

**Nebraska**

**UNIFORM APPLICATION  
2010**

**STATE IMPLEMENTATION REPORT  
COMMUNITY MENTAL HEALTH SERVICES  
BLOCK GRANT**

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**Center for Mental Health Services**

**Division of State and Community Systems Development**

## **Introduction:**

The CMHS Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-64), as implemented by the Interim Final Rule and the Tobacco Regulation for the SAPT Block Grant ( 45 CFR Part 96, parts XI and IV, respectively).

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Adult - Report Summary of areas which the State identified in the prior FY's approved Plan as needing improvement

October 21, 2010

Nebraska Division of Behavioral Health

**Adult - Report Summary of areas which the State identified in the prior FY's approved Plan as needing improvement**

From the FY2010 Adult – Unmet Service Needs section

The Division of Behavioral Health analysis of unmet service needs and critical gaps include the following:

GAP #1: CONSUMER INVOLVEMENT

GAP #2: THE PREVALENCE OF MENTAL ILLNESS AND NUMBER OF INDIVIDUALS SERVED BY SYSTEM.

GAP #3: INFORMATION SYSTEM IMPROVEMENT

GAP #4: SHORTAGE OF BEHAVIORAL HEALTH WORKFORCE

GAP #5: MEDICATION ACCESS

GAP #6: CULTURALLY AND LINGUISTICALLY COMPETENT SERVICES

GAP #7: MENTALLY ILL INMATES IN THE STATE CORRECTIONAL SYSTEM

**Child - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.**

From the FY2010 Child – Unmet Service Needs section

## **2. Unmet Service Needs**

In attempting to identify the prevalence rates of children and youth with severe emotional disturbances (SED) in Nebraska, we look to the number of cases of youth diagnosed with an SED at a specific time. The penetration rate is the number of children/youth with this diagnosis that have received services through the DHHS system which includes the Division of Behavioral Health, the Division of Child and Family Services including the Juvenile Justice Systems and those receiving service paid thru Medicaid or private insurance. Our current data on this prevalence indicates that 3750 (2008 data) children were served by the Nebraska Division of Behavioral Health. At this time, Nebraska does not have the capacity to determine the penetration rate for all systems for children with severe emotional disturbances because youth often cross systems and gathering an unduplicated count is difficult. However, at the end of this upcoming fiscal year, we expect to be able to identify unduplicated counts between the three Divisions pending the compliance with our Administrative Service Organization. Nonetheless, there is minimal ability to monitor children and youth with SEDs that are not receiving services but would qualify and should be receiving appropriate care. The Department is anticipating that the utilization of the children's behavioral help line may provide some additional indication of needs as evidenced by parents calling for assistance and the tracking of relevant data.

In addition, there is a need for a standard outcome measurement system to more accurately identify youth in multiple systems of behavioral health, child welfare, education and juvenile justice. The Department has been working towards this goal. The challenge is the multiple indicators that may be required from the variety of funding streams, review systems or otherwise and oversight bodies. Services in the public system are targeted to specific groups such as those financially eligible for Medicaid or those in child welfare which includes abuse and neglect, juvenile justice and/or severe behavioral health disordered youth. Unfortunately, this results in a gap in services between the

multiple systems which has grown in the current economic conditions of the state and country. An additional difficulty is identifying which target population the Division should serve amidst the challenges of funding limitations, guidelines and priorities. This fall, DHHS will receive the final results of the ‘state ward study,’ administered in order to better identify the prevalence, precursors and implications of youth entering state custody. This study will identify potential gaps in behavioral health services and identify the occurrence of state ward solely to access behavioral health services. This occurrence combined with other issues, has created a high out of home placement rate within Nebraska. Currently, around 60% of state wards are in out-of-home care, but at a steady decline and reduction in the last year from 70%. This decrease demonstrates a trend in the right direction. Without an increase in funding, our challenge is to restructure the delivery of services to promote more preventative and early intervention services in order to reduce the number of out of home placements as well as reduce the need for deep end services. Expanding the service array is imperative as are collaborative partnerships with all systems that directly impact the lives of children, youth and families.

There are several special populations that the Division considers a priority due to service capacity barriers. Most specifically, youth in transition and children ages birth to five. Youth in transition have several barriers that include developmentally appropriate services, payment for services, vocational issues and lack of service providers. There have traditionally been few services that provide the coordinated effort to help youth transition into adulthood besides addressing the more complex needs of mental health disorders. The Division of Behavioral Health has revised the Age Waiver criteria. This waiver addresses youth ages 17-18 that are currently involved in care but will age out and need to transition to adult services. Currently, Nebraska lacks an evidence based practice for this population and is experiencing challenges with identifying appropriate treatment for these youth. Often, these youth are aging out of the child welfare system where placement was secured with treatment in a residential facility. Many adult providers are ill equipped to address the complex needs of this population. Serving these youth effectively will mean more than evidence based treatment, but often habilitating, and the establishment of more informal supports that remained limited while in state care.

It is anticipated that the new services being implemented January 1, 2010 and authorized by LB603 will provide some insight into additional system needs. There will be an evaluation of the Help Line, Family Navigator and Post Adoption/Post Guardianship Services to determine not only service effectiveness but also the implications and system barriers/strengths identified by the use of these services. This component will allow DHHS to further review system needs and strategically plan for service implementation.

Adult - Report Summary of the most significant events that impacted the mental health system of the State in the previous FY

This section addresses both

Adult - Child – Most Significant Events that Impacted the State Mental Health System in the Previous FY Report Summary of the most significant events that impacted the mental health system of the State in the previous FY

Updated November 15, 2010

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## **New Developments and Issues and Recent Significant Achievements**

### **Governor**

On January 20, 2005, Dave Heineman became Nebraska's 39th Governor. On November 7, 2006, Governor Heineman was re-elected to the office. On November 2, 2010, Governor Dave Heineman was re-elected to the office.

## **State of Nebraska Budget Issues:**

At the National Mental Health Block Grant Meeting in Washington, DC (June 23, 2010), it was reported that 48 states are experiencing budget shortfalls. Nebraska is clearly one of those 48 states.

- Nebraska tax revenue, which primarily comes from sales and income tax, dropped two years in a row after years of almost steady growth [source: Nancy Hicks (July 17, 2010) Lincoln Journal Star; accessed on July 19, 2010].  
[http://journalstar.com/news/local/govt-and-politics/article\\_b5665dc8-91e1-11df-9c3b-001cc4c002e0.html](http://journalstar.com/news/local/govt-and-politics/article_b5665dc8-91e1-11df-9c3b-001cc4c002e0.html)

Below is a summary of events since October 2009.

- October 13, 2009 – Kerry Winterer, the CEO of the Nebraska Department of Health and Human Services, sent the following message to the employees:
  - Do not fill existing or new vacant positions unless absolutely essential.
  - Do not incur travel costs that are not immediately required or otherwise necessary for the maintenance of current direct service requirements.
  - Do not lease or purchase additional space or capital equipment unless an emergency exists.
  - Do not initiate programs, contracts, or services that require additional appropriations.
  - Initiate discussions within your organizations and begin making plans for a significant reduction in your current state appropriations. This planning should occur with regard to all appropriations: operations, aid, and capital construction for fiscal years 2010 and 2011.
- November 20, 2009 – Governor Dave Heineman signed into law the budget adjustments approved by the Special Session of the Nebraska Legislature. The package of reductions addresses an anticipated \$335 million shortfall in state revenue during the 2009-2011 biennium (July 1, 2009 to June 30, 2011). The Governor's budget proposal called for an across-the-board reduction of 2.5 percent to the FY2010 year (July 1, 2009 to June 30, 2010) to most state agencies and a 5 percent reduction in FY 2011 (July 1, 2010 to June 30, 2011). Gov. Heineman said "We are addressing Nebraska's revenue shortfall by reducing spending, not by increasing taxes. I appreciate the work of state senators during the past two weeks. We preserved the property tax credit program and we maintained a strong cash reserve for future financial challenges."
- April 14, 2010 – The budget adjustments approved for the state FY2011 year call for a two percent reduction in FY 2011 for most state agencies, with exceptions for education and public safety programs.
- July 9, 2010 - Nebraska Department of Revenue. Net general fund receipts for June 2010 were \$308.8 million, compared to the \$343.6 million that had been projected by the Nebraska Economic Forecasting Advisory Board (NEFAB). Net receipts for the month of June were below the NEFAB projections by \$34.8 million. For Fiscal Year 2009-10, state receipts are \$76.4 million below projections.
- July 16, 2010 – Governor Dave Heineman issued a directive that contract covered employees will take two furlough days between now (July) and the end of the year (December 31, 2010). The furlough is expected to save the state \$3.5 million. The Governor reported how tax receipts for last fiscal year were \$76 million less than projected.

- October 8, 2010 - September State Tax Receipts - The Nebraska Department of Revenue released the State General Fund receipts for September 2010. Net General Fund revenues for the month of September were above the Nebraska Economic Forecasting Advisory Board projections by approximately \$1 million, with \$341 million in actual receipts versus the \$340 million projected. Governor Heineman said, “For the second month in a row, receipts have met projections. This is an encouraging sign. More importantly, receipts for July through September are higher than the same period of time last year. This is the first time quarterly receipts have exceeded the previous year’s quarter in two years. This good news on receipts and the recent decline in the unemployment rate are positive indicators that our economy may be turning the corner.”

For more information, see Governor Dave Heineman’s news index web site:

<http://www.governor.nebraska.gov/news/index.html>

## **Help Line and Family Navigator Contract**

The Division of Behavioral Health announced that Boys Town will operate the children’s behavioral health Help Line and Family Navigator Services beginning on January 1, 2010. These services were authorized in LB 603, passed during the 2009 Legislative Session.

The Help Line will provide a single point of contact that’s available 24 hours a day, seven days a week, operated by trained personnel and supervised by licensed behavioral health professionals. Help Line operators will screen calls for immediate safety needs, identify the potential level of the behavioral health crisis, make recommendations or referrals to appropriate resources, and help the caller connect to emergency resources or providers as necessary. Help Line operators may refer eligible families to Family Navigator Services. Family Navigators will be trained family peer support specialists with personal experience as a family member of a youth with a severe emotional disorder. If asked, Family Navigators will also help people apply for public assistance through the ACCESS Nebraska online application process to identify possible eligibility for state-funded services.

Scot Adams, director of the Division of Behavioral Health in the Department of Health and Human Services (DHHS) said, “The Help Line will be a new resource for parents, guardians and primary caregivers of youth experiencing an urgent behavioral health situation. The Help Line will focus on reducing the stress of the crisis being experienced by the caller, identifying immediate safety concerns, and giving recommendations or referrals to resources. Family Navigator Services will follow within 24 to 72 hours when needed, providing family peer support and helping the family identify existing services.”

This bill also provided funding for an evaluation of these new services. After an additional Request for Proposal process, the Division of Behavioral Health contracted with Hornby Zeller Associates, Inc. to measure the fidelity, effectiveness and outcome of these new services and provide recommendations to the State. The first Annual Report is now available for public review on the Division of Behavioral Health website. It is anticipated that data from these services will suggest areas of need in Nebraska for children’s behavioral health services including formal and informal support services.”

The report is titled, “Nebraska Family Helpline, Family Navigator and Right Turn Post Adoption/ Post Guardianship Services: Fiscal Year 2010 Evaluation Report January 1, 2010 - June 30,2010” produced by Hornby Zeller Associates, Inc. (September 2010).

<http://www.nebraskafamilyhelpline.ne.gov/common/pdf/HZA-FY10-Evaluation-Report.pdf>

Press release on <http://www.dhhs.ne.gov/newsroom/newsreleases/2009/Nov/helpline.htm>

## **Regional Center Discharge Follow-Up Services Project Report**

prepared by the University of Nebraska Medical Center College of Public Health  
Final Report May 24, 2010

### Summary of Findings

- under Nebraska Behavioral Health Reform (2004–2009), there were 316 Regional Center general psychiatric beds closed and approximately thirty million dollars transferred to community services.
- Insurance Status at Admission – According to the Regional Center admission records, only 12% of the BHR consumers had private insurance or paid the cost of care themselves. Forty-two percent (42%) of BHR consumers reported they did not have insurance. The proportion of consumers with Medicaid and Medicare were 25% and 18%, respectively. The other insurance status for the remaining 3% was unknown.
- This study followed 1,225 adult consumers discharged from selected units of the Regional Centers between 1/1/2005-12/31/2008, while Nebraska reformed the public mental health system from a reliance on state hospital care to community-based services.
- Data on psychiatric diagnosis indicates that Behavioral Health Reform (BHR) consumers have more serious and difficult to treat behavioral health conditions than the general population of DBH-CS behavioral health consumers. Close to 50% of BHR consumers had a combination of “Serious Mental Illness, Personality Disorder, and Substance-Related Disorder”, while only 2% of the overall DBH-CS behavioral health consumers had this combination category.
- According to SAMHSA’s Co-Occurring Center for Excellence (COCE), having co-occurring disorders (COD) increases the likelihood of having additional medical, social and legal problems. Our finding indicates that 64% of BHR consumers have serious mental illness, in combination with substance abuse disorders. The COCE states that individuals with COD require a breadth of services including employment, education, housing, and legal assistance which is only possible by inter-agency collaboration to provide integrated care.
- Nationally, awareness of medical co-morbidities among people with serious mental illness has increased in recent years. Preliminary analysis of medical co-morbidities among BHR consumers indicates that medical conditions such as hypothyroidism, diabetes, and hypertension are relatively common in this population. Prevention and treatment of chronic and acute medical illnesses are important in increasing longevity and quality of life among people with behavioral health disorders.
- After discharge from a Regional Center, 76% of BHR consumers used both behavioral and non-behavioral health services (e.g., medical care, social service/economic assistance). The trend

data shows that the proportion of people receiving Medicaid services remained stable while some other services, such as community-based behavioral health and economic assistance, declined over time. The proportion of people who used emergency service also declined during this period.

- Substance Abuse and Mental Health Services Administration collects selected indicators such as readmission rates from state behavioral health programs. Because the type of consumer population served and data systems implemented differ considerably across states, comparison and interpretation of findings from different states needs to be done with caution. Nevertheless, Nebraska has considerably lower readmission rates than the national average – 180 day readmission for Nebraska was 12.3% in 2009 compared to 21.3% nationally for 2008.

See the complete report under the DHHS web site ... Division of Behavioral Health: Community-based Services ... Recent Reports

<http://www.dhhs.ne.gov/beh/Reports.htm>

## **Norfolk Regional Center Discontinued General Psychiatric Beds**

As planned, in June 2010, the Norfolk Regional Center discontinued serving General Psychiatric patients. The eleven individuals who were receiving their treatment at NRC were transitioned into the 90 beds at the Lincoln Regional Center. This marked another accomplishment of NE's Behavioral Health Reform. It also allows NRC to solely provide treatment to those individuals who are committed for Sex Offender Treatment.

## **Lincoln Regional Center Passes Inspections**

October 6, 2009 – The state-run psychiatric hospital passed two unannounced inspections recently. Inspectors with the Federal Centers for Medicare and Medicaid Services focused on treatment at the Lincoln Regional Center and found no deficiencies. LRC maintains Medicare and Medicaid certification and accreditation.

These results are consistent with the inspection conducted earlier by the Nebraska Department of Health and Human Services on behalf of federal officials. That inspection found no basis for complaints alleging inadequate staffing and failure to protect patients' rights.

## **Lincoln Regional Center: Referral Management Process**

In Nebraska, individuals who are committed by a mental health board (civil commitment) are treated at a local community hospital. The one exception to this occurs in Region 5 (Southeast Nebraska including the City of Lincoln) where all civilly committed individuals are provided treatment at the Lincoln Regional Center (LRC).

For the other Regions, the vast majority of committed individuals receive acute treatment at their local community hospital and are then transitioned to community based services. Those individuals who are violent or who cannot be stabilized within a reasonable time frame, can be referred to the Lincoln Regional Center for services. This referral process is managed by a team of individuals from the Regions (Emergency System Coordinators), Division of Behavioral Health / Community-Based Services and DBH LRC.

The Lincoln Regional Center provides 90 beds for General Psychiatric which are utilized by the six Regions. These 90 General Psychiatric beds are divided between six Regions. Each Region is responsible for managing their allotted number of beds. Discharge planning is done collaboratively with the same individuals who are responsible for the referral / admission process. The wait-time for admission to LRC is directly contingent upon the ability of those involved to develop and implement effective discharge plans.

Challenges with effective discharge planning include securing community based services for individuals with co-occurring disorders of mental illness with developmental disabilities, traumatic brain injury, medical problems and related issues. The Division of Behavioral Health is actively engaging in a variety of strategies to ensure that services for these special populations are accessible.

## **Emergency Systems Benchmarks/Diversion Rates**

Starting State Fiscal Year 2009, the Nebraska Psychiatric Emergency Systems Team implemented a process to measure outcomes and emergency system diversion rates across the state. Representatives from the six Regional Behavioral Health Authorities and the Division of Behavioral Health make up the Nebraska Psychiatric Emergency Systems Team. The team formed benchmarks to be used to measure effectiveness of the emergency system. During Fiscal Year 2010, the Division of Behavioral Health implemented a revised method of collecting data. The Emergency system data is gathered by the Regional Emergency Systems Coordinators, and is reported monthly to the Division of Behavioral Health. This change was made in order to improve how we approached collecting data on crisis response programs and emergency system diversion rates. This report reflects those efforts from October 1, 2009 to June 30, 2010.

The following is a description of the findings from the last three quarters of FY2010. From the reporting Regions, there were 2,247 individuals (duplicated count) placed in EPC during the last three quarters of FY2010.

- Goal # 1: the Emergency System is to provide services in the community to support consumers rather than utilizing the commitment process whenever possible. Data shows that a reported 76.1% of individuals (n=1710) had their EPC status dropped prior to receiving a commitment order.
- Goal # 2: the Emergency System is to reduce the number of individuals ordered into an inpatient commitment. During the last three quarters of FY2010, only approximately 12.7% of individuals placed under EPC (n=285) were ordered to complete an inpatient commitment.
- Goal # 3: crisis response services will be in place to prevent consumers from being placed in Emergency Protective Custody. During the last three quarters of FY2010, there were a total of 2,345 calls placed to crisis response programs. Around 72.3% of these calls (n=1,695) necessitated contact by a crisis response program. For these 1,695 consumer contacts, around 90.6% (n=1,536) were diverted from being placed under EPC.

Please contact Sarah Cox in the Division of Behavioral Health for more information on the EPC diversion rates in Nebraska. [[Sarah.Cox@nebraska.gov](mailto:Sarah.Cox@nebraska.gov) | 402-471-7645]

## **Substance Abuse Capacity and Data Management System**

The Division of Behavioral Health (DBH) put significant effort into improving the Substance Abuse Capacity and Data Management System. This management system allows the DBH to collect information on available substance abuse capacity (outpatient and inpatient), individuals waiting for substance abuse treatment and the provision of interim services. Substance Abuse providers track data which is sent to each Regional Behavioral Health Authority (RBHA) who aggregates their Region's data and submits it weekly to DBH. The DBH aggregates the statewide data received from the six RBHAs and facilitates a weekly statewide review and analysis of the data. This provides a management process designed to ensure timely access to substance abuse treatment and to monitor the provision of interim services for those who are waiting to receive treatment. The Substance Abuse Capacity and Data Management System is a rich data resource used by DBH and the RBHAs both on an individual client level (access) and for budget purchases (capacity). The following items are a snapshot of analysis from the Substance Abuse Capacity and Data Management System.

- Ten of the 21 substance abuse services the RBHAs report to the DBH are consistently above 90% available regional capacity. However, agency capacities for these services are not necessarily above 90%, which may allow the RBHAs opportunity to purchase additional units if needed.
- The majority of people waiting for substance abuse service were women with dependent children (44.9%, n=146), followed by intravenous drug users (37.5%, n=122), mental health board commitments (17.2%, n=56), pregnant women (5.8%, n=19), and pregnant intravenous drug users (0.6%, n=2).
- Most people waiting for substance abuse service were waiting for admission into short-term residential services (50.7%, n=175); followed by therapeutic community services (21.2%, n=73), dual disorder residential services (9.6%, n=33), outpatient services (7%, n=24), and intensive outpatient services (5.2%, n=18). Less than 5% of people waiting for service were waiting for halfway house (3.2%, n=11), intermediate residential (1.4%, n=5), outpatient dual (0.9%, n=3) or therapeutic community for youth (0.9%, n=3).
- The average wait for individuals waiting to enter substance abuse treatment is 29.82 days.

## **Consumer Peer-Run Services**

Consumers of mental health services have an important role to inform and improve the mental health system. Part of the transformation of the mental health system is to embrace the concept of consumer recovery. Consumers can provide valuable and unique insight into the way health care is delivered and how it can be made better. Nebraska has successfully accomplished (through partnerships) the implementation of a true Consumer Operated Service Program (COSP). Keya House opened its doors on December 29, 2009.

To that end in Nebraska, Region 5 Behavioral Health Authority supports COSP by contracting with the Mental Health Association of Nebraska (MHA-NE). MHA-NE is a consumer-run, voluntary not-for-profit statewide association with Chapters located in communities throughout Nebraska. MHA-NE brings together service recipients, families, professionals, advocates and concerned citizens to address all aspects of mental health and mental illness. Thus, MHA-NE managed programs meet the criteria for Consumer Peer-Run Services (see the table below).

Region 5 Behavioral Health Authority for Mental Health Association – NE  
FY2011 budget allocation (May 3, 2010)

Program   Funding Source		
Supported Employment - MH		
state funds	\$267,787	
State \$ - Other Sources (Vocational Rehabilitation)	\$100,000	
total		\$367,787
Hospital Diversion – MH (Keya House)		
state funds	\$264,315	
Agency Fundraising/ Donations/ Interest/Other	\$65,000	
total		\$329,315
Combined total both programs		\$697,102

## Family Organizations

In previous years, the Division of Behavioral Health has collaborated with the Division of Children and Family Services to fund like services for families who were child welfare involved and/or at high risk of multiple system involvement. In fiscal year 2010-2011, the Division of Behavioral Health entered into contracts with six family organizations, one in each Region, to provide family peer services to families with a youth experiencing behavioral health challenges. While this service is not new to Nebraska, this specific contract focuses on the target population of youth not yet state involved but who may be at risk for out of home placement and/or child welfare involvement. This additional funding and service availability is an effort to support early intervention for youth and families, and to provide for sustainable supports before, during and after the presence of formal services. This effort also seeks to increase the movement of family centered practice in supporting an effective system of care.

## Keya House Hospital Diversion House

December 29, 2009 – the Mental Health Association of Nebraska celebrated the opening of the KEYA House. This is a unique and progressive program designed to provide adults living with mental illness with a safe and supportive environment to address escalating symptoms associated with their illness prior to the need of more invasive crisis level services. Keya House is a peer-run program for adults at least 19 years old with behavioral health diagnoses, who are not in severe crisis and who live in Southeast Nebraska, the Region V Systems service area.

Keya House offers:

- Peers helping peers with crisis prevention and diversion from psychiatric distress that may lead to hospitalization.
- A comfortable, clean, and furnished four-bedroom house in a quiet and safe neighborhood.
- Self help and proactive recovery tools to regain and maintain wellness.
- Trained peer companions who are compassionate, understanding, empowering, and available twenty-four hours a day.

This program is strictly voluntary and free of charge. The individual can self- refer or be referred by a health professional or a family member. There is a registration process to ensure the appropriateness of the program for each individual as well as for the comfort of other guests. The person may stay for up to five days. Peer companions staff the house twenty four hours a day and can maintain contact and support at the individual's request after the stay is finished.

Guidelines – the individual must:

- Be 19 years or older.
- Not be in crisis or severe emotional distress.
- Not have any known physical illness (fever, flu symptoms, intestinal distress, etc.)
- Be able to maintain acceptable personal hygiene.
- Be responsible for preparing own meals and cleaning up after oneself.
- Understand and sign a safety and responsibility contract.
- Have permanent housing after your stay.
- Must follow the house rules which are explained when you enter the house.

Kasey Moyer, Associate Director of the Mental Health Association of Nebraska (MHA-NE) and a member of the State Advisory Committee on Mental Health Services, provided a report on Keya House as a Hospital Diversion resource at the February 4, 2010 meeting.

For more information on this, see the Mental Health Association of Nebraska (MHA-NE) web site at <http://www.mha-ne.org/>

Nebraska looks forward to developing and supporting additional Consumer Operated Services Programs (COSP) and will continue to utilize resources such as the SAMHSA Center for Mental Health Services Evidence-Based Practices / Knowledge Informing Transformation (KITs).

## **Nebraska's Consumer Voice**

During public comment at the August 13, 2009 State Advisory Committee on Mental Health Services meeting, Alan Green, Executive Director of the Mental Health Association of Nebraska (MHA-NE), made some remarks. One remark involved a document titled, "Nebraska's Consumer Voice: Leading a Change in Mental Health Services" by Melissa Donechske (Mental Health Association of Nebraska | April 2009). On August 13, 2009, the State Advisory Committee on Mental Health Services made a recommendation to the Division of Behavioral Health that "Consumer Voices" be used as a foundation base for strategic planning. Melissa Doncheske was invited to formally present the document to the State Advisory Committee on Mental Health Services on February 4, 2010.

The purpose behind the "Nebraska's Consumer Voice" project is to seek and document consumer opinions/feelings and then encourage dialog between all players (consumers, providers and policy officials) in finding solutions. Here is a quick summary of the document "Nebraska's Consumer Voice: Leading a Change in Mental Health Services".

**ABSTRACT** - The information provided in this paper is the collective voice of mental health consumers from all behavioral health regions in Nebraska, and is a result of our experiences within the system. It is a movement toward infusing recovery principles into Nebraska's mental health service delivery system that will guide individuals toward Self-Help, Self-Determination, and Empowerment. Furthermore, this is an attempt to bring all stake holders, including consumers, providers, family members, and policy makers together to create a new vision of a

system that is more Person-centered and Recovery-focused. Through full consumer participation this paper establishes 11 rules to implement into Nebraska's current and future method of Behavioral Health service delivery.

Here are the 11 Rules.

Rule 1: Transportation Barriers Must Be Eliminated

Rule 2: It Must Be Recovery Focused

Rule 3: There Must Be Access to Services

Rule 4: There Must Be Peer Provider Services

Rule 5: There Must Be Access to Complete Medical Records

Rule 6: Care Must Be Based on Partnership between Consumer and Provider

Rule 7: There Must Be Access to Affordable Housing

Rule 8: There Must Be More Recovery Education

Rule 9: There Must Be Opportunity for Competitive Employment

Rule 10: There Must Be Access to Information Regarding Benefits

Rule 11: Do No Harm (providers be trained in trauma-informed care)

For more information on this, see the Mental Health Association of Nebraska (MHA-NE) web site at <http://www.mha-ne.org/>

## **Transformation Transfer Initiative Grant (TTI)**

On November 4, 2008, the State Advisory Committee on Mental Health Services, which serves as the State Mental Health Planning Council under the Federal Community Mental Health Services Block Grant reviewed this proposal. This Committee made the following recommendation:

“This Committee recommends support for this proposal. This includes Peer Support for both consumers and the family members. It is timely in the state's transformation.”

The Division of Behavioral Health submitted the grant application on November 6, 2008. The Division of Behavioral Health was notified by National Association of State Mental Health Program Directors (NASMHPD) on December 8, 2008 of the grant award. Due to the nature of the grant, a contract needed to be developed between NASMHPD and the Division.

The State Advisory Committee on Mental Health Services wanted both consumers and the family members to be addressed under the TTI grant. The initial work on the TTI grant addressed both. However, as LB603 moved forward, including the § 71-823 Family Navigator Program, the decision was made to drop the family members from the TTI grant. This was because LB603 expects a peer support type of service, called Family Navigator Program be established no later than January 1, 2010. The program shall be administered by the division and consist of individuals trained and compensated by the department. Children and Family Behavioral Health Support Act (71-821 to 71-827) was added to the Nebraska Behavioral Health Services Act under LB603, 2009 (operative date May 23, 2009).

Carol Coussons de Reyes started work as the administrator for the Division of Behavioral Health Office of Consumer Affairs on May 18, 2009. She was the Project Manager for the TTI Grant.

The Division of Behavioral Health contracted with the University of Nebraska Public Policy Center to help assist in the implementation of the TTI grant. The Scope of Work includes Prepare a Request for Proposal (RFP), Administer a Competitive Bid Process, Complete an Evaluation, prepare a report on What Other States Are Doing, and related tasks.

As a result of the competitive bid process, a contract was awarded to Focus on Recovery-United, Inc. (FOR-U), a peer-run organization located in the state of Connecticut. This organization has provided education and training and curricula development over the past 6 years – all for people in recovery by people in recovery. Central to the work at FOR-U is the philosophy of Intentional Peer Support (IPS), developed by Shery Mead. Fundamental to Mead’s work on peer support is establishing intentional relationships. IPS is a way of thinking about purposeful relationships. It is a process where people use the relationship to look at things from new angles, develop greater awareness of personal and relational patterns, and to support and challenge each other as they try new things.

A selected group of individuals received training on peer support during a period of eight days in the city of Lincoln, Nebraska. Participants of the training received information about Intentional Peer Support (IPS), Self-Care, and Person-Centered Planning (PCP). Trainers for these activities were members of the Focus on Recovery-United, Inc. (FOR-U). The training activity was conducted between February 6 and February 11, 2010 (from 9 a.m. to 5 p.m. including weekends) in Lincoln, Nebraska. A total of 31 participants were present at the end of the training activity.

For more information related to the TTI Grant activities see [Adult – Plans to Address Unmet Needs](#) or contact:

Carol Coussons de Reyes, Certified Peer Specialist, MS  
Administrator for the Office of Consumer Affairs  
Division of Behavioral Health  
[carol.coussonsdereyes@nebraska.gov](mailto:carol.coussonsdereyes@nebraska.gov)  
402-471-7853 (office phone)

## **Revising Service Definitions and Regulations**

The Division of Behavioral Health, in partnership with the Division of Medicaid and Long Term Care, have implemented a process to collaborate review each of the service definitions for the Mental Health waiver and non-waiver services. The Division of Behavioral Health has produced four (4) drafts to date. The Division is proceeding with the development of the Title 206 Rules and Regulations revision process. To date, there have been a number of drafts produced with input from a variety of stakeholders. The package of service definitions will be moved into the draft Title 206 Regulations. As a result, they went through public review through the regulation review process on August 19, 2010.

The draft for the Service Definitions and the Regulations can be seen on the NE Department of Health and Human Services web site under the Division of Behavioral Health: Community-based Services section – Quality Improvement Projects <http://www.dhhs.ne.gov/beh/behindex.htm>

- Adult Behavioral Health Service Definitions
- Draft Regulations <http://www.dhhs.ne.gov/beh/2010-pub-hrg-regs.htm>

The approved service definitions and regulations are expected to be implemented by January 2011.

## **Nebraska as is an official SOAR State!**

On May 26, 2010, Nebraska received confirmation from Dr. Gretchen Stiers, Chief of the Homeless Programs Branch at SAMHSA that NE is an official “SSI/SSDI Outreach, Access and Recovery” (SOAR) State!

Homeless individuals with mental health problems often experience challenges with accessing their benefits administered by the Social Security Administration (SSA). In addition, individuals who are transitioning from jails, prisons, and hospitals often have difficulty accessing the services to assist with successful community living. The application process for Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) is complicated, detailed, and often difficult to navigate.

This Federal Technical Assistance will help consumers by teaching staff in community based programs the details needed to be covered in a successful application for SSI/SSDI. These are disability income benefits are needed by consumers to also receive either Medicaid and/or Medicare health insurance. Accessing these benefits is often a critical first step in recovery.

For more information on SOAR technical assistance see: <http://www.prairc.com/soar/>

The “Nebraska SOAR Kick-Off Forum” will be Friday, September 10th from 8:30 AM-5:00 PM at Omaha’s Community Alliance (4001 Leavenworth Street). The Kick-Off will be a one-day planning event for purpose of successful SOAR Nebraska implementation. For more information on the SOAR program in Nebraska contact:

Charles W. Coley, MS  
Program Coordinator  
Nebraska Homeless Assistance Program (NHAP)  
Division of Children and Family Services  
Nebraska Department of Health and Human Services  
Phone: (402) 471-9200                      charles.coley@nebraska.gov

## **Behavioral Health Consumer Survey Shows Positive Results**

November 13, 2009 – People are generally satisfied with services they receive from mental health or substance abuse providers across the state, according to the 2009 Behavioral Health Consumer Survey.

“While we realize that not all consumers who were contacted chose to participate, this is a good statewide sampling and gives us a pretty good look at what they’re experiencing as a group,” said Scot Adams, director of the Division of Behavioral Health in the Department of Health and Human Services. “This information will be very useful as we continue to improve the behavioral health system.”

Results from the adult survey indicate that:

- More than three-fourths (79.8%) of adult consumers were satisfied with their level of involvement in treatment planning;
- 86.3% were satisfied with the services they received;
- 87.8% responded positively to the questions related to quality and appropriateness of services; and
- 82.1% thought that the services were accessible.

A number of parents or guardians responded to the youth survey on behalf of children ages 5 to 19 years old who were receiving services:

- 67.7% indicated they were satisfied with the services their child received;
- Over half (51%) had Medicaid coverage;
- 82.0% responded positively to questions regarding cultural sensitivity including that staff were sensitive to cultural/ethnic backgrounds and the family's religious/spiritual beliefs; and
- 81.1% responded positively to questions regarding social connectedness, including that the responder felt they belonged to their community and would have support they needed from family and friends in a crisis.

Adams said that both surveys represent increasingly positive reports over last year's survey.

The Department contracted with the University of Nebraska Medical Center, College of Public Health, to conduct phone and mail surveys. The surveys can be found at <http://www.dhhs.ne.gov/beh/mh/mh.htm>.

Source: <http://www.dhhs.ne.gov/newsroom/newsreleases/2009/Nov/behsurvey.htm>

## **Groups Receive Youth Suicide Prevention Grants; Future Grants Also Available**

May 21, 2010 – Suicide is the second leading cause of death for Nebraskans ages 15 to 19, but education and awareness can save lives and help prevent many suicides.

The Nebraska Youth Suicide Prevention Project recently awarded grants to five suicide prevention coalition groups. The grants focus on increasing general awareness of suicide as a preventable public health issue and decreasing Nebraska's youth suicide rates.

“We're part of a national effort to prevent suicide among youth,” said Scot Adams, director of the Division of Behavioral Health in the Department of Health and Human Services. “Since we know some youth are at higher risk for suicide, the grants focus on prevention and intervention activities like outreach and screening.”

The five suicide prevention coalition group that recently received grants are:

- Hall County Suicide Prevention Coalition, \$5,000  
Contact: Virgil Harden, Grand Island Public Schools on behalf of the Hall County Suicide Prevention Coalition
- Lincoln Indian Center, \$4,000  
Contact: Clyde Tyndall, Executive Director, Indian Center, Inc.
- Northeast Nebraska Youth Suicide Prevention, \$5,000  
Contact: Rev. Robin Stoops, Norfolk Area Ministerial Association
- South Central Suicide Prevention Coalition, \$5,000  
Contact: Cindi McDowell, South Heartland District Health Department

- Panhandle Suicide Prevention, \$5,000  
Contact: Kimberly Engel, Director, Panhandle Public Health District

In addition, a second round of grant funding is now available. Community-based groups in Nebraska can apply by June 1st for grants of \$1,000 to \$5,000 to implement practices to prevent suicide among youth up to age 24. Applicants should propose community projects focusing on youth at high risk for suicide, including youth involved in multiple systems, minority youth and youth in transition to adulthood, including young returning veterans.

Details of the recent grants and an application for the new round of grants from the Nebraska Youth Suicide Prevention Project can be found at [www.youthsuicideprevention.nebraska.edu](http://www.youthsuicideprevention.nebraska.edu)

Grant funding comes from the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. DHHS will work with the University of Nebraska Public Policy Center and Interchurch Ministries of Nebraska to carry out grant activities and evaluate the project's progress.

For more information contact: Danielle Sodergren, Interchurch Ministries of Nebraska, Suicide Prevention and Military Outreach Coordinator, (402) 476-3391

Source: <http://www.dhhs.ne.gov/newsroom/newsreleases/2010/May/suicideprevention.htm>

## **Take Online Survey as Part of Behavioral Health Strategic Planning Process**

June 14, 2010 – Now's a good time to tell the Division of Behavioral Health what you think should be included in the draft strategic plan for Nebraska's behavioral health system.

"I'd like to encourage consumers, family members and providers to take our short, quick online survey," said Scot Adams, director of the Division of Behavioral Health in the Department of Health and Human Services. "We want to hear from as many people as possible. Your information will be combined with others and help guide the Division as it crafts a strategic plan to prioritize activities for 2011 through 2014."

The online survey and ideas on other ways to participate in the strategic planning process can be found at [http://www.dhhs.ne.gov/behavioral\\_health](http://www.dhhs.ne.gov/behavioral_health).

"The plan will provide a framework to guide activities and priorities for the Division as a principal leader, a partner and a participant in the statewide behavioral health system," Adams said. "It will include broad priorities for the entire behavioral health system, and the plan's goals and objectives will help gauge progress toward meeting critical system priorities."

Adams is leading the process with the help of a Joint Strategic Planning Committee that includes members from the Gambling Advisory Group, the Mental Health Advisory Group, the Substance Abuse Advisory Group, Regional Behavioral Health Authorities and the Division of Behavioral Health.

In addition, three national experts are providing critical expertise, especially in how health care reform relates to behavioral health services. They are: Shery Mead, Shery Mead Consulting;

Monica E. Oss, CEO, Open Minds; and Thomas Kirk, Ph.D., Kirk Consulting.

The draft strategic plan will be available for review this fall. It builds on the vision developed by the Behavioral Health Oversight Commission, whose members were appointed by the Governor.

Source: <http://www.dhhs.ne.gov/newsroom/newsreleases/2010/June/bhsurvey.htm>

## **NE Jail Standards Board Jail Screening Questions**

There was a very important accomplishment this year as part of the Justice Mental Health Grant. The Jail Standards Board, an independent governing board under the Nebraska Crime Commission's Jail Standards Division, approved mental health jail screening questions.

The Division of Behavioral Health has a grant from the U.S. Department of Justice – Bureau of Justice Assistance (BJA) Grant \ Justice and Mental Health Collaboration Program. Nebraska started with a Category I Planning Grant (from 11/01/2007 to 10/31/2008). Under that grant, a strategic plan was completed. The vision in that strategic plan is to develop a seamless system of behavioral health screening, assessment, treatment and supports accessible at appropriate points throughout involvement in the juvenile and criminal justice systems. One of the focus areas was the idea to implement standardized mental health and substance abuse screening instruments in the jails that prompt referrals for services. That ended up becoming Goal 3 under the second grant. For more information on this justice mental health strategic plan see ...

[http://www.dhhs.ne.gov/beh/NEJusticeMHStrategicPlan-UN\\_PPCFinalReport-Oct31\\_2008.pdf](http://www.dhhs.ne.gov/beh/NEJusticeMHStrategicPlan-UN_PPCFinalReport-Oct31_2008.pdf)

The Nebraska Division of Behavioral Health Services applied for and received a Category II: Planning and Implementation grant (from: Sep 01, 2008 to Aug 31, 2011). The overall theme for this second grant is collaborative partnerships to address interagency coordination & communication in order to implement system improvements for persons with mental illness in the Criminal Justice System. The primary target population for the second grant is young adults 18 to 24 years of age.

A Steering Committee was developed for the project and involved state agencies including DHHS Division of Behavioral Health, DHHS Office of Consumer Affairs, DHHS Division of Children and Family Services, Department of Correctional Services, Administrative Office of the Courts Probation Administration, and the Nebraska Crime Commission (Community Corrections Council and Jail Standards).

The Nebraska Justice Mental Health grant follows the Sequential Intercept Model developed through the GAINS Center. The various intercepts are intended to provide mental health intervention across the phases of justice involvement – (1) contact with law enforcement, (2) initial detention and court hearing, (3) involvement in with courts and in jail or prison, (4) reentry to the community, and (5) parole/probation. The Goals for the second grant and the corresponding intercept number for the second grant are below.

Intercept	Goals
1	1: Provide consistent statewide training for Nebraska Law Enforcement Officers to improve responses to people with mental illnesses
1	2: Expand or improve access to crisis response services in Nebraska

2	3: Implement standardized mental health and substance abuse screening protocols in the jails that prompt referrals for services
2	4: Increase resources to community mental health to provide diversion services through the use of Forensic Intensive Case Management
4 & 5	5: Enhance affordable supportive housing for justice involved youth transitioning to adulthood and young adults

As work started on the development of a standardized mental health screening protocol, it was recognized that many of Nebraska jails were utilizing some form of screening. However, the clear identification of mental health risk and needs was not consistently being done nor were there clear linkages to behavioral health services. It was anticipated that the standardized screening would be provided to every person arrested in all 79 Nebraska jails and detention centers. Goal 3 was designed to implement a standardized statewide mental health and substance abuse screening instruments in all the jails that prompt referrals for services. A work group was formed and the task of developing recommendations started.

The Jail Standards Board has the statutory authority to develop and implement minimum standards for adult jails, temporary holding facilities and juvenile detention facilities throughout Nebraska. This Board is responsible for jail standards and an inspection program. It is administered by a "grassroots" representative board, providing optimum opportunity for those impacted by the standards to have input into the process. While the Jail Standards Board operates as an independent governing board, staff and administrative support are provided by the Crime Commission's Jail Standards Division. The Jail Standards Board is comprised of 11 members, nine of which are appointed by the Governor for three year terms. For more information on the Jail Standards Board, see [http://www.ncc.state.ne.us/crime\\_commission/membership/committees/jsb.htm](http://www.ncc.state.ne.us/crime_commission/membership/committees/jsb.htm)

On 7/31/2009, Cameron White, Behavioral Health Administrator for the Nebraska Department of Correctional Services and Jim Harvey, DHHS Division of Behavioral Health, provided an update on the process of the Jail Screening Recommendations and what the current status is on these Recommendations.  
[http://www.ncc.ne.gov/meeting\\_minutes/jsb/minutes/July%2031,%202009%20Meeting%20Minutes.pdf](http://www.ncc.ne.gov/meeting_minutes/jsb/minutes/July%2031,%202009%20Meeting%20Minutes.pdf)

The actual recommendations were developed by the Jail Screening Work Team chartered by the University of Nebraska Public Policy Center, facilitated by Travis Parker, under contract with the Division of Behavioral Health. The recommendation was expanding upon the existing practices. Under the current standards, questions number 2, 4, 6, and 7 were already being used as part of the medical screening. The proposed questions are below.

#### PROPOSED JAIL SCREENING QUESTIONS / July 31, 2009

##### Behavioral Health Questions Asked of the Arresting Officer.

- 1) Has this arrestee demonstrated any behaviors which might suggest the presence of a mental illness? If yes, what?
- 2) Has this arrestee demonstrated any behaviors which might suggest suicidal tendencies? If yes, what?
- 3) Has there been any indication that the arrestee is acting so negatively toward their charge(s) that they might engage in self harming behavior? If yes, what have you observed?

Behavioral Health Questions Asked of the **Detainee**.

- 4) Do you have a serious mental health condition(s) which may need attention while you are here? If yes, what?
- 5) Have you been hospitalized for emotional problems within the last year? If yes, what were the problems, when were you hospitalized and where?
- 6) Have you ever attempted suicide? If yes, what did you do to yourself and how long ago did you do it?
- 7) Are you currently thinking about suicide? If yes, what is your plan? How would you do that?

Responses/Observations of the Jail or Juvenile Detention **Booking Officer**.

- 8) Do you believe that the arrestee is capable of understanding all the questions asked of him/her? If no, do you believe his/her comprehension problems are related to a mental health condition?
- 9) Does this arrestee have any institutional history of alerts (i.e. being placed on suicide watch during a prior incarceration)? If yes, what are those alerts?
- 10) Is there any indication that the arrestee is reacting so negatively toward his/her charge(s) that he/she might engage in self-harming behavior? If yes, what have you observed?
- 11) Do your physical observations of the arrestee align with what he/she is verbally sharing with you (i.e. the arrestee is stating that they have never attempted suicide while avoiding eye contact with you and you notice scars or fresh cuts on one of his/her arms)? If no, what are the discrepancies you have observed?

For the Medical Screening Instrument: Have you ever received an injury to your head, or been treated for an illness that affected your brain, that resulted in a long-term change in your mental abilities?

On 10/16/2009 the Jail Standards Board approved the following motion:

A motion was made by Reiber and seconded by Peschong to approve and adopt the Proposed Jail Screening Questions that were developed through Nebraska's Justice Mental Health Initiative.

[http://www.ncc.ne.gov/meeting\\_minutes/jsb/minutes/October%2016,%202009%20Meeting%20Minutes.pdf](http://www.ncc.ne.gov/meeting_minutes/jsb/minutes/October%2016,%202009%20Meeting%20Minutes.pdf)

After the Jail Standards Board approved the jail screening questions, the Division of Behavioral Health started working with the six Regional Behavioral Health Authorities on implementation issues. The problems mostly involve how to manage the work that needs to be done with reduced budgets on a sustainable basis after the grant ends on August 31, 2011.

## **Joint Meeting of the State Committees on Mental Health & Substance Abuse Services**

On May 6, 2010 in Lincoln, the Division of Behavioral Health facilitated the first ever joint meeting of the State Advisory Committee on Mental Health Services and the State Advisory Committee on Substance Abuse Services. Representatives from the State Committee on Problem Gambling also attended. There were 18 of the 23 members of the State Advisory Committee on Mental Health Services and 8 of 12 members of the State Advisory Committee on Substance Abuse Services

present for this first joint meeting of the two committees. The roll call determined a quorum was met for both committees. The meeting started 8:30 a.m. and ended at 4:20 pm.

This integrated meeting served as another vehicle to continue dialogue and planning for Nebraska's need to enhance and expand services for those with co-occurring disorders. Based upon the knowledge gained and attendees reports, the Division of Behavioral Health plans to host an integrated Advisory Board meeting on an annual basis.

This meeting helped to further document the unmet needs of this population. For more details see GAP #2: ADDRESSING CO-OCCURRING MENTAL HEALTH AND SUBSTANCE ABUSE PROBLEMS.

## **Division of Behavioral Health Honored for Supporting National Guard and Reserve Employees**

Source: <http://www.dhhs.ne.gov/newsroom/newsreleases/2010/Aug/beh.htm>

August 2, 2010 – The Division of Behavioral Health has received the “Pro Patria” award as outstanding public sector employer for 2009, the highest recognition given by the Nebraska Committee for Employer Support of the Guard and Reserve (ESGR). ESGR is a Department of Defense volunteer organization that works with employers and Guardsmen and Reservists to help minimize conflicts between military duties and civilian career responsibilities. Approximately 46 percent of the total available United States military manpower is made up of military reserve components.

The Pro Patria (for {one's} country) award is presented annually to one Nebraska employer in three categories: small private business, large private business, and a public sector employer. It honors Nebraska employers who've provided the most exceptional support to our national defense through leadership practices and personnel policies that support their employees who serve in the National Guard and Reserve.

Over the past four years the Division of Behavioral Health has honored and supported employees' professional military and civilian growth and overall well-being in numerous ways. During employees' military transitions, the Division has been very supportive and caring of their families, providing gifts to families during times of out-processing, training and/or deployment. Scot Adams, Director of the Division of Behavioral Health, accepted the award on behalf of the Division, but stated the award was for the entire NE Department of Health and Human Services.

## **RentWise Sustainability Is Achieved**

On February 4, 2010 Danielle Hill, Executive Director of the Nebraska Housing Developers Association, did a presentation on RentWise to the State Advisory Committee on Mental Health Services. The Committee reacted with a letter of support on the value of the RentWise training. The committee also supported the role the Nebraska Housing Developers Association is filling on developing a sustainable statewide coordination mechanism for a tenant education delivery system.

In their letter of support, Bev Ferguson, Chair the Committee, noted that the RentWise curriculum teaches independent living skills consumers with serious mental illness need such as communicating with your landlord and neighbors, managing your money, finding a place to call home, getting through the rental process, taking care of a home and when you move out. What has been missing is the statewide coordination mechanism for this tenant education program.

At the August 12, 2010, Danielle Hill announced that the Nebraska Housing Developers Association has agreed to serve as the Lead Agency for RentWise in Nebraska. For the last few years, there has been a goal to develop a sustainable statewide coordination mechanism to support RentWise. The Board of Directors for the Nebraska Housing Developers Association has indicated their desire for the Association to provide leadership to RentWise through their last two strategic planning sessions.

Ms. Hill reported there are now six (6) RentWise Networks in various stages of formation:

1. Heartland Family Services, Coordinating Agency for Omaha RentWise Network;
2. Lincoln Housing Authority, Coordinating Agency for Lincoln RentWise Network;
3. Community Action Partnership of Mid-Nebraska, Coordinating Agency for Southwest Nebraska Network;
4. Center for Independent Living, Coordinating Agency for South Central Nebraska Network;
5. Community Action Partnership of Western Nebraska, Coordinating Agency for the Nebraska Panhandle; and
6. Goldenrod Hills Community Action, Coordinating Agency for Northeast Nebraska RentWise.

She also reported there are 50 trainers actively delivering RentWise curriculum. There are more than 300 trainers trained to deliver RentWise.

For more information, contact Danielle Hill, Executive Director, Nebraska Housing Developers Association [(402) 435-0315 x1 / [danielle@housingdevelopers.org](mailto:danielle@housingdevelopers.org)].

## **Child Welfare Reform: Out of Home Framework**

On July 1, 2008, the Department of Health and Human Services, Division of Children and Family Services (CFS), began the process of improving the manner in which the State of Nebraska purchases services for Child Welfare and Office of Juvenile Services clients. On that day, the Department implemented contracts with five lead agencies to provide safety and in-home services to CFS clients, a reduction from over 100 contracts. The new contracts contain incentives to encourage exceptional contractor performance and performance is tied directly to outcomes that have been shown to provide safety, permanency, and well-being for children, youth, and the community.

On September 5, 2008, CFS announced the next steps in its ongoing efforts to improve services to children, youth, and their families by releasing the  [Out-of-Home Care Reform: Framework](#). The high-level plan outlined CFS' intentions to expand lead agencies, to take a performance-based approach to contracting for services, including non-treatment care, and to require lead agencies that are responsible for that care to also provide limited coordination of the services CFS clients receive.

CFS publicized an email address to seek public comment, scheduled fourteen public forums at ten different locations around the state, and held a meeting with all CFS staff to gather information and suggestions about the framework recommendations. A great deal of information was received, reviewed, and considered as CFS moved forward with the reform plan. On November 7, 2008, CFS released a summary of the input in [Out-of-Home Care Reform: Input and Next Steps](#) and updated the [Out-of-Home Care Reform: Timeline \(Revised\)](#). Later that month, CFS incorporated the input into the [Framework Recommendations for Out-of-Home Care Reform](#) and revised the [Out-of-Home Care Reform: Timeline \(Revised\)](#).

CFS then released the [Out-of-Home Care Reform: Request for Qualifications](#) and asked interested organizations to respond by January 15, 2009. Nine agencies responded to the RFQ. Two agencies were disqualified because their applications did not meet submission requirements. The remaining seven applicants were reviewed by Service Area Administrators and a review team, whose members were designated by the Service Area Administrators. The team used the [Out-of-Home Care Reform: Scoring Tool](#), a standard review tool, to rank the applicants. DHHS Finance Section staff also reviewed the financial information the applicants submitted. Because of the number of qualified applicants in several Service Areas, not all successful applicants were asked to continue to the negotiation process. Of the seven applicants, six were selected to continue on to the negotiation process. A list of all applicants and their rankings is provided in [Out-of-Home Care Reform: Applicants and Rankings](#).

## **Children's Public Health Insurance Expansion**

Children's Health Insurance: On September 1, 2009, more of Nebraska's children became eligible for medical assistance through the Children's Health Insurance Program (CHIP). As a result of federal legislation (CHIPRA) and recent Legislative action (LB603), income limits for the CHIP will be relaxed to include children whose family income does not exceed 200% of the Federal Poverty Level (FPL). Kids Connection is health care coverage for qualified children who are without other health insurance and who do not qualify for Medicaid. Federally called the Children's Health Insurance Program (CHIP), it provides the same services covered under Medicaid. The Kids Connection is an extension of Medicaid (Title XIX), making Medicaid providers automatically eligible to provide health care services to CHIP (Title XXI) eligible children. In Lancaster, Douglas and Sarpy Counties, Kids Connection is part of Nebraska Health Connection – the Medicaid Managed Program.

Adult - A report on the purpose for which the block grant monies for State FY were expended, the recipients of grant funds, and a description of activities funded by the grant.

Adult - Child: Purpose State FY BG Expended - Recipients - Activities Description

A report on the purpose for which the block grant monies for State FY were expended, the recipients of grant funds, and a description of activities funded by the grant.

Adult - Child A report on:

- the purpose for which the block grant monies for State FY were expended,
- the recipients of grant funds,
- a description of activities funded by the grant.

**Use of Federal Mental Health Block Grant in FY2010**

This is a report on the purposes for which the Federal Community Mental Health Services Block Grant (MH Block Grant) monies for State Fiscal Year 2010 were expended, the recipients of grant funds, and a description of activities funded by the grant.

The Federal Fiscal Year 2010 Award

According to the Notice of Award issued on 04/10/2010 for the program "Block Grants for Community Mental Health Services", the total FY2010 Federal funds approved for Nebraska was **\$1,943,546** for the award period from 10/01/2009 to 09/30/2011.

**Expenditures of Community Mental Health Block Grant Funds**

The information below shows purpose for which the block grant monies were expended for State Fiscal Year (SFY) 2010 (July 1, 2009 to June 30, 2010).

The MH Block Grant funds are used in three ways:

- (1) The primary purpose was to purchase community mental health services via contracts with the six Regional Behavioral Health Authorities. These funds are used in accordance with the restrictions in Federal law and the annual guidance. 54% of MH Block Grant Funds were expended on Adult Services, and 46% of MH Block Grant Funds were expended on Children's Services.
- (2) The 5% administrative portion was used to support MH Block Grant Adult Goal #2: Empower Consumers. The application for the MH Block Grant provides details on this.
- (3) Funds used to help support the "Independent Peer Review" (per Section 1943 in Attachment A - Community Mental Health Services Block Grant Funding Agreements).

Beginning with the SFY2009 (July 1, 2008), the NE Department of Health and Human Services-Division of Behavioral Health (DHHS-DBH) altered the source of information used for completion of all grant related reports from the use of self-reported "Actuals" from Regional Behavioral Health Authorities (RBHA) to the use of the State Accounting System, Nebraska Information System (NIS). Prior to this time, a portion of DBH reports were completed using the NIS system, while others were completed using the RBHA self-reported Actuals.

This change enables the Division to consistently complete reports as well as to more accurately reflect expenditures within the State Fiscal Year rather than expenditures based upon a contract period. Under the contract period reporting method, expenditures billed by the Region lag behind by a month (the June billing is paid in July). By moving to the NIS system, the new reporting will only show funds paid ending June 30, the close of the State Fiscal Year. Billing for June services paid in July will be reported in the next fiscal year.

**Adult – Child: Purpose State FY BG Expended – Recipients – Activities Description  
Implementation Report / October 22, 2010 / Page 2**

Funds expended in this Implementation Report are comprised of monies from two separate Community Mental Health Services Block Grants, Federal Fiscal Year (FFY) 2009 and FFY2010. In viewing this report, one needs to keep in mind that:

- This report is prepared from the point of view of State Fiscal Year (July 1 to June 30).
- The six Regional Behavioral Health Authorities are under contract with the Department of Health and Human Services (DHHS) Division of Behavioral Health (DBH).
- The Federal Community Mental Health Services Block Grant funds must be obligated and expended within the two-year period.
- There is a lag time for the cash to flow from a Federal Notice of Grant Award, into a contract with Regional Behavioral Health Authorities and ending in a form of payment for services.

**SFY2010 Actual Expenditures**

<b>Adult</b>	<b>Region 1</b>	<b>Region 2</b>	<b>Region 3</b>	<b>Region 4</b>	<b>Region 5</b>	<b>Region 6</b>	<b>Total</b>
Community Support		88,311	17,892	32,181			138,385
Day Rehabilitation		33,751				8,325	42,076
Psych Residential Rehabilitation						160,712	160,712
Dual Residential Tx					15,000		15,000
Day Treatment					14,449		14,449
Medication Management	5,789	45,008					50,797
Outpatient Therapy	26,589		16,936	28,456	137,875	188,832	398,688
Outpatient Therapy - Dual			12,815				12,815
Peer Support			7,245				7,245
Day Support	30,128		31,971				62,099
Supported Employment	1,310	11,251	28,642	35,308			76,511
<b>Total Adult Services</b>	<b>\$63,816</b>	<b>\$178,320</b>	<b>\$115,501</b>	<b>\$95,945</b>	<b>\$167,323</b>	<b>\$357,869</b>	<b>\$978,776</b>
<b>Children</b>	<b>Region 1</b>	<b>Region 2</b>	<b>Region 3</b>	<b>Region 4</b>	<b>Region 5</b>	<b>Region 6</b>	<b>Total</b>
Therapeutic Consultation (PL 100-690) Service	21,511				68,800		90,311
Day Treatment (P.L. 100-690) Service			9,493				9,493
Day Treatment (P.L. 102-321) Service			29,792				29,792
Children's Multi-Systemic Therapy			47,855				47,855
Professional Partner	29,303		53,795	80,000	137,443	169,498	470,039
Professional Partner School Wrap	78,001			80,323	0		158,324
Children's Intensive Outpatient					36,219		36,219
<b>Total Children Services</b>	<b>\$128,814</b>	<b>\$0</b>	<b>\$140,935</b>	<b>\$160,322</b>	<b>\$242,462</b>	<b>\$169,498</b>	<b>\$842,033</b>
<b>Grand Totals From FY10 Region Billing</b>	<b>\$192,631</b>	<b>\$178,320</b>	<b>\$256,436</b>	<b>\$256,268</b>	<b>\$409,786</b>	<b>\$527,367</b>	<b>\$1,820,808</b>
	11%	10%	14%	14%	23%	29%	100%

**The Recipients of Community Mental Health Block Grant Funds**

The six Regional Behavioral Health Authorities were the recipients of the funds. The "Nebraska Behavioral Health Services Act" (Neb. Rev. Stat. §§ 71-801 to 71-818) was passed by the Legislature and signed by the Governor in 2004, with amendments in the years that followed (2005 – 2009). The NBHS Act specifically authorizes “Regional Behavioral Health Authorities” (RBHA) under Neb. Rev. Stat. §§ 71-807 to 71-809. The NBHS Act revised the regional administration of the system. The NBHS Act retained the six geographic “regions” established in 1974. It re-authorized the six regions and renamed them “Regional Behavioral Health Authorities” (RBHA). The RBHA are local units of government organized under the Inter-Local Cooperation Act for the

purpose of planning, organizing, staffing, directing, coordinating and reporting of the local service systems of mental health, and substance abuse within assigned geographic areas (regions). Each county participating in the region appoints one county commissioner to the Regional Governing Board to represent that county and to participate in the decision making of the Regional Behavioral Health Authority (RBHA). The RBHA is staffed by the Regional Program Administrator who in turn hires sufficient staff to accomplish the tasks within the region. RBHA contracts with local providers for service delivery.

### **DESCRIPTION OF ACTIVITIES / ADULT SERVICES**

- Community Support – MH - Community Support is a rehabilitative and support service for individuals with primary Axis I diagnosis consistent with a severe and persistent mental illness. Skilled paraprofessionals provide direct rehabilitation and support services to the individual in the community, most generally the individual's home, with the intention of supporting the individual to maintain stable community living, and prevent exacerbation of mental illness and admission to higher levels of care.
- Day Rehabilitation – MH - Day Rehabilitation services are designed to provide individualized treatment and recovery, inclusive of psychiatric rehabilitation and support for clients with a severe and persistent mental illness and/or co-occurring disorders who are in need of a program operating during day hours. The intent of this service is to support the individual in the recovery process so that he/she can be successful in a community living setting of his/her choice.
- Psychiatric Residential Rehabilitation – MH - Psychiatric Residential Rehabilitation is designed to provide individualized treatment and recovery inclusive of psychiatric rehabilitation and support for individuals with a severe and persistent mental illness and/or co-occurring disorder who are in need of recovery and rehabilitation activities within a residential setting. This service is provided by a professional recovery team in a 24-hour staffed residential facility. The intent of the service is to support the individual in the recovery process so that he/she can be successful in a community living setting of his/her choice.
- Dual Residential – This residential treatment service is intended for adults with a primary Axis I diagnosis of substance dependence and a co-occurring severe and persistent mental illness requiring a more restrictive treatment environment to prevent substance use. This service is highly structured, based on acuity, and provides primary, integrated treatment to further stabilize acute symptoms and engage the individual in a program of maintenance, treatment, rehabilitation and recovery.
- Day Treatment – MH - Day Treatment provides a community based, coordinated set of individualized treatment services for individuals with psychiatric disorders who are not able to function full-time in a normal school, work, and/or home environment and need the additional structured activities of this level of care. This service is less intensive than hospital based day treatment.
- Medication Management – MH - Medication Management is a level of outpatient treatment rendered by a qualified physician that includes evaluation of the individual's need for psychotropic medications, provision of prescriptions, and ongoing medical monitoring of medications. Service expectations include: medical evaluation; medication monitoring; and client education pertaining to the medication and its use.
- Outpatient Therapy (Individual/Group/Family) – Outpatient Individual Therapy is the treatment of psychiatric disorders through scheduled therapeutic visits between the therapist and the individual, and/or the nuclear and/or extended family. The focus of Outpatient Individual Therapy is to improve or alleviate symptoms that may significantly interfere with functioning in at least one life domain (e.g., familial, social, occupational, educational, etc.). The goals, frequency, and duration of Outpatient Individual Therapy will vary according to individual needs and response to therapy. Outpatient Group Therapy is the treatment of psychiatric disorders through scheduled therapeutic

visits between the therapist and the consumer in the context of a group setting of at least three, and no more than twelve, participants with a common goal. The focus of Outpatient Group Therapy is to improve or maintain an individual's ability to function as well as alleviate symptoms that may significantly interfere with their interpersonal functioning in at least one life domain (e.g., familial, social, occupational, educational, etc.). Outpatient Group Therapy must provide active treatment for a primary DSM IV diagnosis. The goals, frequency, and duration of Outpatient Group Therapy will vary according to individual needs and response to treatment. Groups that are educational or supportive in nature do not meet the definition of Outpatient Group Therapy.

The focus of Outpatient Family Therapy is to alter the family system to increase the functional level of the identified consumer/family through services/interventions on the systems within the family unit.

- Day Support - is designed to provide minimal social support to individuals who currently receive, or have received, behavioral health services and are succeeding in their recovery process. The intent of the service is to support the individual in the recovery process so he/she can experience continued success in the community living setting of his/her choice.
- Peer Support - Peer Support services are designed to promote personal growth, self-esteem, and dignity by developing leadership skills, advocacy skills, and sharing information. Peer Support provides structured scheduled activities that promote socialization, recovery, self-advocacy, self-sufficiency, development of supports, development and maintenance of community living skills. The purpose of Peer Support is to provide an opportunity to teach and support consumers in the acquisition and exercise of skills needed for management of symptoms and for utilization of resources within the community or other treatment settings. Peer Support activities include assistance to consumers in developing service plans and goals; scheduling individual meetings with consumers; facilitating group education classes, facilitating Wellness Recovery Action Planning (WRAP); assisting in accessing work and work-related tools, housing, advocacy, ACT, and self-help groups. Peer Support Specialists serve as a resource on local issues regarding recovery and share that information to help consumers attain recovery; ensure structured activities for consumers to increase self-reliance and resources towards independent living; and advise the regional and state staff about consumers and consumer issues to ensure policies are developed in the most effective relevant, data-driven and consumer-centered manner possible.
- Supported Employment – is designed to provide recovery and rehabilitation services and supports in employment-related activities for consumers with a severe and persistent mental illness and/or a co-occurring substance abuse disorder who express a desire to return to work. A supported employment team provides assistance with all aspects of employment development as requested and needed by the consumer. The intent of the service is to support the consumer in the recovery process so the consumer's goals can be successfully obtained.

## **DESCRIPTION OF ACTIVITIES / CHILDREN/YOUTH SERVICES**

- Therapeutic Consultation (P.L. 100-690) – Collaborative, clinical intervention for youth with early indications of Severe Emotional Disturbance. Multidisciplinary based interventions with family, teachers and mental health professional involvement in the school or other natural setting.
- Day Treatment (P.L. 102-321) – Facility based program serving children and adolescents with Severe Emotional Disturbance. The purpose of Day Treatment is an intensive, non-residential service providing counseling and family services, education, behavior modification and skill building, promoting reintegration back to the child's regular school.
- Children's Multi-Systemic Therapy – Multi-Systemic Therapy (MST) is a family and community-based treatment using an ecological approach for youth with complex clinical, social, and educational problems. MST is short-term in duration (usually 3-5 months), with the MST therapist

maintaining a small caseload. Youth referred to MST exhibit a combination of: physical and verbal aggression, school failure and truancy, criminal or delinquent behavior usually associated with contact with delinquent peers, and substance abuse issues. The family, as a whole, will work with a trained MST therapist. The goal of MST is to reduce the frequency and intensity of the youth's referral behavior. The MST therapist will work with the parents assisting them in empowering themselves through gaining the skills and resources needed to address difficulties that will arise while parenting their children. In addition, the youth will learn coping skills to better address family, peer, school, and neighborhood issues

- Professional Partner – Strength-based, family centered approach to working with children with serious emotional disturbances and their families. Provides access to services on a 24-hour, 7day/week basis. Uses a wraparound approach to coordinate services and supports to families. Includes coordinated assessment, flexible funding to provide support, based on needs as outlined by a multidisciplinary team. Emphasizes family empowerment and involvement in planning. Professional Partner-School Wraparound is a variation of the Professional Partner Program, through which a special education teacher, team teacher, or school social worker works with the Professional Partner and the Child and Family Team to coordinate the school plan. Based on the LaGrange Area Department of Special Education (LADSE) approach in LaGrange, Illinois, a team of two wraparound service coordinators are based in the school. Planning efforts around the child and family create an environment in which the school is an integral part of the overall assessment and support for the child and his/her family. This school-based wraparound approach allows the teacher and/or other school personnel to feel comfortable voicing classroom-based concerns (academic and behavioral), and members of the Child and Family Team are also able to understand these concerns. The two individuals work closely together as a team to assist and coordinate services to a combined caseload of approximately 20 children/families. Both individuals bring specific strengths to the team from their varied backgrounds in the school and in the community.
- Children's Intensive Outpatient Therapy – Intensive Outpatient Therapy is a specialized mental health treatment program for youth experiencing a wide range of mental health problems that cause moderate and/or acute disruptions in the youth's life. Outpatient treatment programs provide youth, family, or group treatment services, generally on a regularly scheduled basis. The outpatient program provides to each youth served the appropriate assessment and/or diagnosis of the mental health and/or substance abuse problem, as well as effective treatment to change behaviors, modify thought patterns, cope with problems, improve functioning, improve understanding of factors

producing problems, identify workable steps to address the problems and/or other related goals. Such programs may include the collateral and/or adjunctive services. Adjunctive services are designed to link youth with severe persistent mental illness (SPMI) who are participating in the outpatient program to other programs, and coordinating the various services to achieve successful outcomes. Adjunctive services include information gathering and reporting, coordination of services, referral facilitation, and related activities to assure there is coordination between the various programs serving the youth. Adjunctive services are limited to youth who are not currently admitted to a community support program.

Child - Report Summary of areas which the State identified in the prior FY's approved Plan as needing improvement

see Adult - Summary of Areas Previously Identified by State as Needing Improvement

Child - Report Summary of the most significant events that impacted the mental health system of the State in the previous FY

see Adult - Most Significant Events that Impacted the State in the Previous FY

Child - A report on the purpose for which the block grant monies for State FY were expended, the recipients of grant funds, and a description of activities funded by the grant.

see Adult - Purpose State FY BG Expended - Recipients - Activities Description

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	32,862	25,291	29,000	20,434	70.46
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:** Increased Access to Services

**Target:** To increase by 5% the number of adults (age 18 or older), unduplicated count

**Population:** The adults served in mental health services in the Nebraska Behavioral Health System funded by the Nebraska Division of Behavioral Health Services

**Criterion:** 2:Mental Health System Data Epidemiology  
3:Children's Services

**Indicator:** Number of Persons Served by Age, Gender, and Race/Ethnicity as reported in the Uniform Reporting System (URS) Table 2A

**Measure:** Total Adults Served as reported on URS Table 2A

**Sources of Information:** NE Division of Behavioral Health (Community Mental Health and State psychiatric hospitals) - unduplicated count

**Special Issues:** In January 2009, the Division of Behavioral Health cleaned its data system by administratively discharging nearly 18,000 records of admission to program prior to November 2003 and of which had no activity in the last year. This reduced the number of active cases in the system. This improved the data quality. It is acknowledged that it appears fewer people were served. For FY2010, with the community based services (Magellan Health) data, only the persons admitted to a mental health service or a dual service (consumers who received a specialized program including both mental health and substance abuse services) were counted. In the past, persons served in substance abuse services with a mental health diagnosis or reason for admission field showing "mental health" were included. As a result, the counts on the URS Tables in FY2010 did drop. However, the Division of Behavioral Health believes this is a more accurate method for reporting persons served.

As a result, the performance measure data reported previously, if updated using the new methods, would change.

Adults - Increased Access to Services (Number)

FY 2008 Actual was reported as 32,862 is changed to: 18,063

FY 2009 Actual was reported as 25,291 is changed to: 19,579

FY 2010 Target was reported as 29,000 is changed to: 20,000

URS Table 2A for persons age 18+ FY 2010 Actual is reported as: 20,434

**Significance:**

**Activities and** Narrative: The data is persons served as reported on Table 2A. These are

**strategies/  
changes/  
innovative or  
exemplary model:** reporting the Federal Uniform Reporting System using the capacity to report an unduplicated count of persons served between the Regional Centers (State Psychiatric Hospitals) and community mental health using Magellan Data. Summary from Table 2A "Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity" Estimated Completion Date: Completed

**Target Achieved  
or  
Not Achieved/If  
Not, Explain Why:** Target Achieved.  
1) For FY2010, with the community based services (Magellan Health) data, only the persons admitted to a mental health service or a dual service (consumers who received a specialized program including both mental health and substance abuse services) were counted. In the past, persons served in substance abuse services with a mental health diagnosis or reason for admission field showing "mental health" were included. As a result, the counts on the URS Tables in FY2010 will drop. However, the Division of Behavioral Health believes this is a more accurate method for reporting persons served.  
The Division of Behavioral Health recalculated FY08, FY09 data using the new methods.  
FY 2008 Actual was reported as 32,862 is changed to: 18,063  
FY 2009 Actual was reported as 25,291 is changed to: 19,579  
FY 2010 Target was reported as 29,000 is changed to: 20,000

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	4.71	2.59	3	2.67	112.36
Numerator	16	5	--	4	--
Denominator	340	193	--	150	--

Table Descriptors:

**Goal:** Reduced 30 day readmission rates - Utilization of Psychiatric Inpatient Beds -

**Target:** Non-Forensic (Voluntary and Civil-Involuntary) Patients Readmission to Any State Psychiatric Inpatient Hospital Within 30 Days of Discharge

**Population:** Non-Forensic (Voluntary and Civil-Involuntary) Patients subject to Readmission to Any State Psychiatric Inpatient Hospital

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Percent Readmitted 30 days

**Measure:** Percent Readmitted 30 days | Numerator (Number of Readmissions to ANY STATE Hospital within 30 days) | Denominator - Total number of Discharges in Year

**Sources of Information:** FY2008, FY2009, & FY2010 from URS Table 20A Non-Forensic Patients Readmission to Any State Hospital 30/180 Days of Discharge.

**Special Issues:** There is a new admission criteria for the Regional Centers. All new admissions go to only the Lincoln Regional Center (LRC). Only committed individuals meeting "acute" clinical criteria are admitted. Each Region has an allocation of beds within LRC. Regions are usually admitting patients unable to be safely treated in the community hospital.

**Significance:**

**Activities and strategies/ changes/ innovative or exemplary model:**

**Target Achieved** Target Achieved  
or  
**Not Achieved/If Not, Explain Why:**

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	8.53	9.84	7	5.33	131.33
Numerator	29	19	--	8	--
Denominator	340	193	--	150	--

Table Descriptors:

**Goal:** Reduced 180 day readmission rates - Utilization of Psychiatric Inpatient Beds

**Target:** Non-Forensic (Voluntary and Civil-Involuntary) Patients Readmission to Any State Psychiatric Inpatient Hospital Within 180 Days of Discharge

**Population:** Non-Forensic (Voluntary and Civil-Involuntary) Patients subject to Readmission to Any State Psychiatric Inpatient Hospital

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Percent Readmitted 180 days | Numerator (Number of Readmissions to ANY STATE Hospital within 180 days) | Denominator - Total number of Discharges in Year

**Measure:** Percent Readmitted 180 days

**Sources of Information:** FY2008, FY2009, & FY2010 from URS Table 20A Non-Forensic Patients Readmission to Any State Hospital 30/180 Days of Discharge.

**Special Issues:** There is a new admission criteria for the Regional Centers. All new admissions go to only the Lincoln Regional Center (LRC). Only committed individuals meeting "acute" clinical criteria are admitted. Each Region has an allocation of beds within LRC. Regions are usually admitting patients unable to be safely treated in the community hospital.

**Significance:**

**Activities and strategies/ changes/ innovative or exemplary model:**

**Target Achieved** Target Achieved  
or  
**Not Achieved/If Not, Explain Why:**

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Evidence Based - Number of Practices (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	5	5	5	5	100
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:** Maintain, and expand when possible, the number of Evidence-Based Practices (EBPs) in Nebraska.

**Target:** Maintain, and expand when possible, the number of Evidence-Based Practices (EBPs) in Nebraska.

**Population:** Persons served by NE Division of Behavioral Health who may benefit from Evidence-Based Practices (EBPs) in Nebraska.

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Count of the number of Evidence-Based Practices (EBPs) implemented in Nebraska.

**Measure:** Count of the number of Adult EBPs [1. Assertive Community Treatment (ACT); 2. Supported Employment (SE); 3. Supported Housing; 4. Integrated Treatment For Co-Occurring Disorder (Mental Health / Substance Abuse) Dual Diagnosis Treatments; and 5. Medication Management funded by the Division of Behavioral Health.

**Sources of Information:** NE Division of Behavioral Health

**Special Issues:** Nebraska Division of Behavioral Health is implementing the following Adult Evidence-Based Practices (EBPs)  
1. Assertive Community Treatment (ACT)  
2. Supported Employment (SE)  
3. Supported Housing  
4. Integrated Treatment For Co-Occurring Disorder (Mental Health / Substance Abuse) Dual Diagnosis Treatments  
5. Medication Management

Nebraska has implemented or is developing Fidelity Measurement for the following Assertive Community Treatment (ACT), Supported Employment (SE), and Supported Housing.

**Significance:**

**Activities and strategies/ changes/ innovative or exemplary model:** Narrative: At this time, Nebraska has very limited capacity to report on this measure. Nebraska is developing the following evidence-based practices 1. Assertive Community Treatment (ACT); 2. Supported Employment (SE); 3. Supported Housing; 4. Integrated Treatment For Co-Occurring Disorder (Mental Health / Substance Abuse) Dual Diagnosis Treatments; and 5. Medication

Management. Each one has a different capacity for reporting unduplicated counts of persons served.

**Target Achieved**    Achieved.  
**or**    In previous reports, NE included Multi-Systemic Therapy (MST) under this adult  
**Not Achieved/If**    measure. MST is a youth service. It is counted only under the Child measure.  
**Not, Explain Why:**

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Evidence Based - Adults with SMI Receiving Supported Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	N/A	N/A	700	N/A	N/A
Numerator	717	823	--	842	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:** Implement Supported Housing using the NE Housing Related Assistance program

**Target:** To serve 700 eligible consumers in FY2010. The same level of funding was contracted to the six Regional Housing Coordinators. With the cost of living increasing and the same level of funding available, one may expect fewer persons served.

**Population:** Supported Housing is for adults who are extremely low income with a serious mental illness with the goal of independent housing who are eligible under the Nebraska Housing-related assistance program, as authorized under Neb. Rev. Stat. § 71-812.

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Number of persons served annually, unduplicated count, by the NE Housing Related Assistance program

**Measure:** The count of persons served annually, unduplicated count, by the NE Housing Related Assistance program

**Sources of Information:** Summary of the monthly Housing Related Assistance data reported from the six Regional Behavioral Health Authorities to the Division.

**Special Issues:**

**Significance:** The NE Housing Related Assistance program was developed under NE Behavioral Health Reform. It is designed to be Person-centered, recovery-oriented, accessible, focused on a positive outcome of promoting independent living, and cost effective.

**Activities and strategies/ changes/ innovative or exemplary model:** Narrative: The Nebraska Housing-related assistance program, as authorized under Neb. Rev. Stat. § 71-812, is the basis for reporting the number of consumers who are receiving the Evidence Based Practice service of Supported Housing. This is a conservative count. For example, it excludes consumers who are receiving DHHS funded Behavioral Health support services and have HUD section 8. SAMHSA material was used to guide EBP Implementation. Staff have been specifically trained to implement Supported Housing. The capacity to measure fidelity was developed during FY2008. The Division did the fidelity monitoring in FY2009.

**Target Achieved or** Achieved

**Not Achieved/If  
Not, Explain Why:**

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Evidence Based - Adults with SMI Receiving Supported Employment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	N/A	N/A	400	N/A	N/A
Numerator	453	396	--	686	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

- Goal:** Implement Supported Employment in partnership with Vocational Rehabilitation
- Target:** 400 persons with behavioral health disorders age 19 and older in FY2010
- Population:** persons age 19 and older with mental illness, alcoholism, drug abuse, and/or related addictive disorder.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Number of persons served annually, unduplicated count, under the Supported Employment program as reported by Magellan
- Measure:** The count of persons served annually, unduplicated count, under the Supported Employment program
- Sources of Information:** Community Mental Health data as reported under Magellan Behavioral Health
- Special Issues:** The Division of Behavioral Health has a Memorandum of Understanding (MOU) with Nebraska Vocational Rehabilitation to increase employment opportunities for people with behavioral health (BH) problems. However, the data reported for this indicator is limited to what is collected by the Division of Behavioral Health.
- Significance:** The Supported Employment program was developed under NE Behavioral Health Reform. It is designed to be Person-centered, recovery-oriented, accessible, focused on a positive outcome of promoting employment, and cost effective.

**Activities and strategies/ changes/ innovative or exemplary model:**

**Target Achieved** Achieved  
or  
**Not Achieved/If Not, Explain Why:**

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Evidence Based - Adults with SMI Receiving Assertive Community Treatment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	N/A	N/A	250	N/A	N/A
Numerator	229	266	--	278	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:** Report the number of persons served in Assertive Community Treatment (ACT) in Nebraska.

**Target:** 250 persons served in Assertive Community Treatment (ACT).

**Population:** the number of persons served in Assertive Community Treatment (ACT) for the three(3) teams (Omaha, Lincoln, and Hastings).

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** The count of the number of persons served in Assertive Community Treatment (ACT)

**Measure:**

**Sources of Information:** Community Mental Health data as reported under Magellan Behavioral Health

**Special Issues:** Nebraska is using the Dartmouth Assertive Community Treatment Scale (DACTS) as the fidelity measure. The ACT programs are now being trained on the Tool for Measurement of Assertive Community Treatment (TMACT). At this time, NE uses a PACT Consultant along with DBH Staff to measure fidelity annually. In the future with the TMACTS, the team of individuals will do this is pending the completion of the training.

**Significance:**

**Activities and strategies/ changes/ innovative or exemplary model:** Nebraska continues to implement the evidence-based practice of Assertive Community Treatment (ACT). A first URS Table 16 for ACT was completed with the FY2005 report. Fidelity is measured annually. The SAMHSA EBP Toolkit was used to guide EBP Implementation. Staff have been specifically trained to implement the EBP. The ACT teams are in Omaha, Lincoln, and Hastings. The count is the total persons served (unduplicated) for the fiscal year reported.

**Target Achieved or Not Achieved/If Not, Explain Why:** Achieved

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Evidence Based - Adults with SMI Receiving Family Psychoeducation (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:**

**Target:**

**Population:**

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:**

**Measure:**

**Sources of Information:**

**Special Issues:**

**Significance:**

**Activities and strategies/ changes/ innovative or exemplary model:** Narrative: At this time, Nebraska has no capacity to report on the Number of Persons Receiving Family Psychoeducation measure. Nebraska is developing other evidence-based practices. Receiving Family Psychoeducation is not offered at this time. It will not be reported any time soon.

**Target Achieved or Not Achieved/If Not, Explain Why:**

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Evidence Based - Adults with SMI Receiving Integrated Treatment of Co-Occurring Disorders(MISA) (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	N/A	N/A	80	N/A	N/A
Numerator	2,970	3,856	--	451	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

- Goal:** Report the number of Adults with Serious Mental Illnesses Receiving Integrated Treatment for Co-occurring Disorders (MH/SA) During The Year
- Target:** Adults with Serious Mental Illnesses Receiving Integrated Treatment for Co-occurring Disorders
- Population:** Adults with Serious Mental Illnesses Receiving Integrated Treatment for Co-occurring Disorders
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Count of the number of Adults with Serious Mental Illnesses Receiving Integrated Treatment for Co-occurring Disorders as reported on URS Table 17.
- Measure:**
- Sources of Information:** URS table 17, Receiving Integrated Treatment for Co-occurring Disorders represents an extract for the population presented in table 2a of those person who meet the qualifications for "Dual Diagnosis Residential" Treatment.
- Special Issues:** Receiving Integrated Treatment for Co-occurring Disorders (MH/SA) represents individuals listed as receiving treatment in a dual-diagnosis program based on services authorized, admission reason, and level of care.
- Significance:** For FY2010, with the community based services (Magellan Health) data, only the persons admitted to a dual service (consumers who received a specialized program including both mental health and substance abuse services) were counted as co-occurring disorders. In the past, persons served in both substance abuse services or mental health services during that year were included. As a result, the counts on the URS Tables in FY2010 did drop. However, the Division of Behavioral Health believes this is a more accurate method for reporting persons served.
- Activities and strategies/ changes/ innovative or exemplary model:** Narrative: At this time, Nebraska has very limited capacity to report on this measure. This is a count on the number of persons served under "Dual Diagnosis Residential" Treatment. There is no fidelity measurement at this time.
- Target Achieved or Not Achieved/If** Achieved  
For FY2010, with the community based services (Magellan Health) data, only the persons admitted to a dual service (consumers who received a specialized

**Not, Explain Why:** program including both mental health and substance abuse services) were counted as co-occurring disorders. In the past, persons served in both substance abuse services or mental health services during that year were included. As a result, the counts on the URS Tables in FY2010 will drop. However, the Division of Behavioral Health believes this is a more accurate method for reporting persons served.

The Division of Behavioral Health recalculated the number of co-occurring disorders for FY08 and FY09 using the new methods. Listed below are number of adults served in FY08, FY09 and FY10.

FY2008 Actual 294

FY2009 Actual 396

FY2010 Actual 451

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Evidence Based - Adults with SMI Receiving Illness Self-Management (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:**

**Target:**

**Population:**

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:**

**Measure:**

**Sources of Information:**

**Special Issues:**

**Significance:**

**Activities and strategies/ changes/ innovative or exemplary model:** Narrative: At this time, Nebraska no capacity to report on the Number of Persons Receiving Illness Self-Management. This service is not offered at this time. It will not be reported any time soon.

**Target Achieved or Not Achieved/If Not, Explain Why:**

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Evidence Based - Adults with SMI Receiving Medication Management (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	N/A	N/A	4,200	N/A	N/A
Numerator	3,444	4,728	--	6,546	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:** To develop the capacity to consistently report on the number of persons Receiving Medication Management

**Target:** Persons Receiving Medication Management

**Population:** Persons Receiving Medication Management

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Number of Persons Receiving Medication Management as reported on URS Table 17.

**Measure:**

**Sources of Information:** From the URS table 17, data for the column labeled Receiving Medication Management represents an extract for the population presented in table 2a of those person who meet the qualifications for "Medication Management -- MH"

**Special Issues:** Receiving Medication Management represents individuals listed as receiving medication management in services authorized, or level of care as reported on URS Table 17.

**Significance:**

**Activities and strategies/ changes/ innovative or exemplary model:** Narrative: Nebraska has a limited capacity to report on this measure. Receiving Medication Management is a service offered across the state. There is no capacity to measure fidelity. The SAMHSA EBP Toolkit was not used to guide EBP Implementation. Staff have not been specifically trained to implement the EBP. First successfully reported in URS for FY2006.

**Target Achieved** Achieved  
or

**Not Achieved/If Not, Explain Why:**

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	72.04	71.54	70	75.58	107.97
Numerator	688	739	--	820	--
Denominator	955	1,033	--	1,085	--

Table Descriptors:

**Goal:** To maintain the number of consumers responding Positively About Outcomes in the annual Nebraska Behavioral Health Consumer Survey

**Target:** maintain the number of consumers responding Positively About Outcomes in the annual Nebraska Behavioral Health Consumer Survey

**Population:** All consumers with valid addresses and/or phone numbers within the Magellan Behavioral Health database who do respond to the annual Nebraska Consumer Survey

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Percentage responding positively

**Measure:** Numerator: Average of positive responses to the MHSIP Consumer Survey: Perceptions of Outcomes questions (21. I deal more effectively with daily problems; 22. I am better able to control my life; 23. I am better ablet o deal with crisis; 24. I am getting along better with my family; 25. I do better in social situations; 26. I do better in school and/or work; 27. My housing situation has improved; 28. My symptoms are not bothering me as much). Denominator: total number of responses

**Sources of Information:** Numerator and Denominator Data Source: Nebraska annual consumer survey as reported on Uniform Reporting System/Implementation Report-Table 11. Summary Profile of Client Evaluation of Care using the official consumer survey approved by CMHS.

**Special Issues:** The annual Nebraska Behavioral Health Consumer Survey is funded by the Federal Mental Health Data Infrastructure Grants for Quality Improvement (State DIG).

**Significance:**

**Activities and strategies/ changes/ innovative or exemplary model:** Nebraska uses Federal Mental Health Data Infrastructure Grant funds to pay for this survey. The consumer survey instrument needed to report URS Tables 9, 11, and 11a uses the questions approved by the Federal Center for Mental Health Services. The data are collected under the a contract with University of Nebraska Medical Center, College of Public Health.

**Target Achieved** Achieved  
**or**  
**Not Achieved/If Not, Explain Why:**



**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Adult - Increase/Retained Employment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:** Implement Supported Employment in partnership with Vocational Rehabilitation

**Target:**

**Population:**

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems

**Indicator:**

**Measure:**

**Sources of Information:** Community Mental Health data as reported under Magellan Behavioral Health

**Special Issues:** The Division of Behavioral Health has a Memorandum of Understanding (MOU) with Nebraska Vocational Rehabilitation to increase employment opportunities for people with behavioral health (BH) problems. However, the data reported for this indicator is limited to what is collected by the Division of Behavioral Health.

**Significance:**

**Activities and strategies/ changes/ innovative or exemplary model:**

- Currently report URS Table 4. Profile of Adult Clients by Employment Status.
- Developing the capacity to reporty Table 16: Profile of Adults with Serious Mental Illnesses...Recieving Evidence-Based Services-Supported Employment.
- At this time, Magellan collects the data for employment at time of admission and time of discharge. However, for consumers who are in the system for an extended period of time, there is no capacity to update key data fields such as employment. Thus, at this time, Nebraska does not have the capacity to address the "Increase/Retained Employment (Percentage)" aspect of this measure.
- Under the new Magellan ASO Contract, there will be an annual update of the data including living situation. As a result, over time NE should develop the capacity to report this measure. At this time this measure can not be reported.

**Target Achieved or Not Achieved/If Not, Explain Why:**

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Adult - Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:**

**Target:**

**Population:**

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:**

**Measure:**

**Sources of Information:**

**Special Issues:**

**Significance:**

**Activities and strategies/ changes/ innovative or exemplary model:** Possible to develop this capacity with the UNMC contract on data analysis. No consumer survey data will be used to report on this measure [Decreased Criminal Justice Involvement (Percentage)]. The use of administrative data is being developed using the following strategy. It is the development of Criminal Justice Electronic Data Transfer Interagency Agreement. In June 2009, the Nebraska Department of Health and Human Services - Division Of Behavioral Health (DHHS), the Nebraska Department of Correctional Services (DCS) and the Nebraska Commission on Law Enforcement and Criminal Justice (Crime Commission) signed Electronic Data Transfer Interagency Agreements. The final agreements were officially approved on June 9,2009. These agreements have these three state agencies transferring their data to the Division of Epidemiology, College of Public Health at the University of Nebraska Medical Center in Omaha, NE for the purpose of analysis, compilation and reporting for the mutual benefit of the parties. The initial data covers the time period from January 1, 2005 to December 31, 2008. Before public release, the Report(s) produced under these agreements must be acceptable to the DHHS, DCS and the Crime Commission. The Report(s) remain in draft status until these three code level agencies approve the document. This requirement is due to the sensitive nature of the content of the report(s) using these data.

**Target Achieved or Not Achieved/If** moving in the right direction using administrative data.

**Not, Explain Why:**

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Adult - Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:**

**Target:**

**Population:**

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:**

**Measure:**

**Sources of Information:**

**Special Issues:**

**Significance:**

**Activities and strategies/ changes/ innovative or exemplary model:** -Currently report URS Table 15. Profile of Persons Served by Living Situation.  
-Developing the capacity to reporty Table 16: Profile of Adults with Serious Mental Illnesses...Recieving Evidence-Based Services-Supported Housing.  
- At this time, Magellan collects the data for living situation at time of admission and time of discharge. However, for consumers who are in the system for an extended period of time, there is no capacity to update key data fields such as living arrangement. Thus, at this time, Nebraska does not have the capacity ro address the "Increase Stability in Housing" aspect of this measure.  
- Under the new Magellan ASO Contract, there will be an annual update of the data including living situation. As a result, over time NE should develop the capacity to report this measure.

**Target Achieved or Not Achieved/If Not, Explain Why:**

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:** ]

**Name of Implementation Report Indicator:** Adult - Increased Social Supports/Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	76.27	75.19	75	78.41	104.55
Numerator	720	773	--	850	--
Denominator	944	1,028	--	1,084	--

Table Descriptors:

**Goal:** Adult - Increased Social Supports/Social Connectedness

**Target:** Adult - Increased Social Supports/Social Connectedness

**Population:** Adults who received mental health services and responded to the consumer survey.

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Number of Positive Responses divided by Responses

**Measure:**

**Sources of Information:** Table 9: SAMHSA NOMs: SOCIAL CONNECTEDNESS AND IMPROVED FUNCTIONING

**Special Issues:** The annual Nebraska Behavioral Health Consumer Survey is funded by the Federal Mental Health Data Infrastructure Grants for Quality Improvement (State DIG).

**Significance:**

**Activities and strategies/ changes/ innovative or exemplary model:** Nebraska uses Federal Mental Health Data Infrastructure Grant funds to pay for this survey. The consumer survey instrument needed to report URS Tables 9, 11, and 11a uses the questions approved by the Federal Center for Mental Health Services. The data are collected under the a contract with University of Nebraska Medical Center, College of Public Health.

**Target Achieved or Not Achieved/If Not, Explain Why:** Achieved

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Adult - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	80.42	73.73	78	81.69	104.73
Numerator	809	769	--	910	--
Denominator	1,006	1,043	--	1,114	--

Table Descriptors:

**Goal:** Adult - Improved Level of Functioning (Percentage)

**Target:** Adult - Improved Level of Functioning (Percentage)

**Population:** Adults served in Nebraska mental health system who completed the consumer survey.

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services  
4:Targeted Services to Rural and Homeless Populations

**Indicator:** Number of Positive Responses divided by the total Responses

**Measure:**

**Sources of Information:** Table 9: SAMHSA NOMs: SOCIAL CONNECTEDNESS AND IMPROVED FUNCTIONING

**Special Issues:** Nebraska uses Federal Mental Health Data Infrastructure Grant funds to pay for this survey. The consumer survey instrument needed to report URS Tables 9, 11, and 11a uses the questions approved by the Federal Center for Mental Health Services. The data are collected under the a contract with University of Nebraska Medical Center, College of Public Health.

**Significance:**

**Activities and strategies/ changes/ innovative or exemplary model:**

**Target Achieved** Achieved

or

**Not Achieved/If**

**Not, Explain Why:**

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Maintain Comprehensive Community-Based Mental Health Service Systems

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	717	823	700	842	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:** To maintain the capacity of Supported Housing Services.

**Target:** Provide Supported Housing for adults who are extremely low income with a serious mental illness with the goal of independent housing who are eligible under the Nebraska Housing-related assistance program, as authorized under Neb. Rev. Stat. § 71-812 (3).

**Population:** Supported Housing is for adults who are extremely low income with a serious mental illness with the goal of independent housing who are eligible under the Nebraska Housing-related assistance program, as authorized under Neb. Rev. Stat. § 71-812.

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems

**Indicator:** Number persons served in Nebraska Housing Related Assistance program

**Measure:** Number of persons with SMI who are receiving Support Housing services.

**Sources of Information:** Summary of the monthly Housing Related Assistance data reported from the six Regional Behavioral Health Authorities to the Division.

**Special Issues:**

**Significance:** The NE Housing Related Assistance program was developed under NE Behavioral Health Reform. It is designed to be Person-centered, recovery-oriented, accessible, focused on a positive outcome of promoting independent living, and cost effective.

**Activities and strategies/ changes/ innovative or exemplary model:** The Nebraska Housing-related assistance program, as authorized under Neb. Rev. Stat. § 71-812, is the basis for reporting the number of consumers who are receiving the Evidence Based Practice service of Supported Housing. This is a conservative count. For example, it excludes consumers who are receiving DHHS funded Behavioral Health support services and have HUD section 8. The SAMHSA EBP Toolkit is not published at this time. However, SAMHSA material was used to guide EBP Implementation. Staff have been specifically trained to implement Supported Housing. The capacity to measure fidelity was developed during FY2008. The Division did the fidelity monitoring in FY2009.

**Target Achieved or Not Achieved/If Not, Explain Why:** Achieved



**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Maintain if not increase the number of people receiving Mental Health Services

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	32,862	25,291	29,000	20,434	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:** Maintain if not increase the number of people receiving Mental Health Services.

**Target:** To maintain if not increase the number of persons age 18 or older (unduplicated count)

**Population:** Adults receiving mental health services within the Nebraska Behavioral Health System (NBHS).

**Criterion:** 2:Mental Health System Data Epidemiology

**Indicator:**

**Measure:** Number of adults receiving Mental Health Services as reported on URS Table 2A.

**Sources of Information:** Nebraska Division of Behavioral Health Services Federal Uniform Reporting System/NE Implementation Report 2008, 2009 and 2010.

**Special Issues:** In January 2009, the Division of Behavioral Health cleaned its data system by administratively discharging nearly 18,000 records of admission to program prior to November 2003 and of which had no activity in the last year. This reduced the number of active cases in the system. This improved the data quality. It is acknowledged that it appears fewer people were served. For FY2010, with the community based services (Magellan Health) data, only the persons admitted to a mental health service or a dual service (consumers who received a specialized program including both mental health and substance abuse services) were counted. In the past, persons served in substance abuse services with a mental health diagnosis or reason for admission field showing "mental health" were included. As a result, the counts on the URS Tables in FY2010 did drop. However, the Division of Behavioral Health believes this is a more accurate method for reporting persons served.

As a result, the performance measure data reported previously, if updated using the new methods, would change.

Adults - Increased Access to Services (Number)

FY 2008 Actual was reported as 32,862 is changed to: 18,063

FY 2009 Actual was reported as 25,291 is changed to: 19,579

FY 2010 Target was reported as 29,000 is changed to: 20,000

URS Table 2A for persons age 18+ FY 2010 Actual is reported as: 20,434

**Significance:**

**Activities and**

**strategies/  
changes/  
innovative or  
exemplary model:**

**Target Achieved** Target Achieved.  
**or** 1) For FY2010, with the community based services (Magellan Health) data, only  
**Not Achieved/If** the persons admitted to a mental health service or a dual service (consumers  
**Not, Explain Why:** who received a specialized program including both mental health and substance  
abuse services) were counted. In the past, persons served in substance abuse  
services with a mental health diagnosis or reason for admission field showing  
"mental health" were included. As a result, the counts on the URS Tables in  
FY2010 will drop. However, the Division of Behavioral Health believes this is a  
more accurate method for reporting persons served.  
The Division of Behavioral Health recalculated FY08, FY09 data using the new  
methods.  
FY 2008 Actual was reported as 32,862 is changed to: 18,063  
FY 2009 Actual was reported as 25,291 is changed to: 19,579  
FY 2010 Target was reported as 29,000 is changed to: 20,000

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Maintain per Capita State Expenditures for Community Mental Health Services

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	27.75	31.88	30	35.49	N/A
Numerator	47,482,195	54,560,767	--	60,728,294	--
Denominator	1,711,263	1,711,263	--	1,711,263	--

Table Descriptors:

**Goal:** At least maintain per Capita State Expenditures for Community Mental Health Services.

**Target:** By June 30, 2010, the per capita state expenditures for community mental health services will be maintained at over \$30.00.

**Population:** Total Population

**Criterion:** 5:Management Systems

**Indicator:**

**Measure:** Performance Indicator: per Capita State Expenditures for Community Mental Health Services  
 Numerator: "actual" Mental Health State Expenditures (as reported for the Maintenance of Effort section of the Block Grant Application)  
 Denominator: Total State population

**Sources of Information:** Numerator Data source: Division MOE Report  
 Denominator Data source: Nebraska Databook, Last Updated on 5/20/01 based on data from the U.S. Bureau of the Census Web site (www.census.gov) 2001

**Special Issues:**

**Significance:**

**Activities and strategies/ changes/ innovative or exemplary model:**

**Target Achieved** Achieved  
 or  
**Not Achieved/If Not, Explain Why:**

## ADULT - IMPLEMENTATION REPORT

Transformation Activities:

**Name of Implementation Report Indicator:** Targeted Services to Rural Populations with the Rural Mental Health Program

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	15,514	11,955	11,000	9,356	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:** To maintain services to adults with in non-Metropolitan areas.

**Target:** The number of adults in non-Metropolitan areas receiving services.

**Population:** Adult Persons Served (Unduplicated Count) from rural Counties classified as Non-Metropolitan

**Criterion:** 4:Targeted Services to Rural and Homeless Populations

**Indicator:** Number of non-Metropolitan adults receiving services

**Measure:** Number of non-Metropolitan adults receiving services

**Sources of Information:** Magellan Behavioral Health Information System, as under contract with NE DHHS Division of Behavioral Health.

**Special Issues:** (1) There are 93 Counties in Nebraska. For 2010 reporting, the following were considered to be metropolitan counties per U.S. Census Bureau, November 2007: Cass, Dakota, Dixon, Douglas, Lancaster, Sarpy, Saunders, Seward, Washington. For the purposes of reporting this measure, the remaining 84 Nebraska Counties are classified as rural. In previous years, there were six counties designated as "Metropolitan Statistical Areas" by the U.S. Census Bureau. These counties were Douglas, Sarpy, Cass, Washington, Lancaster, and Dakota county.

(2) In January 2009, the Division of Behavioral Health cleaned its data system by administratively discharging nearly 18,000 records of admission to program prior to November 2003 and of which had no activity in the last year. This reduced the number of active cases in the system.

**Significance:** There are 93 Counties in Nebraska. At this point 9 counties are classified as metropolitan. The remaining counties are considered rural. Given the expansion of the classification of metropolitan counties and the administrative discharge of 18,000 records, a decrease in the number of rural persons served would be expected. Also, with the community based services (Magellan Health) data, only the persons admitted to a mental health service or a dual service (consumers who received a specialized program including both mental health and substance abuse services) were counted. In the past, persons served in substance abuse services with a mental health diagnosis or reason for admission field showing "mental health" were included. As a result, the counts on the URS Tables in FY2010 will drop. Still, based on this report for 2010, there were 9,356 persons served in geographic areas classified as rural.

### Activities and

**strategies/  
changes/  
innovative or  
exemplary model:**

**Target Achieved** Achieved  
**or** (1) For FY2010, with the community based services (Magellan Health) data, only  
**Not Achieved/If** the persons admitted to a mental health service or a dual service (consumers  
**Not, Explain Why:** who received a specialized program including both mental health and substance  
abuse services) were counted. In the past, persons served in substance abuse  
services with a mental health diagnosis or reason for admission field showing  
"mental health" were included. As a result, the counts in FY2010 will drop.  
(2) There are 93 Counties in Nebraska. For 2010 reporting, the following were  
considered to be metropolitan counties per U.S. Census Bureau, November  
2007: Cass, Dakota, Dixon, Douglas, Lancaster, Sarpy, Saunders, Seward,  
Washington. For the purposes of reporting this measure, the remaining 84  
Nebraska Counties are classified as rural. In previous years, there were six  
counties designated as "Metropolitan Statistical Areas" by the U.S. Census  
Bureau. These counties were Douglas, Sarpy, Cass, Washington, Lancaster, and  
Dakota county.  
(3) The Division of Behavioral Health recalculated FY08, FY09 data using the  
new methods. Listed below are number of adults served in FY08, FY09 and  
FY10.  
FY2008 Actual 8,184  
FY2009 Actual 8,747  
FY2010 Actual 9,356

**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	4,049	3,030	2,600	2,689	103.42
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:** To increase access to services

**Target:** To maintain the number of Children (age 0-17) served

**Population:** The persons served in mental health services in the Nebraska Behavioral Health System funded by the Nebraska Division of Behavioral Health Services

**Criterion:** 2:Mental Health System Data Epidemiology  
3:Children's Services

**Indicator:** Access to Services

**Measure:** Total persons served as reported on the URS Table 2 Table 2A. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity Youth URS Table 2A

**Sources of Information:** Division of Behavioral Health Services / DIG Data Base (Community Mental Health and State psychiatric hospitals) - unduplicated count

**Special Issues:** In January 2009, the Division of Behavioral Health cleaned its data system by administratively discharging nearly 18,000 records of admission to program prior to November 2003 and of which had no activity in the last year. This reduced the number of active cases in the system. This improved the data quality. For FY2010, with the community based services (Magellan Health) data, only the persons admitted to a mental health service or a dual service (consumers who received a specialized program including both mental health and substance abuse services) were counted. In the past, persons served in substance abuse services with a mental health diagnosis or reason for admission field showing "mental health" were included. As a result, the counts on the URS Tables in FY2010 will drop. However, the Division of Behavioral Health believes this is a more accurate method for reporting persons served.

**Significance:**

**Activities and strategies/ changes/ innovative or exemplary model:** The data are as reported on URS Table 2A.

**Target Achieved or Not Achieved/If Not, Explain Why:** Target Achieved  
The Division of Behavioral Health recalculated FY08, FY09 data using the new methods. Listed below are number of adults served in FY08, FY09 and FY10.  
FY2008 Actual 2,638

FY2009 Actual 2,579  
FY2010 Actual 2,689

**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	.88	0	.75	0	100
Numerator	1	0	--	0	--
Denominator	113	1	--	10	--

Table Descriptors:

- Goal:** Reduced 30 days readmission rates for youth - utilization of psychiatric inpatient beds
- Target:** Non-Forensic (Voluntary and Civil-Involuntary) youth Patients Readmission to Any State Psychiatric Inpatient Hospital Within 30 Days of Discharge
- Population:** Non-Forensic (Voluntary and Civil-Involuntary) youth Patients subject to Readmission to Any State Psychiatric Inpatient Hospital
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Percent Readmitted 30 days
- Measure:** Percent Readmitted 30 days | Numerator (Number of Readmissions to ANY STATE Hospital within 30 days) | Denominator - Total number of Discharges in Year
- Sources of Information:** URS Table 20A
- Special Issues:** (1) In January 2009, the Division of Behavioral Health cleaned its data system by administratively discharging nearly 18,000 records of admission to program prior to November 2003 and of which had no activity in the last year. This reduced the number of active cases in the system. This improved the data quality. With the Behavioral Health Reform efforts, the focus has shifted from the State Psychiatric Hospitals to community based systems.  
(2) Regional Centers (State Psychiatric Hospitals) in NE no longer serve youth for inpatient. Regional Center Bed Capacity for youth now limited to Male Adolescent Sex Offenders - Residential Treatment Group home (24 beds).
- Significance:** There is a new admission criteria for the Regional Centers. All new admissions go to only the Lincoln Regional Center (LRC). Only committed individuals meeting "acute" clinical criteria are admitted. Each Region has an allocation of beds within LRC. Regions are usually admitting patients unable to be safely treated in the community hospital. Youth are not being admitted to Regional Center inpatient.

**Activities and strategies/ changes/ innovative or exemplary model:**

**Target Achieved**    **Achieved**  
**or**  
**Not Achieved/If**  
**Not, Explain Why:**

**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	2.65	0	2.50	0	100
Numerator	3	0	--	0	--
Denominator	113	1	--	10	--

Table Descriptors:

- Goal:** Reduced 180 days readmission rates for youth - utilization of psychiatric inpatient beds
- Target:** Non-Forensic (Voluntary and Civil-Involuntary) youth Patients Readmission to Any State Psychiatric Inpatient Hospital Within 180 Days of Discharge
- Population:** Non-Forensic (Voluntary and Civil-Involuntary) youth Patients subject to Readmission to Any State Psychiatric Inpatient Hospital
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Percent Readmitted 180 days | Numerator (Number of Readmissions to ANY STATE Hospital within 180 days) | Denominator - Total number of Discharges in Year
- Measure:** Percent Readmitted 180 days
- Sources of Information:** URS Table 20A
- Special Issues:** (1) In January 2009, the Division of Behavioral Health cleaned its data system by administratively discharging nearly 18,000 records of admission to program prior to November 2003 and of which had no activity in the last year. This reduced the number of active cases in the system. This improved the data quality. With the Behavioral Health Reform efforts, the focus has shifted from the State Psychiatric Hospitals to community based systems.  
(2) Regional Centers (State Psychiatric Hospitals) in NE no longer serve youth for inpatient. Regional Center Bed Capacity for youth now limited to Male Adolescent Sex Offenders - Residential Treatment Group home (24 beds).
- Significance:** There is a new admission criteria for the Regional Centers. All new admissions go to only the Lincoln Regional Center (LRC). Only committed individuals meeting "acute" clinical criteria are admitted. Each Region has an allocation of beds within LRC. Regions are usually admitting patients unable to be safely treated in the community hospital. Youth are not being admitted to Regional Center inpatient.

**Activities and strategies/ changes/ innovative or exemplary model:**

**Target Achieved**    **Achieved**  
**or**  
**Not Achieved/If**  
**Not, Explain Why:**

**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Evidence Based - Number of Practices (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	1	1	1	1	100
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:** Maintain, and expand when possible, the number of Evidence-Based Practices (EBPs) in Nebraska.

**Target:** Maintain, and expand when possible, the number of Evidence-Based Practices (EBPs) in Nebraska.

**Population:** Youth served by NE Division of Behavioral Health who may benefit from Evidence-Based Practices (EBPs).

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Count of the number of Evidence-Based Practices (EBPs) implemented in Nebraska.

**Measure:** Count the number of Evidence-Based Practices (EBPs) in Nebraska: Youth EBP [Multisystemic Therapy (MST)] funded by the Division of Behavioral Health.

**Sources of Information:** Region 3 - Mid Plains Center in Grand Island

**Special Issues:** Nebraska Division of Behavioral Health is implementing the following Evidence-Based Practices (EBPs)  
Youth: Multisystemic Therapy (MST)

The only provider is Region 3 - Mid Plains Center in Grand Island

**Significance:**

**Activities and strategies/ changes/ innovative or exemplary model:** Narrative: At this time, Nebraska has very limited capacity to report on this measure. Multisystemic Therapy (MST) is only funded at Region 3 - Mid Plains Center in Grand Island. The data reported is from this provider (unduplicated count of persons served).

**Target Achieved or Not Achieved/If Not, Explain Why:** Achieved

**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Evidence Based - Children with SED Receiving Therapeutic Foster Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:**

**Target:**

**Population:**

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:**

**Measure:**

**Sources of Information:**

**Special Issues:**

**Significance:**

**Activities and strategies/ changes/ innovative or exemplary model:** Narrative: At this time, Nebraska has very limited capacity to report on this measure. Nebraska is developing evidence-based practices. Each one has a different capacity for reporting. Receiving Therapeutic Foster Care – This service is offered in a few areas. The capacity to report the data is poor. No capacity to measure fidelity. The SAMHSA EBP Toolkit was not used to guide EBP Implementation. Staff have not been specifically trained to implement the EBP. Difficult to estimate a completion date.

**Target Achieved or Not Achieved/If Not, Explain Why:**

**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Evidence Based - Children with SED Receiving Multi-Systemic Therapy (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	N/A	N/A	9	N/A	N/A
Numerator	35	9	--	8	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:** To maintain the number of Children with SED Receiving Multi-Systemic Therapy services

**Target:** serve Children with SED in Multi-Systemic Therapy

**Population:** Children with SED Receiving Multi-Systemic Therapy

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** count of persons served in Multi-Systemic Therapy services.

**Measure:** number of Children with SED Receiving Multi-Systemic Therapy served in Region 3 - Mid Plains Center in Grand Island

**Sources of Information:** Mid Plains Center in Grand Island is the only provider of this service.

**Special Issues:** Mid Plains Center in Grand Island is the only provider of this service. The Division believes there was an over count of persons served in this program. The previous reports were 35 served in FY2008 and 9 in FY2009. Starting in July 2009, Mid Plains Center started reporting these data on Magellan. Based on reports from Magellan, the actual number of persons served in FY2010 was 8. This count has been consistent over the last few years.

**Significance:**

**Activities and strategies/ changes/ innovative or exemplary model:**

**Target Achieved** Achieved  
**or**  
**Not Achieved/If Not, Explain Why:**

**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Evidence Based - Children with SED Receiving Family Functional Therapy (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:**

**Target:**

**Population:**

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:**

**Measure:**

**Sources of Information:**

**Special Issues:**

**Significance:**

**Activities and strategies/ changes/ innovative or exemplary model:** Narrative: At this time, Nebraska has very limited capacity to report on this measure. Nebraska is developing evidence-based practices. Each one has a different capacity for reporting. Receiving Family Functional Therapy – This service is not offered at this time. It will not be reported any time soon.

**Target Achieved or Not Achieved/If Not, Explain Why:**

**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	58.40	60.61	55.50	62.72	113.01
Numerator	73	80	--	143	--
Denominator	125	132	--	228	--

Table Descriptors:

**Goal:** To maintain the number of clients reporting positively about outcomes.

**Target:** maintain the number of consumers responding Positively About Outcomes in the annual Nebraska Behavioral Health Consumer Survey

**Population:** All consumers with valid addresses and/or phone numbers within the Magellan Behavioral Health data base who do respond to the annual Nebraska Consumer Survey

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Number of Positive Responses on the consumer survey for Outcomes for Children

**Measure:** Numerator: average of positive responses to the Consumer Survey: Perceptions of Outcomes questions as reported under URS Table 11.

**Sources of Information:** Numerator and Denominator Data Source: Nebraska annual consumer survey as reported on Uniform Reporting System/Implementation Report-Table 11.

**Special Issues:** Nebraska uses Federal Mental Health Data Infrastructure Grant funds to pay for this survey. The consumer survey instrument needed to report URS Tables 9, 11, and 11a uses the questions approved by the Federal Center for Mental Health Services. The data are collected under the a contract with University of Nebraska Medical Center, College of Public Health.

**Significance:**

**Activities and strategies/ changes/ innovative or exemplary model:**

**Target Achieved** Achieved  
**or**  
**Not Achieved/If Not, Explain Why:**

**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Child - Return to/Stay in School (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:**

**Target:**

**Population:**

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:**

**Measure:**

**Sources of  
Information:**

**Special Issues:**

**Significance:**

**Activities and strategies/  
changes/  
innovative or  
exemplary model:** At this time, Nebraska does not have the capacity to report on this measure.

**Target Achieved  
or  
Not Achieved/If  
Not, Explain Why:**

**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Child - Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:**

**Target:**

**Population:**

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:**

**Measure:**

**Sources of Information:**

**Special Issues:**

**Significance:**

**Activities and strategies/ changes/ innovative or exemplary model:** At this time, Nebraska does not have the capacity to report on this measure.

**Target Achieved or Not Achieved/If Not, Explain Why:**

**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Child - Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:**

**Target:**

**Population:**

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:**

**Measure:**

**Sources of  
Information:**

**Special Issues:** At this time, Nebraska does not have the capacity to report on this measure.

**Significance:**

**Activities and  
strategies/  
changes/  
innovative or  
exemplary model:**

**Target Achieved  
or  
Not Achieved/If  
Not, Explain Why:**

**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Child - Increased Social Supports/Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	81.10	90.91	80	85.78	107.23
Numerator	103	120	--	199	--
Denominator	127	132	--	232	--

Table Descriptors:

**Goal:** Maintain Child - Increased Social Supports/Social Connectedness (Percentage)

**Target:** Maintain Child - Increased Social Supports/Social Connectedness (Percentage)

**Population:** Youth age 0-17 who were served in the Nebraska Behavioral Health System and selected under a random sample to receive the annual consumer survey.

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Using data reported under URS Table 9: SAMHSA NOMs: SOCIAL CONNECTEDNESS AND IMPROVED FUNCTIONING (Child/Adolsecent Consumer Survey Results/ 3. Social Connectedness); Performance Indicator-Percent Positive (calculated); Numerator-Number of Positive Responses; and Denominator-Responses.

**Measure:**

**Sources of Information:** Using data reported under URS Table 9: SAMHSA NOMs: SOCIAL CONNECTEDNESS AND IMPROVED FUNCTIONING

**Special Issues:** Nebraska uses Federal Mental Health Data Infrastructure Grant funds to pay for this survey. The consumer survey instrument needed to report URS Tables 9, 11, and 11a uses the questions approved by the Federal Center for Mental Health Services. The data are collected under the a contract with University of Nebraska Medical Center, College of Public Health.

**Significance:**

**Activities and strategies/ changes/ innovative or exemplary model:**

**Target Achieved** Achieved  
**or**  
**Not Achieved/If Not, Explain Why:**

**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Child - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	60.80	62.31	59	64.04	108.54
Numerator	76	81	--	146	--
Denominator	125	130	--	228	--

Table Descriptors:

**Goal:** Maintain Child - Improved Level of Functioning (percentage)

**Target:** Maintain Child - Improved Level of Functioning (percentage)

**Population:** Youth (age 0-17) served in the Nebraska Behavioral Health System and selected using a random sample to receive the annual consumer survey

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services  
4:Targeted Services to Rural and Homeless Populations

**Indicator:** Using data reported under URS Table 9: SAMHSA NOMs: SOCIAL CONNECTEDNESS AND IMPROVED FUNCTIONING - Child/Adolsecent Consumer Survey Results (4. Functioning) ... Performance Indicator-Percent Positive (calculated); Numerator-Number of Positive Responses; Denominator-Responses.

**Measure:**

**Sources of Information:** Annual Nebraska Behavioral Health Consumer Survey

**Special Issues:** Nebraska uses Federal Mental Health Data Infrastructure Grant funds to pay for this survey. The consumer survey instrument needed to report URS Tables 9, 11, and 11a uses the questions approved by the Federal Center for Mental Health Services. The data are collected under the a contract with University of Nebraska Medical Center, College of Public Health.

**Significance:**

**Activities and strategies/ changes/ innovative or exemplary model:**

**Target Achieved** Achieved  
**or**  
**Not Achieved/If Not, Explain Why:**

**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Maintain capacity of Professional Partner Program

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	552	416	415	345	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:** To maintain the capacity of the Professional Partner Program (Wraparound) for children with serious emotional disturbance.

**Target:** The number of children participate in the Professional Partner (wraparound) Program will be maintained.

**Population:** Children and adolescents with serious emotional and behavioral disorders.

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems

**Indicator:** The number of children participating in the Professional Partner Services.

**Measure:** Count of number of children participating in Professional Partners as of June 30 each year.

**Sources of Information:** Magellan Behavioral Health

**Special Issues:** In January 2009, the Division of Behavioral Health cleaned its data system by administratively discharging nearly 18,000 records of admission to program prior to November 2003 and of which had no activity in the last year. This reduced the number of active cases in the system. For FY2010, with the community based services (Magellan Health) data, only the persons admitted to a mental health service or a dual service (consumers who received a specialized program including both mental health and substance abuse services) were counted. In the past, persons served in substance abuse services with a mental health diagnosis or reason for admission field showing "mental health" were included. As a result, the counts on the URS Tables in FY2010 will drop. However, the Division of Behavioral Health believes this is a more accurate method for reporting persons served.

**Significance:**

**Activities and strategies/ changes/ innovative or exemplary model:**

**Target Achieved** Achieved.

**or Not Achieved/If Not, Explain Why:** (1) In January 2009, the Division of Behavioral Health cleaned its data system by administratively discharging nearly 18,000 records of admission to program prior to November 2003 and of which had no activity in the last year. This reduced the number of active cases in the system.

(2) For FY2010, with the community based services (Magellan Health) data, only the persons admitted to a mental health service or a dual service (consumers who received a specialized program including both mental health and substance abuse services) were counted. In the past, persons served in substance abuse services with a mental health diagnosis or reason for admission field showing "mental health" were included. As a result, the counts on the URS Tables in FY2010 will drop. However, the Division of Behavioral Health believes this is a more accurate method for reporting persons served.

(3) Some of the emergency data are not counted.

**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Maintain number of persons age 0-17 receiving services through the Nebraska Behavioral Health System

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	4,049	3,030	2,600	2,689	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:** To maintain the number of persons age 0-17 receiving services through the Nebraska Behavioral Health System

**Target:** The number of children receiving services will be maintained.

**Population:** Children and adolescents receiving Mental Health Services

**Criterion:** 2:Mental Health System Data Epidemiology

**Indicator:** The number of children and adolescents receiving services

**Measure:** Count of number of children receiving services

**Sources of Information:** URS Table 2A

**Special Issues:** In January 2009, the Division of Behavioral Health cleaned its data system by administratively discharging nearly 18,000 records of admission to program prior to November 2003 and of which had no activity in the last year. This reduced the number of active cases in the system.  
For FY2010, with the community based services (Magellan Health) data, only the persons admitted to a mental health service or a dual service (consumers who received a specialized program including both mental health and substance abuse services) were counted. In the past, persons served in substance abuse services with a mental health diagnosis or reason for admission field showing "mental health" were included. As a result, the counts on the URS Tables in FY2010 will drop. However, the Division of Behavioral Health believes this is a more accurate method for reporting persons served.

**Significance:**

**Activities and strategies/ changes/ innovative or exemplary model:**

**Target Achieved or Not Achieved/If Not, Explain Why:** Target Achieved  
The Division of Behavioral Health recalculated FY08, FY09 data using the new methods. Listed below are number of adults served in FY08, FY09 and FY10.  
FY2008 Actual 2,638  
FY2009 Actual 2,579  
FY2010 Actual 2,689



**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Maintain per capita State Expenditures for Community Mental Health Services

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	9.15	9.94	9	11.13	N/A
Numerator	4,120,066	4,473,352	--	5,009,164	--
Denominator	450,242	450,242	--	450,242	--

Table Descriptors:

**Goal:** Maintain per Capita State Expenditures for Community Mental Health Services

**Target:** there will be at least the same level of spending in per capita state expenditures for children's community mental health services.

**Population:** Total children's population ages 0-17 years served in the Nebraska (Nebraska 2000 Census data youth age 0-17 = 450,242).

**Criterion:** 3:Children's Services

**Indicator:** per Capita state expenditures

**Measure:** Performance Indicator: youth Capita State Expenditures; Numerator: funding levels as reported under Set-Aside for Children's Mental Health Services Report; Denominator: Youth population in Nebraska ages 0-17 years (450,242)

**Sources of Information:** Numerator-Set-Aside for Children's Mental Health Services Report  
Denominator-Nebraska Databook, Last updated on 5/21/01 based on data from the U.S. Bureau of the Census Web site ([www.census.gov](http://www.census.gov)) 2001

**Special Issues:**

**Significance:**

**Activities and strategies/ changes/ innovative or exemplary model:**

**Target Achieved** Achieved  
**or**  
**Not Achieved/If**  
**Not, Explain Why:**

## CHILD - IMPLEMENTATION REPORT

**Transformation Activities:**

**Name of Implementation Report Indicator:** Maintain services to all children with serious emotional disorders in non-Metropolitan areas

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	1,820	1,504	1,100	1,195	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:** To maintain services to all children with serious emotional disorders in non-Metropolitan areas.

**Target:** Maintain the number of children in non-Metropolitan areas receiving mental health services.

**Population:** Children served in Nebraska Behavioral Health System receiving mental health services living in non-Metropolitan areas.

**Criterion:** 4: Targeted Services to Rural and Homeless Populations

**Indicator:** Number of non-Metropolitan children receiving mental health services funded by Division of Behavioral Health.

**Measure:** Count of non-Metropolitan children receiving mental health services by Division of Behavioral Health.

**Sources of Information:** Megellan Behavioral Health Information System, as under contract with NE DHHS Division of Behavioral Health, as reported on URS Table 2A

**Special Issues:** (1) There are 93 Counties in Nebraska. For 2009 reporting, the following were considered to be metropolitan counties per U.S. Census Bureau (November 2007): Cass, Dakota, Dixon, Douglas, Lancaster, Sarpy, Saunders, Seward, Washington. For the purposes of reporting this measure, the remaining 84 Nebraska Counties are classified as rural. In previous years, there were six counties designated as "Metropolitan Statistical Areas" by the U.S. Census Bureau. These counties were Douglas, Sarpy, Cass, Washington, Lancaster, and Dakota county.

(2) In January 2009, the Division of Behavioral Health cleaned its data system by administratively discharging nearly 18,000 records of admission to program prior to November 2003 and of which had no activity in the last year. This reduced the number of active cases in the system.

(3) the data reported on URS Table 2A is used. The analysis then considers the county of the person served to determine the urban/rural status.

(4) For FY2010, with the community based services (Magellan Health) data, only the persons admitted to a mental health service or a dual service (consumers who received a specialized program including both mental health and substance abuse services) were counted. In the past, persons served in substance abuse services with a mental health diagnosis or reason for admission field showing "mental health" were included. As a result, the counts on the URS Tables in FY2010 will drop. However, the Division of Behavioral Health believes this is a more accurate method for reporting persons served.

**Significance:**

**Activities and strategies/ changes/ innovative or exemplary model:**

**Target Achieved**    Achieved  
**or**                      The Division of Behavioral Health recalculated FY08, FY09 data using the new  
**Not Achieved/If**    methods. Listed below are number of adults served in FY08, FY09 and FY10.  
**Not, Explain Why:** FY2008 Actual 1,129  
                                 FY2009 Actual 1,207  
                                 FY2010 Actual 1,195

**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Provide a system of integrated services for all children with serious emotional disorders who have multiple and complex needs

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2010 Actual	FY 2010 Percentage Attained
Performance Indicator	1,703	1,500	0	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:** To provide a system of integrated services for all children with serious emotional disorders who have multiple and complex needs.

**Target:** The number of children who are in the custody of the state and who receive integrated care coordination will be maintained.

**Population:** Children served who are wards of the state.

**Criterion:** 5:Management Systems

**Indicator:** The number of children receiving integrated care coordination.

**Measure:** Count of children receiving intergrated care coordination.

**Sources of Information:** Program administrator report.

**Special Issues:** In July 2008, the Department of Health and Human Services, Division of Children and Family Services (CFS), began the process of improving the manner in which the State of Nebraska purchases services for Child Welfare and Office of Juvenile Services clients. CFS implemented contracts with five lead agencies to provide safety and in-home services to CFS clients, a reduction from over 100 contracts. The new contracts contain incentives to encourage exceptional contractor performance and performance is tied directly to outcomes that have been shown to provide safety, permanency, and well-being for children, youth, and the community.  
CFS is still in the contractor selection process. The integrated care coordination function was being populated with data from the contracts between the Regions and CFS. Those contracts ended in 2009. For now, the Division of Behavioral Health is on hold with this measure pending the new contractor selection.

**Significance:** Emerging body of research indicates intensive case management using the wrap around approach can be effective in ensuring appropriate services and reducing expenses of using high cost services.

**Activities and strategies/ changes/ innovative or exemplary model:**

**Target Achieved** Achieved  
or

**Not Achieved/If  
Not, Explain Why:**

Upload Planning Council Letter for the Implementation Report

## Nebraska State Advisory Committee on Mental Health Services

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November 15, 2010

LouEllen Rice  
Grants Management Office, Room 7-1079  
Divisions of Grants Management  
Substance Abuse and Mental Health Services Administration  
One Choke Cherry Road  
Rockville, MD 20857

Dear Ms Rice,

This letter is verification that on November 4, 2010, the Nebraska State Advisory Committee on Mental Health Services met in Lincoln, Nebraska and reviewed the Nebraska State Plan Implementation Report for FY2010. The plan was presented to the Committee, and its contents were discussed. The Committee voiced their appreciation of the time and effort the Division spent on the preparation of the grant application. The Committee noted they were pleased with the State's direction in looking at the whole person and recognizing that primary care and preventative care are critical components of a consumer's well being. The Committee encouraged the State to continue in that direction. The Committee also noted the format in which Implementation Report was reviewed this year made the review process much easier.

The Advisory Committee had no suggestions for changes or amendment to the plan. It was the consensus of the Committee to support the submission of the report.

Sincerely,



Beverly Ferguson  
Chair, Nebraska State Advisory Committee on Mental health Services.

OPTIONAL- Applicants may use this page to attach any additional documentation they wish to support or clarify their application. If there are multiple files, you must Zip or otherwise merge them into one file.