for a Nebraska DHHS System of Care (SOC) Planning Project has brought together Nebraska youth and families, child-serving systems, providers, and Nebraska leaders to develop a comprehensive strategic plan for prevention-oriented, culturally

and linguistically competent, youth and family driven SOC for children/youth with behavioral health concerns and their families. For this project, the CLAS Core Strategy Team (CST) (one of ten 'core strategy teams' for the SOC project) worked to develop recommendations for supporting culture and language preference within a broad array of home and community based services and supports in the child serving system of care. Central to the success of Nebraska's SOC Planning Project is adherence to the CLAS standards. A key focus of the planning process was to promulgate and increase commitment to CLAS standards across all levels of planning and throughout the subsequent strategic plan.

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

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

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

Community stakeholders reported interest in having an overview of health disparities in Nebraska in order to understand the state context they are working in, thus helping them to make informed decisions in their communities. This allowed for further collaboration between the state team worked and OHDHE to provide a training about health disparities across the state and how to begin engaging persons in these communities. The 2 day training was well attended and participants reported the trainings helped to establish a common language across the state when talking about health disparities. The trainings included an introduction to the language used to talk about health disparities, a discussion of CLAS standards, and a look at statistics for Nebraska as a whole.

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

Future technical assistance will be identified.

3. Use of Evidence in Purchasing Decisions

Narrative Question:

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

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. Since 2001, SAMHSA has sponsored a National Registry of Evidenced-based Programs and Practices (NREPP). NREPP[59] is a voluntary, searchable online registry of more than 220 submitted interventions supporting mental health promotion and treatment and substance abuse prevention and treatment. The purpose of NREPP is to connect members of the public to intervention developers so that they can learn how to implement these approaches in their communities. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with (SED). The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[60], The New Freedom Commission on Mental Health[61], the IOM[62], and the NQF.[63] The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[64] SAMHSA and other federal partners (the Administration for Children and Families (ACF), the HHS Office of Civil Rights (OCR), and CMS) have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, identify specific strategies for embedding these practices in provider organizations, and recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. These are services that have not been studied, but anecdotal evidence and program specific data indicate that they are effective. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocols (TIPs)[65] are best practice guidelines for the treatment of substance abuse. The Center for Substance Abuse Treatment (CSAT) draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private substance abuse treatment facilities as alcohol and other drug disorders are increasingly recognized as a major problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)[66] was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

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

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.
2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?
3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?
4. Does the state use a rigorous evaluation process to assess emerging and promising practices?
5. Which value based purchasing strategies do you use in your state:
    a. Leadership support, including investment of human and financial resources.
    b. Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
    c. Use of financial incentives to drive quality.

d. Provider involvement in planning value-based purchasing.

e. Gained consensus on the use of accurate and reliable measures of quality.

f. Quality measures focus on consumer outcomes rather than care processes.

g. Development of strategies to educate consumers and empower them to select quality services.

h. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.

i. The state has an evaluation plan to assess the impact of its purchasing decisions.

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

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[59] Ibid, 47, p. 41

[60] United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[61] The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[62] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

[63] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[64] http://psychiatryonline.org/

[65] http://store.samhsa.gov

[66] http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

C. Environmental Factors and Plan

3. Use of Evidence in Purchasing Decisions

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

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.

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

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

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

An example of a science-to-service resource is the Mid-America Addiction Technology Transfer Center (ATTC) at the University of Missouri-Kansas City, School of Nursing and Health Studies. ATTC works to foster collaboration across service systems, bridging the gap between current research and those working the front lines of addiction and mental health treatment. ATTC serves the HHS Region 7 states of Iowa, Kansas, Missouri, and Nebraska. Topical areas of emphasis include Medication-Assisted Treatment; Motivational Interviewing; Screening, Brief Intervention, and Referral to Treatment (SBIRT); Hepatitis C; and comorbid behavioral health and problem gambling. Recently, a conference on medication assisted treatment was held August 23 and 24 in Omaha Nebraska. **Medication-Assisted Treatment: Tools for Successful Recovery** with R. Corey Waller, M.D., M.S discussed FDA-approved medications now available for addressing the emerging prescription and opioid use epidemic, vital

information for education for specialty substance use disorder (SUD) treatment and healthcare providers.

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

In 2015, DBH developed information resources regarding evidence-based or promising practices available in the public community-based behavioral health service system. DBH published the guide *Trauma Informed Services FY2015* to inform consumers about the availability of trauma-informed and trauma-specific interventions across the state. DBH developed a network provider survey on evidence-based programs and practices (EPP), the results of which will be analyzed to develop a baseline on the use and availability of EPPs in the public behavioral health system. In addition, the DBH maintains a list of best practices in trauma informed care across the state of Nebraska as submitted by the Regional Behavioral Health authorities in their annual budget plans.

DBH is developing internal infrastructure to improve data and fiscal reporting systems that will monitor the use of evidence-based programs and practices in prevention and treatment services.

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

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

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

The specific tool kits for five of the EBPs being implemented in Nebraska are available from SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP) and the International Center for Clubhouse Development (ICCD) Clubhouse Model (http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=189). In addition, there are more EBPs implemented in Nebraska that are not captured in our system but billed under general categories such as "outpatient treatment".

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

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

DBH reviews all purchasing decisions of the Regional Behavioral Health Authorities, based on systems strengths, gaps and consumer need as evidenced by utilization and fiscal data in each Region on an annual basis. Direction for purchasing decisions is outlined in the Annual Regional Budget Plan Guidelines developed by the Division every January. The Regional Behavioral Health Authorities make decisions regarding which services including EBP's are most appropriate for use in their Region. DBH reviews each budget plan based on adherence to the guidelines, rules, regulations, and strategic planning efforts as well as the abovementioned data. The Division Director approves all budget plans.

Besides the guidelines, the DBH impacts purchasing decisions by educating Regions on EBPs, providing technical assistance and support for selected EBPs as appropriate for our system. For example, consultation and support have been provided by the DBH on Assertive Community Treatment, Supported Employment and Supported Housing. See Program Integrity Section for more information on Regional Budget Planning.

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

DBH continues efforts to identify, assess, and develop coordinated purchasing decisions with its partner agencies, including Nebraska Medicaid, Magellan of Nebraska, and Vocational Rehabilitation. When a new CCO is in place, this process will be reviewed and strengthened.

5. Which value based purchasing strategies do you use in your state:
    a. Leadership support, including investment of human and financial resources.
    b. Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
    c. Use of financial incentives to drive quality.
    d. Provider involvement in planning value-based purchasing.
    e. Gained consensus on the use of accurate and reliable measures of quality.
    f. Quality measures focus on consumer outcomes rather than care processes.
    g. Development of strategies to educate consumers and empower them to select quality services.

h. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.
i. The state has an evaluation plan to assess the impact of its purchasing decisions.

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

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

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

In addition, we will implement a process of Results-Based Accountability (RBA) across the Regions and State. RBA is a disciplined way of thinking and taking action that communities can use to improve the lives of those we serve. RBA will provide an opportunity for the State, Regions, Regional Centers and providers to measure whether consumers are better off as a result

of the service received. This initiative involves the review of data utilizing a results based accountability framework and Plan-Do-Study-Act to drill and tell the story behind the data. It also involves the design and implementation of new data templates to more readily understand and have a process for telling the story behind the data. This process mandates collective engagement with DBH, Regions and Regional Centers for collaboration between system partners working together to be accountable to delivering the highest quality services to the State's consumers, families and communities. Data collected will be utilized to evaluate services with particular interest on co-occurring disorders, trauma, prevention, and recovery.

Future technical assistance needs will be identified.

4. Prevention for Serious Mental Illness

Narrative Question:

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

There has been increasing neurobiological and clinical research examining the period before the first psychotic episode in order to understand and develop interventions to prevent the first episode. There is a growing body of evidence supporting preemptive interventions that are successful in preventing the first episode of psychosis. The National Institute for Mental Health (NIMH) funded the North American Prodromal Longitudinal study (NAPLS), which is a consortium of eight research groups that have been working to create the evidence base for early detection and intervention for prodromal symptoms. Additionally, the Early Detection and Intervention for the Prevention of Psychosis (EDIPP) program, funded by the Robert Wood Johnson Foundation, successfully broadened the Portland Identification and Early Referral (PIER) program from Portland, Maine, to five other sites across the country. SAMHSA supports the development and implementation of these promising practices for the early detection and intervention of individuals at Clinical High Risk for psychosis, and states may want to consider how these developing practices may fit within their system of care. Without intervention, the transition rate to psychosis for these individuals is 18 percent after 6 months of follow up, 22 percent after one year, 29 percent after two years, and 36 percent after three years. With intervention, the risk of transition to psychosis is reduced by 54 percent at a one-year follow up.[68] In addition to increased symptom severity and poorer functioning, lower employment rates and higher rates of substance use and overall greater disability rates are more prevalent.[69] The array of services that have been shown to be successful in preventing the first episode of psychosis include accurate clinical identification of high-risk individuals; continued monitoring and appraisal of psychotic and mood symptoms and identification; intervention for substance use, suicidality and high risk behaviors; psycho-education; family involvement; vocational support; and psychotherapeutic techniques.[70] [71] This reflects the critical importance of early identification and intervention as there is a high cost associated with delayed treatment.

Overall, the goal of early identification and treatment of young people at high clinical risk, or in the early stages of mental disorders with psychosis is to: (1) alter the course of the illness; (2) reduce disability; and, (3) maximize recovery.

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

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

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[67] Larson, M.K., Walker, E.F., Compton, M.T. (2010). Early signs, diagnosis and therapeutics of the prodromal phase of schizophrenia and related psychotic disorders. Expert Rev Neurother. Aug 10(8):1347-1359.

[68] Fusar-Poli, P., Bonoldi, I., Yung, A.R., Borgwardt, S., Kempton, M.J., Valmaggia, L., Barale, F., Caverzasi, E., & McGuire, P. (2012). Predicting psychosis: meta-analysis of transition outcomes in individuals at high clinical risk. Arch Gen Psychiatry. 2012 March 69(3):220-229.

[69] Whiteford, H.A., Degenhardt, L., Rehm, J., Baxter, A.J., Ferrari, A.J., Erskine, H.E., Charlson, F.J., Norman, R.E., Flaxman, A.D., Johns, N., Burstein, R., Murray, C.J., & Vos T. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. Lancet. Nov 9;382(9904):1575-1586.

[70] van der Gaag, M., Smit, F., Bechdolf, A., French, P., Linszen, D.H., Yung, A.R., McGorry, P., & Cuijpers, P. (2013). Preventing a first episode of psychosis: meta-analysis of randomized controlled prevention trials of 12-month and longer-term follow-ups. Schizophr Res. Sep;149(1-3):56-62.

[71] McGorry, P., Nelson, B., Phillips, L.J., Yuen, H.P., Francey, S.M., Thampi, A., Berger, G.E., Amminger, G.P., Simmons, M.B., Kelly, D., Dip, G., Thompson, A.D., & Yung, A.R. (2013). Randomized controlled trial of interventions for young people at ultra-high risk of psychosis: 12-month outcome. J Clin Psychiatry. Apr;74(4):349-56.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

C. Environmental Factors and Plan

4. Prevention for Serious Mental Illness

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

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

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

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

1. Identification of students exhibiting behaviors that may interfere with their ability to be successful;

2. Intervention with the student and family to share concerns, seek solutions, and explore options;
3. Referral to in-school or community resources to assist the student; and
4. Support for students within the school environment.

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

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

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

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

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

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

Environmental Factors and Plan

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

Narrative Question:

P.L. 113-76 and P.L. 113-235 requires that states set aside five percent of their MHBG allocation to support evidence-based programs that provide treatment to those with early SMI including but not limited to psychosis at any age.[72] SAMHSA worked collaboratively with the NIMH to review evidence-showing efficacy of specific practices in ameliorating SMI and promoting improved functioning. NIMH has released information on Components of Coordinated Specialty Care (CSC) for First Episode Psychosis. Results from the NIMH funded Recovery After an Initial Schizophrenia Episode (RAISE) initiative[73], a research project of the NIMH, suggest that mental health providers across multiple disciplines can learn the principles of CSC for First Episode of Psychosis (FEP), and apply these skills to engage and treat persons in the early stages of psychotic illness. At its core, CSC is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, relatives, as active participants. The CSC components emphasize outreach, low-dosage medications, evidenced-based supported employment and supported education, case management, and family psycho-education. It also emphasizes shared decision-making as a means to address individuals' with FEP unique needs, preferences, and recovery goals. Collaborative treatment planning in CSC is a respectful and effective means for establishing a positive therapeutic alliance and maintaining engagement with clients and their family members over time. Peer supports can also be an enhancement on this model. Many also braid funding from several sources to expand service capacity.

States can implement models across a continuum that have demonstrated efficacy, including the range of services and principles identified by NIMH. Using these principles, regardless of the amount of investment, and with leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, every state will be able to begin to move their system toward earlier intervention, or enhance the services already being implemented.

It is expected that the states' capacity to implement this programming will vary based on the actual funding from the five percent allocation. SAMHSA continues to provide additional technical assistance and guidance on the expectations for data collection and reporting.

Please provide the following information, updating the State's 5% set-aside plan for early intervention:

1. An updated description of the states chosen evidence-based practice for early intervention (5% set-aside initiative) that was approved in its 2014 plan.
2. An updated description of the plan's implementation status, accomplishments and/ any changes in the plan.
3. The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.
4. A budget showing how the set-aside and additional state or other supported funds, if any, for this purpose.
5. The states provision for collecting and reporting data, demonstrating the impact of this initiative.

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

[72] http://samhsa.gov/sites/default/files/mhbg-5-percent-set-aside-guidance.pdf

[73] http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml?utm_source=rss_readers&utm_medium=rss&utm_campaign=rss_full

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

C. Environmental Factors and Plan

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

P.L. 113-76 and P.L. 113-235 requires that states set aside five percent of their MHBG allocation to support evidence-based programs that provide treatment to those with early SMI including but not limited to psychosis at any age.

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

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

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

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

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

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

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

There have been no changes to the approved 2014 plan. Implementation of the plan has begun. Two FEP CSC teams have been organized and have begun meeting as a team. Both teams have received training on the CSC model delivered by the Center for Practice Innovations in July 2015. Enhanced service coverage has been developed and authorized to provide for FEP CSC team leadership and team level activities, which have been identified as especially important in providing effective and coordinated treatment in a FEP program. This enhanced service coverage will fill the coverage gap for these activities which neither public nor private insurance programs generally cover.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

No technical assistance needs are identified at this time.

Environmental Factors and Plan

6. Participant Directed Care

Narrative Question:

As states implement policies that support self-determination and improve person-centered service delivery, one option that states may consider is the role that vouchers may play in their overall financing strategy. Many states have implemented voucher and self-directed care programs to help individuals gain increased access to care and to enable individuals to play a more significant role in the development of their prevention, treatment, and recovery services. The major goal of a voucher program is to ensure individuals have a genuine, free, and independent choice among a network of eligible providers. The implementation of a voucher program expands mental and substance use disorder treatment capacity and promotes choice among clinical treatment and recovery support providers, providing individuals with the ability to secure the best treatment options available to meet their specific needs. A voucher program facilitates linking clinical treatment with other authorized services, such as critical recovery support services that are not otherwise reimbursed, including coordination, childcare, motivational development, early/brief intervention, outpatient treatment, medical services, support for room and board while in treatment, employment/education support, peer resources, family/parenting services, or transportation.

Voucher programs employ an indirect payment method with the voucher expended for the services of the individual's choosing or at a provider of their choice. States may use SABG and MHBG funds to introduce or enhance behavioral health voucher and self-directed care programs within the state. The state should assess the geographic, population, and service needs to determine if or where the voucher system will be most effective. In the system of care created through voucher programs, treatment staff, recovery support service providers, and referral organizations work together to integrate services.

States interested in using a voucher system should create or maintain a voucher management system to support vouchering and the reporting of data to enhance accountability by measuring outcomes. Meeting these voucher program challenges by creating and coordinating a wide array of service providers, and leading them though the innovations and inherent system change processes, results in the building of an integrated system that provides holistic care to individuals recovering from mental and substance use disorders. Likewise, every effort should be made to ensure services are reimbursed through other public and private resources, as applicable and in ways consistent with the goals of the voucher program

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

C. Environmental Factors and Plan

6. Participant Directed Care

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

No questions – Indicate areas of technical assistance.

The Nebraska Division of Behavioral Health (DBH) supports and promotes the use of person-centered service delivery and participant directed care within the state hospitals, regional and provider systems. Nebraska's public behavioral health system governing regulations "Standards of Care" (NAC 206, Chapter 6) identifies the right of each consumer to: Receive behavioral health services in the most integrated setting appropriate based on an individualized and person-centered assessment, and actively and directly participate in decisions which incorporate independence, individuality, privacy, and dignity and to make decisions regarding care and treatment.

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

Housing Voucher Program:

The Nebraska Housing Assistance Program supports stable and safe housing for people with behavioral health disorders and who are very or extremely low income. Housing assistance is tenant-based and supports the consumer's housing choice in integrated community settings. Housing vouchers allow individuals to obtain and/or maintain affordable housing and can be used for rental payments, utility payments, security and utility deposits, and other housing-related costs, including household formation costs while the consumer is waiting to obtain disability benefits, secure other subsidized housing or achieve self-dependence through employment. Consumers work with the Regional Housing Coordinator to identify and select safe affordable living situations and connect to other supports as identified by the consumers in their Individual Service Plan developed with their behavioral health service providers. Based upon SAMHA's Supporting Housing model, Nebraska's Housing Assistance Program is funded with state general funds and a state documentary stamp tax.

Outpatient Therapy Voucher Program

In response to the rural/farm crisis that started during the 1980's, Interchurch Ministries of Nebraska (IMN) began the formation of a multidenominational organization of churches, agencies and organizations with a direct interest in hardships faced by people residing in rural Nebraska. Church representatives, along with representatives from the Farmers Union, National Farmers' Organization, Nebraska Department of Agriculture, Nebraska Legal Services, Women

in Farm Economics, the University of Nebraska at Lincoln Agriculture Extension Division, and financial lenders throughout the state, worked closely to build a crisis response network, and make it available to anyone working in Nebraska agriculture.

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

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

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

Environmental Factors and Plan

7. Program Integrity

Narrative Question:

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

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 USC §§ 300x–5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 USC § 300x– 55, SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for substance abuse, SAMSHA will release guidance imminently to the states on use of block grant funds for these purposes. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The Affordable Care Act may offer additional health coverage options for persons with behavioral health conditions and block grant expenditures should reflect these coverage options. The MHBG and SABG resources are to be used to support, not supplant, individuals and services that will be covered through the Marketplaces and Medicaid. SAMHSA will provide additional guidance to the states to assist them in complying with program integrity recommendations; develop new and better tools for reviewing the block grant application and reports; and train SAMHSA staff, including Regional Administrators, in these new program integrity approaches and tools. In addition, SAMHSA will work with CMS and states to discuss possible strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance abuse programs, and activities for adults with SMI and children with SED.

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. These strategies may include:(1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered 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 use of behavioral health benefits in light of utilization review, medical necessity, etc. 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.

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a program integrity plan regarding the SABG and MHBG funds?
2. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?
3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:
    a. Budget review;
    b. Claims/payment adjudication;
    c. Expenditure report analysis;
    d. Compliance reviews;
    e. Client level encounter/use/performance analysis data; and
    f. Audits.
4. Describe payment methods, used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.
5. Does the state provide assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How does the state ensure block grant funds and state dollars are used for the four purposes?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

C. Environmental Factors and Plan

7. Program Integrity

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

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

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

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

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

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

Yes. Each year, the Regions are statutorily required to submit a Regional Budget Plan, overviewing the comprehensive array of mental health and substance use disorder services with sufficient capacity for designated geographic area based on a comprehensive needs assessment/strategic plan (Regional Budget Plan - Network Management A.2. Expectations). This budget plan is submitted to the DBH per specific specifications and expectations detailed in Regional Budget Plan Guidelines. Within these guidelines, federal program requirements are listed including the populations to be served with the funding, allowable and unallowable expenditures, and audit requirements, as well as the specific purposes identified by SAMHSA for the block grant. This document, along with their respective plans are incorporated into the subsequent subaward issued by the DBH. The Regions, in turn, pass these same terms and

requirements to subsequent recipients of the funds, which is verified in the Network Services Review in which DBH reviews compliance to contractual requirements.

In addition, it is 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 process used to complete this is discussed in Question #3.

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

Nebraska statute mandates that the DBH approve an annual Regional Budget Plan (RBP) for each Region that includes budget and planning information for the 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.

Monthly, invoices for services performed are submitted to the DBH for payment. All services are documented in the DBH data system and a sampling of these services are subsequently reviewed through verification process discussed below. Expenditures for each block grant and state funds are reviewed monthly to determine if funds are being expended by each entity subawarded these funds as well as to ensure that appropriate maintenance of expenditures are being achieved. Data from services is also reviewed periodically both internally and with external partners for integrity and accuracy.

The DBH and the Regions use internal and external measures for oversight of services purchased through the subawards between the DBH and the Region.

External measures are performed by entities outside entities and include:

1. Fiscal audit as conducted by a certified public accountant, and
2. Accreditation by a nationally recognized accrediting body

Internal measures are performed by DBH and the Regions, and include:

1. Services Purchased Verifications (unit/fiscal -to ensure that services billed were in fact provided and verified by review of client files as well that expenditures billed were allowable and reasonable.)
2. Program Fidelity Reviews (address adherence to service, statutory and regulatory requirements by all providers)
3. Internal Controls (self-review & monitoring)
    a. In compliance with the COSO (Committee Of Sponsoring Organizations) documents:
        i. Standards for Internal Control in Federal Government
        ii. Internal Control Integrated Framework
4. Financial Reliability of Sub-recipients
    a. Pre-award and ongoing
        i. Required use of a form or checklist for risk assessment
        ii. Sub-recipient required to relate financial data to performance accomplishments of the Federal Award
    b. Audit findings – systematic review and follow-up
    c. Written policies
        i. Cash management
        ii. Allowable costs-in accordance with cost principles (2 CFR 200.302)

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

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

The written procedures for these reviews are standardized in the document titled “Audit Manual” and provides 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.

The Nebraska Department of Health and Human Services (NDHHS) Internal Audit Section reviews Single Audit Act reports to identify any areas of non-compliance. The DBH staff contacts the recipient to follow-up on any areas of non-compliance identified and solicits corrective action plans to be accepted, corrected, or modified by NDHHS. The Regions are charged to conduct a similar review and follow-up with any entity they award federal dollars.

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

The DBH ensures payment methodologies are appropriate using tools such as the RBP and annual contracts. For example, the RBP defines what allowable costs are consistent with State of Nebraska procurement statutes as well as SAMHSA and OMB guidance documents. Use of state and/or federal funds are limited to allowable items per each type of funding. Services are purchased on a fee-for-service basis or on a cost reimbursement basis. Both types are subsequently reviewed to ensure the provision of the service occurred and that the costs charged were allowable and reasonable (see questions 2 and 3). At no time are funds sent to the recipient in advance of service provision.

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

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

DBH relays its standards of care through Service Definitions as well as within regulations. The service definitions detail the basic definition, service expectations, staffing, hours of operations and desired outcomes related to each particular level of care and are an attachment to either contracts/subawards or to the regulations. The regulations (NAC 206 Chapter 6) defines consumer rights, consumer grievances, expectations for trauma informed services, consumer eligibility and payments for services, records content, access, and retention, clinical documentation requirements, discharge planning, and requirements for individualized treatment, rehabilitation, and recovery planning with consumers.

Once in the network, 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 does the state ensure block grant funds and state dollars are used for the four purposes?

As indicated in question 1, 2, and 3, the four purposes related to block grant funding are passed through to Regions in the Regional Budget Planning Guidelines. All other recipients have these guidelines pass through in the subaward document directly. In addition, statutory authority related to DBH ensures funding is used only for behavioral health services and the DBH regulations defines the financial eligibility criteria for consumers seeking care. Within these regulations (NAC 206, Chapter 6.005), it clearly defines that DBH reserves the right to be the payer of last resort and that DBH will not reimburse providers for any Medicaid reimbursable service provided to Medicaid consumers or for any services eligible for, or covered under, any health insurance benefit.

Requirements for prevention activities within regulations and subawards require the use of the Strategic Prevention Framework for funded initiatives. Regions are required to utilize and fund the six prevention strategies and have a minimum amount of funding that must be dedicated to substance abuse prevention activities each year.

Each service provider funding through the DBH directly, or through Regions, is required to submit client demographic, service and encounter data to the DBH as a condition of their contract. This allows DBH to analysis this data to demonstrate performance and outcome measures to ensure quality, effective services are being purchased.

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

8. Tribes

Narrative Question:

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the 2009 Memorandum on Tribal Consultation[74] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

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

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that 67% of American Indian and Alaska Natives live off-reservation. SSAs/SMHAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the state. States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

Please consider the following items as a guide when preparing the description of the state's system:

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

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

[74] http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

C. Environmental Factors and Plan

8. Tribes

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the 2009 Memorandum on Tribal Consultation74 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.

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

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

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

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

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

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

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

9. Primary Prevention for Substance Abuse

Narrative Question:

Federal law requires that states spend no less than 20 percent of their SABG allotment on primary prevention programs, although many states spend more. Primary prevention programs, practices, and strategies are directed at individuals who have not been determined to require treatment for substance abuse.

Federal regulation (45 CFR 96.125) requires states to use the primary prevention set-aside of the SABG to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance abuse. The program must include, but is not limited to, the following strategies:

- Information Dissemination provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the information source to the audience, with limited contact between the two.
- Education builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental capabilities. There is more interaction between facilitators and participants than there is for information dissemination.
- Alternatives provide opportunities for target populations to participate in activities that exclude alcohol and other drugs. The purpose is to discourage use of alcohol and other drugs by providing alternative, healthy activities.
- Problem Identification and Referral aims to identify individuals who have indulged in illegal or age-inappropriate use of tobacco, alcohol or other substances legal for adults, and individuals who have indulged in the first use of illicit drugs. The goal is to assess if their behavior can be reversed through education. This strategy does not include any activity designed to determine if a person is in need of treatment.
- Community-based Process provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning
- Environmental Strategies establish or changes written and unwritten community standards, codes, and attitudes. The intent is to influence the general population's use of alcohol and other drugs.

States should use a variety of strategies that target populations with different levels of risk. Specifically, prevention strategies can be classified using the IOM Model of Universal, Selective, and Indicated, which classifies preventive interventions by targeted population. The definitions for these population classifications are:

- Universal: The general public or a whole population group that has not been identified based on individual risk.
- Selective: Individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- Indicated: Individuals in high-risk environments that have minimal but detectable signs or symptoms foreshadowing disorder or have biological markers indicating predispositions for disorder but do not yet meet diagnostic levels.

It is important to note that classifications of preventive interventions by strategy and by IOM category are not mutually exclusive, as strategy classification indicates the type of activity while IOM classification indicates the populations served by the activity. Federal regulation requires states to use prevention set-aside funding to implement substance abuse prevention interventions in all six strategies. SAMHSA also recommends that prevention set-aside funding be used to target populations with all levels of risk: universal, indicated, and selective populations.

While the primary prevention set-aside of the SABG must be used only for primary substance abuse prevention activities, it is important to note that many evidence-based substance abuse prevention programs have a positive impact not only on the prevention of substance use and abuse, but also on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. This reflects the fact that substance use and other aspects of behavioral health share many of the same risk and protective factors.

The backbone of an effective prevention system is an infrastructure with the ability to collect and analyze epidemiological data on substance use and its associated consequences and use this data to identify areas of greatest need. Good data also enable states to identify, implement, and evaluate evidence-based programs, practices, and policies that have the ability to reduce substance use and improve health and well-being in communities. In particular, SAMHSA strongly encourages states to use data collected and analyzed by their SEOWs to help make data- driven funding decisions. Consistent with states using data to guide their funding decisions, SAMHSA encourages states to look closely at the data on opioid/prescription drug abuse, as well as underage use of legal substances, such as alcohol, and marijuana in those states where its use has been legalized. SAMHSA also encourages states to use data-driven approaches to allocate funding to communities with fewer resources and the greatest behavioral health needs.

SAMHSA expects that state substance abuse agencies have the ability to implement the five steps of the strategic prevention framework (SPF) or an equivalent planning model that encompasses these steps:

1. Assess prevention needs;
2. Build capacity to address prevention needs;
3. Plan to implement evidence-based strategies that address the risk and protective factors associated with the identified needs;
4. Implement appropriate strategies across the spheres of influence (individual, family, school, community, environment) that reduce substance abuse and its associated consequences; and
5. Evaluate progress towards goals.

States also need to be prepared to report on the outcomes of their efforts on substance abuse- related attitudes and behaviors. This means that state-funded prevention providers will need to be able to collect data and report this information to the state. With limited resources, states should also look for opportunities to leverage different streams of funding to create a coordinated data driven substance abuse prevention system. SAMHSA expects that states coordinate the use of all substance abuse prevention funding in the state, including the primary prevention set-aside of the SABG, discretionary SAMHSA grants such as the Partnerships for Success (PFS) grant, and other federal, state, and local prevention dollars, toward common outcomes to strive to create an impact in their state's use, misuse or addiction metrics.

Please consider the following items as a guide when preparing the description of the state's system:

1. Please indicate if the state has an active SEOW. If so, please describe:
    - The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);
    - The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and
    - The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).
2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. Please describe if the state has:
    a. A statewide licensing or certification program for the substance abuse prevention workforce;
    b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and
    c. A formal mechanism to assess community readiness to implement prevention strategies.
5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (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)?
6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.
7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.
8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.
9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?
10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?
11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

C. Environmental Factors and Plan

12. Primary Prevention for Substance Abuse

Federal law requires that states spend no less than 20 percent of their SABG allotment on primary prevention programs, although many states spend more. Primary prevention programs, practices, and strategies are directed at individuals who have not been determined to require treatment for substance abuse.

Federal regulation (45 CFR 96.125) requires states to use the primary prevention set-aside of the SABG to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance abuse.

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

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

In effort to decrease the number of interruptions in school schedules the Student Health and Risk Prevention (SHARP) Surveillance System was created as the umbrella that encompasses the coordinated administration of three school-based student health surveys in Nebraska, including the Youth Risk Behavior Survey, the Youth Tobacco Survey, and the Nebraska Risk and Protective Factor Student Survey. Prior to 2010, schools were asked to conduct surveys three out of every four semesters. Beginning in 2010, with the creation of SHARP, schools are now asked for assistance only once every two years. All three surveys are administered at the same time in the fall of even calendar years. In partnership with the SEOW, the DBH and the Nebraska Department of Education and the DBH are responsible for identifying and monitoring factors that may affect the health, learning, and quality of life of Nebraska youth. SHARP includes the ONLY student health surveys endorsed by these two state agencies. DBH manages this contract and serves as the feedback loop to the SEOW.

The Nebraska Risk and Protective Factor Student Survey collects data on risk and protective factors related to four domains (community, school, family, and individual/peer). Having information on the presence of these factors at the school and community level allows schools and communities to design and/or select effective and locally-appropriate prevention strategies that can reduce substance abuse, delinquency, and other problems while supporting improvements in health and learning.

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

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

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

As a requirement of DBH's annual Regional Budget Planning process at least 50 percent of the SABG Primary Prevention dollars received by community coalitions must be used to fund community based and environmental strategies. Emphasis is placed on using a multi-strategy approach where one or more environmental strategies are designed to impact the community and societal levels (of the social-ecological model) as well as impacting the individuals in their community's target populations. In order to address the availability of substances and community norms around these concerns sub-recipients are expected to familiarize themselves with the wealth of approaches that can be used, and pick those that best fit their assessed needs, as balanced against community readiness and coalition capacity. Beyond this, sub-recipients of the SABG have the flexibility to implement a variety of evidence-based programs, policies, and substance abuse prevention practices in their community as long as the interventions are supported by a local need assessment and driven by a planning process using the Strategic Planning Framework.

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

DBH's Five Year Strategic Plan for Prevention addresses capacity building with the goal of strengthening leadership, infrastructure and workforce at the State and Regional levels in order to support strong community coalitions and their volunteer members. The plan includes two major

activities (1) ensure sound structure, active membership, and on-going leadership role of the State's substance abuse prevention advisory council and (2) promote leadership through technical assistance and training to establish statewide priorities for Regions and communities.

DBH is currently engaged in a technical assistance effort with CSAP/JBS to formalize core competencies, conduct a workforce needs assessment survey and develop an overarching workforce development plan that can address the prevention goals identified in the strategic plan to sustain a professionalized workforce. Technical assistance (TA) is being provided in separate phases and the consultants are currently developing an evaluation plan and instruments to measure the progress of Nebraska's substance abuse prevention Workforce Development Plan, Training/TA plan and Training/TA providers.

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

Nebraska's prevention system has identified a set of prevention professional core competencies and as part of the assistance described above is working to formalize the skills, knowledge and abilities that will be required for each level of the prevention workforce. The state does not have a licensing or certification program at this time. However, DBH now requires that all paid Prevention staff (both Regional and community coalitions) complete 12 hours of continuing education relevant to the prevention of mental illness and/or substance use disorders and support proficiency across the agreed upon set of core competencies. Additionally, the state has been successful sustaining a strong cadre of at least eight Substance Abuse Prevention Skills Training (SAPST) trainers. DBH has committed to hosting at least one SAPST workshop each year and now the state has the capacity to readily conduct a SAPST training on an as needed basis when new preventionists join the workforce.

As part of SAPST training as well as previous grant experiences, the influence of the Strategic Prevention Framework (SPF) continues to grow throughout the Regional Prevention Coordination System as training and technical assistance to area coalitions has been refined to specifically focus on application of the SPF. Community coalitions benefit enormously from this hands-on, face-to-face training and technical assistance that takes them through every step of the prevention planning process and allows them to network and strategize with their peers. Bolstered by the provision of specific techniques and tools designed for each stage of the SPF process, communities have demonstrated significant increases in their capacity to engage in effective planning. Regional Prevention Coordinators, through a contractual partnership with the State and community coalitions, will continue to build on existing success by further providing extensive community-based training and technical assistance to assess community readiness, identify outcomes and prioritize the most effective interventions in the development of local sustainability plans.

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

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

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

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

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

State prevention staff, in collaboration with the Prevention Advisory Council, serve as the evidence-based workgroup for the State of Nebraska. A decision making process has been developed to review and select appropriate programming. This involves completion of an assessment of available evidence of effectiveness, consideration of the overarching state and local level prevention strategy, and an understanding of the local level climate and capacity to implement. Nebraska has a small paid prevention workforce statewide that would overlap substantially with the Prevention Advisory Council if an additional committee were to be formed. We have found that the process of reviewing concerns related to evidence-based prevention is best done in conjunction with other advisory efforts.

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

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

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

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

- Across Ages
- All Stars
- CASASTART - Striving Together to Achieve Rewarding Tomorrows
- Character Counts
- Common Sense Parenting
- LifeSkills Training Program
- Me360
- Parent and Family Skills Training
- Project Northland
- Protecting You/Protecting Me
- PRIME For Life
- Slick Tracy
- Strengthening Families
- Too Good for Drugs
- Too Smart to Start Drugs
- W.A.I.T. (Abstinence Education)
- Why Try
- Educational materials developed in support of Red Ribbon Week, Prevention Week, and safe Prescription Drug disposal.

DBH sponsors a variety of **alternative** activities such as youth trainings and/or summits throughout the school year and summer breaks designed to develop youth leadership within their home communities. Another frequently used strategy is partnerships with law enforcement to coordinate promotional letters sent to students to encourage safer and wise choices during prom and graduation season. Nebraska also has many successful mentoring programs, namely Teammates and the Big Brothers Big Sisters Mentoring Program that provide positive

alternatives to our youth. Other strategies include the Health Rocks Teen program, Community drop-in centers and drug free dances/parties.

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

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

Environmental strategies represent the other majority half of funding efforts to establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population. The primary program used for this strategy is Communities Mobilizing for Change on Alcohol (CMCA) and Challenging College Alcohol Abuse. Other environmental strategies implemented throughout the year include compliance checks for alcohol and tobacco, sobriety checkpoints and party patrols. In support of the State's social norms campaign to prevent underage drinking, the prevention system continues to focus on preventing the sale and use of alcoholic beverages products to minors. This is includes implementation of social host ordinances at the local level, regular provision of Responsible Beverage Server Training (RBST) and Training for Intervention Procedures (TIPS). Concentrated review of use policies and procedures is active in every region of the state via the Life of An Athlete Program. Specific program activities include: revision of student codes of conduct to support healthy lifestyle choices; policy changes that encourage positive behavior among the athletic community; youth leadership training to develop team unity; and student athlete, coach, parent, and community education on the impact of lifestyle choices and how to make healthier ones.

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

DBH's Prevention System is striving to create population level change, thus it is imperative that communities be targeted with prevention initiatives that demonstrate measurable change in behaviors or in important risk factors that lead to behavior change. DBH supports a structured, community-based approach to substance abuse prevention through the Strategic Prevention Framework. Sub-recipients complete an assessment process, including the selection of their local prevention priorities, contributing factors, and root causes prior to choosing prevention strategies. 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.

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

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

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

DBH's Five Year Strategic Plan for Prevention calls for Nebraskans to have access to effective prevention services that produce measurable outcomes and use resources efficiently. The primary method to gather and evaluate process data is reported through the Nebraska Prevention information reporting System (NPIRS). This is an internet based reporting system designed to collect prevention activity data for prevention strategies, interventions or activities funded via contract with the DBH. NPIRS is available for use by internal state staff as well as any entity conducting prevention activities in Nebraska which includes but is not limited to community coalitions, private not for profit agencies, and Regional Behavioral Health Authorities. Key feature of NPIRS include: internet based reporting, reporting at multiple levels and coordinated reporting between various funding sources. The systems collects the following types of process data:

- Number of T/TA activities and Numbers served by T/TA
- Number of sub-recipients reporting monthly data
- Number of evidence-based programs, policies, or practices implemented
- Number of people served/reached by Institute of Medicine prevention category

- Number and demographics reached through selected strategies
- Use Leveraged and/or Braided Funding Sources

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

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

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

Nebraskans Prevention Performance Indicators		
Indicator	Indicator Type	2017 Target
Percent of high school students who consume alcohol	Lifetime Use	25%
Percent of young adults aged 19 and 20 who report consuming alcohol currently	30 Day Use	43%
Percent of young adults ages 19 to 25 who report binge drinking	30 Day Use	43%
Percent of males aged 19 and 20 who report binge drinking	30 Day Use	35%
Percent of high school students who report using prescription drugs not prescribed by a physician	30 Day Use	10%
Percentage of Adults aged 18 and older who report using prescription drugs not prescribed by a physician	Past Year Use	4%
Percentage of high school students who report using marijuana	Past Month Use	11%
Percentage of tobacco retailers who sell tobacco products to minors	Past Year Sold	Less than 20%

These performance indicators are an essential part in evaluating the prevention system and the impact on the state- and community level outcomes. The identification and prioritization of outcomes helps monitor the progress of Nebraska's prevention system and holds the DBH

accountable for these prevention targets as the system moves forward. Ultimately, DBH strives to reduce rates of substance abuse among students and young adults while increasing the amount of positive lifestyle choices made.

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

Environmental Factors and Plan

10. Quality Improvement Plan

Narrative Question:

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

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

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

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

Section 1 Introduction

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

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

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

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

The Division of Behavioral Health CQI program will ensure:

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

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

The CQI Program is based on the following assumptions:

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

Core Principles

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

- **Customer Focused**. Understanding and respecting needs and requirements of all customers and striving to exceed expectations.

- **Strengths Based.** Effective growth and change build on the consumer/family and system's strengths.

- **Recovery Oriented.** Services are characterized by a commitment to promoting and preserving wellness and choice. This approach promotes maximum flexibility to meet individually defined goals in a consumer's recovery journey.

- **Representative Participation and Active Involvement**. Effective programs involves a diverse representation of stakeholders. The stakeholders are provided the resources, education and opportunity to make improvements required and influence decision making.

- **Data Informed Practice**. Successful QI processes create feedback loops, using data to inform practice and measure results. There is a commitment to seek IT structures, staff, skills and other resources in the provision of data.

- **Use of Statistical Tools**. For continuous improvement of services, tools and methods are needed that foster knowledge and understanding. CQI organizations use a defined set of analytic tools such as run charts, cause and effect diagrams, flowcharts, Pareto charts, histograms, and control charts to turn data into information.

- **Continuous Quality Improvement Activities**. Quality improvement activities emerge from a systematic and organized framework for improvement. This framework, adopted by the DBH, 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. Through a learning collaborative with DBH, the six Regions across Nebraska and the three State Regional Centers, system partners support working together in collaboration, creating a system of coordinated services to better meet the needs of consumers and families and supporting our providers. The collaborative utilizes an "all teach-all learn" philosophy to work collaboratively, holding ourselves accountable to delivering the highest quality services to the community and to our State's consumers and families in a cost effective manner utilizing Results-Based Accountability (RBA) and the Plan, Do, Study, Act (PDSA). CQI is ultimately about learning. It is about delving into details, doing PDSA's and continuously making improvements. Challenging ourselves to be accountable to delivering the highest quality services to the State's consumers, families and community. Working together in collaboration creates a system of coordinated services to better meet the needs of individuals and families.

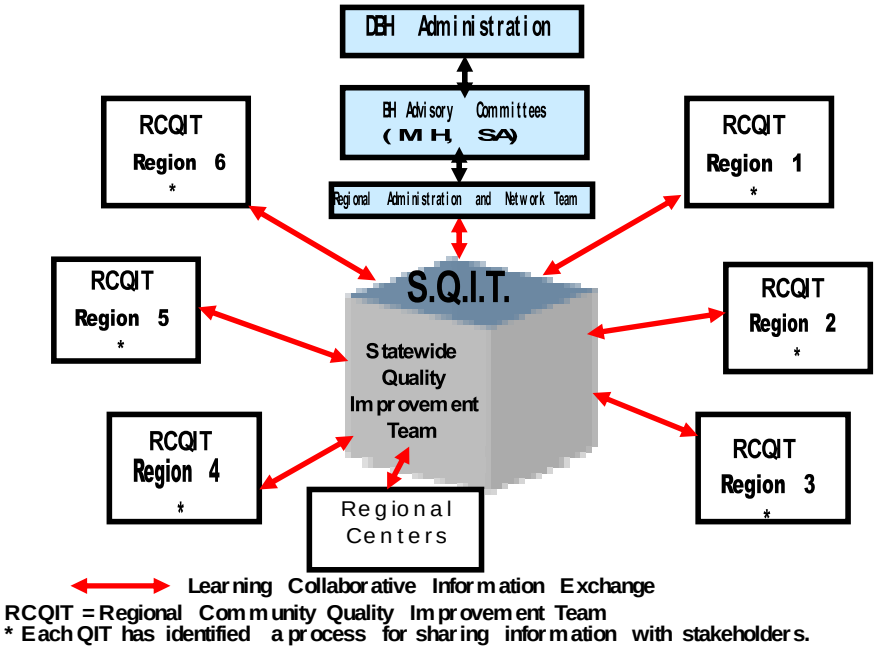
- **Plan, Do, Study, Act (PDSA).** Develops a plan to test the change (Plan), carrying out the test (Do), observing and learning from the consequences (Study), and determining what modifications should be made to the test (Act). PDSA activities will be conducted through an "all teach-all learn" style of learning collaborative to review and evaluate data with the six Regional Behavioral Health Authorities and the three State Regional Centers. (See Appendix 1).

- **Results-Based Accountability**. Results-Based Accountability (RBA) is a disciplined way of thinking and taking action that communities can use to improve the lives of those we serve. RBA will provide an opportunity for the State, Regions, Regional Centers and providers to measure whether consumers are better off as a result of the service received. (See Appendix 2).

Section 2 Leadership and Organization

Leadership and Stakeholders:

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



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

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

Membership includes but is not limited to:

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

The responsibilities include:

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

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

Membership includes:

- Regional Administrators
- DBH Team
- Network Team

The responsibilities include:

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

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

Membership includes:

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

Consultants include:

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

Responsibilities of SQIT include:

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

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

Membership includes:

- Consumers
- Regional Staff
- Providers
- Other Community Stakeholders

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

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

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

Membership includes:

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

The responsibilities include:

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

Section 3 Annual Goals

QI Program Goals for FY16/17 include:

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

Section 4 RBA Performance Measurement

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

FY16 DBH State Priorities

Result – Statewide Population

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

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

Indicators - Statewide Population

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

1. **Decrease in substance use:**
   - Binge drinking 12-17[1, 2]
   - Binge drinking 18+[1] /19+[3]
   - Marijuana use 12-17[1, 2]
2. **Decrease in Nebraskans needing involuntary emergency inpatient care:**
   - Involuntary hospitalizations through EPC admissions[4]
   - Mental Health Board commitments[4, 5]

Performance Measures – Region/Program Level

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

1. **How well do we do it?**
   - % positive response to general satisfaction with services received[6]
   - % positive response to staff sensitive to trauma[6]
   - % programs with improvement in trauma informed scores[7]
   - % programs with improvement in co-occurring capable/enhanced scores[8]
   - % consumers discharged with treatment completed status[4]

2. **Is anyone better off?**
   - #/% positive response to improved QOL[6]
   - #/% positive response to improvement in symptoms[6]
   - Average # days / % of consumers who binge drank in last 30 days[6]
   - #/% decrease in substance use[4]

Data Sources:

[1] *National Survey on Drug Use and Health*
[2] *Youth Risk Behavior Survey*
[3] *Young Adult Alcohol Opinion Survey*
[4] *Provider Entered Treatment Data*
[5] *Electronic Commitment Reporting Application*
[6] *Consumer Survey Data*
[7] *Trauma-Informed Program Self-Assessment Scale by Fallot and Harris*
[8] *COMPASS-EZ™ by ZiaPartners, Inc.*

Section 5 Emergencies & Critical Incidents

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

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

Risk Communication Cadre is a pool of behavioral health professionals with competency in risk communication, risk assessment, and public information. The Risk Communication Cadre is identified jointly by DBH 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.

Section 6 Complaints & Grievances

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

The DBH requires 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, DBH regulations require each provider to establish a written consumer grievance policy with the following components:

1. Consumers and as applicable, their legal representative(s) and family of their choosing must be informed of and given a copy of written procedures for addressing and resolving grievances established by each provider;

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, Office of Consumer Affairs; the Division of Public Health, Facility Complaint Intake and the Investigations Section, the designated Protection and Advocacy organization for Nebraska; the Consumer Specialist of the Regional Behavioral Health Authority (RBHA); the office of the Ombudsman; the Department's System Advocate, and the vendor who is contracted for system management. This information must also be readily available to consumers, families, staff, and others. More information on processes and standards for response to complaints and grievances can be found in regulations: http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-206/Chapter-06.pdf.

Appendix 1

Plan-Do-Study-Act (PDSA) Model

Plan – Plan for a specific improvement activity

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

Do - Do carry out the plan for improvement

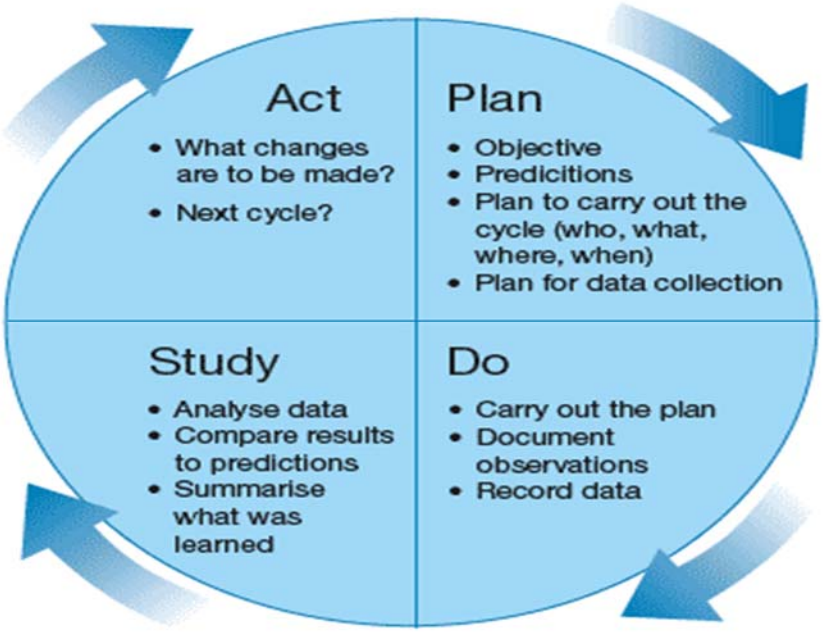
- Gain approval and support of the selected improvement solution
- Implement the improvement solution
- May use a trial or pilot implementation
- Document observations and data

Study - Study the data and determine results

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

Act – Action for full implementation or reject and try again

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



Appendix 2

The RBA "TURN-THE-CURVE" TEMPLATE

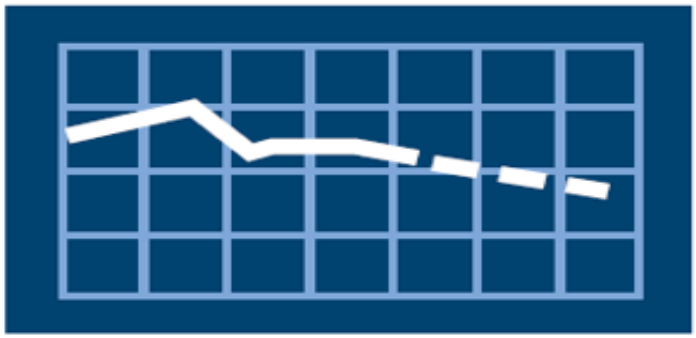
This template is an overview of the step-by-step RBA "turn-the-curve" decision-making process.

1 What is the "end"?

Choose either a result and indicator or a performance measure.

2 How are we doing?

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



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

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

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

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

5 What works to turn the curve?

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

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

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

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

11. Trauma

Narrative Question:

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

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems [76]. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses, and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders. Research has also indicated that with appropriate supports and intervention, people can overcome traumatic experiences. However, most people go without these services and supports.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often themselves re-traumatizing, making it necessary to rethink doing “business as usual.” These public institutions and service settings are increasingly adopting a trauma-informed approach guided by key principles of safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues, and incorporation of trauma-specific screening, assessment, treatment, and recovery practices.

To 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 approach consistent with “SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach”. [77] 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 supportive and avoid traumatizing the individuals again. It is suggested that the states uses SAMHSA’s guidance for implementing the trauma-informed approach discussed in the Concept of Trauma [78] paper.

Please consider the following items as a guide when preparing the description of the state’s system:

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

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

75 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

76 http://www.samhsa.gov/trauma-violence/types

77 http://store.samhsa.gov/product/SMA14-4884

78 *Ibid*

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

C. Environmental Factors and Plan

11. Trauma

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

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3. How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?
4. Does the state provide trainings to increase capacity of providers to deliver trauma specific interventions?

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

DBH has included definitions and language in the regulations to support trauma-informed care and provide clarity in expectations related to psychological trauma, trauma-informed services and coordination of a trauma-informed system. More on regulation can be found at: http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-206/Chapter-06.pdf

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

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

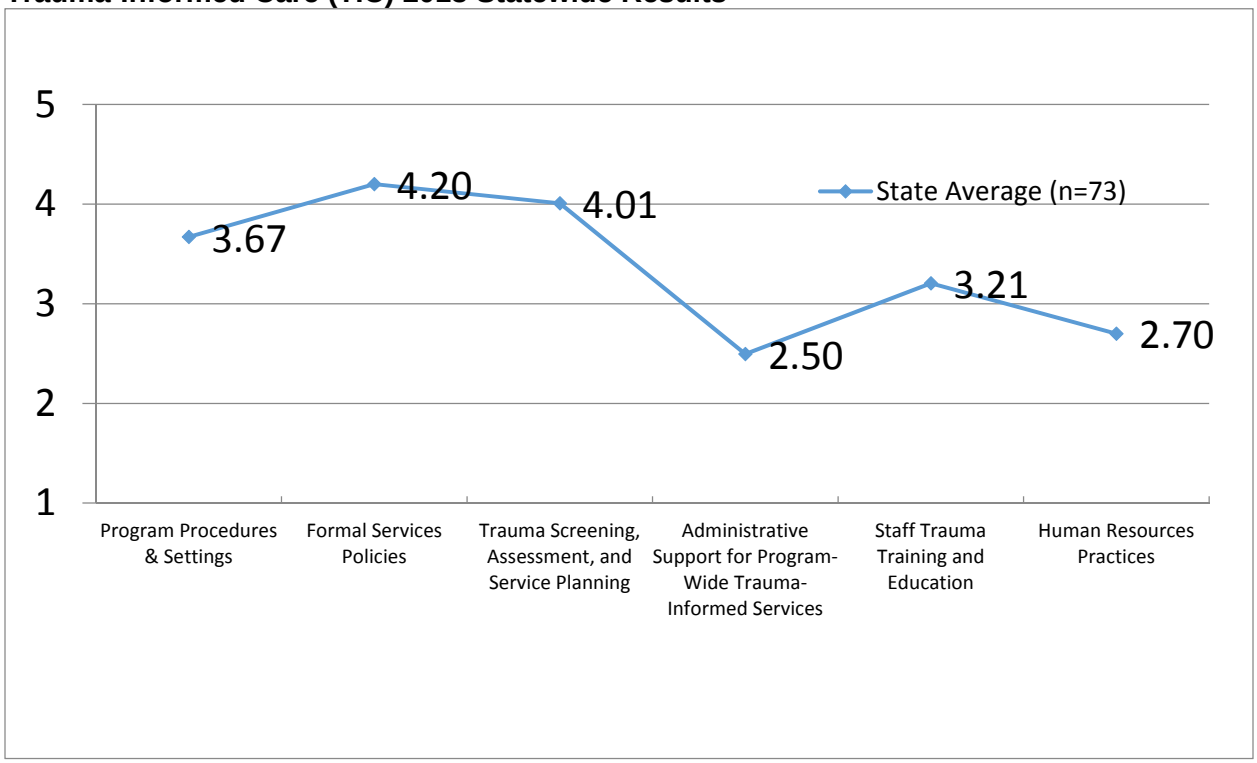
Through the DBH Regional Budget Plan (RBP) Guidelines and contracts with the six Regional Behavioral Health Authorities (RBHAs), it is expected that providers connect individuals with trauma histories to trauma-focused therapy. Expectations set include that network development and coordination across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

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

RBHAs must also annually submit a list of the number of the trauma specific services that providers have available, to support consumer choice in selecting trauma services. Over the last few years, the DBH noted a range of services listed as trauma specific. A repository was developed and placed on our Network of Care website.
http://dhhs.ne.gov/behavioral_health/Documents/FY15TraumaInformedDec2014.pdf

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

Trauma-Informed Care (TIC) 2013 Statewide Results



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

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

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

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

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

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

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

There is no area of technical assistance need identified at this time. The State hospitals will seek out technical assistance in the future.

12. Criminal and Juvenile Justice

Narrative Question:

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one third meet criteria for having co-occurring substance abuse and mental health problems. Successful diversion from or re-entering the community from detention, jails, and prisons is often dependent on engaging in appropriate substance use and/or mental health treatment. Some states have implemented such efforts as mental health, veteran and drug courts, crisis intervention training and re-entry programs to help reduce arrests, imprisonment and recidivism.[79]

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 use 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.[80] [81] 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 use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[82]

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

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as a 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 consider the following items as a guide when preparing the description of the state's system:

1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?
2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Do the SMHA and SSA coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?
4. Are cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

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

[79] http://csgjusticecenter.org/mental-health/

[80] The American Prospect: In the history of American mental hospitals and prisons, *The Rehabilitation of the Asylum*. David Rottman,2000.

[81] 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.

[82] 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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

C. Environmental Factors and Plan

12. Criminal and Juvenile Justice

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

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

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

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

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

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

Intercept 1 – Training to Law Enforcement

Crisis Intervention Team: In Omaha, a Crisis Intervention Team (CIT) model was developed and adopted as a cooperative community partnership involving law enforcement agencies, mental health service providers, mental health consumers, family members, and community funders. Through participation in this program, CIT police officers learn to recognize common forms of mental illness and to utilize the most effective means of communicating with people undergoing crisis. The officers are trained to de-escalate the individuals in crisis and allow the consumer to participate in the decision-making regarding their treatment. CIT officers must successfully complete 40 hours of training to become certified. This training has been offered to law enforcement providers in other Regions. 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. This training has been offered to law enforcement providers in other Regions. For more information on BETA see the website at:
http://www.region5systems.net/trainings

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

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

The video series uses experts from law enforcement and behavioral health to describe a likely scenario and the techniques, combined with 3 demonstration scenarios depicting how an individual experiencing Psychosis, Depression, or Mania would likely act and sound, and how an officer uses the de-escalation techniques. Other videos in the training series explain the resources available to the officers. For more information see:
http://dhhs.ne.gov/behavioral_health/Pages/beh_video_09.aspx

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. Teams use natural supports and resources to build upon a consumer's strengths to help resolve an immediate behavioral health crisis in the least restrictive environment by assisting the consumer to develop a plan to resolve the crisis. The service is provided by licensed behavioral health professionals who complete brief mental health status exams and substance use disorder screenings, assess risk, and provide crisis intervention, crisis stabilization, referral linkages, and consultation to hospital emergency room personnel, if necessary. The goal of the service is to avoid an Emergency Protective Custody hold or inpatient psychiatric hospitalization. This service is available in all Regions.

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. All Jails in Nebraska utilize the same set of questions to screen for mental health/suicidality in persons detained. In addition:

Region 3 – Behavioral Health funds additional 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 county jails. Target population of the service is transition age youth, 18 through 25 years of age. At time of booking, individuals are screened for multiple risk factors such as mental illness, substance use, homelessness, and related areas. Potential participants are identified through this process. A face to face meeting is then conducted with the potential participant to introduce ICM and develop a collaborative and individualized treatment plan. If issues arise while in county jail the staff can call upon the psychiatrist (if available to the specific county) to evaluate the inmate.

Fee for Service Voucher Program: Many criminal offenders do not have the financial ability to pay for their own rehabilitative programs. The Fee for Service Voucher Program was created to reduce the financial barriers of specifically identified offenders receiving substance abuse treatment through a financial assistance program. Vouchers are not intended to supplant other means of financial assistance for offenders, but instead as a resource available to parole and probation officers for offenders when a need exists. Whenever possible, offenders are expected to contribute toward the financial obligations associated with evaluations and treatment. Services provided for by the Fee for Service Voucher Program include Substance Abuse Evaluations, Outpatient Treatment, Intensive Outpatient Treatment and Short-Term Residential Treatment. The Fee for Service Voucher program is funded through a combination of general funds and offender fees. The voucher program is administered by the Office of Probation Administration. The target population eligible for vouchers includes Felony Drug Offense Offenders, Parole Offenders, Felony Offenders under Sanction or Violation Status, Class I Misdemeanor Drug Offense, and 3rd Offense DUI and Felony DUI.

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

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

Regional Behavioral Health Authority

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

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

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

In Dawes County, the Crisis Rapid Response Emergency Community Support Specialist responds after the Crisis call, and meets with the individual in jail to develop a plan in preparation for this person's release. The individualized plan can include Emergency

Community Support, obtaining an identification card, a Social Security number, and referrals for assessment and/or other behavioral health services.

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

Behavioral Health staff provided Mental Health and Substance Use education and training with law enforcement and county jail staff and, should an individual, or jail staff member on behalf of an individual, request behavioral health support, the Region responds. Individualized services could include Emergency Community Support, Community Support, Outpatient Therapy, Crisis Assessment or any other service requested. Likewise, when an individual who is receiving services finds him/herself in jail, the Region becomes actively involved in the discharge process.

Region 3 – Adams and Buffalo Counties:

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

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

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

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

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

Region 5 – Lancaster County

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

Region 6 – Douglas, Sarpy, and Washington Counties

Region 6 funds the Intensive Case Management program for transitional age youth 18-24 who are being released from a county jail. Region 6 is a member of the 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 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.

Re-Entry Program:

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

Regional Behavioral Health Authority Activities for the Population

Region 3 – Adams and Buffalo Counties

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

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

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

Region 5 – Lancaster County

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

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

Region 6 – Douglas, Sarpy, and Washington Counties

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

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

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

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

Justice Behavioral Health Committee

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

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

Expected Outcomes of this collaborative work includes:

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

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

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

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

Youth Behavioral Health Services Stakeholder Committee

A new workgroup was formed to explore how our systems can collaborate to improve outcomes for the youth we collectively serve. Stakeholders from the Divisions of Medicaid and Long Term Care, Children and Family Services, Behavioral Health, Magellan Behavioral Health and others were convened to look at the Assessment Process/Evaluation as prepared and delivered to the

court, discuss roles, data sharing, successes, communication and other issues to strengthen the services provided to youth on probation.

Probation – Behavioral Health Regions Partnership Meeting

The Division of Behavioral Health staff participate in the Probation – Behavioral Health Regions Partnership Meeting to increase the ability of the Regional provider networks to provide services which are designed to meet the needs of the criminal justice population. This includes development of a network of providers who can perform assessments addressing criminogenic needs and services for this population. At a meeting, the Division of Behavioral Health, Probation and RBHAs, the following information is presented and discussed:

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

Work continues to build on the issues described above.

In addition, the NDCS has formed and charged a cross system workgroup, including staff from the DBH, to get an inventory of all NDCS, Parole and Probation programs and examine a processed for inmates involved in our systems and when they should engage in programming and how to most effectively utilize our resources, including behavioral health resources.

Technical assistance with developing a collaborative approach among stakeholders, including multisystem agencies, community organizations and people with mental illnesses and their families, to encourage innovation and expand the Stepping Up Initiative across the state.

13. State Parity Efforts

Narrative Question:

MHPAEA generally requires group health plans and health insurance issuers to ensure that financial requirements and treatment limitations applied to M/SUD benefits are no more restrictive than the requirements or limitations applied to medical/surgical benefits. The legislation applies to both private and public sector employer plans that have more than 50 employees, including both self-insured and fully insured arrangements. MHPAEA also applies to health insurance issuers that sell coverage to employers with more than 50 employees. The Affordable Care Act extends these requirements to issuers selling individual market coverage. Small group and individual issuers participating in the Marketplaces (as well as most small group and individual issuers outside the Marketplaces) are required to offer EHBs, which are required by statute to include services for M/SUDs and behavioral health treatment - and to comply with MHPAEA. Guidance was released for states in January 2013.[83]

MHPAEA requirements also apply to Medicaid managed care, alternative benefit plans, and CHIP. ASPE estimates that more than 60 million Americans will benefit from new or expanded mental health and substance abuse coverage under parity requirements. However, public awareness about MHPAEA has been limited. Recent research suggests that the public does not fully understand how behavioral health benefits function, what treatments and services are covered, and how MHPAEA affects their coverage.[84]

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

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.

Please consider the following items as a guide when preparing the description of the state's system:

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

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

[83] http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf

[84] Rosenbach, M., Lake, T., Williams, S., Buck, S. (2009). Implementation of Mental Health Parity: Lessons from California. Psychiatric Services. 60(12) 1589-1594

Please use the box below to indicate areas of technical assistance needed related to this section:

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

Footnotes:

C. Environmental Factors and Plan

13. State Parity Efforts

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

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3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?

MHPAEA and Health Plans and Health Insurance Issuers

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

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

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

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

Consumer Assistance for the Health Insurance Marketplace

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

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

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

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

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

14. Medication Assisted Treatment

Narrative Question:

There is a voluminous literature on the efficacy of FDA-approved medications for the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for medication-assisted treatment of these disorders is described in SAMHSA TIPs 40[85], 43[86], 45[87], and 49[88]. SAMHSA strongly encourages the states to require that treatment facilities providing clinical care to those with substance use disorders be required to either have the capacity and staff expertise to use MAT or have collaborative relationships with other providers such that these MATs can be accessed as clinically indicated for patient need. Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

SAMHSA strongly encourages states to require the use of FDA-approved MATs for substance use disorders where clinically indicated (opioid use disorders with evidence of physical dependence, alcohol use disorders, tobacco use disorders) and particularly in cases of relapse with these disorders. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please consider the following items as a guide when preparing the description of the state's system:

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

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

[85] http://store.samhsa.gov/product/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction/SMA07-3939

[86] http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214

[87] http://store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA13-4131

[88] http://store.samhsa.gov/product/TIP-49-Incorporating-Alcohol-Pharmacotherapies-Into-Medical-Practice/SMA13-4380

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

C. Environmental Factors and Plan

14. Medication Assisted Treatment

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

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The Nebraska Division of Behavioral Health (DBH) contracts with the six Nebraska Behavioral Health Regions and includes a provision in these contract that SUD providers may not refuse to serve individuals receiving Medication Assisted Treatment (MAT). The DBH Chief Clinical Officer monitors pharmacy program changes and advises in the establishment of prior authorization criteria and clinical appropriateness of use to ensure that written policies and procedures for processing requests for initial and continuing authorizations of MAT services are in place. DBH will continue to promote and sponsor training opportunities and disseminate materials to increase provider competence in this area and to educate consumers on how to effectively use these services. Additionally DBH continues discussions with state leadership to increase the availability and accessibility for all opioid addicted individuals who would benefit from them.

Additionally, to promote education of providers, the DBH maintains linkages on its website to the Mid-America ATTC website and their "Buprenorphine Treatment: A Training for Multidisciplinary Addiction Professionals." Once on this site, providers can also access a variety of resources, information and training materials on MAT.
DBH partners with a variety of entities to educate providers on Medication Assisted Treatment (MAT). It is through these partnerships that DBH is able to reach providers to provide education and support. Examples of these collaborations are described below.

Magellan of Nebraska seeks to increase the use of acamprosate, naltrexone (both in oral and injectable form), buprenorphine-and new medications as their proven benefits

emerge-in treatment of substance use disorders where clinically appropriate. The program not only focuses on patients who have been discharged from inpatient substance use treatment programs, but also targets individuals receiving outpatient case or disease management services. Through MAT measures, Magellan of Nebraska monitors the number of cases in which physicians are prescribing medications and follows member readmission rates.

As part of this intervention, Magellan of Nebraska continually collaborates with its health plan partners to help facilitate the incorporation of these medications into client formularies. Additionally, Magellan of Nebraska focuses on provider education efforts to illustrate the importance of using appropriate medications when developing members' substance use disorder treatment plans.

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

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

www.Complex.Care: Improving Treatment for Patients with Chronic Pain, Addiction, & Mental Health Disorders with R. Corey Waller, M.D., M.S. With chronic pain as one of the most common complaints in primary care and hospital settings, physicians are finding they need to know more about the three things for which they received the least amount of training: 1.) appropriate risk screening for addiction, 2.) safer pain treatment protocols, and 3.) how to treat patients with behavioral health conundrums.

During Dr. Waller's presentation in Nebraska, system level breakout session attendees identified several barriers to providing evidence based medication assisted treatment, including funding, access, and ability to adhere to the evidence base. However, workforce challenge was by far the greatest barrier to the practice. Issues with recruitment and retainage, leadership capacity and development, lost revenue during training periods for clinicians, the overall workforce shortage, and stigma relating to substance use disorders in general were identified as barriers to implementing medication assisted treatment across the state.

The session attendees also identified solutions to the barriers. This, in many instances, involves a cultural shift for many agencies. It is important to train all staff working with individuals

receiving treatment, including receptionists, paraprofessionals, nurses and other practitioners in trauma informed care, including supporting women whose children are born testing positive for drugs. This can be incorporated into the existing Trauma Informed Care initiatives and training within Nebraska, to ensure mothers have a positive experience during childbirth episodes and are supported in receiving treatment as appropriate. This shift leads to a positive workplace culture and positive outcomes for staff and consumers, key to retaining staff in their positions.

It was also identified that medication assisted treatment needs to have a strong leadership presence in the state. Given the lack of psychiatrists or board certified addictionologists, other professions, including therapists, could take ownership in bringing professionals and consumers together to talk about furthering access to medication assisted treatment. The process of gathering stakeholders and having conversations will help this movement gain momentum.

The issue of retention was also discussed. In order to raise addiction professionals' salaries without additional funding, it was suggested that salary parity between mental health professionals and substance abuse professionals be explored. Additionally, hiring practices which emphasize "emotional intelligence" as a key factor in hiring staff produces positive results in retention in workforce

DBH leadership attending the session will be following up on the key ideas and opportunities to grow workforce and support an increase in the use of medication assisted treatment. They will be partnering with systems partners, including the Division of Medicaid and Long Term Care, Department of Corrections, Office of Probation and others, gathering information on current expenditures, utilization and other data to make informed decisions about moving forward.

Future TA requests should be expected.

Environmental Factors and Plan

15. Crisis Services

Narrative Question:

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

SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, Practice Guidelines: Core Elements for Responding to Mental Health Crises[89] ,

> "Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports being used to address crisis response include the following:

Crisis Prevention and Early Intervention:

- Wellness Recovery Action Plan (WRAP) Crisis Planning
- Psychiatric Advance Directives
- Family Engagement
- Safety Planning
- Peer-Operated Warm Lines
- Peer-Run Crisis Respite Programs
- Suicide Prevention

Crisis Intervention/Stabilization:

- Assessment/Triage (Living Room Model)
- Open Dialogue
- Crisis Residential/Respite
- Crisis Intervention Team/ Law Enforcement
- Mobile Crisis Outreach
- Collaboration with Hospital Emergency Departments and Urgent Care Systems

Post Crisis Intervention/Support:

- WRAP Post-Crisis
- Peer Support/Peer Bridgers
- Follow-Up Outreach and Support
- Family-to-Family engagement
- Connection to care coordination and follow-up clinical care for individuals in crisis
- Follow-up crisis engagement with families and involved community members

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

[89]Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427

Please use the box below to indicate areas of technical assistance needed related to this section:

Information describing how other states are addressing Emergency Departments' wait times for psychiatric patients

Footnotes:

C. Environmental Factors and Plan

15. Crisis Services

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

The Nebraska Division of Behavioral Health (DBH) recognizes the importance of having services in place to assist individuals in crises. DBH contracts with the Regional Network to have a minimum capacity to provide cornerstone emergency services 24 hours per day on an unscheduled basis to address acute psychiatric or substance abuse emergencies. All emergency services shall be coordinated through the provider network by network management between DBH, Mental Health Boards, law enforcement, hospital emergency services and current and anticipated providers of care for the individual. The minimum capacity of emergency services include:

1. A 24 hour clinician on call
2. Mobile outreach and crisis intervention
3. Emergency shelter
4. Civil Protective Custody and Emergency Protective Custody holding and evaluation
5. Emergency evaluation services

Dependent upon consumer needs, all emergency services provided by network providers focus on outcomes which lead to a referral to the least restrictive, least intensive level of care, or a rapid return to community living with appropriate supports, as necessary. For people in crisis, services within the Continuum of Care include:

- Crisis Response;
- Emergency Protective Custody;
- Mental Health Board Hearing (with possible) Commitment;
- Inpatient Treatment: and,
- Outpatient Treatment.

The DBH manages implementation of the statewide emergency system through ongoing contact with each of the emergency system coordinators, as a group and individually as needed to insure an effective Continuum of Care for crisis services. DBH organizes and conducts a minimum of two conference calls per month with the Regional Emergency Systems Coordinators and staff with the residentially based Lincoln Regional Center (LRC) to maintain relevancy with crisis centered activities within each Region and at LRC, and to insure that consumers are receiving treatment in accordance with their strengths and needs. These calls allow opportunities for individual case reviews, brainstorming of difficult cases, identification of strengths and needs in statewide treatment options, and the sharing of local developments that are occurring within Regional/LRC partner networks. In addition to routine phone conferences, the DBH holds quarterly face-to-face meetings at various locations throughout the state. These day long

meetings allow for more robust emergency system topical conversations with subsequent recommendations for change if indicated.

The DBH encourages emergency system coordinators to be in ongoing communication with each other and with LRC staff, and to work together to meet consumer needs when those treatment options are not available within a Region. In addition to ongoing communication with Regional Emergency Systems Coordinators, the DBH utilizes the statewide weekly mental health and substance abuse waiting list information as a measure in determining capacity for, and, access to, treatment for consumers with mental health board commitments.

Each week, Regional providers of mental health and substance abuse services are required to submit to the respective Regional Behavioral Health Authority and the DBH, the number of consumers by priority who received services, and, the number of consumers according to their priority level who are placed on the provider's waiting list for services. Priority levels include: (1) pregnant injecting drug users; (2) other pregnant substance users; (3) other injecting drug users; (4) women with dependent children; and, (5) *all others including those consumers with Mental Health Board Commitments.* With incorporation of provider submitted data by Region, the resultant reports, the (Statewide) Weekly Substance Abuse Capacity Report, the (Statewide) Weekly Mental Health Capacity Report and, the (Statewide) Weekly Substance Abuse Priority Waiting/Interim Services List for Priority Populations and (Statewide) Weekly Mental Health Waiting List, are compiled and distributed to the Regions to monitor and to share with providers.

State regulations provide service definitions that describe the types of crisis services individuals can receive in different areas of Nebraska. Below is the list of crisis services available along with their definition:

- **Emergency Psychiatric Observation**: Emergency Psychiatric Observation provides less than 24 hours of care in a secure, medically supervised hospital setting for evaluation and stabilization of acute psychiatric and/or substance use disorder symptoms.

- **Crisis Stabilization**: Crisis Stabilization is intended to provide immediate, short-term, individualized, crisis-oriented treatment and recovery services needed to stabilize acute symptoms of mental illness, alcohol and/or other drug use, and/or emotional distress. Individuals in need exhibit a psychiatric and/or substance use disorder crisis with a moderate to high risk for harm to self/others and need short-term, protected, supervised, residential placement. The intent of the service is to treat and support the individual throughout the crisis; provide crisis assessment and interventions; medication management; linkages to needed behavioral health services; and assist in transition back to the individual's typical living situation.

- **Crisis Assessment**: Crisis Assessment is a thorough assessment for a consumer experiencing a behavioral health crisis. The Crisis Assessment must be completed by the appropriate professional. The Crisis Assessment takes place in a setting such as a Mental Health Center, Hospital, or Substance Abuse Treatment Center. The Crisis Assessment will determine behavioral health diagnosis, risk of dangerousness to self and/or others, recommended behavioral health service level and include the consumer's stated

assessment of the situation. Based on the Crisis Assessment, appropriate behavioral health referrals will be provided.

- **Emergency Protective Custody Crisis Stabilization**: Crisis Stabilization is designed to provide custody, screening, emergency mental health evaluation, and crisis intervention to individuals placed in emergency protective custody under the auspices of Nebraska Mental Health Commitment Act by law enforcement. Crisis Stabilization services include immediate, short-term, individualized, crisis-oriented treatment and recovery needed to stabilize acute symptoms of mental illness, alcohol and/or other drug abuse, and/or emotional distress. Individuals in need exhibit a psychiatric and/or substance use disorder crisis as defined under the Commitment Act at risk for harm to self/others and need short-term, protected, supervised services. The intent of the service is to treat and support the individual throughout the crisis; provide crisis assessment and interventions; medication management; linkages to needed behavioral health services; and assist in transition back to the individual's typical living situation.

- **24-Hour Crisis Line**: The 24-Hour Crisis Line must be answered by a live voice 24 hours a day and 7 days a week and have the ability to link to a licensed behavioral health professional, law enforcement, and other emergency services. The 24-Hour Crisis Line is designed to assist consumers in pre-crisis or crisis situations related to a behavioral health problem. The desired outcome is ensuring the safety of the consumer in a time of distress that has the potential to lead to a life-threatening situation.

- **Mental Health Respite**: Mental Health Respite is designed to provide shelter and assistance to address immediate needs which may include case management on a 24/7 basis to consumers experiencing a need for transition to another home or residential setting or a break from the current home or residential setting. Mental Health Respite provides a safe, protected, supervised residential environment on a short-term basis. The intent of the service is to support a consumer throughout the transition or break, provide linkages to needed behavioral health services, and assist in transition back into the community.

- **Emergency Community Support**: Emergency Community Support is designed to assist consumers who can benefit from support due to a behavioral health need and who are either currently residing in a community setting or transitioning from a psychiatric hospital into a community setting. Emergency Community Support services include case management, behavioral health referrals, assistance with daily living skills, and coordination between consumer and/or consumer's support system and behavioral health providers.

- **Crisis Response**: Crisis Response is designed to use natural supports and resources to build upon a consumer's strengths to help resolve an immediate behavioral health crisis in the least restrictive environment by assisting the consumer to develop a plan to resolve the crisis. The service is provided by licensed behavioral health professionals who complete brief mental health status exams and substance use disorder screenings, assess

risk, and provide crisis intervention, crisis stabilization, referral linkages, and consultation to hospital emergency room personnel, if necessary. The goal of the service is to avoid an Emergency Protective Custody hold or inpatient psychiatric hospitalization.

- **Urgent Medication Management**: Urgent Medication Management is the level of outpatient treatment where the sole service rendered by a qualified provider is the evaluation of the consumer's need for psychotropic medications and provision of a prescription. Urgent Medication Management is provided within 72 hours of contact and referrals for this service must come from a provider within a Region's behavioral health network.
- **Urgent Outpatient Psychotherapy**: Urgent Outpatient Therapy is an intense intervention for consumers with an urgent/emergent behavioral health crisis. The purpose of the service is to support the consumer in achieving crisis resolution and determining next steps for further treatment if needed. Urgent Outpatient Psychotherapy services are intended to assure that consumers receive immediate treatment intervention when and where it is needed.
- **Hospital Diversion**: Hospital Diversion is a peer-operated service designed to assist consumers in decreasing psychiatric distress, which may lead to hospitalization. It is designed to help consumers rethink crisis as an opportunity to change toward a more self-determined independent life. Meaningful involvement can ensure that consumers lead a self-determined life in the community, rather than remaining dependent on the behavioral health system for a lifetime. Hospital Diversion offers consumers the opportunity to take control of their crisis or potential crisis and develop new skills through a variety of traditional self-help and proactive tools designed to maintain wellness. Trained Peer Companions are the key ingredients in helping other consumers utilize self-help tools. Peer Companions provide contact, support, and/or referral for services, as requested, during and after the stay as well as manning a Warm Line. Hospital Diversion is located in a family/home setting in a residential district that offers at least 4-5 guest bedrooms and is fully furnished for comfort. Participation in the service is voluntary.

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

16. Recovery

Narrative Question:

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

Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of health (access to quality health and behavioral health treatment), home (housing with needed supports), purpose (education, employment, and other pursuits), and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. This includes the use of psychotropic or other medications for mental illnesses or addictions to assist in the diminishing or elimination of symptoms as needed. Further, the use of psychiatric advance directives is encouraged to provide an individual the opportunity to have an active role in their own treatment even in times when the severity of their symptoms may impair cognition significantly. Resolution of symptoms through acute care treatment contributes to the stability necessary for individuals to pursue their ongoing recovery and to make use of SAMHSA encouraged recovery resources.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- Drop-in centers
- Peer-delivered motivational interviewing
- Peer specialist/Promotoras
- Clubhouses
- Self-directed care
- Supportive housing models
- Recovery community centers
- WRAP
- Evidenced-based supported
- Family navigators/parent support partners/providers
- Peer health navigators
- Peer wellness coaching
- Recovery coaching
- Shared decision making
- Telephone recovery checkups
- Warm lines
- Whole Health Action Management (WHAM)
- Mutual aid groups for individuals with MH/SA Disorders or CODs
- Peer-run respite services
- Person-centered planning
- Self-care and wellness approaches
- Peer-run crisis diversion services
- Wellness-based community campaign

employment

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

Recovery is based on the involvement of consumers/peers and their family members. States should 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 engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system.

Please consider the following items as a guideline when preparing the description of the state's system:

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?
2. How are treatment and recovery support services coordinated for any individual served by block grant funds?
3. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
4. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer-run services?
5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?
6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).
7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?
8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.
9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.
10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?
11. Describe how the state is supporting the employment and educational needs of individuals served.

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Technical assistance is requested in developing peer services and peer bridgers involvement in the behavioral health system.

Footnotes:

C. Environmental Factors and Plan

16. Recovery

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

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

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

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

2011-2015 Goals:

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

Strategies - The Division of Behavioral Health will:

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

For more details see http://dhhs.ne.gov/behavioral_health/Pages/2010BHStrategicPlan.aspx.

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

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

The State has documented evidence of hiring people in recovery.

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

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

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

advocacy organizations, criminal justice). It is vital for those involved in in cross system collaboration to maintain communication in order to fully assess the effectiveness of on-going services and to determine if additional services are needed.

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

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

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

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

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

4. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer-run services?

The DBH offers multiple training opportunities for the professional workforce on recovery principles and recovery oriented practice and systems, including the role of peer providers. In May 2015 the DBH secured consultation from the Technical Assistance Collaborative Center, Inc. (TAC). The workforce was invited to attend the presentation titled: Building Provider Capacity to deliver services aligned with principles and practices of Recovery, Wellness and Community Integration. Participants gained a further understanding of recovery, wellness, and community integration, as well has how to increase overall system capacity to deliver recovery oriented services to support community integration.

In 2014 the Nebraska Department of Health Human Services (DHHS) and the University of Nebraska Medical Center Behavioral Health Education Center of Nebraska (BHECN) entered

into a tri Division contract. The purpose of this partnership is to coordinate the implementation of trauma informed care training and resources to support the DHHS service delivery. These divisions include: DBH, Division of Public Health, and Division of Children and Family Services. As a result of this work, a statewide resource for the professional workforce on the causes and effects of trauma and to provide a singular source for training on trauma-informed care has been created. The trauma informed care training utilizes the core principles established in *SAMHSA's Concept of Trauma and Guidance for a Trauma- Informed Approach*, which includes the following principles:

1. Safety
2. Trustworthiness and Transparency
3. Peer Support
4. Collaboration and Mutuality
5. Empowerment, Voice and Choice
6. Cultural, Historical, and Gender Issues

The DBH offers a certification program. Eligibility to take the exam through the DBH OCA is for persons who have completed a forty hour (40) Peer Support Training Program and have a certificate of attendance/completion from training facilitators of the program.

The OCA Facilitator's Circle conducts a minimum of one to two Peer Support and Wellness Specialist (PSWS) trainings per year. Peer support training programs are for individuals with experience with any lived behavioral health condition and/or trauma. Certification and training is a great opportunity for those who are working/volunteering in the behavioral health field serving military, veterans, individuals, families, and/or children/youth who have been impacted by a behavioral health condition and/or trauma.

Information on the training brochure is found at http://dhhs.ne.gov/behavioral_health/Documents/NEOCAPeerTrainingBrochure2014.pdf and the certification program is found at http://dhhs.ne.gov/behavioral_health/Pages/DBHOCAPeer.aspx .

DBH is in the process of updating and promulgating new regulations for services with the inclusive of peer run services. Within the Title 206 Behavioral Health Services Regulations are Service Definitions. One example of standards in this area are under the Crisis Services, the service definition for HOSPITAL DIVERSION. The basic definition is:

> Hospital Diversion is a peer-operated service designed to assist consumers in decreasing psychiatric distress, which may lead to hospitalization. It is designed to help consumers rethink crisis as an opportunity to change toward a more self-determined independent life. Meaningful involvement can ensure that consumers lead a self-determined life in the community, rather than remaining dependent on the behavioral health system for a lifetime. Hospital Diversion offers consumers the opportunity to take control of their crisis or potential crisis and develop new skills through a variety of traditional self-help and 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

5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?

The DBH Office of Consumer Affairs (OCA) focuses on four areas:

- Consumer/Peer Support - consumers helping consumers; Relationships - build and strengthen consumer involvement; Planning - how to get the best out of the system; and Advocacy - how to find the best information and resources out there now.

OCA supports the implementation of recovery-oriented approaches through its work with:

- Two Peer Support studies have been completed:
  - http://dhhs.ne.gov/behavioral_health/Documents/Nebraska%20Peer%20Support%20Certification%20Study.pdf
  - http://dhhs.ne.gov/behavioral_health/Documents/Nebraska%20Peer%20Support%20Focus%20Group-Survey%20Report%20Final.pdf
- The Nebraska Network of Care Website to provide information for consumers: http://dhhs.ne.gov/behavioral_health/Pages/networkofcare_index.aspx
- Peer Support and Wellness Specialists: http://dhhs.ne.gov/behavioral_health/Pages/DBHOCAPeer.aspx
- Webinars: http://dhhs.ne.gov/behavioral_health/Pages/beh_mh_mhconsumer_webinars.aspx
- Website page dedicated to Trauma: http://dhhs.ne.gov/behavioral_health/Pages/trauma.aspx
- Consumer Involvement in Advisory meetings: http://dhhs.ne.gov/behavioral_health/Pages/DBHOCAPeoplesCouncil.aspx

As noted elsewhere in the application, DBH also has:

- Family Peer Support Navigators
- Peer-Run Crisis Diversion Services
- Peer-Run Warmlines- Lincoln, Omaha, and North Platte
- Housing Related Assistance
- Supported Employment

6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).

As mentioned previously, the DBH has demonstrated the hiring of persons in recovery. These positions serve as an opportunity for individuals in recovery and family members to be involved in the planning, delivery, and evaluation of behavioral health services.

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

Other opportunities for involvement in the planning, delivery, and evaluation of behavioral health services are

- **The OCA Facilitators Circle:** There are 19 peers trained as facilitators in the Nebraska Peer Support and Wellness Specialist Curriculum.
- **OCA Peer Support and Wellness Specialist Certification Program:** The OCA hosts one to two trainings per year. For more information on the program, see the peer support training web page.
- **Peer Support and Wellness Specialist Co-Supervision:** The Certified Peer Support and Wellness Specialist are invited to provide supervision to each other during several quarterly calls hosted by the Office of Consumer Affairs.
- **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 our website.
- **The Statewide Behavioral Health Conference:** www.nebraskastateconference.org
- **Partner's in Recovery Art Shows, Recovery Jams, and Recovery Film Festivals:** The Nebraska Recovery Network hosts art shows, recovery jams, and film festivals that are open to the public via contract with the Office of Consumer Affairs.
- **Artist of the Arboretum-** OCA features a monthly Artist of the Arboretum at the Lincoln Regional Center.
- **NAMI Trainings for Support Group Leaders:** The Office of Consumer Affairs contracts with NAMI to host trainings for support group leaders.

- **SQIT (State Wide Quality Improvement Team)**
- **Division of Behavioral health Tuesday Data Call**
- **Joint State Advisory Committee on**: Mental Health Services and Substance Abuse Services;

NAC 206 Chapter 6-000 outlines consumer and family's standards of care which is inclusive of the Consumer rights. Consumer rights outline the right for involvement in care.

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 his/her private physician;
3. Have clinical records made available to themselves and individuals of their choice by his/her written request;
4. Actively and directly participate in decisions which 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 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 his/her behavioral health care;
9. Receive care from providers who adhere to a strict policy of non-discrimination in the provision of services;
10. Be free of sexual exploitation and, harassment;
11. Voice complaints and file grievances without discrimination or reprisal and to have those complaints and grievances addressed in a timely manner (see 206 NAC 6-003); and
12. Receive behavioral health services in the most integrated setting appropriate for each consumer based on an individualized and person-centered assessment and incorporated into the individual treatment rehabilitation and recovery plan.

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

In addition to the partnerships with the RBHAs and the hiring of persons in recovery, the DBH contracts with the following to support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services.

- Nebraska Federation of Families for Children's Mental Health- Provide Network Management of state wide family peer support and family navigator services.
- Mental Health Association of Nebraska- to provide the annual NE Behavioral Health: Success, Hopes, and Dreams conference
- Nebraska Recovery Network- to provide recovery events and education and awareness
- NAMI Nebraska to support consumer and family leadership, support groups, and training.

- League of Human Dignity to increase consumer participation
- Annual CPSWS conference
- Technical assistance contracts to increase consumer participation and increase peer services. Technical assistance has been secured through the UNL Public Policy Center and the Technical Assistance Center, INC.

DBH is strengthening its commitment to peer support by partnering with the University of Nebraska-Lincoln Public Policy Center in developing the *Office of Facilitation of Recovery* at the Lincoln Regional Center (LRC). An administrator with lived experience will lead the office and be solely assigned to the state hospital. The DBH Community-Based Section is also strengthening the peer support commitment by reorganizing staff to lead peer support and other recovery initiatives.

DBH has a new initiative underway – the Peer Bridger Program at LRC, the state hospital. LRC will develop and implement a "Peer Bridger Pilot Program" that will provide peer support to LRC general psychiatric patients as they transition to the community. The Peer Bridger Pilot Program will develop relationships with patients during their stay at the hospital and continue to provide peer support after discharge. Though the Nebraska model is yet to be designed, the literature review of other programs highlight outcomes such as:

- Engagement in a uniquely personal, positive supportive relationship with a peer
- Involvement in an array of Peer Support Meetings
- Linkage to a broad range of community-based service and natural supports
- Teaching community adjustment and wellness self-management skills

Expected benefits include:

- Shorter hospital lengths of stay
- Improved social connectedness
- Improved community tenure

8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.

DBH conducts an annual Behavioral Health Consumer Survey. The survey solicits input from adult and youth consumers receiving mental health and/or substance abuse services from the publicly funded, community-based behavioral health system in Nebraska. The survey consists of forty questions and aims to assess the quality and impact of the services received by measuring seven domains: Access, Quality and Appropriateness, Outcomes, Participation in Treatment Planning, General Satisfaction, Functioning and Social Connectedness.

The DBH data team analyzes the seven domains at the state level and compares outcomes longitudinally to previous iterations of the Consumer Survey dating back to 2006. Domains are also analyzed at the regional level, and by consumer race/ethnicity, gender, age, service type, and length of stay. In addition to the service domains, physical health status of consumers was also examined.

Consumers and family members participate on the DBH Statewide Quality Improvement Team (SQIT). SQIT is primarily responsible for the identification and prioritization of opportunities for regional and statewide improvement affecting the Nebraska Behavioral Health System, implementation of quality initiatives and development of the annual Continuous Quality Improvement (CQI) plan.

Under the Nebraska Behavioral Health Services Act each Region is expected to encourage and facilitate the involvement of consumers in all aspects of service planning and delivery. The Region is to coordinate such activities with the DBH Office of Consumer Affairs. Each Region is also expected to have a Regional Advisory Committee consisting of consumers, providers, and other interested parties.

In 2013 and 2014, DBH and OCA engaged consumers and families in two activities to assess consumer outreach activities. In 2013, DBH worked with the University of Nebraska Public Policy Center to conduct a survey and focus groups in each of the behavioral health regions of Nebraska. There were four groups that participated in the surveys and focus groups: Adult peer support specialists, family peer support specialists, consumers of adult peer support, and consumers of family peer support. In 2014, OCA convened a study group to review and identify strategies and recommendations to optimize consumer and family involvement. The final work product, *Consumer and Family Involvement in Nebraska*, is planned to be released in late 2015.

9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.

OCA promotes and provides information and resources focused on wellness strategies and recovery education to consumers and families and providers. It accomplishes this by promoting workforce recruitment and training efforts through the Peer Support and Wellness Specialist Certification program, People's Council, Open Door Calls, Statewide Behavioral Health Conference, and coordinated activities with the RBHA Regional Advisory Committees.

And, DBH's prevention system utilizes universal, selective and indicated prevention interventions intended to prevent or reduce the risk of developing a behavioral health problem. Early intervention strategies designed to create environments and conditions that support behavioral health and the ability of individuals to withstand challenges are also promoted throughout this system.

10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?

The State of Nebraska recognizes that safe and stable housing are components needed for recovery by people who have behavioral health disorders who also experience extremely low income.

The governing regulations of Nebraska's public behavioral health system specifically identifies consumer rights, including the right to receive services and housing in the most integrated and supportive, as well as least restrictive, settings possible. The State plan and corresponding funding mechanism that address housing needs of persons served are identified in the Housing Assistance Program's Manual.

Following the Permanent Supportive Housing model developed by SAMHSA, the purpose of the Housing Assistance Program is to address housing service needs for people with behavioral health disorders. This includes the use of rental assistance, other housing-related assistance, facilitation of community integration and a housing first approach as strategies to prevent homelessness as well as sustain stable housing while persons served continue to receive behavioral health services to support their recovery. Assistance provided by the Housing Assistance Program affords opportunity for a consumer to achieve or remain in permanent, affordable, community integrated housing of his/her choice while receiving behavioral health services supportive of recovery.

Through contract with each of the six Regional Behavioral Health Authorities, the Housing Assistance Program is administered by these entities throughout the state. As Nebraska is primarily a rural and frontier state, with 84 of 93 counties are classified as rural, this approach allows for local variances in housing unit types, consumer choice and associated costs.

In 2014, DBH completed a limited evaluation of DBH's activities in the context of community integration with the assistance the Technical Assistance Collaborative (TAC). In 2015, TAC was retained to assist DBH further develop the community integration activities, including developing a three year Strategic Supportive Housing Plan. The DBH planning process will incorporate two work groups, one focusing on housing, and the other on services necessary for individuals to live in supportive, integrated settings within the community.

DBH also maintains contracts with providers for:

- Oxford House, for persons served who are in treatment for addiction, and,
- Nebraska Projects for Assistance in Transition from Homelessness (PATH)

11. Describe how the state is supporting the employment and educational needs of individuals served.

Successful employment remains a recognized component for persons on the path to recovery. As funded by the Division of Behavioral Health, Supported Employment is an available option for persons with behavioral health needs. Consumers enrolled in community based services (i.e., Community Support, Outpatient therapy) who identify the desire for a job will be referred to Supported Employment. In partnership with the Regions and the Nebraska Department of Vocational Rehabilitation, the Division of Behavioral Health developed and implemented a Milestone based pilot project. This pilot helped establish a one year baseline and determination of best practices in the implementation of supported employment services with persons who have behavioral health needs. A cost study was also conducted as part of this project.

Working closely with Regional staff and providers of Supported Employment services within each Region, recorded consumer data was analyzed, and the DBH funded Milestones were determined.

Educational needs are identified through various sources with referrals made accordingly. For adults considering job advancement or recreational growth, Community Support Workers facilitate access to local Community Colleges, larger four year Colleges and Universities, or to educational opportunities on-line. The Professional Partner Program facilitates educational opportunities for youth (through age 26 years) through the development of the Individualized Program Plan. The Case Manager, known as the Professional Partner, assists the youth in finding the best fit for educational opportunities, while the Program's associated Wrap Around funding supports enrollment, materials and other fees.

Technical assistance is requested in developing peer services and peer bridgers involvement in the behavioral health system.

17. Community Living and the Implementation of Olmstead

Narrative Question:

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated arrangement appropriate and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to Section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office of Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other residences that have institutional characteristics to house persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.
2. How are individuals transitioned from hospital to community settings?
3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?
4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

C. Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings.

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.

Since the Nebraska Behavioral Health Reform Act (BHRA) of 2004, Nebraska's behavioral health system has been engaged in a process of reform designed to monitor and improve outcomes, reduce reliance on state operated inpatient facilities, and promote person-centered, recovery-oriented services throughout the system. In February 2011, the Division of Behavioral Health (DBH) released a five year strategic plan, the *Nebraska Division of Behavioral Health Strategic Plan 2011-2015* that builds off of the BHRA and work of recent Behavioral Health Oversight Commissions, and identifies strategies to move DBH toward "the development of recovery-oriented systems of care that are community-based…."

In November 2012, the DBH sought to further evaluate its current approach toward supporting individuals with mental illness in integrated community settings within the context of its overall system activities and implementation of its strategic plan. As part of this process, DBH retained the Technical Assistance Collaborative (TAC) to conduct a limited evaluation of DBH's activities in the context of community integration, and to provide guidance regarding ways that DBH can strengthen its approach to supporting community integration within the overall implementation of its strategic plan.

DBH is committed to strengthening the behavioral health system's ability to support individuals in the most integrated settings possible. TAC conducted a preliminary review of Nebraska's behavioral health system, which included interviews with relevant stakeholders. TAC's observations, identified themes that emerged during the process, and provided recommendations that provide direction for DBH to strengthen its ability to support individuals in integrated settings. Each recommendation contains more specific recommendations that served as actionable steps that DBH can begin to take, including steps to:

1. Maximize services and funding strategies to support community integration; and,
2. Maximize housing opportunities and partnerships to support community integration.

On February 5, 2013, TAC spent the day with leadership from the DBH and facilitated a discussion related to community integration in Nebraska. The morning consisted of a presentation by TAC on trends and activity at the national level regarding community integration, including several examples of how various states are working on ADA and *Olmstead*. During the afternoon, TAC facilitated a discussion with DBH staff to identify

strengths and potential weaknesses in the system related to community integration, and provided some insight as to how states have addressed similar issues.

In a follow up to the February meetings, DBH requested Kevin Martone, Executive Director of TAC, to facilitate a workshop at the Annual Statewide Behavioral Health Conference on May 14, 2013. The purpose was similar to the initial meeting with DBH in that a national perspective that included the experiences of other states was presented. The audience consisted of approximately 75 stakeholders, including consumers, family members, service providers, legal advocates, and state staff, and a question and answer session followed the presentation.

In addition to the conference presentation, four feedback sessions were held at the conference on May 14-15, 2013 in order for TAC to directly solicit perspectives from stakeholders about community integration issues in Nebraska. Each group received a handout with a definition of community integration as defined by the U.S. Department of Justice as a basis for the facilitated discussion. Each session lasted roughly an hour and a half, and participants were asked to provide comments in relation to the definition and how they perceived the concept of community integration in Nebraska's behavioral health system.

In April 2013, Dr. Scot Adams, Director of the Division of Behavioral Health appointed a workgroup to explore how the flow of individuals through LRC could be improved. The Systems Enhancement Initiative (SEI) Workgroup members appointed by Dr. Adams consisted of LRC staff, consumers, Regional Emergency Community Systems Coordinators, and DBH Community-Based Services (DBH-CB) staff. Their work began in April 2013 and was completed in December 2013.

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

- Recommendation 1. Develop additional housing options.
- Recommendation 2. Develop more opportunity for peer support.
- Recommendation 3. Develop health information technology and telecommunication options.
- Recommendation 4. Enhance community-based service options.
- Recommendation 5. Enhance discharge planning.

In April 2014, DBH released the report Community Integration in Nebraska's Behavioral Health System, which provides a limited evaluation of DBH's activities in the context of community integration, including observations, identified themes that emerged during the planning process, and guidance regarding ways that DBH can strengthen its approach to supporting community integration within the overall implementation of its strategic plan.

In 2014, DBH partnered with Region 6 RBHA to conduct focus groups with key stakeholders from Region 6 to explore strategies that would strengthen and promote recovery-oriented services and opportunities for integrated, community living. This initiative identified high-priority gaps within Region 6's system and made recommendations to address these gaps. The report, *Omaha/Region 6 Adult Behavioral Health SOC Assessment and Planning*, was released in November 2014. At this time, each of the other five RBHAs are in the process of assessing service gaps in their areas. Once this is completed, a plan for addressing these gaps statewide will be developed.

In 2015 TAC was retained to provide further technical assistance. Between May 27-29, 2015, six work groups formed together to meet and discuss various topics on community integration.

Workgroup Activities:

- Housing focus group met to review current options for affordable housing including supported housing, and identify possibilities for expansion and partnership.
- DBH and LRC leadership met to review the housing focus group feedback and discuss the strategic supportive housing planning process and proposal for technical assistance form TAC.
- A provider focus group met and received training on the topic of "building provider capacity to deliver services aligned with principles and practices of Recovery, Wellness and Community Integration".
- An emergency services workgroup met to discuss building successful partnerships to support coordination of recovery oriented systems and community integration.
- The Office of Consumers Affairs met with TAC to review the role of the Office of Consumers Affairs and People's Council.
- DBH leadership, the Office of Consumer Affairs, and BHECN met to discuss the Peer Support partnership between DBH and BHECN.

Following the end of the sessions DBH received a proposal for next steps from TAC. DBH plans to secure further technical assistance from TAC to implement recommendations resulting from this work.

2. How are individuals transitioned from hospital to community settings?

DBH has partnered with each RHBA to ensure that appropriate community-based services are in place state-wide. Community-based services may range from intensive, hospital-level care to a secure, specialized wing of a nursing home, other residential facility, or day treatment program.

The transition period from the hospital to community settings, in particular, is one of the most vulnerable times for consumers. The DBH and RHBA incorporate core strategies for care transition from hospital to community setting in the discharge planning process. This process is

governed by regulations established in the Nebraska Administrative Code Title 206 – Behavioral Health Services.

Discharge planning must occur in advance of a consumer's discharge from any behavioral health service. The discharge plan must be strength-based, recovery-oriented, trauma-informed and include participation by the consumer and family/legal guardian as appropriate. The discharge plan must be documented in the consumer's record.

The discharge plan must:

1. Begin on admission and be updated on an ongoing basis with the direct and active participation of the consumer and family/legal guardian, as appropriate and with the consumer's consent.
2. Be a component of the Individual Treatment, Rehabilitation, and Recovery Plan and be consistent with the goals and objectives identified with the direct and active participation of the consumer, family/legal guardian as appropriate.
3. Address the consumer's need for ongoing services to promote recovery. A crisis/safety/relapse plan must be in place and address triggers, helpful intervention strategies, and contact information for resources useful in a crisis;
4. Document all referrals; and
5. Document pre-discharge planning, recommendations, and/or arrangements for a post-treatment/ rehabilitation/recovery plan including but not limited to: Accessing and using medication, Housing, Employment, Transportation, Social connectedness – formal and informal support systems, and Plans to address unmet goals.

All service providers contribute to the formulation of the discharge plan based on their respective knowledge and expertise, observations of the patient, and their discipline-specific plan/ recommendations for aftercare.

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

The Nebraska Division of Behavioral Health has been working to build a person-centered, recovery-oriented system of care. As part of this process, DBH has also sought to assess its role in supporting the community integration of individuals served through the system. DBH is working with the Technical Assistance Collaborative, Inc. (TAC) to identify cross agency/division opportunities to support community integration and internally to incorporate recommendations to enhance support of community integration activities.

In April 2015, the DHHS DBH updated the Nebraska Administrative Code Title 206 – Behavioral Health Services. "Standards of Care" regulations to incorporate recommendations regarding community integration planning and implementation efforts.

In November 2012, the Nebraska Division of Behavioral Health began a review of its current approach toward supporting individuals with mental illness in integrated community settings within the context of its overall system activities and implementation of its new five year

strategic plan, the *Nebraska Division of Behavioral Health Strategic Plan 2011-2015*. As part of this process, DBH identified and initiated three assessment and planning efforts to assess its systems of care.

First, DBH initiated a study in 2012 to assess its role in supporting community integration of individuals served through the public behavioral health system. April 2014, DBH released the report Community Integration in Nebraska's Behavioral Health System, which provides a limited evaluation of DBH's activities in the context of community integration, including observations, identified themes that emerged during the planning process, and guidance regarding ways that DBH can strengthen its approach to supporting community integration within the overall implementation of its strategic plan.

Second, in November 2014, DBH released the final report *Nebraska DBH System Enhancement Initiative* upon completion of the 2013 Behavioral Health System Enhancement Initiative (SEI). SEI identified and began the implementation of necessary supports to discharge individuals from the Lincoln Regional Center (LRC), Nebraska's State Hospital. The SEI was charged with developing specific recommendations for thirty-six individuals currently at LRC who have been there for longer than one year, as well as developing recommendations for systemic improvements. This initiative involves key stakeholders and also utilized a survey tool that was distributed to LRC and Regional Behavioral Health Authorities (RBHA) administrators and key staff to identify contributing barriers to discharge and preliminary recommendations to resolve these issues.

In 2014, DBH partnered with Region 6 RBHA to conduct focus groups with key stakeholders from Region 6 to explore strategies that would strengthen and promote recovery-oriented services and opportunities for integrated, community living. This initiative identified high-priority gaps within Region 6's system and made recommendations to address these gaps. The report, Omaha/Region 6 Adult Behavioral Health SOC Assessment and Planning, was released in November 2014. At this time, each of the other five RBHAs are in the process of assessing service gaps in their areas. Once this is completed, a plan for addressing these gaps statewide will be developed.

DBH continues to assess and implement recommendations to strengthen its approach to supporting community integration within the overall implementation of its strategic plan, as identified in April 2014. In 2015, DBH leadership and LRC leadership have hosted focus groups, developed workgroups, and reviewed collaborative activities with system partners, including The Office of Consumer Affairs and the Behavioral Health Education Center of Nebraska (BHECN).

Workgroup Activities:

- Housing focus group has met to review current options for affordable housing including supported housing, and identify possibilities for expansion and partnership.

- Provider focus group has met to build provider capacity to deliver services aligned with principles and practices of Recovery, Wellness and Community Integration.
- An emergency services workgroup has met to build successful partnerships to support coordination of recovery oriented systems and community integration.
- An Office of Consumers Affairs workgroup has met to review the role of the Office of Consumers Affairs and People's Council.
- A Peer Support Partnership workgroup has met to identify and build on the partnership between DBH and BHECN.

4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?

The State of Nebraska is not involved in any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI.

5. Is the state involved in a partnership with other state agencies to address community integration?

DBH incorporates sister agencies and key system stakeholders into its various planning processes. Among these include the strategic planning process that led to the five year strategic plan and the State Advisory Committee on Mental Health Services that is required as part of the federal block grant planning process. These mutual planning processes provide a forum for DBH to develop and advance its ideas on mental health system priorities, such as person-centered planning and recovery supports. They have also led to DBH's active role in facilitating affordable housing opportunities for its target population and addressing community integration-related issues when they arise.

DBH will engage other state agencies and key system stakeholders in working through the next steps to implement identified actions supporting community integration. This includes the development of a three year Strategic Supportive Housing Plan, training in Wellness and Recovery to promote community-based, recovery oriented services that support individuals living integrated settings, increasing consumer participation and peer services.

To further planning efforts to build provider capacity in the areas of Recovery, Wellness and promoting Community Integration, DBH will develop training for various systems and partners on the principles and practices of Wellness, Recovery and Community Integration and implementing the Recovery Self-Assessment Scale. This training will serve to kick off implementation of a self-assessment process that will get buy in from the various systems and partners, create sustainability of training, identify steps to implement the recovery tool and identify outcomes that best measure recovery.

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

18. Children and Adolescents Behavioral Health Services

Narrative Question:

MHBG funds are intended to support programs and activities for children with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious mental disorder that contributes to substantial impairment in their functioning at home, at school, or in the community.[90] Most mental health disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[91] For youth between the ages of 10 and 24, suicide is the third leading cause of death.[92]

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[93] Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with more than 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.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or substance use disorders and co-occurring disorders and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child's, youth's and young adult's functioning in their home, school, and community. The system of care approach provides individualized services, is family driven and youth guided, and builds on the strengths of the child, youth or young adult and their family and promotes recovery and resilience. Services are delivered in the least restrictive environment possible, and using evidence-based practices while providing effective cross-system collaboration, including integrated management of service delivery and costs.[94]

According to data from the National Evaluation of the Children's Mental Health Initiative (2011), systems of care[95]:

- reach many children and youth typically underserved by the mental health system;
- improve emotional and behavioral outcomes for children and youth;
- enhance family outcomes, such as decreased caregiver stress;
- decrease suicidal ideation and gestures;
- expand the availability of effective supports and services; and
- save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious 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 consider the following items as a guide when preparing the description of the state's system:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with serious mental, substance

use, and co-occurring disorders?

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?
6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?
7. What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

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

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[90] Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

[91] Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[92] Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[93] The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[94] Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010.

[95] Department of Health and Human Services. (2013). Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions: Joint CMS and SAMHSA Informational Bulletin. Available from http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf.

Please use the box below to indicate areas of technical assistance needed related to this section:

Training and technical assistance is needed for SOC implementation

Footnotes:

C. Environmental Factors and Plan

18. Children and Adolescents Behavioral Health Services

MHBG funds are intended to support programs and activities for children with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults. SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?

The Nebraska Department of Health and Human Services (DHHS) Division of Behavioral Health (DBH) serves as the chief behavioral authority for the State of Nebraska as dictated in Neb. Rev. Stat. §71-806. In relationship to Nebraska's System of Care (SOC), DBH has the authority and responsibility to direct and coordinate the public behavioral health system, including integration and coordination of the system; comprehensive statewide planning for the provision of an appropriate array of community-based behavioral health services and continuum of care; development and management of data and information systems; prioritization and approval of all expenditures of funds received and administered by the division; and promotion of activities in research and education to improve the quality of behavioral health services, recruitment and retention of behavioral health professionals, and access to behavioral health programs and services. DHHS DBH works in partnership with six Regional Behavioral Health Authorities (RBHA) to carry out its charge.

The RBHA have structures and mechanisms to support a coordinated system of care approach to support recovery and resilience of children and youth with behavioral health needs. The RBHA develop local systems of care across the state responsive to local needs and building upon the unique strengths and communities of each region, forging partnerships with youth, families, providers, DHHS divisions of Children and Family Services (CFS) and Medicaid and Long-Term Care (DHHS Medicaid), county leaders, local system stakeholders, and community leaders and members.

RBHA funding is intended to serve individuals who are not Medicaid eligible or do not have insurance coverage. Each RBHA braids funding from state, federal, and local county sources to develop local networks of providers to ensure an array of non-traditional supports not covered by Medicaid are available, ranging from emergency to resiliency-oriented supports to wraparound. System coordination is central to their purpose, coordinating the local behavioral health system in the region through strategic strengths-based/recovery-focused processes that empower individuals and communities to assure that network providers, system partners and the many stakeholders of the behavioral health system work in a coordinated manner that supports

individuals across the life span to promote resiliency and achieve recovery. Each RBHA has established multi-stakeholder collaborative structures to coordinate efforts in formal functional areas for Consumers (including youth) and Family Involvement and Inclusion, Network Management, Emergency Services System, Prevention Services System, and Youth System of Care (YSC). Each RBHA has implemented since 1995 a Professional Partner Program (PPP) using a fidelity-based version of the wraparound care coordination model to support services to families who have children with serious emotional disorders and to ensure that youth and families have a voice and ownership in developing an accessible, comprehensive, individualized family support plan.

Each RBHA Network includes a Youth Systems coordination function, responsible for the children's behavioral health system within their respective Region. The Youth Systems Coordinator coordinates activities and collaborates with community based partners to ensure that children and youth with behavioral health disorders receive the most appropriate services located within their community, whenever possible. They also collaborate with the RBHA Network providers and other agencies serving youth to engage in activities that address the behavioral health needs of youth transitioning into adulthood. Youth Systems Coordinators promote quality improvement by participating in statewide youth system coordination, enhance SOC principles, assess RBHA Network providers of youth services for Family Centered Practice models (FCP), and provide technical assistance when needed and as appropriate to increase providers' ability to incorporate FCP and SOC principles into their practices.

The youth systems services infrastructure facilitates the involvement of youth, families, and system partners at the regional and individual family levels. Over time the DBH and DHHS CFS have coordinated services provided and to date both contract to provide PPP and FN/FPS. The structures in each RBHA, alongside parallel structures for child welfare through the DHHS CFS's five Service Areas (SAs) are long-standing and provide a key component of the foundation upon which the SOC strategic plan implementation efforts are built. While their geographic boundaries are not fully aligned, there is much overlap and each RBHA works with assigned SAs. This enhanced regional alignment is key to sustainability, as both RBHAs and SAs have established networks among SOC stakeholders in each region.

In late summer 2014, the Nebraska's Children's Mental Health System of Care Planning Project was completed. The SOC Strategic Plan offers the central organizing structure to capitalize on infrastructure currently in place including the support and involvement of leaders across the state's many child-serving systems.

Nebraska's System of Care (NeSOC) Strategic Plan is the result of a statewide planning process which occurred between July 2013 and July 2014. The process involved a comprehensive, highly participatory process featuring youth, family and system partners. The population of focus for NeSOC Strategic Plan is defined, inclusively, as:

Children and youth with serious emotional and behavioral health needs and their families across all of Nebraska's child-serving systems.

Our vision, mission and values describe our hopes and intentions for the future, guides our efforts and provides a foundation for a system of care for children, youth and their families.

Vision Simply Said: *All Nebraska children, youth and families will reach their full potential by experiencing improved wellness and mental health, exhibiting greater well-being, functioning successfully in the community and realizing greater stability in their living situation.*

Mission Simply Said: *Nebraska will improve the lives of children, youth and families by working within partnerships to improve service delivery systems, including the cost and quality of care,* as *a means of providing meaningful benefits and measureable outcomes to children, youth and families as experienced in the context of everyday living.*

Values: *Youth-guided; family-driven; individualized; culturally and linguistically competent; accessible; cost-effective, trusted partnerships.*

Accomplishments of the NE SOC Strategic Planning phase to include:

- Families, youth and providers responded to a statewide survey for self-assessment of readiness for system of care. Over 1,100 people participated.
- Strategic plan development was accomplished through 10 Core Strategy Teams that met between October 2013 and March 2014. Over 262 youth, family and system partners participated on a team.
- Youth voice in plan development was gathered through a series of focus groups targeting youth who were experiencing or had experienced Nebraska's behavioral health system and other child-serving systems. A total of 143 youth participated in focus groups.
- The strategic plan development resulted in 9 goals broken down into a comprehensive set of important implementation strategies that reflect Nebraska's diversity and complexity. Addressing the strategies and activities requires state, regional, tribal and local level actions.

The enthusiasm for a statewide system of care and the commitment of participating partners and representatives continued beyond the initial planning phase and fueled the formation of an informal SOC workgroup that met monthly from January through June 2015. Guided by *Nebraska's System of Care Strategic Plan* the informal SOC workgroup addressed the following elements necessary to operationalize the strategic plan:

- **Responded to the Readiness Assessment:** Reviewed strengths and weaknesses. Prioritized gaps and opportunities.
- **Planned for potential implementation funding:** Investigated and formulated a potential application for a System of Care Implementation Cooperative Agreement.
- **Addressed future NeSOC governance and funding:** Convened ad hoc work teams to address associated governance and funding strategies.
- **Investigated action steps for youth and family partners:** Convened ad hoc group to look at ways to incorporate youth and family as equal partners.
- **Took initial steps towards NeSOC implementation:** Identified and prioritized eight strategies from strategic plan that can be implemented at low/no cost.

No/Low Cost Strategies

1. Explore and identify requirements necessary to build a culturally responsive, trauma informed and community-based crisis continuum across systems that includes a dedicated on-call team, in-home services and brief out-of home options for children and youth in crisis, such as crisis residential, respite, therapeutic foster care, and emergency shelter.
2. Identify options for braided funding approaches to support a culturally responsive, trauma-informed and community-based crisis continuum across systems.
3. Develop a competency training/education inventory to be used across systems and inclusive of the following eight domains: trauma-informed/capable care; child and adolescent development; cultural and linguistic competence; children and youth with developmental disabilities and behavioral health needs; screening/assessment/evaluation/referral; family and person centered practice; treatment planning/ interventions/service delivery; quality improvement; professionalism and ethics. Support the development of SOC principles and practices education/training for the system workforce and identify resources to disseminate education/training throughout the state.
4. Develop standards for supporting equal partnership for children, youth and family participation in SOC activities, including financial support needed to fully participate in SOC activities.
5. Develop a SOC governance structure for a locus of accountability at the state level and support the implementation of the strategic plan by the SOC Leadership Team. Support the formation of regional, tribal and community SOC teams that build upon current local strengths, and assume locus of accountability for SOC efforts at the local level. Form the SOC Leadership Team, inclusive of equal representation of youth, family, and system partners charged with pursuing dissemination and implementation of the Nebraska SOC Strategic Plan.
6. Identify regulations, barriers and gaps that prevent effective collaboration and/or development of a single services plan for children, youth, and families across systems.
7. Map current children and youth service and support opportunities, eligibility requirements, funding sources, and relevant policies, practices and regulations across systems.
8. Identify a common Quality Improvement process that supports monitoring, evaluation and outcome measures and can be used across systems.

- **Developed mechanism for moving forward:** Formed informal workgroups tasked with development of draft work plans specific to one or more of the eight strategies.
- **Initiated Financial Investment Blueprint Project,** facilitated by a DBH contract with TriWest Group. Project focuses on investigation of dollars currently spent as well as examination of spending and service utilization within a system of care approach
- **Creation of a proposal** to be submitted to the NDHHS Chief Executive Officer, Courtney Phillips seeking authorization to move forward with the implementation of the strategic plan. The proposal outlines the development of a SOC governance structure for a locus of accountability at the state level and supports the implementation of the strategic plan by the SOC Leadership Team. Implementation will be carried out through standing work teams and as governed by developed work plans for each team.
- In 2015 the **State Legislature** i**nitiated a study** to assess the behavioral health needs of children and youth as well as the state's System of Care strategic plan completed in 2014.

Nebraska is now poised to begin the process of implementing a Behavioral Health System of Care that works within partnerships to improve service delivery systems including the cost and quality of care, as a means of providing meaningful benefits and measureable, positive outcomes for children, youth and families. Movement forward capitalizes on partner commitment and work completed to date.

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

In collaboration with system partners, the DBH developed and implemented guidelines, as outlined in the PPP manual, for children and young adults with mental and substance use disorders and their families for individualized care planning. The PPP manual is reviewed at least annually, with updates identified and incorporated as needed based upon quality improvement processes led by DBH. Most recently in 2015, the PPP program evaluation, outcomes, and admission criteria are being assessed in order to continue to identify improvements that better assess the impact of PPP on children and youth, better measure family functioning over time, improve quality care, increase access to High Fidelity Wraparound Services, increase involvement of children, youth, and families, and continue in efforts to build strong partnerships across child serving agencies to implement family centered care.

With ten wraparound components at its core, an individualized service plan is developed for each youth/young adult and his/her family, based upon the strengths and concerns of the youth/young adult and his/her family across life domains, including mental health, substance abuse, residential, family, education, vocational, financial, social/recreational, medical, legal, safety, and cultural.

The Professional Partner, youth/young adult and family identifies wraparound team members who will contribute to the development of an Individual Family Service Plan (IFSP) (or Plan of Care - for the purposes of transition aged programs). The IFSP must be a clear, outcome focused plan with time sensitive and measureable goals and objectives that are purposed to support the safety, well-being, recovery and resiliency of the youth. The identified goals and objectives will directly reflect the information reported in the Intake/Interpretative Summary.

The format for the IFSP plan may vary but must include at a minimum:

- Clear demonstration of youth/young adult/family partnership in the plan development
- Youth/young adult and Family Strengths
- Presenting Problems
- Goals and Expected Outcomes/Pre-Discharge Plan
- Objectives/Interventions must be measureable and timely
- Team Members, both formal and informal
- Safety planning

The PPP implements a quarterly review/revision of the IFSP and ongoing monitoring and evaluation of service provision to improve outcomes. For short term programs, IFSP plans are reviewed no less frequently than once every 30 days.

In addition to the IFSP the following sets of data are submitted to the DBH and reviewed at least quarterly:

- Youth and family characteristics (demographic data);
- Youth and family progress as the plan is implemented;
- Examination of the organizational variables that potentially influence the success of the PPP (e.g., amount of involvement by youth/young adult and family, mixture or make-up

of the multi-disciplinary team responsible for development of the service plan, implementation of the service plan);

- Change over time in family functioning. Change over time is collected with the utilization of the Protective Factor Survey.
- Change over time in the impact of the functional impairment resulting from behavioral health challenges. Change over time is collected with the utilization of the Child and Adolescent Functional Assessment Scale (CAFAS) OR Preschool and Early Childhood Functional Assessment (PECFAS). The following areas are reviewed:
    - School/Work Role Performance
    - Home Role Performance
    - Community Role Performance
    - Behavior Toward Others
    - Moods/Emotions
    - Self-Harmful Behavior
    - Substance Use
    - Thinking
- Review of the effects and costs of the services and supports.
- Suicide Behaviors Questionnaire- Revised (SBQ-R) and Early Identification, Referral and Follow –up Form (EIRF) data

In addition the DBH is working to update NAC 206 regulations to include children's services.

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?

In 2011, the Legislature established the Nebraska Children's Commission (Commission), a 26-member body charged with creating a statewide strategic plan to reform child welfare programs and services, including children's behavioral health. The Commission is comprised of representatives of the three branches of state government and members of the general public including: guardians ad litem, prosecuting attorneys, foster and biological parents, children's services providers, child advocacy organizations, foster care review board members, court-appointed special advocate volunteers, and youth currently or previously in foster care. The Commission serves as a permanent forum for collaboration among state, local community, public, and private stakeholders across child serving programs and services with the intent to improve the safety and well-being of Nebraska children and families.

In 2012, Nebraska explored and planned for the launch of an Alternative Response (AR) Model within CFS to allow families an opportunity to address issues prompting the child abuse/neglect reporting without removing children at low risk of harm from their natural environment. An AR stakeholder group has been formed with members including DBH, CFS, RBHAs, CFS's Service Administrators, the Federation of Families, and others. Pilots of the AR Model, began in State Fiscal Year 2015, in a limited and evaluative manner. AR is an effort to change further the state's culture away from thinking that the safety of a child can only be achieved through removal from the family home. The focus of the pilot is more on enhancing the family's protective factors while maintaining the child's safety. As such, communities enrolled in the pilot are collaborating in ways that inform and strengthen the System of Care.

Collaborative partnerships are the foundation for implementation of the System of Care strategies as identified by the informal workgroup meeting from January through June 2015. Operationalizing the selected strategies will be carried out through the Standing Work Team mechanism and each team's correlating work plans. The following standing work teams will be implemented within the SOC structure:

The **Continuous Quality Improvement** (CQI) standing work team will be charged with identifying and implementing evaluation measures that can be applied across systems. Further development of the work plan will be the function of the CQI Standing Work Team once convened.

The **Training and Technical Assistance** work team will be charged with identifying and implementing training across systems at the regional, tribal and community levels. Further development of the work plan will be the function of the Training and TA Standing Work Team once convened.

The **Cross-System Development** work team is charged with further development and implementation of system of care principles and practices across systems, organizations and other entities. Further development of the work plan will be the function of the Cross-System Development Standing Work Team once convened.

The **Social Marketing and Communication** work team is charged with developing a messaging and channel strategy designed to change the behaviors of those involved in Nebraska's behavioral health system.

The **Financial Investment** work team is charged with developing a financial investment blueprint of cross-system services, supports, and funding streams for children and youth and to leverage these resources to maximize funding sources. The team will develop a work plan that addresses tailoring of services and payments to different population needs across state agencies. This team is working with an outside consultant funded by the Division of Behavioral Health, in the initial phases of the blueprint project and incorporates the following timeline:

- **Phase 1: April to June 30, 2015 -** Focuses on the initial design of the blueprint and data collection.
- **Phase 2: July 1, 2015 to Winter 2016 -** Focuses on data analysis and report preparation.

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.

At the state level, the Professional Partner Program sponsors two statewide training events per calendar year in which all Professional Partners and their supervisors are required to attend, with encouragement for participation from youth and families along with representatives from family organizations, the DHHS CFS, Juvenile Justice, school districts and other interested parties.

Central to the success of Nebraska's SOC Planning Project is adherence to the National Standards for Culturally and Linguistically Appropriate Services (CLAS). A key focus of the planning process was to promulgate and increase commitment to the CLAS standards across all levels of planning and the subsequent strategic plan. Technical Assistance in the form of an all-day workshop specific to CLC/CLAS was offered to all CST members as well as members of the Project Management Team, project leadership and key staff of system partners. Vivian Jackson, Ph.D., National Center for Cultural Competence, Georgetown University Center for Child and Human Development, presided over the day's agenda which included topics specific to clarity of concepts and elements of CLC.

In addition the Training and Technical Assistance work team, within the SOC structure, will be charged with identifying and implementing training across systems at the regional, tribal and community levels. Further development of a work plan that addresses the following strategy will be the function of the Training and TA work team.

Strategy: *Develop a competency training/education inventory to be used across systems and inclusive of the following eight domains: trauma-informed/capable care; child and adolescent development; cultural and linguistic competence; children and youth with developmental disabilities and behavioral health needs; screening/assessment/evaluation/referral; family and person centered practice; treatment planning/ interventions/service delivery; quality improvement; professionalism and ethics. Support the development of SOC principles and practices education/training for the system workforce and identify resources to disseminate education/training throughout the state.*

Training and TA Work Plan

Targeted Outputs
A. Identify and map existing Training and TA resources including training data bases and physical (on-site) trainings at state and national level. Identify gaps and opportunities.
B Compile inventory list and map community-based/integrated trainers available on each of the eight domains identified in the strategy.
C. Assess need through survey of communities and collaborations about training, TA and trainers offered, invested in and used.
D. Identify training initiatives amenable to inclusion of youth and families as trainers, participants and/or target audience.

The **Cross-System Development** work team is charged with further development and implementation of system of care principles and practices across systems, organizations and

other entities and will also be working to identify training needs across the system. The following strategies apply: **1)** Explore and identify requirements necessary to build a culturally responsive, trauma informed and community-based crisis continuum across systems that includes a dedicated on-call team, in-home services and brief out-of home options for children and youth in crisis, **2)** Identify regulations, barriers and gaps that prevent effective collaboration and/or development of a single services plan for children, youth, and families across systems. **3)** Map current children and youth service and support opportunities, eligibility requirements, funding sources, and relevant policies, practices and regulations across systems.

5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?

Utilization of services is monitored at both the regional and state level, with findings documented, reported, and made available at least annually and as needed. Using a collaboratively developed and agreed upon Services Purchased review format and procedures, representative chart samples of each provided service for children and youth undergo on-site inspection to ensure appropriate provision of identified services.

A second collaboratively developed component, the Program Fidelity review is conducted a minimum of every three years (with an additional need based option). This review addresses the services' adherence to established professional and program standards. As with the Services Purchased review format, representative chart samples of each provided children's service undergo on-site inspection to ensure appropriate provision of identified services. In many cases, the Services Purchased and Program Fidelity reviews are conducted jointly. Should reviews reveal deficit areas, the state provides service providers with technical assistance in their development of a corrective action plan, with return monitoring of the implemented plan until deficiencies are corrected.

For contracted children's services, including those services provided through the Professional Partner Program, expenditures are monitored through a multi-leveled, detailed monthly line item review of submitted RBHA and provider billing documents. Adjustments and budgetary shifts are made throughout the contract year to ensure appropriate funding levels.

Outcomes for youth receiving services through the Professional Partner Program and FN/FPS programs are monitored monthly at the local team level, with ongoing adjustments in the plan to meet the youth's desired goal. With the use of standardized instruments (e.g., Child and Adolescent Functional Assessment Scale), information is collected, aggregated, and presented for discussion at the state level. Through this process, and recognizing the importance of the family unit in the youth's success, the DBH collaboratively developed and made priority, a measurable goal for families to experience an increase in their ability to better function as a unit.

Youth outcomes are reviewed by the respective RBHA at least quarterly, and are shared annually and as needed through administrative and Network Team meetings. Combined statewide data are analyzed and trended quarterly by the DBH Quality Improvement and Data Team and presented for review and discussion at least annually and as needed. Through the DBH Managed Care partner, Magellan Behavioral Healthcare, National Outcome Measures data for children and

those enrolled in the Professional Partner Program is collected and analyzed. A separate data 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.

SOC implementation activities will also incorporate monitoring and tracking service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders. The **Continuous Quality Improvement** (CQI) standing work team, within the SOC structure, will be charged with identifying and implementing evaluation measures that can be applied across systems. Further development of the work plan that addresses the following strategy will be the function of the CQI work team once convened.

Strategy: *Identify a common Quality Improvement process that supports monitoring, evaluation and outcome measures and can be used across systems.*

CQI Work Plan Targeted Outputs:

Targeted Outputs
A. Establish and define a youth service population of interest.
B. Map what outcomes/ indicators are currently being tracked by the major systems: Education, Children & Family Services, Medicaid, DBH, Public Health, Juvenile Justice, etc.
C. Operationalize functional outcomes listed in the SOC Strategic Plan to promote quantitative data collection and analysis.
D. Establish baseline data for the identified youth service population of interest across systems.
E. Develop a pilot project that enables cross system benefits and partnerships as a means of positively impacting the most complex, high-touch cases in a member outcome and fiscally responsible manner.
F. Develop and implement MOU's to enable data sharing across systems and programs.

System of Care evaluation results completed by SAMHSA in their *Report to Congress 2012-2013*, provided valuable analysis of outcomes and serves as a resource for the CQI work team for further development of measures and outcomes associated with NeSOC. Below are examples of baseline and outcome measures, developed by the CQI work team, as aligned with the SOC functional outcomes identified during the strategic planning phase.

Baseline:

- Percentage of youth successfully discharged from residential levels of care vs. total residential level of care discharges. (Baseline measure)
- Identification of most common service discharged to from residential care. (Baseline measure that would promote insight into potential SOC service/step down gaps)

Outcome Measures:

- Percentage of youth successfully discharged from a residential care setting into community based services who had 180 days community tenure post-discharge. (Outcome Measure)
- Percentage of youth discharged from a residential setting who had a readmission to a residential setting or higher level of care (i.e.. Acute Inpatient) at 90 and 180 days post discharge. (Outcome Measure)

The DBH Continuous Quality Improvement (CQI) Program establishes accountability for continually improving DBH as an organization and the services provided to consumers and families in the state of Nebraska. The CQI team has identified the following RBA performance measures for 2016:

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

Result – Statewide Population

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

1. Nebraskans are physically and emotionally healthy.

Indicators - Statewide Population

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

1. Decrease in substance use:
- Binge drinking 12-17
- Binge drinking 18+ /19+
- Marijuana use 12-17

2. Decrease in Nebraskans needing involuntary emergency inpatient care:
- Involuntary hospitalizations through EPC admissions
- Mental Health Board commitments

Performance Measures – Region/Program Level

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

1. How well do we do it?
   - % positive response to general satisfaction with services received
   - % positive response to staff sensitive to trauma
   - % programs with improvement in trauma informed scores
   - % programs with improvement in co-occurring capable/enhanced scores
   - % consumers discharged with treatment completed status
2. Is anyone better off?
   - #/% positive response to improved QOL
   - #/% positive response to improvement in symptoms
   - Average # days / % of consumers who binge drank in last 30 days
   - #/% decrease in substance use

6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?

In 2013, the Legislature directed the University of Nebraska Medical Center to create the Behavioral Health Screening and Referral Pilot Program. The program provides an "integrated care" model in which there is:

- Behavioral health screening for children & adolescents

- Availability of further assessment and diagnosis in the primary care office
- Initial treatment options in the primary care office from an on-site psychologist
- Back-up specialty consultation, using telehealth, from UNMC child psychiatry, psychology, psychiatric nursing, and developmental pediatrics
- Referral to psychiatric care for most severe clients

Pilot sites for the Screening & Referral Program include:

- Columbus Children's Healthcare Clinic, a pediatric practice serving a non-metro county
- Western Nebraska Behavioral Health, a child psychology practice partnering with family medicine practices in Chadron, Alliance, and Valentine serving frontier counties
- Dundee Children's Physicians, a pediatric practice in Midtown Omaha serving an urban county

These Screening& Referral Program Early Screening, Assessment, and Treatment (ESAT) teams are making a difference in the lives of Nebraska children with behavioral health needs.

ESAT team activities	**At the pilot sites**
Screen children for behavioral health concerns	1,660 screenings are complete
Provide treatment from an integrated team	Of those at risk, 77% of parents welcome treatment
Train teachers on children's behavioral health	Teachers respond overwhelmingly to offers for training.

Medical home - The ESAT teams provide integrated care, from a pediatrician and a psychologist, in one location.
In the medical home model, physicians and specialists integrate treatment in order to provide the best care possible. The ESAT teams are proving that integrated care in a medical home is effective.

Early Intervention – Parents take children to the doctor's office and this is a great place offer a variety of services. By offering screenings and treatment in this setting, programs are able to reach a huge number of families that otherwise would not receive behavioral health support.

Help for schools - Teachers are in a great position to impact the behavioral health of students. As teachers learn more about behavioral health, they are more likely to be compassionate with students and refer families to an appropriate professional. Educators are hungry for information so that they can provide the best education for these at-risk students. As part of the Behavioral Health Screening and Referral Pilot Program, BHECN engaged stakeholders in the Nebraska Panhandle, the Columbus/Norfolk area and Omaha in order to create meaningful training plans that are tailored to the specific needs of each community. BHECN employs a five phase process in each community:

1. Identify lead organizations and local partners;

2. Facilitate inclusive decision making;
3. Assess capacity and current assets;
4. Develop site specific plans; and
5. Disseminate training and plan for evaluation and follow up consultation.

This training will be available in-person and via distance learning. The training will be on working with behavioral health challenges in the school setting. Future trainings will likely be web-based and on-demand and train-the-trainer opportunities will also be emphasized to build local capacity and sustainability. Possible future training topics identified by local stakeholders include: 504 plans, psychopharmacology, de-escalation techniques, and working with students who have attention deficits.

BHECN is ready to convert the ESAT pilot to a permanent program. The tremendous response from parents, doctors, psychologists and teachers shows there will be a large and ongoing need. The Columbus, Panhandle and Omaha sites will remain and two new sites will be added using funds already allocated. As BHECN has implemented the ESAT pilot project, they have discovered ways to make the program run efficiently without compromising quality. These efficiencies will produce cost savings that can fund program expansion.

7. What age is considered the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

The age that a child/adolescent is no longer eligible to receive behavioral health services in the child/adolescent system is 19 years of age. If a youth is identified as needing continued care as they transition to adulthood, DHHS CFS begins the process to educate and connect the youth to the RBHA.

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. There are plans to review this process as part of the SOC work and look at ways to improve.

The 2013 the Legislature passed numerous bills that impacted the building of services and supports for children, including to expand telehealth services for schools, extend Title IV foster care eligibility until age 21, and change Foster Care Licensures and Kinship Home/Relative Home provisions to support permanency with kin and relatives.

In 2014 the Legislature passed a bill that updates Young Adult Bridge to Independence Act which provides foster care transition services and authorizes a pilot program for alternative

response in certain Nebraska child welfare cases. The bill made a number of changes to the existing Young Adult Bridge to Independence Act, including:

- Stipulating that payments made on behalf of a former state ward after the appointment of a guardian would no longer terminate on or before the individual's 19th birthday if he or she is eligible for extended guardianship assistance
- Requiring continuation of services by the department until age 21 if a former ward is in the bridge to independence program regardless of whether he or she is regularly attending school or training programs
- Requiring the state Department of Health and Human Services (DHHS) to provide information on community resources if a former ward voluntarily terminates a support agreement; and
- Requiring that a DHHS independence coordinator meet with former wards who are determined no longer eligible for the program.

In addition to administrative memos and legislative actions, the DBH offers the following assistance to support transition age youth

- Professional Partner Programs
- Family Peer Support and Transition Age Peer Services
- Transition Age Supported Housing
- Transition Age Supported Employment
- Age waiver for youth ages 17 and 18 to receive services in the adult NBHS.

Currently under way for future SOC work is the further development of transition age youth peer support and certification offered to peer specialists who specialize in this area.

Training and technical assistance is needed for SOC implementation

19. Pregnant Women and Women with Dependent Children

Narrative Question:

Substance-abusing pregnant women have always been the number one priority population in the SAMHSA block grant (Title XIX, Part B, Subpart II, Sec.1922 (c)). A formula based on the FY 1993 and FY 1994 block grants was established to increase the availability of treatment services designed for pregnant women and women with dependent children. The purpose of establishing a "set-aside" was to ensure the availability of comprehensive, substance use disorder treatment, and prevention and recovery support services for pregnant and postpartum women and their dependent children. This population continues to be a priority, given the importance of prenatal care and substance abuse treatment for pregnant, substance using women, and the importance of early development in children. For families involved in the child welfare system, successful participation in treatment for substance use disorders is the best predictor for children remaining with their mothers. Women with dependent children are also named as a priority for specialized treatment (as opposed to treatment as usual) in the SABG regulations. MOE provisions require that the state expend no less than an amount equal to that spent by the state in a base fiscal year for treatment services designed for pregnant women and women with dependent children.

For guidance on components of quality substance abuse treatment services for women, States and Territories can refer to the following documents, which can be accessed through the SAMHSA website at http://www.samhsa.gov/women-children-families: *Treatment Improvement Protocol (TIP) 51, Substance Abuse Treatment; Addressing the Specific Needs of Women; Guidance to States; Treatment Standards for Women with Substance Use Disorders; Family-Centered Treatment for Women with Substance Abuse Disorders: History, Key Elements and Challenges.*

Please consider the following items as a guide when preparing the description of the state's system:

1. The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.
2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.
3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.
4. Discuss who within your state is responsible for monitoring the requirements in 1-3.
5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)
    a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
    b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?
6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)
    a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
    b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

C. Environmental Factors and Plan

19. Pregnant Women and Women with Dependent Children

Substance-abusing pregnant women have always been the number one priority population in the SAMHSA block grant (Title XIX, Part B, Subpart II, Sec.1922 (c)). A formula based on the FY 1993 and FY 1994 block grants was established to increase the availability of treatment services designed for pregnant women and women with dependent children. The purpose of establishing a "set-aside" was to ensure the availability of comprehensive, substance use disorder treatment, and prevention and recovery support services for pregnant and postpartum women and their dependent children. This population continues to be a priority, given the importance of prenatal care and substance abuse treatment for pregnant, substance using women, and the importance of early development in children. For families involved in the child welfare system, successful participation in treatment for substance use disorders is the best predictor for children remaining with their mothers. Women with dependent children are also named as a priority for specialized treatment (as opposed to treatment as usual) in the SABG regulations. MOE provisions require that the state expend no less than an amount equal to that spent by the state in a base fiscal year for treatment services designed for pregnant women and women with dependent children.

1. The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.

The Nebraska Division of Behavioral Health (DBH) places a high priority on Women's Services through the Regional Behavioral Health Authorities (Region). In the State to Region services contracts, the Regions are required to closely monitor provider compliance with the following priorities for admission to behavioral health services, including emergency, inpatient, residential, and non-residential services reimbursed under the contract:

- Substance Abuse priority populations:
    1. Pregnant Injecting Drug Users
    2. Other Pregnant Substance Users
    3. Other Injecting Drug Users
    4. Women with Dependent Children
    5. All Others

Providers serving women will publicize the availability of these services and publicize that a pregnant woman will receive priority admission.

At the state level, the DBH works closely with the Departments of Corrections, Juvenile Justice, Probation, Courts, Child and Family Services, Medicaid and the Public Policy Center to ensure that these entities are knowledgeable of substance abuse treatment services that are available to pregnant women and women with dependent children, and that these individuals have priority status when seeking substance abuse services.

As a resource for front line Child and Family Services (CFS) workers, the DBH developed a document that outlined the priority population referral process, defined interim services, discussed components of the waiting list, identified Regional resources and answered specific questions posed by CFS workers. This fact sheet was distributed to other agencies and departments for reference.

2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.

In the State to Region contract for substance abuse services, Regions are required to adhere to the priority populations of pregnant injecting drug users, other pregnant substance users, other injecting drug users, women with dependent children and all others in providing substance abuse treatment. The Region ensures that this priority list is maintained at the provider level via inclusion in the Region to Network Provider contract.

Regional providers of substance abuse services are required to admit pregnant women into services within 48 hours of initial contact. Admission may be immediate into the appropriate recommended treatment, or, placement on the waiting list with the provision of interim services within 48 hours, with these interim services continuing until the woman is admitted into the recommended treatment. Should the Provider not have an opening immediately available, the Provider works with Region personnel to find openings within the Region and throughout the state to offer the pregnant woman. Should the pregnant woman choose to wait for an opening with the intake provider, the woman's name is placed on the waitlist, according to her priority, and no later than 48 hours following initial contact, is admitted into interim services. The intake provider contacts the woman weekly to follow her progress and to update her on available openings with the intake provider as well as available openings statewide. The provider maintains this weekly contact with the pregnant woman until she is admitted into services or declines substance abuse treatment.

Each week, Regional providers of substance abuse services are required to submit to the respective Regional Behavioral Health Authority and the Division of Behavioral Health, the number of consumers by priority who received services, and, the number of consumers according to their priority level who are placed on the provider's waiting list for services. Priority levels include: (1) pregnant injecting drug users; (2) other pregnant substance users; (3) other injecting drug users; (4) women with dependent children; and, (5) all others, including those consumers with Mental Health Board Commitments. With incorporation of provider submitted data by Region, the resultant reports, the (Statewide) Weekly Substance Abuse Capacity Report, and, the (Statewide) Weekly Substance Abuse Priority Waiting/Interim Services List for Priority Populations, are compiled and distributed to the Regions to monitor and to share with providers.

In the weekly reporting of provider capacity and priority waiting/interim services information, the provider maintains responsibility to ensure services are provided to pregnant women seeking substance abuse services within 48 hours. In addition, the pregnant woman is contacted at least one time per week to assess her satisfaction with interim services and update her as needed should treatment openings in the recommended service become available. The information submitted for the weekly reports ensures that this process is followed, with follow-up as needed by the Region.

The Region maintains ongoing contact with each substance abuse treatment provider to ensure pregnant women are admitted to treatment within 48 hours, and, when the intake provider has no

openings immediately available, assists the intake provider by identifying providers with openings to offer the pregnant woman.

Through the annual Services Purchased and tri-annual Program Fidelity reviews and audits, the Region conducts formal reviews of individual consumer's substance abuse treatment at the provider level. A component of these reviews is the timeliness of admission into interim and recommended substance abuse services. At least once per three year cycle, and, using a DBH developed Substance Abuse Treatment and Prevention Block Grant tool, providers utilizing Women's Set Aside funding are assessed their capability in providing services for pregnant women and women with dependent children.

The Division of Behavioral Health manages the Weekly Substance Abuse Capacity Report and the Weekly Substance Abuse Priority Waiting/Interim Services List for Priority Populations by compiling data submitted by each substance abuse provider through statewide distribution. The Regional Field Representative monitors each weekly report, and follows up with each Region when a priority level pregnant woman has been on the waitlist for two weeks or longer.

Through a component of the annual Region Network Contract Compliance Review, the Division of Behavioral Health specifically addresses the Region's ability to ensure sufficient treatment capacity for pregnant women and other priority populations as well as the ability to ensure that these individuals receive substance abuse services within 48 hours of initial contact either via admission into recommended substance abuse services or admission into appropriate interim services.

3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.

Refer to the answer in Question #2 above.

As Regional contracted providers of substance abuse services are required to admit pregnant women into services within 48 hours of initial contact, it is imperative that providers have knowledge of available openings that is accurate, current and geographically relevant.

Each week, Regional providers are required to submit to the respective Regional Behavioral Health Authority and the DBH a listing of individuals in the priority population categories according to these criterion: a. total and available substance abuse treatment service capacity; b. substance abuse treatment programs that are at or above 90% capacity; c. the number of individuals who are waiting for substance abuse treatment by priority population level; d. the length of time individuals remain on the waiting list, and, e. if individuals on the waiting list are receiving interim services.

The DBH compiles individual provider data into a statewide listing according to a. through e. above and distributes this listing to each Region. In turn, the Region shares this statewide listing with each of its substance abuse providers.

Should a provider not have an opening immediately available, the provider reviews this listing, and in conjunction with the respective Region personnel, works to find openings within the Region and then throughout the State to offer to the pregnant woman. Should the pregnant woman choose to wait for an opening with the intake provider, the woman's name is placed on the waitlist, according to her priority, and no later than 48 hours following initial contact, is admitted into appropriate services or admitted into recommended interim services. The intake provider maintains contact a minimum of once per week with the pregnant woman who is receiving interim services to offer a list of current treatment openings and seek her choice of treatment options. The provider maintains this weekly contact with the pregnant woman until she is admitted into appropriate services or declines substance abuse treatment.

4. Discuss who within your state is responsible for monitoring the requirements in 1-3.

Each Region sends their Weekly Substance Abuse Capacity Report and Weekly Substance Abuse Priority Waiting/Interim Services List data to the Nebraska Division of Behavioral Health Data Team. The Data Team aggregates the regional data to track trends on a state level, including:

a. total and available substance abuse treatment service capacity
b. substance abuse treatment programs that are at or above 90% capacity
c. the number of individuals who are waiting for substance abuse treatment by priority population level
d. the length of time individuals remain on the waiting list, and
e. if individuals are receiving interim services.

Please note that all individuals who are documented on the Weekly Substance Abuse Priority Waiting/Interim Services List must receive interim services while waiting.

The Data team shares this information with DBH staff, including the Field Representatives/ Contract Managers for each Region and Region staff. The Field Representatives/Contract Managers then reviews their Region's capacity and waitlist and discusses any issues revealed with Region staff.

5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP).

DBH has 11 Women's Set Aside Providers across the state that provide an array of services for pregnant women and women with dependent children. All Regions in Nebraska have services available for pregnant women and women with dependent children. Below is the list of the providers and the services they provide:

- Panhandle Mental Health Center: Outpatient Substance Abuse Services
- Human Services, Inc.: Short Term Residential
- Region II Human Services Arm in Arm Program: Community Support

- St. Francis Alcohol and Drug Treatment Center: Outpatient Substance Abuse Services
- South Central Behavioral Services: Outpatient Substance Abuse Services
- The Bridge Inc.: Therapeutic Community
- Well Link, Inc.: Dual Disorder Residential & Intermediate Residential
- St. Monica's: Community Support & Therapeutic Community
- Lincoln Medical Education Foundation: Substance Abuse Assessment & Outpatient Substance Abuse Services
- Heartland Family Services: Intensive Outpatient Therapy & Therapeutic Community
- Santa Monica: Halfway House

In addition to providing treatment services, these providers must ensure the following services are available:

- Gender-specific substance abuse treatment and other therapeutic interventions for women that may address issues of relationships, sexual and physical abuse, and parenting
- Pre-natal care
- Primary medical care for women who are receiving substance abuse services
- Primary pediatric care including immunizations for children of women receiving substance abuse services
- Therapeutic interventions for children in custody of women in treatment which may, among other things address their development needs, and their issues of sexual and physical abuse and neglect
- Transportation services to ensure that women and children have access to services
- Child care while receiving services
- Sufficient case management to ensure access to services

5a. How many of the programs offer medication assisted treatment for the pregnant women in their care?

The DBH does not require Women's Set Aside Providers providing clinical care to those with substance use disorders to directly offer MAT services but does require such provides to have collaborative relationships with other providers such that these MATs can be accessed as clinically indicated for patient need. If the Women's Set Aside Provider does not have a affiliation agreement or MOU with a provider of MAT services, they make referrals to medical and psychiatric providers.

5b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?

All Regions in Nebraska have physicians who provide MAT services. The metropolitan areas have the largest number of physicians authorized to treat opioid addiction. A review of the SAMHSA Buprenorphine Physician Locator identified only on waived physician located in the western most area of the state, however, not all physicians choose to be listed in the locator service. Women's Set Aside Providers who provided information about the availability of MAT

services for women accessing their services reported they are able to make referrals to medical and psychiatric providers for MAT services.

6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP).

All eleven Women's Set Aside Providers across the state provide an array of services for women with dependent children. Outpatient services are provided either directly or through affiliation agreements, memoranda of understanding or contract. Qualifying services include pre-natal care, primary pediatric care, therapeutic interventions for children in custody of women in treatment, and case management services. Support services include transportation services to ensure that women and children have access to services and child care while receiving services.

Residential services are provided directly by six providers in five of the six behavioral health regions. Region 2 does not have a provider of residential services but coordinates residential services with providers in the other five regions. At times when residential services are at capacity within a region, the providers coordinate with the other regions for residential services via affiliation agreement or MOU.

Intensive Outpatient Treatment (IOP) services are available through Heartland Family Services, a provider in Region 6. The IOP *Better Together* allows entire families who are at risk of losing child custody due to substance abuse issues to live in contiguous apartments and receive on-site daily enhanced intensive outpatient substance abuse treatment, 24 hour peer support for their recovery, parenting education and support. IOP consumers also benefit from housing and case management support the program offers. The program employs an Advisory Council that meets quarterly.

6a. How many of the programs offer medication assisted treatment for the pregnant women in their care?

The DBH does not require Women's Set Aside Providers providing clinical care to those with substance use disorders to directly offer MAT services but does require such provides to have collaborative relationships with other providers such that these MATs can be accessed as clinically indicated for patient need.

6b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?

Please see the answer in Question #5b above.

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

Environmental Factors and Plan

20. Suicide Prevention

Narrative Question:

In the FY 2016/2017 block grant application, SAMHSA asks states to:

1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised National Strategy for Suicide Prevention (2012).
2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.
3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document Guidance for State Suicide Prevention Leadership and Plans.[96]

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

[96] http://www.samhsa.gov/sites/default/files/samhsa_state_suicide_prevention_plans_guide_final_508_compliant.pdf

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

C. Environmental Factors and Plan

20. Suicide Prevention

1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised National Strategy for Suicide Prevention (2012).

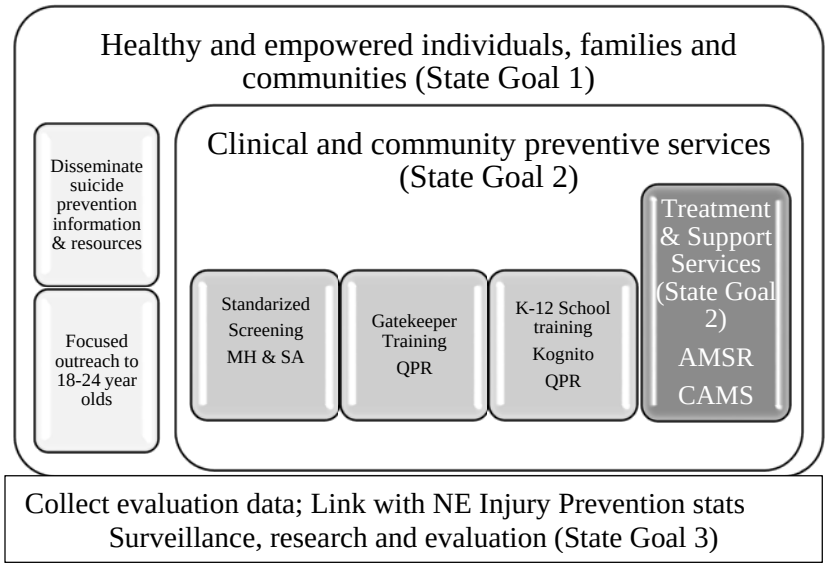
The Nebraska state suicide prevention plan is current through 2015 and can be found at http://www.suicideprevention.nebraska.edu/Documents/2014/SuicideCoalitionReport2013.pdf

These goals were prioritized through a multiple stage process including a statewide summit and a strategic planning process led by the Nebraska State Suicide Prevention Coalition (NSSPC). The NSSPC works throughout the year to promote suicide prevention activities statewide via local coalitions and other grassroots initiatives. The NSSPC supplements the state plan with an up to date activity plan (last revised in 2013). Together these documents provide overall direction for Nebraska's suicide prevention work.

There are three goals within the current plan:

1. Nebraskans will view suicide as a preventable public health problem. [Healthy and empowered individuals, families and communities]
2. Empirically supported suicide prevention programs are implemented across Nebraska. [Clinical and community preventive services; Treatment and support services]
3. Data is used to evaluate effectiveness of suicide prevention in Nebraska. [Surveillance, research and evaluation]

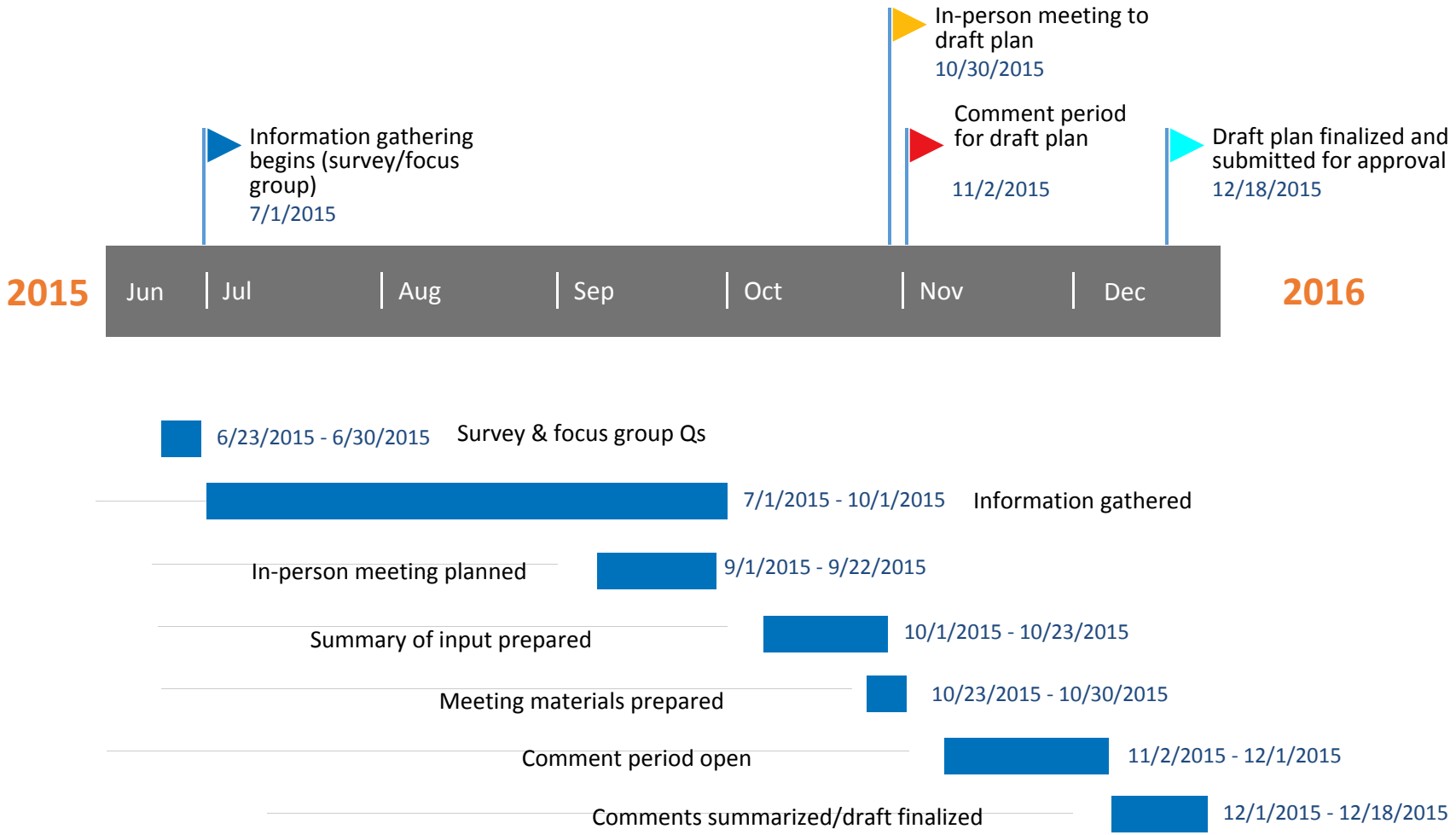
As a 2014 recipient of the Garrett Lee Smith Youth (GLS) Suicide Prevention grant and in continued partnership with the NSSPC, the DHHS Division of Behavioral Health is actively engaged in a strategic planning process to update the State's suicide prevention plan. System change will be promoted by working through the DHHS and Regional Behavioral Health Authorities to ensure suicide prevention becomes an expected component of service delivery and data collection. The figure below illustrates how GLS grant activities fit within the 2012 national framework and will influence revision of the current statewide plan to support suicide prevention across the lifespan.



In effort to be as inclusive as possible, while also revising the state's goals in alignment with National Strategy for Suicide Prevention, engagement of a broad range of stakeholders will serve two purposes, a) to gain input and b) to gain consensus.

See proposed planning process below.

Proposed State Suicide Prevention Plan Update Process - 2015



2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.

Block grant sub-recipients are encouraged to utilize braided funding to help improve the lives of children and youth, specifically those with SED and that are transition aged. The following logic model demonstrates how the plan is related to the needs Nebraska is facing and the outcomes we hope to achieve. Through continued monitoring and evaluation, the state will be able to target the evidence-based practices to areas and populations of greatest need and address disparities in subpopulations.

Needs	Approach	Outcomes
10 – 24 year olds have high suicide rates in Nebraska	State coordinated, locally implemented EBP's including means restriction	Reduced youth suicide rate in Nebraska
Treatment professionals are not routinely assessing risk of suicide	AMSR and CAMS Clinician Training	Increase # clinicians trained to asses, manage and treat youth at risk for suicide
Adults in contact with youth need to recognize and act on signs of suicide risk	QPR gatekeeper training; social marketing activities (including restriction of lethal means of suicide)	Gatekeepers prepared to recognize and act on suicide risk in every behavioral health region of Nebraska
School personnel need to understand warning signs of suicide and how to intervene	Kognito and QPR gatekeeper training; SPRC School Suicide Prevention Specialist Training	Schools use effective suicide prevention approaches Increase # persons in public school systems trained to identify risk of suicide Increase # of youth at risk who are identified, referred & receive services
Youth in families with a legacy of suicide are at risk for suicide	Implement LOSS teams in each regional behavioral health region	Quality post-vention services are available in Nebraska Increased # of LOSS teams in state
Youth with behavioral health disorders are at high risk for suicide	Implement standardized screening (Professional Partners; Family Navigators; Regional Network Providers in mental health and substance abuse)	Standardized screening protocols are sustained and tracked for youth with behavioral health disorders at risk for suicide
Young adults in Nebraska are at risk for suicide	Focused outreach to young adults in communities and on post-secondary campuses (community colleges, Cosmetology schools, Massage schools, Universities, workforce development programs, returning military work development programs, youth in transition to adulthood programs)	Increased awareness of suicide prevention among young adults Increased awareness of National Suicide Prevention Hotline Decreased number of suicides for young adults

3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. See attachment.

2015 Nebraska State Suicide Prevention Leadership and Plan
Nebraska Suicide Plan Progress Update:

The Division of Behavioral Health is building on the success experienced during Nebraska's previous GLS grant (2009 – 2012) by continuing to serve the entire State. The state sustained several key youth suicide prevention strategies at the end of Nebraska's previous GLS grant in 2012 (requiring suicide screening for wraparound programs; requiring suicide screening for family peer support programs; supporting the state suicide prevention coalition; supporting the national suicide prevention hotline). Additionally, legislation was passed this year making youth suicide prevention training a requirement for all K-12 public schools.

The principle of 'one is too many' led the Nebraska State Suicide Prevention Coalition to suggest the grant be used to implement strategies based upon system improvement rather than focusing only on geographic areas of high need. While activities are intended to reach across the lifespan, the State is focusing on two primary two subpopulations: **1) youth in K-12 schools and 2) youth with behavioral health disorders**.

Nebraska's has chosen to focus on youth with behavioral health disorders because they are at high risk for suicide and cross over into many other systems. DHHS believes we can make the most significant systemic changes in the behavioral health system in Nebraska that will in turn impact the multiple systems that children and youth with behavioral health disorders are often involved in (e.g., child welfare, juvenile justice). Since our behavioral health system is state coordinated but locally controlled, we believe that focusing our efforts in this area will also positively impact local communities.

Children and youth 10-21 will be impacted four ways:

1. K-12 school personnel will receive gatekeeper training (Kognito or QPR)
2. Screening for youth with serious emotional problems served through Professional Partner Program
3. Screening for youth in contact with family navigators in the child welfare system
4. Screening for youth serviced through crisis services and office or home-based therapy provided by regional network service providers

Young adults will be reached three ways:

1. Focused outreach to post-secondary settings (awareness/QPR)
2. Focused outreach to community work development programs
3. Awareness activities directed at the community level

As a result of the previous GLS grant and suicide prevention plan the preferred gatekeeper training model was established by the state to create a common language for identification and referral of children and youth at risk for suicide. We have ten (out of an original 24) trainers who were recertified to continue this training this year. Additional trainers will be prepared and placed within each behavioral health region. The State continues to use the four in-state AMSR trainers to expand training to each regional area. The state is working to enhance sustainability

by planning linkages with the University of Nebraska Medical Center's Behavioral Health Education Center of Nebraska (BHECN), an established training organization dedicated to improving the competency of Nebraska's behavioral health workforce. In the previous grant the state chose the SBQ-R screening tool and integrated its use with the Professional Partner Programs in each Region and introduced it to Family Navigators in the child welfare system. The Division of Behavioral Health is re-instituting reporting of screening data collected by Professional Partners, re-introducing and familiarizing the Family Navigators with the screening tool, making referrals and data collection/reporting. The Division of Behavioral is also expanding use of the SBQ-R to regional network providers and building on data collection and reporting expectations into the system.

The following Evidence Based Practices are currently being implemented to help meet the goals state suicide prevention plan:

1. **Kognito Training Suite for School Personnel in Grades K-12 - online** training simulations designed to build skills and increase confidence so that one individual can influence a positive change in another's behavior. Their core approach is based on research in neuroscience, social cognition and game mechanics.
2. **QPR (Question, Persuade, Refer) Gatekeeper training** – continue efforts to assist communities with implementing culturally appropriate suicide prevention strategies and preventing youth/young adult suicide by using local trainers.
3. **SBQ-R Screening tool** - continue to promote these protocols and expand their use to network providers serving children and youth.
4. **AMR (Assessing and Managing Suicide Risk) clinician training** – a one-day in-person training in every Region to be offered each year of the grant.
5. **CAMS (Collaborative Assessment and Management of Suicidality) clinician training –** to be augmented with AMSR and addresses practical clinical practices such as charting, treatment planning and assessing risk systematically.
6. **LOSS (Local Outreach to Suicide Survivors) postvention model –** identify communities that are ready for LOSS implementation. Develop team in conjunction with local law enforcement and are deployed immediately after a suicide to provide information and support to survivors.
7. **Means Restriction** – continue distributing information about restricting lethal means of suicide in communities and hospitals. Build on development of the discharge protocol that was adopted by the NE State Trauma Board in 2012.

The Division of Behavioral Health will ensure suicide prevention remains a priority in our system by expanding requirements for standardized screening in contractual agreements with providers; continuing to track suicide and self-injury data from hospitals; making suicide prevention reporting to system oversight and monitoring groups an imperative; moving post-secondary systems toward requiring gatekeeper training; and creating local demand for effective suicide prevention practices within state and local systems.

Environmental Factors and Plan

21. Support of State Partners

Narrative Question:

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with 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, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of emergency management/homeland security and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please consider the following items as a guide when preparing the description of the state's system:

1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.
2. Attach any letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA, including the state education authorities, the SMAs, entity(ies) responsible for health insurance and the health information Marketplace, adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency, etc.

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

C. Environmental Factors and Plan

21. Support of State Partners

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities.

1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.

2. Attach any letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA, including the state education authorities, the SMAs, entity(ies) responsible for health insurance and the health information Marketplace, adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency, etc.

The Division of Behavioral Health works with a wide variety of public and private entities to promote recovery, prevention and treatment initiatives to ensure success of MHBG and SAPTBG programs. Below is a sampling of these relationships:

- DHHS Complex Care Team
- DHHS Division of Medicaid and Long Term Care
    - Sharing of data to evaluate and monitor public behavioral health system
    - Children's System of Care (SOC) Committee and participating in development of SOC Financial Blueprint
    - Coordinated service definitions for medically necessary BH services
    - Trauma Informed Care Initiative
    - Regular staff meetings on behavioral health issues, managed care, legislation, etc.
- DHHS Division of Children & Family Services
    - Alternative Response implementation, evidence-based practices to assess a family's strengths and needs and the likelihood of abuse or neglect if children remain at home while receiving services.
    - Coordination of services for children's wraparound and Family Peer support services for children and youth with behavioral health needs or at risk for out of home placement
    - Children's System of Care Committee and participating in development of SOC Financial Blueprint
    - Nebraska Homeless Assistance Program
        - Coordination and participation in continuums of care for outreach and assistance to homeless individuals experience behavioral health disorder
        - Promotion and funding for SOAR
    - Trauma Informed Care Initiative
    - Trauma trainings for Staff and service providers
- DHHS Division of Public Health

  - Children's System of Care Committee and participating in development of SOC Financial Blueprint
  - Health workgroups
  - Promotion of and education about health equity
  - Tobacco cessation, prevention of tobacco sales to minors and retailer education on tobacco sale laws
  - Trauma trainings for staff and service providers
  - Co-Sponsor of annual Healthy Youth Nebraska conference
  - Trauma Informed Care Initiative
  - Student Health And Risk Prevention (SHARP) survey workgroup

- DHHS Division of Developmental Disabilities
  - Children's System of Care Committee and participating in development of SOC Financial Blueprint
  - Case reviews and problem solving
- Lincoln Medical Education Partnership – School Community Intervention & Prevention (SCIP)
  - Statewide prevention and early intervention services for youth with behavioral health concerns
- Nebraska Supreme Court and the Administrative Office of the Courts & Probation,
  - Coordination of services definitions
  - Children's System of Care Committee and participating in development of SOC Financial Blueprint
  - Trauma Informed Care Initiative
  - Youth Initiative
  - Justice Behavioral Health Committee
    - Standardized Model for Delivery of Substance Use Disorder Services for juvenile and adult probationers/problem-solving court participants
    - Training for completing Addiction Severity Index and Children's Addiction Severity Index
- Nebraska Department of Education
  - Children's System of Care Committee and participating in development of SOC Financial Blueprint
  - Suicide education in schools
  - Student Health And Risk Prevention (SHARP) survey workgroup
- Nebraska Department of Highway Safety
  - Co-sponsor of statewide underage drinking prevention media campaign
  - Impaired driving prevention and education
- Nebraska State Patrol
  - SYNAR
  - Submission of MHBD Commitment for Federal gun checks
- Nebraska Vocational Rehabilitation

    - Coordinated provisions of employment supports for behavioral health consumers including implementation of braided funding for milestones designating steps for successful consumer outcomes (e.g., permanent competitive employment); joint oversight and evaluation of service providers of the milestone approach; sharing of data to monitor and measure outcomes
- Nebraska Department of Economic Development and Nebraska Investment Financing Association (NIFA)
    - Promotion of housing options for consumers and housing planning
    - Stakeholder in three year Strategic Supportive Housing Plan
- Regional Behavioral Health Authorities
    - Coordination with to establish, monitor and evaluate services throughout the state
    - COD & Trauma Initiatives
    - System of Care
    - Statewide prevention efforts
- Nebraska State Suicide Prevention Coalition
    - Suicide education, intervention, prevention and postvention development and support
- Nebraska Federation of Families with Children's Mental Health
    - Children's System of Care Committee and participating in development of SOC Financial Blueprint
    - Family navigator
    - Family peer certification program development
    - Promotion of and advancement of peer involvement and Recovery Orientated Systems of Care
- Nebraska Children & Family Foundation
    - Children's System of Care Committee and participating in development of SOC Financial Blueprint
    - Youth Partner lead for Children's System of Care
- Prevention Partnership Committee
    - Promotes child wellbeing, and providing safe, stable, nurturing relationships and environments for children and families
- Nebraska Prevention Center for Alcohol and Drug Abuse
    - Nebraska Colligate Consortium to reduce high-risk drinking and the negative effects of excessive alcohol use
- University of Nebraska-Lincoln: survey research, evaluation and support
    - Bureau of Sociological Research (BOSR) – annual Consumer Survey
    - Office of Research & Economic Development (Survey, Statistics and Psychometrics)
- University of Nebraska Medical Center
    - Student Nurse training
    - Collage of Public Health
- University of Nebraska Medical Center Behavioral Health Education (BHECN)
    - Trauma training;

    - Development, support of peer training
    - Workforce development, education and training of professionals
- University of Nebraska Public Policy Center
    - Evaluation state peer certification process
    - Coordination of suicide prevention services and intervention
    - Coordination of Disaster Behavioral Health services

Please see attachments of letters of support with the description of roles and collaboration with the SSA/SMHA.

MEMORANDUM OF UNDERSTANDING
BETWEEN THE

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF BEHAVIORAL HEALTH

AND
DIVISION OF MEDICAID & LONG-TERM CARE

This memorandum of understanding (MOU) is entered into by and between the Nebraska Department of Health and Human Services, **DIVISION OF BEHAVIORAL HEALTH** (DBH), and **DIVISION OF MEDICAID & LONG-TERM CARE** (MLTC), collectively referred to as the "Divisions."

I. PURPOSE

This MOU sets forth the nature and scope of the exchange of information between MLTC and DBH for the purpose of DBH carrying out its duties as the chief behavioral health authority for the State of Nebraska and directing the administration and coordination of the public behavioral health system according to law.

II. AUTHORITY

Disclosure of information by MLTC to DBH is for DBH to carry out its duties as the chief behavioral health authority for the State of Nebraska and direct the administration and coordination of the public behavioral health system according to Neb. Rev. Stat. 71-806. The information disclosed is protected by the Health Insurance Portability and Accountability Act and 42 CFR Part 2.

III. DEFINITIONS

A. BEHAVIORAL HEALTH SERVICES. Services including, but not limited to, consumer-provided services, support services, inpatient and outpatient services, and residential and nonresidential services, provided for the prevention, diagnosis, and treatment of behavioral health disorders and the rehabilitation and recovery of persons with behavioral health disorders.

B. INPATIENT. Psychiatric services provided in freestanding psychiatric hospitals and any psychiatric services in a hospital setting where the patient is admitted and generally stays at least one (1) night.

C. MEDICAID. The medical assistance program as set forth in Title XIX of the Social Security Act, as amended, and administered by MLTC.

D. PASRR. Pre-Admission Screening and Resident Review provisions of OBRA '87, as amended.

E. SCHIP. The State Children's Health Insurance Program, as set forth in Title XXI of the Social Security Act, as amended, and administered by MLTC.

F. SED. Serious emotional disturbances regarding an individual under eighteen (18) years of age who has significant emotional disturbances and is at the greatest risk for needing services based upon diagnosis, duration of impairment, and level of functioning.

G. SPMI. Severe and persistent mental illness regarding an adult with a primary diagnosis of schizophrenia, major affective disorder, or other major mental illness; at a significant risk of continuing in a pattern of either institutionalization or living in a severely dysfunctional way if needed mental health services are not provided; for which this pattern has existed for or is likely to endure for twelve (12) months or longer; and, who has a degree of limitation that seriously interferes with the individual's ability to function independently in an appropriate and effective manner, as demonstrated by functional impairments that substantially interfere with or limit at least two (2) of three (3) areas of vocational or educational, social skills, or activities of daily living.

H. UTILIZATION REVIEW. Process used to monitor or evaluate the clinical necessity, appropriateness, or efficiency of health care services, procedures, or setting.

IV. PARTIES' RESPONSIBILITIES

A. MLTC Responsibilities:

1. MLTC shall provide DBH with eligibility, expenditures, and utilization reports, as well as claims data, for behavioral health services covered by this MOU. These reports and claims data will be discrete by month, annualized by state fiscal year by discrete service, and will be provided on a quarterly basis within thirty (30) days after the end of each quarter. MLTC shall also provide DBH with ad hoc reports, as reasonably requested. Information provided by MLTC shall also include information received from its at risk provider.

2. MLTC shall provide the names, social security numbers, and dates of birth of Medicaid and SCHIP recipients to DBH for development or review of duplicated or shifted service reports from MLTC and its at risk provider within seven (7) days after the end of each month.

3. MLTC shall collect cost report information and shall make available to DBH, upon request, a summary Medicaid provider cost report that includes at least the following data: provider, each service rendered, total units of each service, total costs of each service, and unit cost for each service or current reports that provide information on claims and cost for services.

4. MLTC shall provide data that DBH needs in order to conduct oversight activities. This data shall include but not be limited to quarterly reports of current providers and quarterly reports of pending administrative appeals regarding adverse action against providers. These reports shall be provided within thirty (30) days after the end of each quarter.

5. MLTC shall grant DBH access to data extracts covered by this MOU from the MMIS and its at risk provider systems, upon request. MLTC shall grant DBH access to facilitate data analysis related to administration of the programs covered by this MOU.

B. DBH Responsibilities:

1. DBH shall not redisclose information received from MLTC under this MOU unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose.

2. DBH shall safeguard alcohol and drug records, information, data, or any other documents that are copied, removed, or transmitted in an electronic format or on an electronic medium, in accordance with 42 CFR 2.53(b).

3. When receiving, transmitting, transporting, storing, processing, or otherwise utilizing any information received from MLTC under this MOU identifying or otherwise relating to clients in alcohol or drug addiction programs ("protected information"), DBH is fully bound by regulatory provisions governing the confidentiality of alcohol or drug abuse patient records, found at 42 CFR Part 2, and may not use or disclose the information except as permitted or required by applicable law.

4. Resist any effort to obtain access to the protected information, except as expressly allowed or required by 42 CFR Part 2.

5. Use appropriate safeguards to prevent the unauthorized use or redisclosure of the protected information.

6. DBH shall use the data to identify new and emerging trends and populations to contribute to prevention and treatment priorities. This will help MLTC to assist DBH in identifying client populations receiving Medicaid benefits that may benefit from prevention, recovery, rehabilitation, or treatment services and ensure that such services are delivered in a cost-effective manner.

7. All data requested shall be destroyed or deleted as required by the DBH records retention and disposition schedule.

8. DBH shall use requested data to carry out its duties as the chief behavioral health authority for the state and direct the administration and coordination of the public behavioral health system according to law.

C. DBH and MLTC Joint Responsibilities:

1. MLTC and DBH shall share utilization and expenditures data to assist the Divisions in the administration and oversight of Nebraska's publicly funded behavioral health system, and in fulfilling the specific responsibilities described herein. All data shall be shared in accordance with applicable law.

2. MLTC and DBH shall collaborate to assure private vendors comply with all applicable law, all terms of any contract entered into with MLTC and DBH including those items regarding conducting utilization review of psychiatric hospital admissions and prior authorizations of selected community behavioral health services, and oversight and monitoring.

3. MLTC and DBH agree to share electronic data on a reasonable basis. This access shall be provided in such a way as to ensure the integrity of, and the effective and efficient administration of, the Medicaid, DBH, SCHIP programs and other related development and oversight activities involving the Divisions. MLTC and DBH agree that any research, proposals, presentations, or program applications relating to the SPMI or SED populations that have been developed as a result of this MOU will not be released without the express consent of the other.

V. DURATION

This MOU is effective immediately, and will remain in effect if and until amended or rescinded.

DATE: 7/29/15

ON BEHALF OF DHHS:

Courtney N. Phillips, MPA
Chief Executive Officer
Department of Health and Human Services

CHARTER

NEBRASKA PARTNERSHIP FOR VETERANS CARE

The Partnership is a cooperative effort by the State of Nebraska, VA Nebraska-Western Iowa Health Care System, and the Nebraska National Guard, to address the opportunities and challenges for Nebraska Veterans.

VISION: The Partnership will collaborate and coordinate to assist Nebraska Veterans in accessing a dynamic, client focused, integrated health care system which meets their basic needs and enhances their physical and mental/behavioral health.

MISSION: To develop a collaborative and coordinated prevention and integrated care delivery model for the veterans of our state.

GOALS:

1. Charter members will work to identify all resources that are and can be available to help Nebraska veterans and their families. This should include personnel, providers, facilities, programs, etc., in effort to integrate our services and goals of this partnership.
2. Charter members will work together to create a seamless prevention and care model that is customer friendly. Members will work to provide regularly updated information.
3. Charter members will identify where collaboration presently exists, in and out of the partnership, and document that collaboration. This will help expedite the care model development process and to support communication of what is being done, who is doing it and what do we now need to be doing. This information will be used to also develop a process to identify future work and partners.
4. Charter members will work to create a cooperative and coordinated information campaign for our stakeholders, our providers, our citizens and all the users of our veterans' services.
5. Charter members will identify barriers to access for mental health services for rural veterans and use this information to make recommendations to governmental, institutional or provider entities that could affect access changes.

STRUCTURE: The Partnership presently consists of the Nebraska DHHS, Nebraska Department of Veterans' Affairs, Nebraska National Guard, and VA Nebraska-Western Iowa Health Care System.

CHARTER DECLARATION

We, as individual and organizational statewide partners, embrace our role as vital contributors and are committed to providing valuable services to all veterans of Nebraska.

As public acknowledgement of this role, I would like to add my signature to the Nebraska Partnership for Veterans Care Charter Document.

_____ Date 24 NOV 08
Director, Nebraska Department of Veterans' Affairs

_____ Date 24 NOV 2008
Director, VA Nebraska-Western Iowa Health Care System

_____ Date 24 NOV 08
Director, Nebraska Military Department

_____ Date 11/24/2008
Director, DHHS Division of Behavioral Health

08-29

March 15, 2007

GUIDELINES

of the

NEBRASKA COMMUNITY CORRECTIONS COUNCIL

JUSTICE BEHAVIORAL HEALTH COMMITTEE

1.0 NAME & AUTHORITY

This committee of the Community Corrections Council of Nebraska shall be known as the Justice Behavioral Health Committee (Committee). The Committee is a voluntary membership organization established under the direction of the Community Corrections Council. These guidelines define how the Committee fulfills its responsibilities in keeping with its purpose, mission, vision, and expected outcomes.

2.0 PURPOSE

The Justice Behavioral Health Committee exists to create, review, and facilitate the implementation of standards for substance abuse evaluations and treatment, and standards for mental health evaluations and treatment for the criminal justice population.

3.0 MISSION, VISION & EXPECTED OUTCOMES

3.1 Mission

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

3.2 Vision

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

3.3 Expected Outcomes

- Safer Community
- Recidivism Reduction
- Risk Reduction
- Effective & Competent Client Care
- Adherence to and expansion of the Nebraska Standardized Model.

4.0 MEMBERSHIP

4.1 Representation

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

1. The four behavioral health Community Corrections Council members
2. The Executive Director of the Community Corrections Council
3. The Probation Administrator or a permanent designee
4. The Deputy Probation Administrator for Community Corrections Programs
5. The Deputy Probation Administrator for Information Systems
6. The Justice Systems Treatment Specialist, Probation Administration
7. Two Chief Probation Officers - one juvenile, one adult
8. The Executive Director of the Crime Commission or a permanent designee
9. The Information~~al~~ Services Chief of the Crime Commission
10. The Statewide Coordinator for Problem-Solving Courts
11. A representative from the Department of Health and Human Services, Office of Behavioral Health
12. A representative from the Department of Health and Human Services, Medicaid Office
13. Two representatives from the Behavioral Health Regions

14. The Director of the Office of Juvenile Services or a permanent designee

15. Two Licensed Mental Health Practitioners – one must be on the LMHP Licensing Board

16. Two Licensed Alcohol and Drug Counselors – one must be on the LADC Licensing Board

17. A University Criminal Justice representative

18. The Deputy Administrator for Parole

19. Two psychiatrists or physicians – one being the Department of Correctional Services Medical Director

20. Two representatives from the Department of Correctional Services – one from Behavioral Health and one from Substance Abuse

21. The Work Ethic Camp Facility Administrator

22. Two licensed psychologists – one must be from the HHS Regulation and Licensure Credentialing Division or Board of Psychologists

23. A representative from the Governor's Policy Research Office

24. A County Attorney

25. A Criminal Defense Attorney

26. A Consumer

27. The Director of Consumer Affairs for Behavioral Health

4.2 Vacancies

The membership shall be reviewed annually to determine vacancies. Vacancies shall be filled by calling for nominations, discussing the candidates, and conducting a ballot vote. After a vote to fill a vacancy is successful, a formal invitation to join the Justice Behavioral Health Committee will be sent along with meeting dates and other relevant Committee materials. Any clarifications regarding voting will be decided by the sitting chair.

5.0 MEETINGS

5.1 Frequency

The Justice Behavioral Health Committee shall meet quarterly. If a quorum is not reached, and such is known prior to the meeting, the meeting may be cancelled.

5.2 Quorum

Ten members of the Justice Behavioral Health Committee shall constitute a quorum. Every act or decision done or made by a quorum of the Committee members present at a meeting shall be regarded as the act and decision of the Committee as a whole.

5.3 Voting

After a motion is made and seconded, a vote will carry after receiving two-thirds (2/3) of those members present.

Only voting members and active staff shall sit at the meeting table during regular agenda items.

Voting shall occur by roll call. Minutes & Agendas will be approved by consent vote.

5.4 Proxies

Proxy voting will not be allowed.

6.0 ATTENDANCE

6.1 Minutes

Attendance, those present and those not present, will be reflected in the meeting minutes.

6.2 Attendance Requirements

It is expected that members will make every effort to attend every Committee meeting. Members must attend at least two meetings during each calendar year. Four consecutive absences will result in review of membership by the Committee and the member will be contacted by a member of the Committee.

If a member knows he or she will not be present at a meeting, the member must inform staff of his or her absence prior to the meeting.

7.0 SUB-COMMITTEES

7.1 Makeup

Members of any sub-committee may be on the Justice Behavioral Health Committee, but it is not required—sub-committees are open to those not on the Justice Behavioral Health Committee.

The Chairperson of any sub-committee of the Justice Behavioral Health Committee must be a member of the Committee. The Justice Behavioral Health Committee shall nominate and vote on all sub-committee chairpersons.

7.2 Reporting Responsibilities

The Chairperson of each sub-committee is responsible for reporting at each Justice Behavioral Health Committee. If the Chairperson is unable to attend, he or she shall appoint someone else from the sub-committee to report.

8.0 OPEN MEETINGS ACT

All meetings of the Justice Behavioral Health Committee, except those closed sessions permitted by law, shall be open and public. All meetings shall conform to the Open Meetings Act, including requirements for notice of meetings, preparation and distribution of agendas, posting of the Act, and the taking of minutes.

Public testimony shall be heard at the end of each meeting.

9.0 REPORT TO THE COMMUNITY CORRECTIONS COUNCIL

The acting chairperson of the Justice Behavioral Health Committee, or designated Committee member, shall report at the first meeting of the Community Corrections Council meeting after the regular Committee meeting.

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

Narrative Question:

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating mental health and substance abuse agencies, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance abuse, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance abuse prevention and treatment advisory council to ensure that the council reviews issues and services for persons with, or at risk for, substance abuse and substance use disorders. To assist with implementing a BHPC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.[97]

Additionally, Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) applicable to the SABG and the MHBG, 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 block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

For SABG only - describe the steps the state took to make the public aware of the plan and allow for public comment.

For MHBG and integrated BHPC; States must include documentation that they shared their application and implementation report with the Planning Council; please also describe the steps the state took to make the public aware of the plan and allow for public comment.

SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).
2. What mechanism does the state use to plan and implement substance abuse services?
3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?
4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[98]

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[97] http://beta.samhsa.gov/grants/block-grants/resources

[98] There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

C. Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating mental health and substance abuse agencies, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance abuse, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance abuse prevention and treatment advisory council to ensure that the council reviews issues and services for persons with, or at risk for, substance abuse and substance use disorders.

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).

The Nebraska Behavioral Health Services Act is the enabling legislation which mandates the Division of Behavioral Health (DBH) role as the chief behavioral health authority for the State of Nebraska. This enabling legislation also established the State Advisory Committee on Mental Health Services and the State Advisory Committee on Substance Abuse Services. When meeting in joint session, the two advisory committees serve as a behavioral health advisory council.

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

The joint committee continues its active involvement in the state plan by providing advice and assistance to the DBH on the ongoing planning efforts that inform and shape planning at State, regional, and local levels. This includes guiding review of behavioral health strategic plan initiatives, needs assessments, consumer surveys, Results-based Accountability, Continuous Quality Improvement and other efforts guiding activities across the systems, and prioritization of state planning activities in the state application. Recent activities include:

February 13, 2014 Joint Committee Meeting
Meeting topics included: Needs Assessment and Readiness Assessment for the System of Care initiative; Peer Support and Wellness studies developed for the Transformation Transfer Initiative; Nebraska Behavioral Health Annual Consumer Survey data.

May 8, 2014 Joint Committee Meeting
Meeting topics included: Subcommittee work activities of Prevention Advisory Council; System of Care Stakeholder Town Hall Meetings; DBH Strategic Plan; findings from the Peer Support Survey; SAMHSA Block Grant Review and Updates.

August 14, 2014 Joint Committee Meeting
Meeting topics included: Marijuana and Synthetic Drug Use in Nebraska; Nebraska's use of

prevention research to guide prevention strategies; Nebraska Housing and Community Development Consolidated Plan planning activity; Subcommittee work activities of Prevention Advisory Council.

November 13, 2014 Joint Committee Meeting
Meeting topics included: Affordable Care Act and MHPAEA in Nebraska; SAMHSA Block Grant Implementation and Priority Indicators review and updates; Subcommittee work activities of the Prevention Advisory Council; Annual SYNAR Report review and update.

January 27, 2015 Joint Committee Meeting
Meeting topics included: SAMHSA Block Grant First Episode Psychosis 5% Set Aside; Youth Suicide Prevention planning and activity; SAMHSA 2016/2017 Block Grant Needs Assessment and Priorities; Office of Consumer Affairs – Network of Care, OCA Survey.

March 17, 2015 Joint Committee Meeting
Meeting topics included: Subcommittee work activities of the Prevention Advisory Council; Office of Consumer Affairs: Mission, Vision, and Core Functions; Role of the Lincoln Regional Center (State Hospital) Medical Director; Community Integration Strategy planning; Suicide Prevention and LOSS Teams; SAMHSA 2016/2017 Block Grant Needs Assessment and Priorities.

August 13, 2015 Joint Committee Meeting
SAMHSA 2016/17 Block Grant – Review and recommendations on the Needs Assessment, Priorities, Application; Community Integration planning; Advisory Committee Structure planning. *See Attachment: Comment on the State Block Grant Plan.*

Additional information is available on the DBH website.
State Advisory Committee for Mental Health Services
State Advisory Committee for Substance Abuse Services

2. What mechanism does the state use to plan and implement substance abuse services?

In its capacity as the Single State Authority, the DBH has established mechanisms to comprehensively consider the substance abuse needs statewide and develop methods for addressing them. These mechanisms include:

- State Advisory Committee for Substance Abuse Services
- Prevention Advisory Council (a subcommittee of the State Advisory Committee on Substance Abuse Services) serves as the evidence-based workgroup for the State of Nebraska;
- Nebraska Division of Behavioral Health Strategic Plan 2011 – 2015;
- Nebraska Division of Behavioral Health Five Year Prevention Statewide Strategic Plan FY13-FY17;
- Nebraska State Epidemiological Outcome Workgroup; and,
- Statewide Quality Improvement Team.

3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?

Yes. The advisory committees' joint meetings enable the members to serve as a behavioral health advisory council to address both mental health and substance abuse disorders. Nebraska adopted the joint committee structure in 2010 and continues to successfully utilize this model.

The expertise and experience of the members allows them to provide advice and assistance to the DBH on behavioral health services for adults and children with mental illnesses and addiction disorders and promote the interests of consumers and their families. The advisory committees meet jointly on all occasions and occasionally break out separately to address issues relating to the charge of their respective committee.

Meeting jointly with the State Advisory Committee on Substance Abuse Services affords the State Advisory Committee on Mental Health Services the opportunity to review behavioral health services, activities and reports and provide advice and assistance to the DBH. Examples of recent issues and concerns addressed to the joint committee include:

- Incorporation of the Prevention Advisory Council as a standing subcommittee of the State Advisory Committee on Substance Abuse Services;
- Integration of mental health promotion, substance abuse prevention, trauma-informed care, and shared risk and protective factors;
- Nebraska System of Care 2014 Strategic Planning Project – Planning for Transformation through Partnerships;
- Patient Protection and Affordable Care Act and Mental Health Parity and Addiction Equity Act in Nebraska;
- Combined Behavioral Health Assessment and Plan Implementation and Priority Updates;
- Peer Support and Wellness as part of the Transformation Transfer Initiative.

4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?

The joint advisory committees' combined members are representative of the service population across the State of Nebraska. Each committee's membership is defined by state statute and appointment to the committees is by executive action of the Governor of the State of Nebraska.

State statute requires committee members to have a demonstrated interest, commitment and specialized knowledge, experience, or expertise relating to the provision of mental health/substance abuse services. Membership is composed of individuals in recovery from diverse cultures, family members of individuals in recovery, parents of children with SED, providers of mental health and substance use disorder services, representatives of partner state

agencies, and other interested citizens. Every opportunity is taken to recommend diversity in membership among individuals volunteering to serve on the committee.

Council members are appointed from representative areas across the State. Fifty-six percent of the total membership of the council are individuals in recovery, family members of individuals in recovery – including family members of adults with SMI and of young children, and others. Forty-four percent of the total membership are representatives of partner state agencies and providers. Twenty three of the thirty council members (77%) reside urban areas, seven (16%) reside in rural areas and two (7%) reside in frontier areas. Nebraska is a large geographic state with low population density, 84 of 93 counties are considered rural; nearly 95 percent of its land area is considered rural and 46.8 percent of its land area is classified as *Frontier and Remote*, using the most restrictive classification developed by the USDA Economic Research Service and the Federal Office or Rural Health Policy.

5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

Nebraska Revised Statute 71-814 (2) established the responsibilities and duties of the State Advisory Committee on Mental Health Services: "The committee shall be responsible to the division and shall (a) serve as the state's mental health planning council as required by Public Law 102-321, (b) conduct regular meetings, (c) provide advice and assistance to the division relating to the provision of mental health services in the State of Nebraska, including, but not limited to, the development, implementation, provision, and funding of organized peer support services, (d) promote the interests of consumers and their families, including, but not limited to, their inclusion and involvement in all aspects of services design, planning, implementation, provision, education, evaluation, and research, (e) provide reports as requested by the division, and (f) engage in such other activities as directed or authorized by the division."

Nebraska Revised Statute 71-815 (2) established the responsibilities and duties of the State Advisory Committee on Substance Abuse Services: "The committee shall be responsible to the division and shall (a) conduct regular meetings, (b) provide advice and assistance to the division relating to the provision of substance abuse services in the State of Nebraska, (c) promote the interests of consumers and their families, (d) provide reports as requested by the division, and (e) engage in such other activities as directed or authorized by the division."

Committee meetings include two opportunities (near the beginning and the end of meetings) for public comment regarding discussions and issues that are before the committees. Throughout the day, following each topic, committee members are asked for recommendations to the DBH regarding actions or next steps for the DBH to consider when moving forward in each respective area. All committee members have equal voice/vote in committee recommendations. Administrative staff from the Community Based Services Section of DBH as well as staff from the Office of Consumer Affairs attend meetings to listen to committee discussion as well as public comment for a better understanding of committee perspective.

A lunch presentation during each meeting typically revolves around individuals with lived experience sharing successes, barriers and challenges in their individual roads to recovery. This keeps the consumer perspective in front of the committee as well as DBH staff, and allows successes and challenges to have "face" to support the reality of challenges for those we are serve.

The DBH will be seeking on-site technical assistance in November 2015 on how to further improve and enhance advisory committee members participation.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.

See the tables *Behavioral Health Advisory Council Members* and *Behavioral Health Council Composition by Member Type*.

The U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) values the importance of a thoughtful planning process that includes the use of available data to identify the strengths, needs, and service gaps for specific populations. By identifying needs and gaps, states can prioritize and establish tailored goals, objectives, strategies, and performance indicators. In addition, the planning process should provide information on how the state will specifically spend available block grant funds consistent with the statutory and regulatory requirements, environment, and priorities described in this document and the priorities identified in the state's plan.

Evidence of the process and input of the Planning Council required by section 1914(b) of the PHS Act (42 U.S.C. 300x-4(b)) for the MHBG must be included in the application that addresses MHBG funds. States are also encouraged to expand this Planning Council to include prevention and substance abuse stakeholders and use this mechanism to assist in the development of the state block grant plan for the SABG application.

SAMHSA Combined FY 2016-17 Block Grant Application

SAMHSA offers states the opportunity to complete a combined application for mental health and substance abuse services, submit a biennial versus an annual plan, and provide information regarding their efforts to respond to various federal and state initiatives. The new design also reflects the increasing trend among states to integrate their mental health, substance abuse prevention, and treatment administration.

The Division of Behavioral Health (DBH) within the Nebraska Department of Health and Human Services utilizes the combined application for FY 2016-17 Block Grant Application - Community Mental Health Services Plan and Report &Substance Abuse Prevention and Treatment Plan and Report.

Nebraska SAMHSA Combined Block Grant FY 2014-15 Application

The SAMHSA approved application from 2014-15 is posted on the DBH web site.
http://dhhs.ne.gov/behavioral_health/Pages/beh_mh_mh.aspx
The application was submitted on September 3, 2013. A revision for the FY 2014 five percent set-aside of the Mental Health Block Grant allocation to support "evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders," was submitted on July 30, 2014.

Nebraska SAMHSA Combined Block Grant FY 2016-17 Application
Public Comment on the State Plan

The stakeholder input process for the development of the combined Nebraska SAMHSA Combined Block Grant FY 2016-17 Application provided opportunities for public input and comment. These opportunities were afforded to stakeholders and the public through a variety of means.

Three meetings of the Joint State Advisory Committee on Mental Health Services (SACMHS) and State Advisory Committee on Substance Abuse Services (SACSAS) afforded stakeholders opportunities to review and comment on components of the plan. The SACMHS, which serves as the State Mental Health Planning Council, and the SACSAS consist of 34 members representing stakeholders from all geographic areas of the State and actively participates in developing priorities for the State Plan. Input is solicited from of persons who are service recipients and/or in recovery, families of individuals with substance use and mental disorders, providers of services and supports, Regional Behavioral Health Authority representatives, and state employees representing various behavioral health system partners who are all members of the State Mental Health Planning Council.

The joint state advisory committees meetings are open to the public and follow the Nebraska Open Meetings Act, providing advance publicized notice of the time and place of the meeting and an agenda of the matters to be considered at the meeting. At each meeting of the joint state advisory committees there are two designated times for public comment. Public comment not provided verbally at the meeting may be send to an identified contact at DBH.

> The State of Nebraska draft priorities for the SAMHSA Combined Block Grant application was a matter on the agenda and was reviewed at the January 27, 2015 joint committee meeting.
>
> The State of Nebraska draft priorities for the SAMHSA Combined Block Grant application was a matter on the agenda and was reviewed at the March 17, 2015 joint committee meeting.
>
> The State of Nebraska complete draft SAMHSA Combined Block Grant application was a matter on the agenda and was reviewed at the August 13, 2015 joint committee meeting.

The State of Nebraska complete draft SAMHSA Combined Block Grant application was posted on the DBH web site on August 4, 2015. The public as able to download the State Plan or view it online, and then offer comments via email or submit written comments to an identified contact person from DBH. A notice for public comment was included with the web site posting, providing a window for public comment to be submitted and considered.

The State of Nebraska final SAMHSA Combined Block Grant FY 2016-17 application will also be available on the DBH web site and WebBGAS for public review and comment after submission to SAMHSA.

Comments Received from the Joint State Advisory Committee Meeting January 27, 2015

The Joint Committee SACMHS and SACSAS reviewed the state planning activities and draft State Plan Needs Assessment – Behavioral Health Service System and priorities. DBH presented

information describing the ongoing work activities with consumers and families of consumers, state-led Results-based Accountability and Continuous Quality Improvement activities, and work with providers, the region partners and other organizations across the state. DBH staff facilitated a discussion on identified draft State Priorities and to identify other potential needs.

The meeting agenda and minutes are posted on the DBH web site on each of the committees' web pages: http://dhhs.ne.gov/publichealth/Pages/hew_sua_sacsa.aspx and http://dhhs.ne.gov/behavioral_health/Pages/beh_mh_sacmhs.aspx.

Comments received included:

- Expand cooperative activities with the school systems to support mental health education among students and their families, including early outreach and supportive care opportunities.
- Continue to expand interagency cooperation between the Division of Behavioral Health and Department of Education to support more school-based behavioral health education and referral activities.
- Implement the System of Care planning activities, particularly connecting and expanding behavioral health and education partnerships to better serve youth and young adults and their families.
- Providing more preventative activities in the mental health field, educating not only consumers but also their families and extended families.
- Build more connections (i.e., bridges) between services to 1) improve coordination of available services between providers and 2) use of navigators and Peers to facilitate consumer access to services across the various providers.
- Expand the number of doctors and beds to address the long wait to access services, particularly in the Omaha area.
- Continue to advocate for Medicaid coverage of Peer support services; recognition of the integral role of Peers throughout the system of care to facilitate information, education, navigation, and supportive services.
- Develop a better understanding about what is happening in the criminal justice system in order to identify and address behavioral health care needs for individuals who are entering the criminal justice system and for those who are re-entering the community upon their release. Identify what we know, what we need to know, how we can integrate this information and how we can collaborate to do these things. Work to identify those known things that can be addressed sooner than later, while we develop other cooperative data and service activities.
- Establish inter-agency agreements for information and data sharing in order to maximize the utility of the new DBH centralized data system's ability to build data interfaces with other agencies data collection systems.
- Promote the use of Peer mental health navigators to help people transition from the criminal justice system, hospitals, homelessness, etc., where the Peer will be a coach, a person who will walk with them to navigate through the community-based system to obtain services and care.
- Address barriers to services that impact availability and access to a doctor (especially for persons with medication needs who are transitioning between systems of care), the ability to timely re-start suspended Medicaid or initially enroll in Medicaid upon exiting the criminal justice system.
- Develop a process to reliably coordinate assistance to individuals with behavioral health needs who are leaving the criminal justice system to assist and facilitate this transition and access services.

- Increase overall capacity of available community services where services are needed and provide funding to increase the availability of services.
- Increase availability of and funding for sex offender treatment services.
- Eliminate barriers to inter-agency data sharing which can impede coordination of services and transition of access to care.
- Data showing decrease in abstinence upon discharge from treatment services is of concern. How can we now use this information to identify needed improvements?
- Improve our consumer survey methods which provide only a point in time measure of the perceptions of persons who have received services while ignoring the fact that recovery is a process that can fluctuate.
- Focus activity at points of intersection of primary health care and behavioral health care in order to address a gap in services where behavioral health care is not integrated into primary health care.
- Plan for providing behavioral health care to individuals who may be diverted from the criminal justice system, which will create a real funding and resource issue for someone, be it the Probation system or community-based services.
- Identify and plan for addressing the needs of individuals in the criminal justice system who have mental health issues and more complex, higher resource needs who will be requiring services and funding to assist them upon their re-entry into the community.

Comments Received from the Joint State Advisory Committee Meeting March 17, 2015

The Joint Committee SACMHS and SACSAS reviewed the proposed draft State Priorities. DBH staff described how the needs assessment activities inform not only the boarder work of the DBH but also the State priorities to identify in the SAMHSA 2016-17 Block Grant application. Staff invited comments and recommendations on the information developed through the described planning processes and input on data collection and measurement during the two year block grant cycle. Members provided the following comments, many of which stimulated detailed discussions.

- Tuberculosis screening to be provided to all persons entering a substance abuse treatment service is a required state priority area. The goal, performance indicator and target are identified.
- Surrounding states have created Peer Support credentialing systems to fund services.
- The basis of Peer to Peer relationships are different for Peer Support certification versus credentialing and both systems should be honored.
- Nebraska's Office of Consumer Affairs is working to develop Peer Support credentialing via the 206 Regulation process.
- Develop an indicator of Peer Support services and workforce using records and surveys.
- Utilize crisis interventions reported in the emergency systems.
- Review the usage of more intensive outpatient services and identify outcomes.
- Capture more than admission and discharge data; track episodic treatment of care.
- Track movement through treatment service from inpatient to outpatient continuum.
- Reporting systems are set up differently across the state which will affects measurement.
- Consumer financial resources affect service access; Insurance can drive service type delivery.
- Track usage of warm lines and Safe Harbor and Keya House.
- Can we capture the length of stay in a facility, e.g., via EPC, and follow-up service journey?

- Can we improve reporting by reducing the reporting burden on providers and improve the reporting systems themselves?
- Providers embracing trauma-informed and co-occurring services encounter barriers in the energy within the larger systems and infrastructures (e.g., Medicaid, Magellan).
- Use of Evidence-based Practices (EBP) should be encouraged but individual EPBs should not be designated for priority funding, for example Supported Employment.
- Individual situations and treatment needs should dictate selection of EBPs.
- Use of EPBs in a frontier or rural setting may require adapting it and funding mechanisms should recognize the programmatic need for such adaptations.
- Continue working the RBA process to develop measures that track substance use goals for both mental health and substance abuse service consumers using a continuum not just abstinence.

The meeting agenda and minutes are posted on the DBH web site on each of the committees' web pages: http://dhhs.ne.gov/publichealth/Pages/hew_sua_sacsa.aspx and http://dhhs.ne.gov/behavioral_health/Pages/beh_mh_sacmhs.aspx.

Comments Received from the Joint State Advisory Committee Meeting August 13, 2015

The Joint Committee SACMHS and SACSAS reviewed the Nebraska SAMHSA Combined Block Grant FY 2016-17 Application. DBH staff reviewed the SAMHSA Block Grant application process, presented financial information contained in the expenditure tables, identified funded services and maintenance of effort, reviewed the State Plan needs assessment and State Priorities.

Discussion included the First Episode Psychosis set-aside, stability of block grant funding, continuous quality improvement driven by data, funding to assist persons experiencing homelessness, and continued work to support a recovery-oriented system of care in Nebraska. There was a call for additional questions, comments, and recommendations. Members provided the following comments.

- Members commented the goals and priorities look good and are in alignment. The focus on co-occurring disorders is appropriate and further thought should be given about ways to incorporate mental health with physical health. Wood noted it will be a natural extension and working with DHHS Division of Public Health will reinforce that aspect. Harker added that work on this is being done through region integration efforts.
- Members commented that there is a lot of data provided on binge drinking but it seems like most of our youth are smoking marijuana and taking Xanax. In response, Wood noted available data shows underage alcohol consumption continues to be the number one problem among youth in Nebraska. She noted in regards to marijuana use, the perception of risk is going down while usage is going up and we are watching the trends.
- Is the Division of Behavioral Health tracking the use of synthetics (marijuana)? Wood answered in the affirmative. It was noted that many are seeing a dramatic increase in the use of synthetics and when Wood reported that the use of synthetic marijuana is included with measuring marijuana use, it was suggested to identify it separately.

- Members noted that a lot of the data comes from the Omaha area where the population is larger but the differences between that data and data from sparsely populated areas are great; Western Nebraska is not only sparsely populated compared to eastern Nebraska but has a different culture with dramatically different social and environmental factors, including sharing a border with Colorado where personal use of marijuana is now legal.
- A question was asked if individuals who in a rage cause harm to others is an example of a mental health problem. Harker responded that there hasn't been much discussion nor is the data consistent enough to inform us about associated behavioral health issues. Extreme prudence should be exercised to not link behavioral health issues and acts of rage violence.
- A question was posed as to whether behavioral risk surveys include environmental factors. DeVries noted the youth surveys, such as the YRBS, ask a limited number of questions about environmental factors. In addition, DeVries reported the BRFSS survey group is working to add a marijuana section in the survey to provide more data in the future.

Comments Received from the Online Posting of the Nebraska Draft Combined Block Grant Application

The Nebraska Draft SAMHSA Combined Block Grant FY 2016-17 Application was posted to the DBH web site on August 4, 2015. The members of the Joint Advisory Committees SACMHS and SACSAS were notified of the posting of the draft application and provided a summary of topics with page references to facilitate their review and preparation for the August 13, 2015 Joint Advisory Committee meeting.

The public announcement on the availability of the draft application on the DBH web site included a specific contact person to whom to direct questions and comments. All public comment and/or inquiries would be logged, reviewed, and receive a response. The comment period officially ended at close of business on August 21, 2015. At the close of the official comment period DBH had not received any written correspondence or email providing public comment on the draft application.

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year: 2016

End Year: 2017

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Adria Bace (MH)	State Employees	Dept of 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	DHHS Div of Medicaid and Long Term Care	PO Box 94661 Lincoln, NE 68509 PH: 402-471-1920	cameron.white@nebraska.gov
Mark Schultz (MH)	State Employees	Vocational Rehabilitation	2828 Stratford Avenue Lincoln, NE 68508 PH: 402-471-1202	mark.schultz@nebraska.gov
Linda Krutz (MH)	State Employees	NE Crime Commission	301 Centennial Mall South - 5th floor Lincoln, NE 68509 PH: 402-471-4327	Linda.Krutz@nebraska.gov
Nathan Busch (MH)	State Employees	DHHS Division of Children & Family Services	301 Centennial Mall So Lincoln, NE 68508 PH: 402-471-1791	nathan.busch@nebraska.gov
Kasey Moyer (MH)	Providers		Mental Health Assoication, 1645 N Street, #A Lincon, NE 68508 PH: 402-441-4371	kmoyer@mha-ne.org
Joel Schnieder (MH)	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		17110 Palisades Drive Omaha, NE 68136 PH: 402-681-5439	velvethammer1@cox.net
Diana Waggoner (MH)	Family Members of Individuals in Recovery (to include family members of adults with SMI)		13609 California, #210 Omaha, NE 68154 PH: 402-708-1960	diana@waggoneragency.com
Janet Johnson (SA)	Providers		Choices Treatment Center, 2737 No. 49th Street, Lincoln, NE 68504 PH: 402-476-2300	janet.l.johnson09@gmail.com
Ann Ebsen (SA)	Others (Not State employees or providers)		309 Oakridge Court Papillion, NE 68005 PH: 402-331-8830	aebsen@aol.com
Jay Jackson (SA)	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Jackson Services, 30612 205th Ave Columbus, NE 68601 PH: 402-562-3755	jayjackson@jackson-services.com
Randy See (SA)	Others (Not State employees or providers)		Hall County Juvenile Services, 117 West First Street Grand Island, NE 68801 PH: 308-385-5124	randy.see@hallcountyne.gov
Kathleen Hanson (MH)	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1330 Lincoln Mall, Apartment A404 Lincoln, NE 68508 PH: 402-817-1135	Khanson1757@msn.com
Karla Bennetts	Parents of children with SED		301 N Briggs Street Wilcox, NE 68982	kbennetts@familiescares.org

(MH)			PH: 308-991-6099	
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
Rev. Bradley Hoefs (MH)	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		3410 No. 205th Street Elkhorn, NE 68022 PH: 402-968-3683	bradhoefs@yahoo.com
Sheri Dawson (MH & SA)	State Employees	DHHS Division of Behavorial Health	DHHS- Division of Behavioral Health, 301 Centennial Mall So Lincoln, NE 68508 PH: 402-471-7818 FAX: 402-471-7859	sheri.dawson@nebraska.gov
Ingrid 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	mike.phillips@douglascounty-ne.gov
Patti Jurjevich (MH)	Providers		3801 Harney Street Omaha, NE 68131 PH: 402-444-6573	pjurjevich@regionsix.com
Kimberly Mundil (SA)	Providers		14901 NW 37th Street Raymond, NE 68428 PH: 402-610-3566	kimberly.mundil@bryanhealth.org
Paige Hruza (SA)	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1306 N 112th Circle, #C5922 Omaha, NE 68554 PH: 308-850-0554	Paige51266@yahoo.com
Mary Thunker (MH)	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		8911 Decatur Street Omaha, NE 68114 PH: 402-640-8196	mthunker@gmail.com
Beverly Ferguson (MH)	Parents of children with SED		3405 Portia Place Norfolk, NE 68701 PH: 402-371-2745	bfergy04@cableone.net
Phyllis McCaul (MH)	Parents of children with SED		933 "A" Street Lincoln, NE 68502 PH: 402-441-4361	pmccaul@region5systems.net
Ashley Pankonin (MH)	Parents of children with SED		33060 RD 769 Grant, NE 69140 PH: 308-352-6720	ashleypankonin@gmail.com
Dusty Lord (SA)	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1901 SW 11th St Lincoln, NE 68522 PH: 402-805-5502	djdustylord@hotmail.com
Todd Stull (SA)	Providers		16262 "L" Street Omaha, NE 68135 PH: 402-917-7132	toddstullmd@insideperformance.net
Mary Wernke (SA)	Family Members of Individuals in Recovery (to include family members of adults with SMI)		1849 County Road 74 Hemingford, NE 69348 PH: 308-487-6397	mary@letterperfect.net
Bob Doty (MH)	State Employees	NE Dept of Economic Development	P.O. Box 94666 Lincoln, NE 68509 PH: 402-471-2095	bob.doty@nebraska.gov

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2016

End Year: 2017

Type of Membership	Number	Percentage
Total Membership	34	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	7	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	3	
Parents of children with SED*	4	
Vacancies (Individuals and Family Members)	3	
Others (Not State employees or providers)	2	
Total Individuals in Recovery, Family Members & Others	19	55.88%
State Employees	7	
Providers	7	
Federally Recognized Tribe Representatives	0	
Vacancies	1	
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	0	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

State Advisory Committee on Mental Health Services and the State Advisory Committee on Substance Abuse Services were presented information and provided comments and recommendations at three joint meetings in 2015 (January 27, March 17, and August 13) as well as having the draft document provided to them on August 4, 2015 for full review. A summary of comments and recommendations from these meetings were included as a separate attachment under item C22 in the Environmental Factors and Plan section of this application.

Footnotes:

Information on State Advisory Committees membership regarding race, ethnicity, or LGBTQ status is not collected.