

Nebraska

UNIFORM APPLICATION
FY 2009

SUBSTANCE ABUSE PREVENTION AND TREATMENT
BLOCK GRANT

OMB - Approved 09/20/2007 - Expires 09/30/2010

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Center for Substance Abuse Treatment
Division of State and Community Assistance

Introduction:

The SAPT 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).

Public reporting burden for this collection of information is estimated to average 563 hours per response for sections I-III, 50 hours per response for Section IV-A and 42 hours per response for Section IV-B, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0080); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0080.

Form 1

State: Nebraska
DUNS Number: 808819957-

Uniform Application for FY 2008 Substance Abuse Prevention and Treatment Block Grant

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

Agency Name: Department of Health and Human Services
Organizational Unit: Division of Behavioral Health
Mailing Address: PO Box 95026
City: Lincoln Zip Code: 68509

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

Name: Scot L Adams, Ph. D
Agency Name: Division of Behavioral Health
Mailing Address: PO Box 95026
City: Lincoln Zip Code: 68509

Telephone: (402) 471-8553 FAX: (402) 471-9449

Email Address: scot.adams@dhhs.ne.gov

III. State Expenditure Period:

From: 7/1/2006 To: 6/30/2007

IV. Date Submitted:

Date: Original: Revision:

V. Contact Person Responsible for Application Submission:

Name: Robert Bussard Telephone: (402) 471-7821
Email Address: bob.bussard@dhhs.ne.gov FAX: (402) 471-7859

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**FORM 3: UNIFORM APPLICATION FOR FY 2009 SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT
Funding Agreements/Certifications
as required by Title XIX of the Public Health Service (PHS) Act**

Title XIX of the PHS Act, as amended, requires the chief executive officer (or an authorized designee) of the applicant organization to certify that the State will comply with the following specific citations as summarized and set forth below, and with any regulations or guidelines issued in conjunction with this Subpart except as exempt by statute.

SAMHSA will accept a signature on this form as certification of agreement to comply with the cited provisions of the PHS Act. If signed by a designee, a copy of the designation must be attached.

I. Formula Grants to States, Section 1921

Grant funds will be expended “only for the purpose of planning, carrying out, and evaluating activities to prevent and treat substance abuse and for related activities” as authorized.

II. Certain Allocations, Section 1922

- Allocations Regarding Primary Prevention Programs, Section 1922(a)
- Allocations Regarding Women, Section 1922(b)

III. Intravenous Drug Abuse, Section 1923

- Capacity of Treatment Programs, Section 1923(a)
- Outreach Regarding Intravenous Substance Abuse, Section 1923(b)

IV. Requirements Regarding Tuberculosis and Human Immunodeficiency Virus, Section 1924

V. Group Homes for Recovering Substance Abusers, Section 1925

Optional beginning FY 2001 and subsequent fiscal years. Territories as described in Section 1925(c) are exempt.

The State “has established, and is providing for the ongoing operation of a revolving fund” in accordance with Section 1925 of the PHS Act, as amended. This requirement is now optional.

VI. State Law Regarding Sale of Tobacco Products to Individuals Under Age of 18, Section 1926

- The State has a law in effect making it illegal to sell or distribute tobacco products to minors as provided in Section 1926 (a)(1).
- The State will enforce such law in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under the age of 18 as provided in Section 1926 (b)(1).
- The State will conduct annual, random unannounced inspections as prescribed in Section 1926 (b)(2).

VII. Treatment Services for Pregnant Women, Section 1927

The State “...will ensure that each pregnant woman in the State who seeks or is referred for and would benefit from such services is given preference in admission to treatment facilities receiving funds pursuant to the grant.”

VIII. Additional Agreements, Section 1928

- Improvement of Process for Appropriate Referrals for Treatment, Section 1928(a)
- Continuing Education, Section 1928(b)
- Coordination of Various Activities and Services, Section 1928(c)
- Waiver of Requirement, Section 1928(d)

FORM 3: UNIFORM APPLICATION FOR FY 2009 SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

Funding Agreements/Certifications

As required by Title XIX of the PHS Act (continued)

IX. Submission to Secretary of Statewide Assessment of Needs, Section 1929

X. Maintenance of Effort Regarding State Expenditures, Section 1930

With respect to the principal agency of a State, the State “will maintain aggregate State expenditures for authorized activities at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.”

XI. Restrictions on Expenditure of Grant, Section 1931

XII. Application for Grant; Approval of State Plan, Section 1932

XIII. Opportunity for Public Comment on State Plans, Section 1941

The plan required under Section 1932 will be made “public in such a manner as to facilitate comment from any person (including any Federal person or any other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.”

XIV. Requirement of Reports and Audits by States, Section 1942

XV. Additional Requirements, Section 1943

XVI. Prohibitions Regarding Receipt of Funds, Section 1946

XVII. Nondiscrimination, Section 1947

XVIII. Services Provided By Nongovernmental Organizations, Section 1955

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

State: Nebraska

Name of Chief Executive Officer or Designee: Scot L. Adams

Signature of CEO or Designee:

Title: Director Division of Behavioral Health

Date Signed:

If signed by a designee, a copy of the designation must be attached

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

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

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

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

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

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

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

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
- (b) Establishing an ongoing drug-free awareness program to inform employees about –
 - (1) The dangers of drug abuse in the workplace;
 - (2) The grantee's policy of maintaining a drug-free workplace;
 - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
 - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- (d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will –
 - (1) Abide by the terms of the statement; and
 - (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- (e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

- (f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted –
- (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

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

Office of Grants and Acquisition Management
 Office of Grants Management
 Office of the Assistant Secretary for Management and Budget
 Department of Health and Human Services
 200 Independence Avenue, S.W., Room 517-D
 Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

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

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

person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

- (2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
- (3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

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

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

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

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

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

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

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

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Director, Division of Behavioral Health
APPLICANT ORGANIZATION State of Nebraska	DATE SUBMITTED

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. Type of Federal Action: <input type="checkbox"/> a. contract <input type="checkbox"/> b. grant <input type="checkbox"/> c. cooperative agreement <input type="checkbox"/> d. loan <input type="checkbox"/> e. loan guarantee <input type="checkbox"/> f. loan insurance	2. Status of Federal Action <input type="checkbox"/> a. bid/offer/application <input type="checkbox"/> b. initial award <input type="checkbox"/> c. post-award	3. Report Type: <input type="checkbox"/> a. initial filing <input type="checkbox"/> b. material change For Material Change Only: Year _____ Quarter _____ date of last report _____
4. Name and Address of Reporting Entity: <input type="checkbox"/> Prime <input type="checkbox"/> Subawardee Tier _____, if known: _____ Congressional District, if known: _____	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, if known: _____	
6. Federal Department/Agency:	7. Federal Program Name/Description: CFDA Number, if applicable: _____	
8. Federal Action Number, if known:	9. Award Amount, if known: \$ _____	
10.a. Name and Address of Lobbying Entity <i>(if individual, last name, first name, MI):</i>	b. Individuals Performing Services <i>(including address if different from No. 10a.) (last name, first name, MI):</i>	
11. Information requested through this form is authorized by title 31 U.S.C. Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.	Signature: _____ Print Name: _____ Title: _____ Telephone No.: _____ Date: _____	
Federal Use Only:	Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)	

**DISCLOSURE OF LOBBYING ACTIVITIES
CONTINUATION SHEET**

Reporting Entity:

Page

of

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.
2. Identify the status of the covered Federal action.
3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.
4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.
5. If the organization filing the report in item 4 checks "subawardee", then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.
6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.
7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.
8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., "RFP-DE-90-001."
9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.
10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.

(b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).
11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No.0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503.

ASSURANCES – NON-CONSTRUCTION PROGRAMS

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

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

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

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

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

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Director, Division of Behavioral Health	
APPLICANT ORGANIZATION State of Nebraska		DATE SUBMITTED

State: Nebraska

FY 2006 SAPT Block Grant

Your annual SAPT Block Grant Award for FY 2006 is reflected on line 8 of the Notice of Block Grant Award.

\$7,863,913

Nebraska

Goal #1: Continuum of Substance Abuse Treatment Services

GOAL # 1. The State shall expend block grant funds to maintain a continuum of substance abuse treatment services that meet these needs for the services identified by the State. Describe the continuum of block grant-funded treatment services available in the State (See 42 U.S.C. 300x-21(b) and 45 C.F.R. 96.122(f)(g)).

FY 2006 (Compliance):

FY 2008 (Progress):

FY 2009 (Intended Use):

GOAL # 1. The State shall expend block grant funds to maintain a continuum of substance abuse treatment services that meet these needs for the services identified by the State. Describe the continuum of block grant-funded treatment services available in the State (See 42 U.S.C. 300x-21(b) and 45 C.F.R. 96.122(f)(g)).

FY 2006 (Compliance):

Legislative Bill 1083 passed the Unicameral in April 2004, This bill establishes the Division of Behavioral Health within the Department of Health and Human Services (NRRS 71-801 to 71-818) The Division is responsible for the statewide planning, organizing, coordinating and delivery of behavioral health services including, Mental Health, Substance Abuse, Addiction Services, Problem Gambling both Treatment and Prevention activities. The intended purpose of the bill was to politically support the staff efforts to down size the State's Psychiatric Hospitals and to move funds from the hospital accounts into community based programming. The bill provides the first opportunity for the Division of Behavioral Health to fully implement plans to move clients to appropriate level of care, and to more fully fund community based services and to plan for these state funded services within the context of an overall service delivery system including private and public providers. Moving clients to community programming has been the goal of the Division of Behavioral Health since the Mid 90's as the office has been working with Magellan Behavioral Health to implement modified managed care and gate keep admissions to the state psychiatric hospitals to those most in need. LB 1083 provides the political and financial support to accomplish the planning to implement this goal.

Additionally, LB 1083 and subsequent legislation of the 2005 legislature emphasized the need for community based alternative services to Regional Centers and permitted the closure of up to two of the state's three centers once those services were available. The community based services included the provision for community hospitals being paid for "emergency" admissions to stabilize persons who would have traditionally been admitted to one of the Regional Centers. Table 1 does not include funds from the closure of the regional centers.

LB 1083 continued the Regional structure for behavioral health planning and funding in the state by dividing the state into six administrative regions (Behavioral Health Authorities). Each region is required to match state general fund appropriations, but not funds transferred from the hospital account. Under the statute the regions must provide one dollar in local funds for every three of state general funds received each year. Of the local funds 40% must be from local tax sources. The Six regions are local units of government created by counties for the purpose of partnering with the State to provide for local planning and oversight to non-profit private entities for the delivery of Substance Abuse services. The six Regional bodies include:

Region 1 – Panhandle

Banner, Box Butte, Cheyenne, Dawes, Deuel, Garden, Kimball, Morrill, Scotts Bluff, Sheridan, Sioux;

Region 2 – Southwest

Arthur, Chase, Dawson, Dundy, Frontier, Gosper, Grant, Hayes, Hitchcock, Hooker, Keith, Lincoln, Logan, McPherson, Perkins, Red Willow, Thomas;

Region 3 -- South Central

Adams, Blaine, Buffalo, Clay, Custer, Franklin, Furnas, Garfield, Greeley, Hall, Hamilton, Harlan, Howard, Kearney, Loup, Merrick, Nuckolls, Phelps, Sherman, Valley, Webster, Wheeler;

Region 4 – Northern

Antelope, Boone, Boyd, Brown, Burt, Cedar, Cherry, Colfax, Cuming, Dakota, Dixon, Holt, Keya Paha, Knox, Madison, Nance, Pierce, Platte, Rock, Stanton, Thurston, Wayne;

Region 5 – Southeast

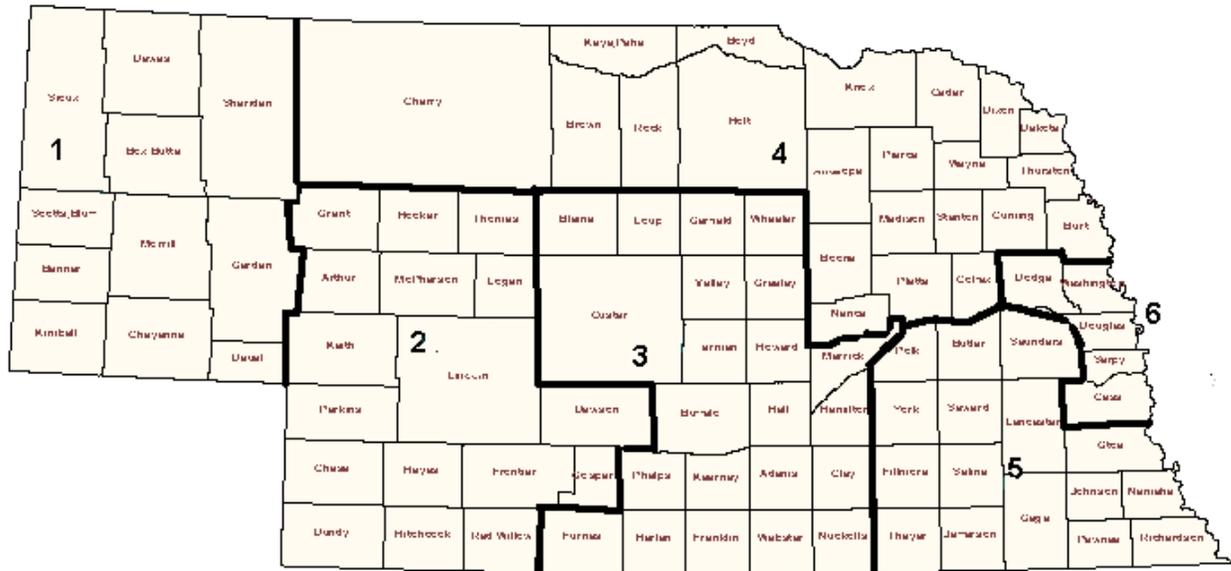
Butler, Fillmore, Gage, Jefferson, Johnson, Lancaster, Nemaha, Otoe, Pawnee, Polk, Richardson, Saline, Saunders, Seward, Thayer, York; and

Region 6 -- Omaha Metro

Cass, Dodge, Douglas, Sarpy, Washington.

Each region has a similar structure. Regional Governing Board is the oversight with one elected representative from each county within the region. The Regional Governing Board hires the Regional Administrator. That administrator hires staff to support the monitoring, planning and oversight functions designated by state law and Division of Behavioral Health regulations and contracts and the Authorities own office procedures.

Map 1 Nebraska Substance Abuse Regions



Nebraska Mental Health and Substance Abuse Regions

**Table 1: Nebraska Substance Abuse Fund Distribution
State Fiscal Year 2006-2007**

<u>Region/Fund</u>	<u>Federal Block</u>	<u>State General</u>	<u>BH Redesign And Rate Increase</u>	<u>Total</u>
1	\$657,460	\$619,352	\$101,683	\$1,378,495
2	\$431,086	\$454,732	\$289,616	\$1,175,434
3	\$1,020,144	\$832,041	\$308,189	\$2,160,374
4	\$910,638	\$513,127	\$404,438	\$1,828,203
5	\$1,646,769	\$1,303,987	\$509,123	\$3,459,879
6	\$2,431,862	\$2,122,050	\$378,914	\$4,932,826
Subtotal	\$7,097,959	\$5,869,036	\$1,991,963	\$14,935,211
Direct Contracts				
Prevention	\$307,500	\$63,893	\$0	\$371,393
Treatment	\$142,325	\$940,422	\$24,643	\$1,107,390
TOTALS	\$7,547,784	\$6,873,351	\$2,016,606	\$16,437,741

Source: Nebraska Department of Health and Human Services, Division of Behavioral Health, Regional allocations and direct contract awards July 2006 to June 2007.
Does not include

In January of each year the Office of Mental Health, Substance Abuse and Addiction Services prepares guidelines for Regional Budget Plan. These guidelines outline the necessary information required of regions as they propose the service system for their area. Agencies are invited by the regions to apply for funds administered under the Nebraska Behavioral Health System. Each region then prepares a "Regional Budget Plan" that designates which services will be purchased from which providers with the funds allocated to it (July 1 to June 30). The Regional Budget Plan becomes the basis for the service contract between the Region and State. Contracts are further negotiated between the Region and State based on system needs. Generally contracts are finalized in June or July. After the year is completed the regions file an actual expenditures report identifying which agencies got how much funding and from which funding source during the reporting year. Funding summaries are received at the Division of Behavioral Health in September. These funding summaries form the basis for the reporting on Form 6.

Regional Behavioral Health Authorities may choose to have services immediately available within the region or contract with service providers in other regions. Each service provider establishes their own contracting with the region. Reimbursement rates for services are uniform throughout the state for "authorized" services. Regions may choose to reimburse for "registered" services and pay for those services on a unit basis. Authorized services are those services paid for clients who's care is "managed" under the Nebraska Behavioral Health System managed care contract authorization system operated by Magellan Behavioral Health Services. Registered services are services in which an agency enrolls clients and are usually "non-residential" in nature. All clients paid for by a state or federal dollars are to be either registered or authorized into a web based client information system operated by Magellan Behavioral Health Services, Inc. Agencies may choose to register private pay clients into the Magellan data system.

Continuum of services in Nebraska.

The following table depicts the funded services by region

Service name /Region	1	2	3	4	5	6
Emergency Services						
24 Hour Clinician on Call	X					
Crisis/Urgent Assessment (CADAC)	X	X	X	X	X	X
Social Detoxification	X		X	X	X	X
Civil Protective Custody	X		X		X	X
Emergency Community Support					X	
Residential Services						
Intermediate Residential					X	X
Short Term Residential	C	C	X	C	X	X
Therapeutic Community			X		X	X
Halfway House		C	X	X	X	X
Dual Diagnosis MH/SA		C		X	X	X
Non-Residential Services						
Partial Care					X	
Intensive Outpatient	X	X	X	X	X	X
Outpatient	X	X	X	X	X	X
Community Support	X	X	X	X	X	X
Methadone Maintenance						X
Prevention Services						
Information Dissemination	X	X	X	X	X	X
Education	X	X	X	X	X	X
Alternatives	X	X	X	X	X	X
Problem Identification	X	X	X	X	X	X
Community Based	X	X	X	X	X	X
Environmental	X	X	X	X	X	X
Evidence based practices	E	E	E	E	E	E

E=expanded service C-Contracted Service
 Source: Division of Behavioral Health

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GOAL # 1. The State shall expend block grant funds to maintain a continuum of substance abuse treatment services that meet these needs for the services identified by the State. Describe the continuum of block grant-funded treatment services available in the State (See 42 U.S.C. 300x-21(b) and 45 C.F.R. 96.122(f)(g)).

FY 2008 (Progress):

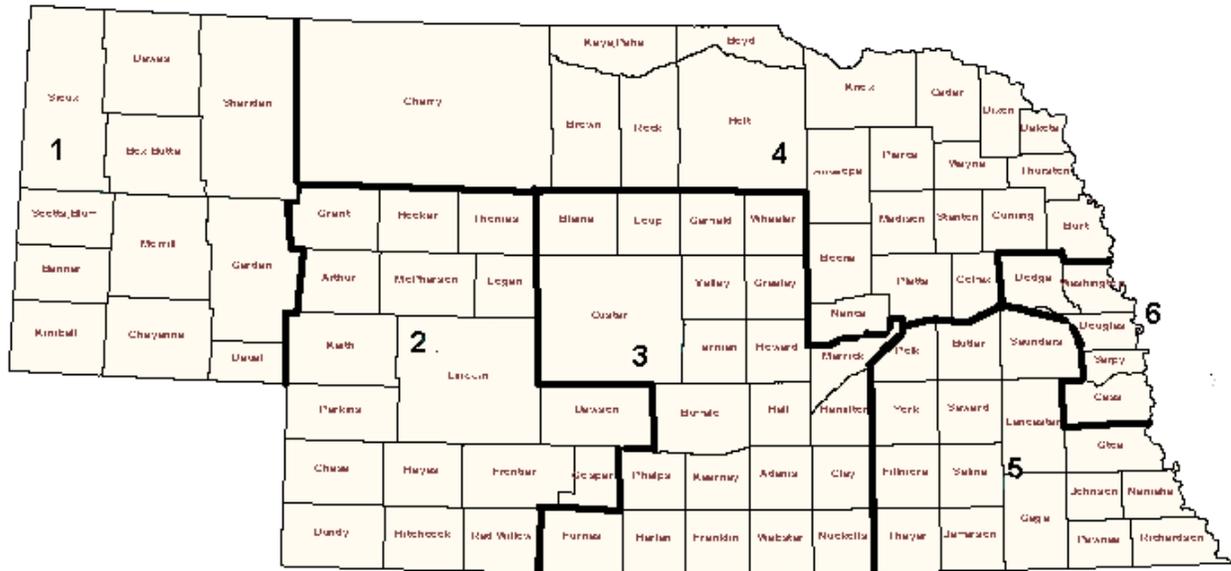
State Law (Nebraska Revised Statutes, section 71-801 through 71-818) designates the Division of Behavioral Health within the Department of Health and Human Services as the agency responsible for the planning, funding, regulating and monitoring substance abuse services. The Division works with the Division of Public Health, licensure and regulations unit to regulate both professionals and facilities of the state. The Division also works with the Division of Public Health Community Services Unit to promote the Strategic Prevention Framework – State Incentive Grant process and planning and funding prevention programs throughout the state. The Division of Behavioral Health is responsible in state statutes for the Treatment and Prevention of Substance Abuse programs.

The statute divides the state into six administrative regions, known as Regional Behavioral Health Authorities. The six Regions, or Regional Behavioral Health Authorities, are local units of government created by counties for the purpose of partnering with the State to provide for local planning and oversight.

Please refer to Table 1 for a list of counties served by each Regional Behavioral Health Authority, target population totals, and unduplicated count of the numbers of persons served in substance abuse programs in that region in Fiscal Year 2008.

Table 1: Behavioral Health Authorities – Counties, Target Population and Number of Persons to be Served			
Behavioral Health Authority	Counties Served	Target Population	Persons Served SFY 2007
1 (Panhandle)	Banner, Box Butte, Cheyenne, Dawes, Deuel, Garden, Kimball, Morrill, Scotts Bluff, Sheridan, Sioux	7,276	
2 (Southwest)	Arthur, Chase, Dawson, Dundy, Frontier, Gosper, Grant, Hayes, Hitchcock, Hooker, Keith, Lincoln, Logan, MacPherson, Perkins, Red Willow, Thomas	8,228	
3 (South Central)	Adams, Blaine, Buffalo, Clay, Custer, Franklin, Furnas, Garfield, Greeley, Hall, Hamilton, Harlan, Howard, Kearney, Loup, Merrick, Nuckolls, Phelps, Sherman, Valley, Webster, Wheeler	18,279	
4 (North)	Antelope, Boone, Boyd, Brown, Burt, Cedar, Cherry, Colfax, Cuming, Dakota, Dixon, Holt, Keya Paha, Knox, Madison, Nance, Pierce, Platte, Rock, Stanton, Thurston, Wayne	17,912	
5 (Southeast)	Butler, Fillmore, Gage, Jefferson, Johnson, Lancaster, Nemaha, Otoe, Pawnee, Polk, Richardson, Saline, Saunders, Seward, Thayer, York	32,871	
6 (Omaha Metro)	Cass, Dodge, Douglas, Sarpy, Washington	50,946	
	Total	135,512	

Map 1 Nebraska Substance Abuse Regions



Nebraska Mental Health and Substance Abuse Regions

The oversight for each Behavioral Health Authority (Region) is provided by a Regional Governing Board, comprised of one Commissioner from each county within the region. An Administrator is hired by each Regional Governing Board. The Administrator employs staff to plan, implement, monitor and evaluate substance abuse programming. Oversight functions designated by statute and regulations are provided within the Region and reported to the Division of Behavioral Health .

Each Behavioral Health Authority (Region), utilizing input from consumers, providers and other stakeholders, performs an assessment, and evaluates the services needs within their region. They then contract with not-for-profit providers for the specific services needed. The providers are generally local, but Regions occasionally contract with providers in other areas within Nebraska for specialized services.

Funding for substance abuse services comes from a combination of federal, State and local tax match monies. Federal monies are provided by the Federal Block Grant. State funds are appropriated legislatively to the Division of Behavioral Health . The Division then uses a consistent formula to distribute State funds among the Regional Behavioral Health Authorities. The formula takes into consideration population, need and prior funding history. By statute, each Region is required to match state general fund appropriations. The Region must provide one dollar in local funds for every three of State

general funds received each year. Of the local funds, 40% must be from local tax sources.

Continuum of services in Nebraska.

The following table depicts the funded services by region with those services to experience additional expansion (E) in FFY 2008.

Service name /Region	1	2	3	4	5	6
Emergency Services						
24 Hour Clinician on Call	X				E	E
Crisis/Urgent Assessment (CADAC)	X	X	X	X	X	X
Social Detoxification	X		X	X	X	X
Civil Protective Custody	X		X		X	X
Emergency Community Support			E		E	E
Residential Services						
Intermediate Residential					X	X
Short Term Residential	X	X	X	X	X	
Therapeutic Community			X		X	X
Halfway House			X	X	X	X
Dual Diagnosis MH/SA				E	E	E
Non-Residential Services						
Partial Care					X	
Intensive Outpatient	X	X	X	X	X	X
Outpatient	X	X	X	X	X	X
Community Support	X	X	X	X	X	X
Methadone Maintenance						X
Prevention Services						
Universal Direct /Indirect	E	E	E	E	E	E
Selective	E	E	E	E	E	E
Indicated	E	E	E	E	E	E

E=expanded service
Source: Division of Behavioral Health

Progress in Technical Assistance Plans

Prevention services will continue a transition begun in State Fiscal Year 2007 with the closure of "Regional Prevention Centers" and the development of Regional Prevention Coordinators positions. Each region now has regional prevention coordinators whose job will be to foster and fund community coalitions. Coalitions are funded to implement evidence based and promising practices within communities to affect change in those communities. This resource change was identified in the System Performance Review conducted by CSAP in the spring 2006. The regional coordinators also assist communities in

applying the Strategic Prevention Framework planning process in communities through out the state whether the community is funded through the Strategic Prevention Framework - State incentive Grant, Drug Free Schools and Communities funding, Block Grant or Other federal initiatives so that funds are used to foster measurable change.

CSAP performance review was conducted in 2006. This review resulted in a technical assistance plan that included a review of the tobacco laws of Nebraska, improvement to the Minimum Data Set for prevention providers, improvements to reporting and staffing of the prevention effort and a revision to the prevention system to be focused on community coalitions. The Division of Behavioral Health, partnering with the Division of Public Health has expanded the number of community coalitions ready for the Strategic Prevention Framework model. Training has been local in that each of the regional prevention coordinators has taken the SWCAPT SPF training course, a tool kit has been developed and new internet based software has been developed to measure and report performance at the coalition level. This new software replaces the 1996 windows based Minimum Data Set and is compliant with the CSAP and National Institute of Medicines guidelines on nomenclature for prevention efforts. Tobacco law review was proposed but not prioritized by the Departments' administration. As the result of the Division working with the Division of Public Health an epidemiological profile was completed in January 2008. This profile along made possible the establishment of the priorities established by the Nebraska Partners in Prevention (NePiP) for Strategic Prevention Framework – State Incentive Grant of:

- Decreased under age drinking
- Decrease in 18-025 year old binge drinking
- Reduction in DWI across all age groups.

Community Coalitions will be reviewing data for their areas and identifying strategies and programs to implement to affect these priority goals in prevention. Block Grant funded coalitions will be joining in the effort by using the SPF-sig planning model.

Treatment services have benefited in FY 2008 from additional funds made available through the downsizing of State Regional Centers (State Hospitals). The input of both substance abuse and mental health consumers and providers is being considered in planning and funding decisions. February 2008 stated priorities as they relate to substance abuse treatment are:

- Decreasing time spent on waitlists by consumers at all levels of care.
- Improving provision of interim services to those who do wait for treatment.
- Improving consistency of provision of services to pregnant women, and women with dependent children.

- Development of state-wide standards of care and quality improvement programming that reflects priorities and best/evidence-based practices.
- Promotion of Standardized Model throughout treatment system.
- Promotion of recovery-based model of care.
- Inclusion of consumers in all aspects of planning and evaluation, with particular emphasis on peer-provided services.
- Promotion of early screening in hospitals, primary care facilities, schools and other venues, with resulting referral and access to treatment services.
- Enhancing ability/capacity to treat co-occurring disorders at all levels of treatment.
- Enhance ability to provide trauma-informed care.
- Enhanced integration of substance abuse treatment with primary care and wellness promotion.
- Development of improved technical assistance and continuing education.

The Division has worked with CSAT to identify the technical assistance needs of the state as a result of the Core Technical Review conducted in the spring 2007. Among those areas identified as needing improved were; data handling; improvements in handling financial information within the new department of Health and Human Services; defining, delivering and documenting interim services to women, women with children, up to 6 week post partum women, and IV drug abusers, and included in the Request for Proposal for a new treatment data system (Administrative Service Organization under managed care) input and report capabilities for treatment National Outcome Measures. Magellan Behavioral Health Services, Inc., received the award to the ASO bid and is working with the state to assure full SOMMS outcome reporting within the data system as well as improved "health" measures tracking so that tracking of TB, HIV and Health related information can be achieved at the program and state levels. Block Grant 101 training is schedule in Fiscal Year 2009 and will provide the basis for staff and programs working together to strengthen services to priority populations.

The Division is working with the support services to add codes to the Divisions accounting system to account for set asides within the Departments accounting system. Currently the Division reviews annual expenditures as expressed by the several regional governing authorities to calculate the amount of funds for each of the set asides. With the accounting system coding could be rolled up each month from reports submitted by the regional behavioral health authorities in billing documents. This would significantly improve accuracy of Nebraska Information System (the automated accounting system) for women's, and prevention set asides.

New or enhanced services created through LB 1083 include

Mental Health	Substance Abuse	Dual Disorder / Both MH & SA
Assertive Community Treatment	Community Support-SA	Dual Disorder Residential
Community Support-MH	Halfway House SA	Support Employment
Emergency Community Support	Intermediate Res SA	
Crisis Assessment	Methadone Maintenance	
Crisis Stabilization	Outpatient-SA	
Day Rehab	Short Term Residential (Enhanced)	
Day Treatment	Short Term Residential	
Intensive Community Services-MH	Social Detox	
Outpatient-MH	Therapeutic Community SA	
Psych Res Rehab MH		
Transitional Res MH		
Urgent Med Management		
Urgent Outpatient		
Housing Related Assistance		

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FY 2009 (Intended Use):

Continuum of services in Nebraska.

Prevention services will continue a transition begun in State Fiscal Year 2007 with the closure of "Regional Prevention Centers" and the development of Regional Prevention Coordinators positions. Each region now has regional prevention coordinators whose job will be to foster and fund community coalitions. Coalitions are funded to implement evidence based and promising practices within communities to affect change in those communities. The regional coordinators also assist communities in applying the Strategic Prevention Framework planning process in communities through out the state whether the community is funded through the Strategic Prevention Framework - State incentive Grant, Drug Free Schools and Communities funding, Block Grant or Other federal initiatives so that funds are used to foster measurable change.

Treatment services should benefit in FY 2009 from additional funds made available through the downsizing of State Regional Centers (State Hospitals). The input of both substance abuse and mental health consumers and providers is being considered in planning and funding decisions. Current priorities as they relate to substance abuse treatment are:

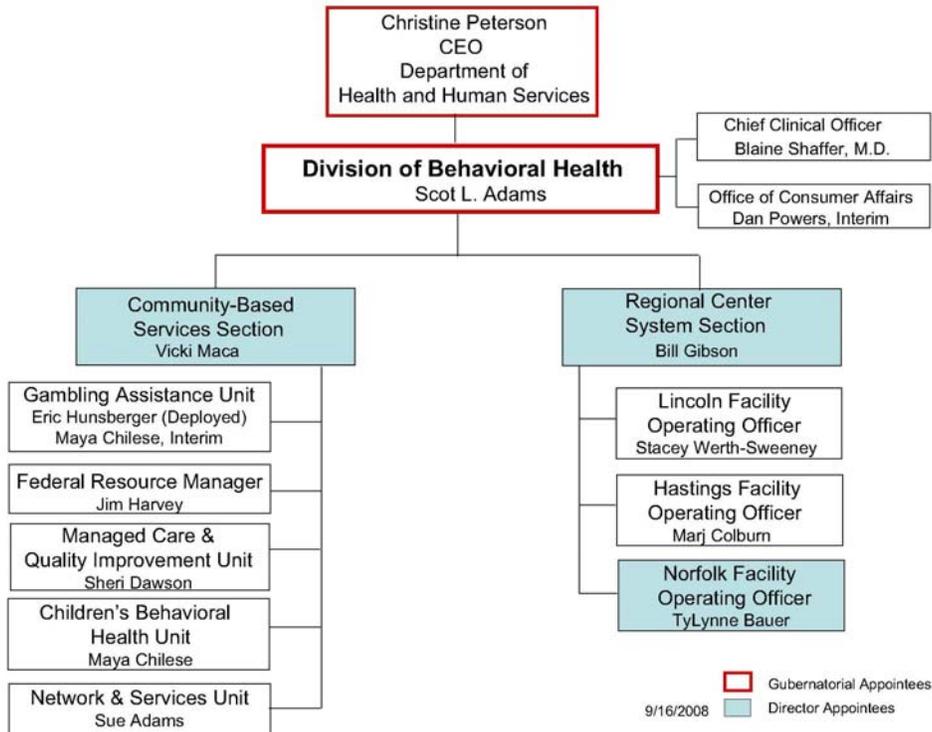
- Decreasing time spent on waitlists by consumers at all levels of care.
- Improving provision of interim services to those who do wait for treatment.
- Improving consistency of provision of services to pregnant women, and women with dependent children.
- Development of state-wide standards of care and quality improvement programming that reflects priorities and best/evidence-based practices.
- Promotion of Standardized Model throughout treatment system.
- Promotion of recovery-based model of care.
- Inclusion of consumers in all aspects of planning and evaluation, with particular emphasis on peer-provided services.
- Promotion of early screening in hospitals, primary care facilities, schools and other venues, with resulting referral and access to treatment services.
- Enhancing ability/capacity to treat co-occurring disorders at all levels of treatment.
- Enhance ability to provide trauma-informed care.

- Enhanced integration of substance abuse treatment with primary care and wellness promotion.
- Development of improved technical assistance and continuing education.

Service Organization within Nebraska

The Division of Behavioral Health is a division of the Nebraska Department of Health and Human Services. The Division is authorized in the Nebraska Behavioral Health Services Act - (Nebraska Revised Reissued Statutes 71-801 to 71-818). The Division is administered by a Division Director - Dr. Scot Adams. The Director is a Governor's appointed position. The Division is further divided into two sections. Community Services and Regional Centers. (See Figure 1: Organizational Chart) The Regional Centers are the three state psychiatric hospitals, Norfolk, Hastings and Lincoln. Substance Abuse services are provided to clients of the regional centers through programs and services for the mentally ill and dangerous.

The Division's other major component is the Community Services Section Headed by Vicki Maca, as directed, this section is held responsible for the planning, coordinating, training, and reporting on Substance abuse, Mental Health and Compulsive Gambling services funded through a combination of local, state and federal revenues. The Community services section administers a variety of federal and state revenues to fund prevention and treatment services, throughout the state including services to the four Nebraska Native American tribes. To facilitate the delivery of services the Division contracts directly with some providers or through a regional entity.

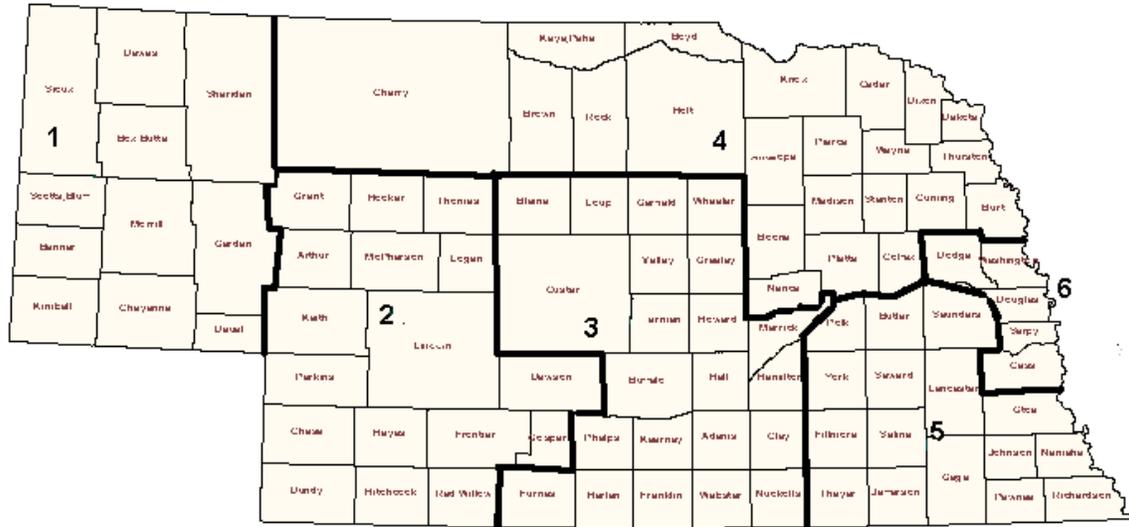


Regional Behavioral Health Authorities

Each of the six Regional Behavioral Health Authorities is authorized by the legislature at NRRS 71-807 and is constituted by Inter-Local Agreement. The Six regions are depicted in Map 1 and each of the counties of the regions is given in Table 1. One county commissioner is appointed from each of the participating counties to sit on the Regional Governing Board. That Board hires an Executive to handle the day to day operations of the Region. It is the responsibility of the Executive to hire staff and manage the agency.

Each Behavioral Health Authority (Region), utilizing input from consumers, providers and other stakeholders, performs comprehensive assessments, and evaluates the services needs within their region. They then contract with not-for-profit providers for the specific services needed. The providers are generally local, but Regions occasionally contract with providers in other areas within Nebraska for specialized services.

Map 1: Substance Abuse Regions



Nebraska Mental Health and Substance Abuse Regions

Funding for substance abuse services comes from a combination of federal, State and local tax match monies. Federal monies are provided by the Federal Block Grant. State funds are appropriated legislatively to the Division of Behavioral Health. The Division then uses a consistent formula to distribute State funds among the Regional Behavioral Health Authorities. The formula takes into consideration population, income and prior funding history. By statute, each Region is required to match state general fund appropriations. The Region must provide one dollar in local funds for every three of State general funds received each year. Of the local funds, 40% must be from local tax sources.

State Regional Partnership

The Division of Behavioral Health and the Regional Program Authority have set up a series of committees to conduct the work of the state. Each region participates either directly or through representatives. These Committees include: Chief Financial Officers, Emergency Network Coordinators, Children's Network Coordinators, Audit Work Group, Service Definitions Workgroup, and Prevention Coordinators. Committees and coordinators meet quarterly in person and through teleconference at intervals throughout the year to problem solve. Committee membership include representatives from all six of the Regional Behavioral Health Authorities, such as the chief financial officers, network coordinators, treatment and children's service coordinators and prevention coordinators, Division of Behavioral Health staff, staff of other Division within the

Table 1 - Behavioral Health Authorities of Nebraska

Behavioral Health Authority	Counties Served
1 (Panhandle)	Banner, Box Butte, Cheyenne, Dawes, Deuel, Garden, Kimball, Morrill, Scotts Bluff, Sheridan, Sioux
2 (Southwest)	Arthur, Chase, Dawson, Dundy, Frontier, Gosper, Grant, Hayes, Hitchcock, Hooker, Keith, Lincoln, Logan, MacPherson, Perkins, Red Willow, Thomas
3 (South Central)	Adams, Blaine, Buffalo, Clay, Custer, Franklin, Furnas, Garfield, Greeley, Hall, Hamilton, Harlan, Howard, Kearney, Loup, Merrick, Nuckolls, Phelps, Sherman, Valley, Webster, Wheeler
4 (North)	Antelope, Boone, Boyd, Brown, Burt, Cedar, Cherry, Colfax, Cuming, Dakota, Dixon, Holt, Keya Paha, Knox, Madison, Nance, Pierce, Platte, Rock, Stanton, Thurston, Wayne
5 (Southeast)	Butler, Fillmore, Gage, Jefferson, Johnson, Lancaster, Nemaha, Otoe, Pawnee, Polk, Richardson, Saline, Saunders, Seward, Thayer, York
6 (Omaha Metro)	Cass, Dodge, Douglas, Sarpy, Washington
Source: Nebraska Revised Reissued Statutes 71-807	

Department of Health and Human Services, representatives of other departments of state government and the Administrative Services Organization (ASO) staff.

Administrative Services Organization (ASO) contract

On February 1, 2008, the State of Nebraska, Administrative Services, Materiel Division, Purchasing Bureau, issued a Request for Proposal, RFP Number #2356Z1 for the purpose of selecting a qualified contractor to provide "Behavioral Health/Children and Family Services/Medicaid and Long-Term Care" Administrative Services Organization (ASO) [Request for Proposal 2356Z1].

The State of Nebraska was seeking a qualified contractor to provide a comprehensive ASO that will automate, manage, maintain, and coordinate the Mental Health and Substance Abuse treatment, Gambling Addictions and Child Welfare and Juvenile Services for the identified populations of the Behavioral Health, Children and Family Services, and Medicaid and Long-Term Care Divisions. The RFP release date was February 1, 2008. The bid opening date was April 1, 2008. On April 16, 2008, it was announced that Magellan Behavioral Health was selected as the Administrative Service Organization contractor for the Division of Behavioral Health, Division of Children & Family Services and the Division of Medicaid & Long Term Care. This contract ends on June 30, 2010. There are annual options for contract renewal for State Fiscal Years 2011, 2012 and 2013.

This Magellan Behavioral Health contract for Administrative Services Organization (ASO) covering the three DHHS Division of Behavioral Health, Division of Children & Family Services and Division of Medicaid & Long Term Care is a recent significant achievement. This should increase the level of coordination between these three Divisions. It does establish the possibility of reporting an unduplicated count of persons served receiving services across multiple systems funded by DHHS.

Core Technical Review and Corrective Action Plan

The Division of Behavioral Health underwent a Core Technical Review in the April 2007. The final report was received in October 2007. The Division prepared a Corrective Action Plan that was approved in February, 2008. The corrective action plan was implemented beginning March, 2008 with the initiation of the Technical Assistance Plan approved March 11, 2008. In Fiscal Year 2009 the Division will continue to work through the activities designated in the Corrective Action plan and seek additional Technical Assistance.

The Corrective Action Plan identified 8 broad areas of concern from the Core Technical Review. These areas of concern included:

- Needs Assessment
- Limited Capacity to move Toward Data Orientated Decision Making
- Sub-recipient Monitoring Processes
- Peer Review
- CPA Firm Selection and Tracking Set Asides
- Level of Care Determination
- Interim Services
- Uniformity of Women's Services

Needs assessment:

Nebraska Division of Behavioral Health has contracted with the University of Nebraska - Public Policy Center to conduct a needs assessment. Begun in May 2008, the Needs Assessment first effort is the collection of subjective data from community surveys. There have been "community forums" in all six Region Behavioral Health Authorities of the state plus an internet based survey. Preliminary analysis of data indicates major concerns of the citizens as:

- Poor availability of services
- Service not available at the time needed
- Long wait lists
- Poor results of treatment
- No treatment for certain population groups
- Priority populations do not match state demographics
- Lack of housing alternatives for recovering individuals
- Integrated Services for individuals with substance abuse and mental health is lacking around the state
- There are too few state dollars in the system to address the capacity needs of those suffering with addictions
- Interim services - both before and after services are provided are virtually nonexistent
- There is a lack of choice for consumers to choose from treatment modalities
- Residential services are lacking in the rural areas of the state
- Additional Halfway and Three Quarter way houses are needed
- Supportive services to address homelessness, individuals with corrections backgrounds, women, women with children, and adolescents are needed.

One highlight that emphasized the work of the Division with the Community Corrections Council in the development of the Standardized Model for Assessing Substance Abuse among Offenders was:

- Probation system and correction system are found to be positively working together with addiction services

As described in the Needs Assessment part of this application, a statistical modeling to estimate need by race, gender and age categories is anticipated to be conducted by the University of Nebraska-Medical Center during Fiscal Year 2009. The College of Public Health, Department of Epidemiology has agreed to update work begun in the 1997 and 2001 assessment projects and to develop statistical estimates for needs in the State using small area estimation processes.

Limited Capabilities to conduct Data Orientated Decision Making:

Beginning in FY 2008 and continuing into FY 2009, two items will affect this observation. The Division is in the process of funding a new Prevention Data System built on the models of other prevention system to collect information to support block grant reporting and decision making at the State and sub-state levels. Beta testing began in late August 2008 for the Nebraska Prevention Information Reporting System (NPIRS) that is an internet based system built and managed with the expertise of the staff at Region 6 Behavioral Health Authority. NPIRS began capturing community coalition level performance information. This community level information will be reported through the Regional Behavioral Health Authorities, to the state and into grant applications. Coalitions, providers and Regional Behavioral Health Authorities have been working with the State to implement the NPIRS over the design and development stages that began in October 2007. The Web address for NPIRS is: <http://www.npirs.org>.

On the treatment side, a series of revisions was included in the Administrative Service Organizations (ASO) request for proposal let in February 2008. These strengthened data sets include full National Outcome Measures and reporting requirements for the State Outcomes Monitoring and Measurement System (SOMMS). The Successful bidder to the State's request for proposal was the same organization that previously held the administrative services organization contract (Magellan Behavioral Health, Inc.). Toward an effort to comply with the new contract details the first SOMMS data transfer by the ASO contractor occurred in August 2008. Calendar Year 2007 data, as well as the First and Second quarter 2008 data were transferred to the Federal Contractor for SOMMS. Because of programming errors Arrests in Prior 30 days, Detailed Not in Labor Force, and Social Connectedness measures were not properly included. . Corrections to the reporting system are being made and the October 2008 SOMMS transfer is scheduled to include these data items.

As a part of the ASO bid process in February 2008, more reporting to programs and Regional Behavioral Health Authorities has been required. The Division is working to make available monthly, quarterly, and fiscal year reports meaningful to sub-state entities and programs include SOMMS variables. .

Noted in the Core Technical Review Report was the inability of staff within the Division to manage data. The report indicated staff was able to review the data but there were not sufficient staff to compile reports and to analyze the data. A

new position for data manager has been approved, and as of August, 2008 the Department wide Personal Service Limitation includes this position. As of August 2008, position description had been drafted and submitted to the Personal section of the Departments' Support Services. An additional position within the Division to support the data manager is also being considered. This will affectively limit the number of interns and other staff who have to be cobbled together to manage the information from the data system, analyze that information and make recommendations to management.

Sub-recipient monitoring processes

The Core Technical Review field research indicated that sub-recipient monitoring by the state was lacking. The Division of Behavioral Health has contracted with the six Regional Behavioral Health Authorities to conduct sub-recipient reviews. Annual program audits and fiscal reviews are conducted at each program by the regional authorities. Division of Behavioral Health personnel often join in those reviews. The Division and regional authorities working together have formed both an audit and a finance work group. These groups have meet to review current procedures in each of the regions and are meeting to further strengthen the review process, including reviews of interim services to persons on wait lists.

Peer Review

Peer review process was reviewed in the Core Technical Review. That review indicated that while the peer reviews were being conducted (with the exception of 2006) the results of the peer review were not being documented within the Division. Documentation of decisions such as training or technical assistance to providers was lacking. The Division is working with the 2009 contractor (Nebraska Association of Behavioral Health Organizations) to realize more meaningful reporting. The Division has established a Quality Improvement Team (D-QIT) that meets every 3 weeks to review processes and procedures. The Peer Review system has been placed into the Divisions Quality Review Team (D-QIT). Additionally, in a recent national workshop conducted by SAMHSA it was learned that other states had integrating national accreditation into their peer reviews and was using reports from accreditation organizations to further training and technical assistance activities. Nebraska will be looking to this possibility in Fiscal Year 2009.

CPA Firm Selection and Tracking Set Asides

In an opinion from a National Association of Public Accountants, the Core Technical Review concern sub-recipients selected audit firms were expressed. The opinion indicated that Regions and sub-recipients (programs) could be audited by the same audit firm with reasonable assurance that the firm will not have a conflict of interest in the audit process.

It was the observation that the state's accounting process of utilizing "regional actual" was not sufficient as to tracking funds between grant years and tracking funds by set aside (prevention, women's etc.) The Division is working with the Department of Health and Human Services Support Section to develop a coding scheme that satisfied both the state's need and assures accountability by funding source to the regional and program level.

Level of Care Determination

Within the Core Technical Review a number of issues were identified related to the level of care determination. The Division's regulations, contract documents, and Magellan policies were all reviewed by the team and found that while they describe the service array as good, there was a lack of specifics as to what constituted admission and discharge requirements and "standards for care". The Division is working within the Department of Health and Human Services to strengthen Division regulations and policies. Under the new ASO contract, a Quality Improvement Team consisting of representatives of the three Department Divisions participating in the ASO has been organized consisting of providers, state and Magellan staff, including the Division of Behavioral Health's clinical director - Blaine Shaffer, MD. This quality improvement team will be reviewing policies and procedures and will issue further guidance to programs and the ASO provider to strengthen the authorization and continued stay reviews. The first meeting of this group occurred in July 2008. At the same time all data elements are being reviewed toward how to report the elements in meaningful ways to service providers, and the Service Definitions Team is meeting to further refine the Standards of Care within the guidance documents for Magellan and within the provider's manual being written.

Interim Services

When the Core Technical Review team met with program representatives at two of the state funded agencies in April 2007, those agencies were not able to list nor document the provision of interim services to pregnant and post partum women, nor IV drug abusers. Those agencies could also not enumerate the order of selection among the service population for priority populations, even though both agencies reported to the capacity management, wait list system operated by the Division in cooperation with the Regional Behavioral Health Authorities.

The First of the Technical Assistance Documents was the desk top review of the method the Division of Behavioral Health uses to convey the Block Grant requirements to its regions, and from the regions to the providers. The first re-writes on these conveyance documents occurred in May 2008 for the Fiscal Year 2009 Regional/agency contracts. The report by the consultant indicated additional wording changes.

The Division is in the process of strengthening the SFY 2009 contract documents to include an enumeration of the priority populations and to enumerate the interim services to be provided to those persons on the wait list and other block grant items suggested by the consultant. Among the requirements added to contract provisions was that agencies must document services to priority persons on wait lists, maintain unique client identifiers for each person on the wait list, charitable choice provisions, restrictions on services in penal institutions, employee education on confidentiality requirements, TB requirements and payment of last resort. These efforts will be placed under the close watch of the Division – Quality Improvement Team. Additional clarification will be forthcoming to the programs once the Division staff has received Block Grant 101 training in October 2008.

Uniformity of Women's Services

As with the Level of Care determination uniformity of women's services was an issue at the Core Technical Review. As part of the Administrative Services Organization RFP a quality review team has been organized. That team consists of representatives of the three Divisions participating in the ASO. This includes Medicaid. The Division of Behavioral Health and Medicaid have a set of service definitions crafted as part of the Substance Abuse Waiver services within Medicaid reimbursement. The service definitions work group and a special Magellan Task Force will be reviewing the Substance Abuse Waiver service definitions to further guide Magellan and programs.

Behavioral Health Oversight Commission:

LB 928 (2008), section 18 establishes the Behavioral Health Oversight Commission. The Behavioral Health Oversight Commission officially began on July 1, 2008 and will terminate on June 30, 2009. The first meeting was on July 24, 2008 and the second on August 11, 2008.

The commission consists of twelve members appointed by the Governor as follows:

- (i) One consumer of behavioral health services,
- (ii) one consumer advocate of behavioral health services,
- (iii) three providers of community-based behavioral health services, including one representative from each congressional district,
- (iv) three regional behavioral health authority administrators, including one from each congressional district,
- (v) one representative of the Norfolk Regional Center,
- (vi) one representative of the Lincoln Regional Center,
- (vii) one representative of the city of Norfolk, and
- (viii) one representative of the city of Hastings.

The purpose of the Behavioral Health Oversight Commission is to implement a process that will produce a “strategic vision” for behavioral health for the State of Nebraska within existing resources by April 2009.

Governor Heineman’s Welcome to the Behavioral Health Oversight Commission. Governor Dave Heineman made the following statements in welcoming the Behavioral Health Oversight Commission on July 24, 2008

“Thank you to all of you for agreeing to serve. Everybody involved said ‘yes’ and I appreciate that. I also want to acknowledge what the previous Oversight Commission did. Some of you were part of that, there were more than that but they did great work. They played a transitional role in going from our Institutional Model to Community-Based Care Giving. I think we continue to evolve and improve. I think if you look at the big picture, if you look back over the last four years, we’ve made great progress and I want to thank those members for that and everybody who has been involved in the system, who is committed to that. It’s fair to say, I think, over the last four years our entire system has changed in terms of mental illness and mental health and I think it’s changed for the better.

At the same time I also want to acknowledge for you that we have restructured Health and Human Services to provide greater accountability and greater transparency. In terms of what we’re doing, I think we’re making very good progress, if you look across a wide variety of issues that we deal with including the ones that you’re going to deal with here.

But now it’s time to look to the future. We need to talk about developing a strategic vision for those we serve with mental illness in the coming years. This Commission has an important enough duty, in my mind, to advise Scot and his Health and Human Services team on these behavioral health issues. I also want to acknowledge and I think we all need to be upfront about it, the State has limited resources. Within that context, think about sharing your thoughts with Health and Human Services about the appropriate balance of services provided by the regional centers, the behavioral health regions and local providers.

A final, last piece of advice I can give you is simply this, you have one year. So, I want to encourage you to focus on a few key issues. In a year’s timeframe I don’t think you can take on the whole world but that will be up to you. I would just recommend that you take a look at a few key issues, give us your thoughts and advice and let us go to work on those.

But mostly I wanted to come here today to say thank you for agreeing to serve. This is an important issue to people, the clients that we serve in this State that everybody’s part of and it’s been a predominant issue for a number of years but we changed that four years ago and we’re continuing to move forward. I just want to say thank you to each and every one of you for what you’re doing and good luck and now I’ll get out of your hair.”

The Behavioral Health Oversight Commission Charter Statement
(Adopted on August 11, 2008)

The Behavioral Health Oversight Commission shall be responsible to the Division of Behavioral Health (DBH) and shall oversee and support implementation of the Nebraska Behavioral Health Services Act. The Commission will provide advice and assistance to DBH regarding promotion of:

(i) the interests of consumers and their families; (ii) both individual and systemic recovery; and, (iii) consumer involvement in all aspects of implementation of the Nebraska Behavioral Health Services Act. This Commission will provide a strategic vision for behavioral health for the State of Nebraska recognizing limited resource availability, and the importance of an environment of recovery for all behavioral health consumers.

State Substance Abuse Advisory Committee:

71-815. State Advisory Committee on Substance Abuse Services; created; members; duties.

(1) The State Advisory Committee on Substance Abuse Services is created. Members of the committee shall have a demonstrated interest and commitment and specialized knowledge, experience, or expertise relating to the provision of substance abuse services in the State of Nebraska. The committee shall consist of twelve members appointed by the Governor and shall include at least three consumers of substance abuse services.

(2) The committee shall be responsible to the division and shall (a) conduct regular meetings, (b) provide advice and assistance to the division relating to the provision of substance abuse services in the State of Nebraska, (c) promote the interests of consumers and their families, (d) provide reports as requested by the division, and (e) engage in such other activities as directed or authorized by the division.

Source: Laws 2004, LB 1083, § 15; ; Laws 2005, LB 551, § 5; ; Laws 2006, LB 994, § 94. ;

The substance abuse advisory committee meets quarterly to discuss and provide recommendations to the Division Director on operational issues related to substance abuse services in the state. A similar committee meets in each of the Six Behavioural Health Authorities to recommend to the Regional Governing Board and Executives operational issues related to mental health and substance abuse services in that region.

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Nebraska

Goal #2: 20% for Primary Prevention

GOAL # 2. An agreement to spend not less than 20 percent on primary prevention programs for individuals who do not require treatment for substance abuse, specifying the activities proposed for each of the six strategies or by the Institute of Medicine Model of Universal, Selective, or Indicated as defined below: (See 42 U.S.C. 300x-22(a)(1) and 45 C.F.R. 96.124(b)(1)).

Institute of Medicine Classification: Universal Selective and Indicated:

- **Universal:** Activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk.
 - o **Universal Direct. Row 1**—Interventions directly serve an identifiable group of participants but who have not been identified on the basis of individual risk (e.g., school curriculum, after school program, parenting class). This also could include interventions involving interpersonal and ongoing/repeated contact (e.g., coalitions)
 - o **Universal Indirect. Row 2**—Interventions support population-based programs and environmental strategies (e.g., establishing ATOD policies, modifying ATOD advertising practices). This also could include interventions involving programs and policies implemented by coalitions.
- **Selective:** Activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- **Indicated:** Activities targeted to individuals in high-risk environments, identified as having minimal but detectable signs or symptoms foreshadowing disorder or having biological markers indicating predisposition for disorder but not yet meeting diagnostic levels. (Adapted from The Institute of Medicine Model of Prevention)

FY 2006 (Compliance):

FY 2008 (Progress):

FY 2009 (Intended Use):

GOAL # 2

-- An agreement to spend not less than 20 percent on primary prevention programs for individuals who do not require treatment for substance abuse, specifying the activities proposed for each of the six strategies (See 42 U.S.C. 300x-22(b)(1) and 45 C.F.R. 96.124(b)(1)).

FFY 2006 (Compliance):

GOAL 1: Comprehensive Substance Abuse Prevention Planning

The Division of Behavioral Health will seek to ensure that inclusive, comprehensive and evidence-based planning processes guide the allocation of substance abuse prevention resources.

Objective 1.1 – The Division of Behavioral Health will facilitate the ongoing development of an effective, coordinated and sustainable State Prevention System that can create a unified State substance abuse plan (Governor’s Vision 2010) across State and Tribal governmental entities.

- The Division of Behavioral Health facilitates Nebraska Partners in Prevention (NePiP), a gubernatorial advisory council established to oversee implementation of the Nebraska State Incentive Cooperative Agreement and the creation of a coordinated and integrated state prevention system. NePiP is actively chaired by the Lt. Governor and includes four primary Work Groups, including the Policy and Strategic Planning Work Group (PSPWG) which provides State agency leadership for state prevention system coordination and development. Membership of the PSPWG is composed of the following state policy makers and heads of key state agencies responsible for administering state and federal funding streams for alcohol, tobacco and other drugs (ATOD): Commissioner of Education, Nebraska Department of Education (NDE); Policy Secretary for Nebraska Health and Human Service System (NHHSS); Director of Finance, NHHSS; Deputy Director for Behavioral Health, NHHSS; Deputy Director for Public Health, NHHSS; Executive Director of the Nebraska Commission on Law Enforcement and Criminal Justice; Director, Nebraska Office of Highway Safety; Nebraska U.S. Attorney, U.S. Attorney’s Office; Executive Director, Nebraska Indian Commission; State Senator, Nebraska Legislature.
- PSPWG members provided guidance for state and local 1) prevention system development and 2) substance abuse prevention assessment and planning processes. NePiP also oversees the State Epidemiological Workgroup and the development of a coordinated state data infrastructure, and sponsor implementation of a statewide student survey that collects community, regional and state-level data on youth ATOD use, antisocial behaviors, and risk, protective and other factors. PSPWG members also provide leadership for the development of Governor’s Vision 2010, Nebraska’s Strategic Plan for Substance Abuse Prevention. Other state-level entities that have been engaged by the PSPWG to participate in this planning process include: Liquor

Control Commission, Department of Corrections, Court Administrators Office, State Patrol, Economic Development, Attorney General's Office, Nebraska's Tribal Councils, Mexican American Commission, Resource Conservation and Development Councils, the Nebraska National Guard and the Drug Enforcement Administration. The PSPWG also provides leadership for strategic planning for prevention work force development across disciplines, which will serve as a component of Governor's Vision 2010

Objective 1.2 – The Division of Behavioral Health will contract with each of the six Behavioral Health Regions to coordinate comprehensive and inclusive data-driven substance abuse prevention strategic planning processes within each region.

- The Behavioral Health Regional contracts were modified again in FFY 06 to more clearly outline expectations for prevention system coordination in order to ensure that data-driven, evidence-based planning processes are used to drive allocations of SAPT funding. Under the conditions of the contract, Behavioral Health Regions are required to complete broad-based, data-driven regional strategic prevention planning processes with all regional stakeholders. The strategic planning process for prevention developed by Nebraska was disseminated to all Behavioral Health Regional prevention staff. This process is available online at: http://nebraskaprevention.gov/pdf/Final_Toolkit.pdf. The regional strategic plans are to be used to drive all regional funding allocations through the SAPT funds.

Objective 1.3 – The Division of Behavioral Health will contract for, and coordinate, statewide and regional training and technical assistance on substance abuse prevention system and community assessment and planning processes to communities and their prevention systems.

- The Division of Behavioral Health contracted for and coordinated training and technical assistance (T/TA) to support the following priority areas for substance abuse prevention system development and substance abuse prevention initiatives:
 - the collection and analysis of data regarding substance abuse and related mental health disorders and other problems, as well as organizational development assessments of prevention systems
 - the use of evidence-based planning processes,
 - the selection and implementation of culturally and locally-appropriate evidence-based strategies,
 - monitoring, continuous improvement and evaluation of strategies and prevention system development
 - prevention workforce development, and
 - Development of new prevention leadership, particularly within

underrepresented populations and sectors.

- Eligible applicants for this assistance included non-profit, tribal and governmental agencies, organizations and coalitions engaged in the prevention of substance abuse.
- Priority was placed on leadership and workforce development, as well as the continued development of new leadership—particularly within underrepresented populations—within the substance abuse prevention field.
- The Division on Behavioral Health also sponsored regional Nebraska Substance Abuse Prevention Specialist Trainings (NE SAPST) throughout the state. In addition to the regular SAPST modules, the NE SAPST includes an in-depth historical overview of substance abuse and modules on economic evaluation, prevention system development, and each step of the strategic prevention framework.

Goal 2: Substance Abuse Prevention Training and Technical Assistance
The Division of Behavioral Health will seek to ensure that locally-appropriate, responsive, comprehensive and highly qualified training and technical assistance is available to assist local, regional and state coalitions to acquire the knowledge, skills and abilities needed to effectively reduce substance abuse.

Objective 2.1 – Regional Prevention Centers

The Division of Behavioral Health will contract with each of the six Behavioral Health Regions to coordinate Regional Prevention Centers that will focus solely on providing training and technical assistance to build the substance abuse prevention capacity of regional and local prevention system coalitions.

- The Division of Behavioral Health contracted with each Behavioral Health Region to provide a Regional Prevention Center in each region that would focus solely on providing training and technical assistance to build the substance abuse prevention capacity of regional and local prevention system coalitions. The Behavioral Health Regional contracts were modified to clearly outline expectations for Regional Prevention Center activity.

Objective 2.2 – Training and Technical Assistance Network

The Division of Behavioral Health will facilitate the creation and coordination of a multidisciplinary network of training and technical assistance providers that will assist prevention systems at the state, regional and local levels to acquire and build capacity to effectively reduce substance abuse.

- The Division of Behavioral Health continued to coordinate a multi-disciplinary NePiP Subcommittee that is facilitating the creation and coordination of a cross-disciplinary network of training and technical assistance providers designed to assist prevention systems at the state, regional and local levels to

acquire and build capacity to effectively reduce substance abuse. Subcommittee members include key representatives from public health, behavioral health, law enforcement/public safety, education, higher education, and Nebraska tribal nations, Nebraska Legislature, SWCAPT and the Prairielands Addiction Technology Transfer Center.

Goal 3: Prevention Services.

The Division of Behavioral Health will seek to ensure that effective, locally and culturally-appropriate substance abuse prevention services are available and in place at the regional and local levels.

Objective 3.1 – Coordination of Prevention Services

The Division of Behavioral Health will contract with 1) the six Behavioral Health Regions to coordinate regional prevention services, and 2) other professional substance abuse prevention entities to deliver statewide prevention services across the six federal strategies.

Objective 3.1.1 – Information Dissemination

The Division of Behavioral Health will contract with the six Behavioral Health Regions and other professional substance abuse prevention entities to provide information dissemination prevention services throughout all 93 counties of Nebraska as an integrated component of a comprehensive state substance abuse prevention plan to reduce substance abuse.

- The Division will maintain a statewide Clearinghouse for Alcohol and other Drug Information
- Each of the six Behavioral Health Regions will maintain at least one Associate RADAR network site linked to the state Clearinghouse which will provide clearinghouse services specific to substance abuse prevention
- Associate radar sites will be established at other venues throughout the State

- The Division contracted for the operation of a statewide Clearinghouse for Alcohol and other Drug Information, including the provision of technical assistance and support to the Associate RADAR Network centers located in Regional Prevention Centers and community-based prevention centers around the state.

- Each of the six Behavioral Health Regions operated an Associate RADAR network site linked to the state Clearinghouse which provided clearinghouse services specific to substance abuse prevention.

- Associate radar sites were maintained at other venues throughout the State, including private providers and the Nebraska National Guard.

- The Prevention Minimum Data Set recorded 6,463 information dissemination events during State Fiscal Year 06.

Objective 3.1.2 – Education

The Division of Behavioral Health will contract with the six Behavioral Health Regions, the Native American Tribal Nations, and other professional substance abuse prevention entities to coordinate and provide prevention education services to stakeholders throughout the State as an integrated component of a comprehensive state substance abuse prevention plan to reduce substance abuse.

- The Division of Behavioral Health contracted with the six Behavioral Health Regions and the Omaha Nation to provide prevention education services. These prevention education services were designed to be culturally and developmentally appropriate, and to address an array of services (e.g. including family management classes with a strong substance abuse prevention component) as well as classroom and small group sessions for preschoolers, school age youth, adults and middle aged and older adults. Specific prevention education services were provided to youth living in low income, high unemployment areas of the state.
- The Prevention Minimum Data Set recorded 1,297 prevention education events during State Fiscal Year 06.

Objective 3.1.3 – Alternatives

The Division of Behavioral Health will contract with the six Behavioral Health Regions, the Native American Tribal Nations, and other professional substance abuse prevention entities to coordinate and provide alternative prevention activities to stakeholders throughout the State as an integrated component of a comprehensive state substance abuse prevention plan to reduce substance abuse.

- The Division of Behavioral Health contracted with the six Behavioral Health Regions and the Omaha Nation for provision of alternative services. The predominant populations that were served were youth (middle and high school aged), elementary students, parents/families, civic groups/coalitions, and teachers/administrators/counselors. Each Behavioral Health Region: 1) provided or contracted for youth/adult leadership services; 2) supported training for adult sponsors and drug free youth groups; 3) provided or contracted for mentoring services; and 4) provided or contracted for community activities that encouraged youth to abstain from alcohol, tobacco, and other drugs, and encouraged adults to model low-risk use of alcohol.
- In State Fiscal Year 2006, 492 alternative events occurred.

Objective 3.1.4 – Problem Identification and Referral

The Division of Behavioral Health will contract with the six Behavioral Health Regions, the Native American Tribal Nations, and other professional substance abuse prevention entities to coordinate and provide problem identification and referral prevention services to stakeholders throughout the State as an integrated component of a comprehensive state substance abuse prevention plan to reduce substance abuse.

- The Division of Behavioral Health contracted with each of the six Behavioral Health Regions to provide problem identification and referral services, either through direct service or through subcontracts with service providers.
- The Division of Behavioral Health also contracted with the Lincoln Medical Education Foundation to provide technical assistance and support for the ongoing implementation of School Community Intervention Program (SCIP). A key focus of SCIP is to create knowledgeable, interdisciplinary school-based teams that can effectively identify students at risk of developing substance abuse problems and design and implement early interventions.
- The Division of Behavioral Health also contracted with the Nebraska Department of Education to fund the Student Assistance Program, which provided early identification and intervention services for school-age youth across the state.
 - A total of 814 separate problem identification and referral events were recorded in State Fiscal Year 2006 on the Prevention Minimum Data Set.

Objective 3.1.5 – Community-Based Processes

The Division of Behavioral Health will contract with the six Behavioral Health Regions, the Native American Tribal Nations, and other professional substance abuse prevention entities to coordinate and provide community-based processes and prevention services to stakeholders throughout the State as an integrated component of a comprehensive state substance abuse prevention plan to reduce substance abuse.

- The Division of Behavioral Health contracted with each Behavioral Health Region to provide or contract for prevention services that address community-based processes. An increasing focus of the Regional Prevention System Coordination plans and the work of each Regional Prevention Center were to build the capacity of local community-based organizations and coalitions to enable local communities to effectively identify and address local substance abuse prevention issues.
- The Division of Behavioral Health provided direct and indirect training and technical assistance to assist community coalitions with broad-based memberships (e.g. including public and behavioral health, education, law enforcement and public safety) to identify priority local substance abuse

prevention needs and select and implement locally and culturally-appropriate substance abuse prevention strategies.

- In State Fiscal Year 2004, the Prevention Minimum Data Set recorded 2,211 community-based events.

Objective 3.1.6 – Environmental Strategies

The Division of Behavioral Health—as an integrated component of a comprehensive state substance abuse prevention plan to reduce substance abuse—will contract with the six Behavioral Health Regions, the Native American Tribal Nations, and other professional substance abuse prevention entities to coordinate the implementation of environmental prevention strategies that have proven effective in decreasing alcohol, tobacco and other drug use.

- The Division of Behavioral Health contracted with each Behavioral Health Region to provide or contract for environmental prevention services. In addition, through efforts of Tobacco Free Nebraska (TFN), local tobacco coalitions were funded to support efforts to reduce local tobacco access. These activities included working with local law enforcement agencies to conduct unannounced compliance checks in addition to the official SYNAR checks. In partnership with TFN and other state agencies involved in tobacco control and cessation, the Division of Behavioral Health worked to develop additional strategies for expanding upon SYNAR activities in order to facilitate expanded community and regional participation in environmental strategies related to tobacco use.
- The Nebraska Broadcasters Association and the Division coordinated the “Drugs Are a Dead End” campaign which produced three sets of biannual radio and television public service announcements (P.S.A.s) about substance abuse. Each set of P.S.A.s were aired continuously throughout the State on radio and television stations.

- Environmental strategies were recorded on the Prevention Minimum Data Set 453 times in State Fiscal Year 2006.

- A total of 22,987 media events occurred during State Fiscal Year 06.

GOAL 4: State Prevention Infrastructure

The Division of Behavioral Health will work to facilitate the enhanced development of an effective, integrated and collaborative state prevention system across State and Tribal entities and federal and state funding streams in order to maximize prevention resources and outcomes

Objective 4.1 – Data Collection and Assessment

The Division of Behavioral Health will facilitate the ongoing development of a

coordinated statewide data collection and needs assessment system that will collect epidemiological, population-based data on local, regional and state-level risk and protective factors, risk behaviors and related problems, and social indicator information.

- The Division continued to facilitate the development and ongoing work of a State Data Monitoring Work Group (DMWG) organized under NePiP to: 1) develop a statewide ATOD data collection and analysis system, and 2) develop a statewide prevention evaluation and outcomes reporting system. Efforts to identify state databases and data holdings, link existing data resources and fill gaps in data, conduct strategic planning for a statewide ATOD data system, and develop an evaluation and outcomes reporting system are ongoing. The DMWG also provides leadership for a State Epidemiological Work Group that was first convened in April 2005 to develop an innovative, proactive substance abuse prevention surveillance system that will: 1) quickly identify and track emergent drug use trends (e.g. new drugs and drug combinations, consumption methods, drug using populations and drug contexts) before they become major social and public health issues; 2) identify emergent epicenters of drug use and related health risks (e.g. HIV/AIDS, STDs, TB); and 3) support the ability of State and local prevention systems to effectively identify and address local substance abuse priorities and respond quickly to emergent drug use.
- The Nebraska Risk and Protective Factor Student (NRPFS) Survey was administered to 41,500 6th, 8th, 10th and 12th students across the state in 191 school districts in 72 of Nebraska's 93 counties in October 2005. This was the second implementation of this survey, which was designed to provide baseline community-level information for five major categories: 1) substance abuse and antisocial behaviors (including problem gambling), 2) community risk factor profiles, 3) community protective factor profiles, 4) source and place of use information for students who reported using alcohol and/or cigarettes, and 5) youth gambling. The focus of the survey continues to be to provide local-level data for community planning, and so communities are allowed to aggregate their data for community reports in the manner most locally appropriate. In some cases, data is aggregated by school building or district, in other cases public and parochial schools within a community aggregated their data to create a community profile of all students. In some rural and frontier areas (particularly in areas where school districts had less than 25 enrolled students), communities elected to aggregate data by county or multi-county groupings. Participation in the survey was spread across the state. The survey will be administered again in October 2007, and data from the survey will be used to track changes in substance abuse rates at the local, regional and state levels. Community-level reports were released to participating school districts in January 2006, and regional reports were released in February 2006. The comprehensive 2005 State NRPFS survey report is being finalized. The NRPFS survey, the survey item construct

dictionary, and the State regional reports can be accessed at:
http://nebraskaprevention.gov/state_and_local_data.htm.

Objective 4.2 – Data-Driven Resource Allocation

The Division of Behavioral Health will work within the State Prevention System to collaboratively increase the ability of local, regional, State and Tribal prevention entities to use data-driven decision-making and evidence-based processes to allocate and manage prevention resources effectively and decrease substance abuse rates.

- The Division continued to work through the State Prevention System to increase the ability of local, regional, State and Tribal prevention entities to use data-driven decision-making and evidence-based processes to allocate and manage prevention resources. This included continued implementation of the common, evidence-based and data-driven strategic planning process developed through NePiP; delivering a statewide Nebraska Substance Abuse Prevention Specialist Trainings that covered all phases of prevention system and prevention substance abuse planning; implementing the NRPFS Survey; and making contract changes to require that the Behavioral Health Regions to use data-driven decision-making and evidence-based processes to allocate and manage prevention resources effectively and decrease substance abuse rates.

Objective 4.3 – Evidence-Based Substance Abuse Prevention Planning Processes

The Division of Behavioral Health will work within the State Prevention System to collaboratively increase the skills, abilities and capacities of local, regional, State and Tribal prevention entities to use common, comprehensive and evidence-based planning processes that are needs-based rather than funds-driven, and which enable those entities to effectively identify and plan to address substance abuse prevention priorities.

- An Evidence-Based Planning Toolkit for substance abuse prevention planning produced by the Division of Behavioral Health for the Nebraska State Incentive Cooperative Agreement is used as the basis for strategic planning. The Toolkit provides complete instructions and worksheets on every step of the substance abuse prevention planning used at the state, sub-state/regional and community levels in Nebraska. Training and technical assistance in using the toolkit was provided at the state, sub-state and community levels through a variety of training events, including the Nebraska Substance Abuse Prevention Specialist Training.
- The Division facilitated the use of Prevention System assessment and planning tools and logic model developed during the Nebraska State Incentive Cooperative Agreement to assess and develop the capacity of substance abuse prevention system infrastructures at the State, sub-state,

and community levels. The prevention infrastructure assessment tool—which includes analysis of 18 key systems areas with associated indicator measures—can be located online at:

http://nebraskaprevention.gov/sica_news.htm by clicking on “RFA Worksheets.” The prevention system assessment was piloted in 14 community coalitions across the state in FY 2004, and is currently being implemented at the State and sub-state levels as an integral component of the Nebraska SPF SIG assessment and evaluation process. The assessment was revised to include strategic sustainability indicators, with the revisions implemented into the organizational assessment processes of community coalitions across the state.

Objective 4.4 – Implementation of Comprehensive and Evidence-Based Prevention Strategies

The Division of Behavioral Health will work within the State Prevention System to collaboratively increase the skills, abilities and capacities of local, regional, State and Tribal prevention entities to select and implement comprehensive and evidence-based substance abuse prevention strategies that are locally and culturally-appropriate, and to sustain the outcomes generated by those strategies in order to reduce substance abuse.

- During implementation of the Nebraska State Incentive Cooperative Agreement, the Division facilitated the development and dissemination of a “Guidance Document for Selecting Science-Based and Promising Prevention Strategies.” This guidance document contained detailed information to help communities select locally and culturally-appropriate evidence-based substance abuse prevention strategies that could effectively and significantly reduce local substance abuse rates. The guidance document included extensive information on those strategies (approximately 90 in number) that have proven to be effective in achieving substance abuse prevention outcomes among 12-17 year old youth. This document served as a collective compendium of existing information sources, and incorporated newly collected information, particularly for environmental strategies. In addition to archival sources, the information in the document included information gleaned from extensive interviews that were conducted with program developers, the scientific research community, and state and community-level prevention practitioners. Whenever available, information and practical considerations regarding lessons learned during actual community implementation were included. The document also included information on assessing and enhancing community readiness, implementation and sustainability issues (e.g. adaptation and fidelity, developmental appropriateness), prevention planning and Internet resources for selecting substance abuse prevention strategies. Strategy information in the Guidance Document was organized into four sets of matrices and profiles, all arranged in alphabetical order: Science-Based – Environmental Approaches; Science-Based – Individual Approaches; Promising – Environmental Approaches; and

Promising – Individual Approaches. The matrices provide an at-a-glance overview of the key features of each listed strategy. The set of profiles that follow each matrix provide more comprehensive information on the strategies featured in that matrix. Community coalitions are encouraged to review the matrices first to identify those strategies that 1) are proven effective at the producing the outcomes identified by the community, 2) address the community's priority risk and protective factors, and 3) are appropriate to the community's target population(s) and resources.

- The Division continued to facilitate the use of the “Guidance Document for Selecting Science-Based and Promising Prevention Strategies” **through** training and technical assistance.
- During FYY06, the Division facilitated the development of a major expansion of the Guidance Document, which now includes matrices and profiles for 202 evidence-based behavioral health prevention strategies that cover the human lifespan and the gamut of behavioral health prevention issue areas.

Objective 4.5 – Evaluation and Data Reporting

The Division of Behavioral Health will work internally and within the State Prevention System to facilitate the development of a statewide prevention evaluation and outcomes reporting system.

- The Division continued to facilitate the State Data Monitoring Work Group (DMWG), which was organized under NePiP to: 1) develop a statewide ATOD data collection and analysis system, and 2) develop a statewide prevention evaluation and outcomes reporting system. The DMWG also provides leadership for a State Epidemiological Work Group that was first convened in April 2005 to develop an innovative, proactive substance abuse prevention surveillance system that will: 1) quickly identify and track emergent drug use trends (e.g. new drugs and drug combinations, consumption methods, drug using populations and drug contexts) before they become major social and public health issues; 2) identify emergent epicenters of drug use and related health risks (e.g. HIV/AIDS, STDs, TB); and 3) support the ability of State and local prevention systems to effectively identify and address local substance abuse priorities and respond quickly to emergent drug use.

Objective 4.6 – Work Force Development

The Division of Behavioral Health will facilitate the creation and implementation of a comprehensive prevention workforce development strategic plan to meet the needs of prevention professionals throughout State, Tribal, regional and local substance abuse prevention entities.

- The Division continued to facilitate the Work Force Development Leadership Team (WFDLT), which was convened under NePiP. This Leadership team has been meeting since September 2003, and is charged with assessing

existing competencies across disciplines and developing a coordinated state plan to address prevention work force needs. WFDLT developed and implemented a comprehensive, multi-sector workforce survey, and continues to meet to conduct strategic planning for prevention work force development in order to 1) develop and support training for existing prevention professionals across disciplines, 2) recruit a diverse body of new prevention professionals, and 3) provide for greater professionalization and utilization of evidence-based strategies and technologies. Members of the Leadership Team include the following state offices and entities: Health and Human Services - Behavioral Health; Health and Human Services – Tobacco Program; Health and Human Services – Child and Adolescent Health; Health and Human Services – Minority Health; U.S. Attorneys Office; Highway Safety Office; Nebraska Department of Education; University of Nebraska; Prairielands Addiction Technology Transfer Center; Omaha Nation of Nebraska; and the Southwest Center for the Application of Prevention Technologies.

GOAL 5: SYNAR Compliance

The Division of Behavioral Health will work to decrease rates of tobacco merchant noncompliance with regard to sales to minors.

Objective 5.1 – State Prevention System Involvement in Tobacco Sales Compliance

The Division of Behavioral Health will facilitate the ongoing work of a State SYNAR/Tobacco Work Group to collaboratively and effectively identify and address issues related to tobacco sales to minors in order to reduce the number of such illegal sales to minors.

- During FY 2006, the Division facilitated the ongoing work of a State SYNAR/Tobacco Work Group consisting of the Division, the Tobacco Free Nebraska Program, the Nebraska State Patrol and the Attorney General's Office. This Work Group meets to collaboratively and effectively identify and address issues related to tobacco sales to minors, in order to reduce the number of such illegal sales to minors.

Objective 5.2 – Regional and Local Involvement in Tobacco Sales Compliance

The Division of Behavioral Health will work with Tobacco Free Nebraska and other State Prevention System partners to develop additional strategies to promote regional and local participation in SYNAR compliance, including environmental and merchant education strategies.

- During FY 2006, the Division continued to work with the Tobacco Free Nebraska program to localize SYNAR involvement through a contract with one Behavioral Health Region to coordinate SYNAR compliance checks within the Omaha metropolitan area.

Objective 5.3 -- The Division of Behavioral Health will contract with the Nebraska State Patrol, local law enforcement agencies, and other appropriate substance abuse prevention entities to coordinate and/or conduct compliance checks on tobacco retailers.

- The Nebraska State Patrol conducted was contracted to conduct up to 950 compliance checks in FY 2006.

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GOAL # 2

-- An agreement to spend not less than 20 percent on primary prevention programs for individuals who do not require treatment for substance abuse, specifying the activities proposed for each of the six strategies (See 42 U.S.C. 300x-22(b)(1) and 45 C.F.R. 96.124(b)(1)).

FFY 2008 (Progress):

2.1 –The Division of Behavioral Health will facilitate the ongoing work of a State SYNAR/Tobacco Work Group in order to reduce the number of such illegal sales to minors.

Division of Behavioral Health continues to work with the Division of Public Health Tobacco Free Nebraska, Division of Public Health Community Affairs Office, State Treasurer Office, Nebraska State Patrol and Nebraska Attorney Generals office. The work group has met electronically over the year to exchange information. Decision was made by the Director of Behavioral Health to share violator's information from compliance checks. Request for violator information has been received from Lorillard and Phillip Morris tobacco. State Treasurer Field staff is using the tobacco licensee list developed from the Division of Behavioral Health to review licensee information and to send correct information back to the division staff. The tobacco licensee list was developed with the assistance of all the municipal and county clerks of the state. Information is continually updated through clerk and treasury staff reports on new tobacco outlets determined through field observations.

2.2 –The Division of Behavioral Health will work with Tobacco Free Nebraska and other State Prevention System partners to develop additional strategies to promote regional and local participation in SYNAR compliance, including environmental and merchant education strategies.

Tobacco Free Nebraska continues efforts to strengthen community coalitions to foster merchant education. Regional Prevention Coordinators are also working within their regions with Substance Abuse coalitions to model merchant education programs similar to those conducted for alcohol beverages. Alcohol Beverage Server training legislation was proposed in the FY 2008 legislative session but did not receive support due to conflicting information. A committee of state, local and regional representatives has established, along with the Liquor Control Commission guidelines for server and merchant education. This model is being used by Tobacco advocates.

2.3 -- The Division of Behavioral Health will contract with the Nebraska State Patrol, local law enforcement agencies, and other appropriate substance abuse prevention entities to coordinate and/or conduct compliance checks on tobacco retailers.

The Division of Behavioral Health is the lead contract agency for the SYNAR tobacco compliance checks. The Division has contracted with the Nebraska State Patrol to complete compliance checks in all areas of the state excluding the City of Omaha. Through arrangements with Pride Omaha and Omaha Police compliance checks in Omaha are conducted by the Omaha Police Department using SYNAR compliance check protocols. Omaha has a system of quarterly compliance checks and has a violation rate below 8 percent. The State compliance rate is estimated to be around 12 percent.

2.4 -- The Division of Behavioral Health will contract with Regional Governing Authorities for Prevention Coordinators in each of the six regional authorities.

Each region has designated a Prevention Coordinator. Substance abuse block grant prevention funds are designated to each region. Prevention Coordinators are responsible for their regions planning, coordination and monitoring activities. Each region must pass down to community coalitions 50% of the block grant funds for community planning using the Strategic Prevention Framework planning process, and for implementation of community priorities. Regional Prevention Coordinators are responsible and trained in the Strategic Prevention Framework process and can provide training and technical assistance to community coalitions.

2.5 -- The Division will work with Regional Governing Authorities designated prevention coordinators to train local coalitions in evidence based and promising practices in prevention, including utilization of the SPF-SIG planning model.

Training was provided to Regional Prevention Coordinators, Division of Behavioral Health and Division of Public Health Community Affairs Office staffs by the University of Oklahoma under auspices of the South West Center for Applied Prevention Technology (SWCAPT) in summer through early autumn 2007. Staffs met to discuss additional training needs to prepare for SPF-SIG funds to be released in the spring 2008 and to provide to Community Coalitions receiving block grant funds training on the SPF-SIG model. 20 staff members participated in the training.

2.6 -- The Division of Behavioral Health will work with the Division of Public Health to facilitate the conduct of the Risk and Protective Factors survey in FY 2008.

The Risk and Protective Factor Survey was completed in the fall 2007 with survey results released at the end of April 2008.

2.7 -- Under auspices of the Department of Health and Human Services, the Division of Behavioral Health and Division of Public Health will make available data for community planning through an internet based information system designed to provide decision support to community coalitions.

The creation of an internet based information system continues to evolve. For the present, communities funded by SPF-SIG in the late summer 2008 will have a data packet prepared for them by the Division of Public Health Community Affairs Office.

2.8 -- The Division of Behavioral Health and the Division of Public Health will explore an internet based reporting system for block grant and SPF-SIG, Drug Free Communities funded entities.

The Nebraska Prevention Information Reporting System (NPIRS.org) was initiated in an Alpha test site in May 2008. Results from user input of the alpha site were used to develop a Beta site that became operational in August 2008. All community coalitions, the regions and state are using the Beta site. Training on the site processes and users manual are being completed by the Region 6 Behavioral Health Authorities programmers responsible for site development under the 69,000 block grant funded contract with the Division of Behavioral Health.

2.9 -- Participate in development of the epidemiological study for the state and for the regions that identifying areas of greatest need.

The Division of Behavioral Health continues to work with the Division of Public Health Community Affairs Office on the epidemiological work group activities. An EPI profile of Nebraska was completed in January 2008, with the Nebraska Partners in Prevention using that information to select the three priorities for SPF-Sig funds. Those three selected priorities include:

Reduction in underage drinking

Reduction in DWI in all age groups

Reduction of binge drinking among 18 – 25 year olds.

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GOAL # 2

-- An agreement to spend not less than 20 percent on primary prevention programs for individuals who do not require treatment for substance abuse, specifying the activities proposed for each of the six strategies (See 42 U.S.C. 300x-22(b)(1) and 45 C.F.R. 96.124(b)(1)).

FFY 2009 (Intended use):

2.1 –The Division of Behavioral Health will facilitate the ongoing work of a State SYNAR/Tobacco Work Group in order to reduce the number of such illegal sales to minors.

2.2 –The Division of Behavioral Health will work with Tobacco Free Nebraska and other State Prevention System partners to develop additional strategies to promote regional and local participation in SYNAR compliance, including environmental and merchant education strategies.

2.3 -- The Division of Behavioral Health will contract with the Nebraska State Patrol, local law enforcement agencies, and other appropriate substance abuse prevention entities to coordinate and/or conduct compliance checks on tobacco retailers.

2.4 -- The Division of Behavioral Health will contract with Regional Governing Authorities for Prevention Coordinators in each of the six regional authorities.

2.5 -- Under auspices of the Department of Health and Human Services, the Division of Behavioral Health and Division of Public Health will make available data for community planning through an internet based information system designed to provide decision support to community coalitions.

2.6 -- The Division of Behavioral Health and the Division of Public Health will support the Nebraska Prevention Information Reporting System (<http://www.NPIRS.org>) for block grant and SPF-SIG, Drug Free Communities funded entities and work to improve the system with the assistance of Region 6 Behavioral Health Authority.

2.7 -- The Division of Behavioral Health will continue to participate in development of the epidemiological study for the state and for the regions that identifying areas of greatest need.

2.8 - The Division of Behavioral Health will work with the Division of Public Health and Division of Children and Family Services to promote a system of care that includes prevention activities.

2.9 - The Division of Behavioral Health in cooperation with regional coordinators will fund training events throughout the state to introduce, enhance and improve the use of evidence based, promising and local prevention strategies for the

reduction of underage drinking, reduction of Driving under the influence and reduction of binge drinking.

2.10 - The Division on Behavioral Health will participate in at least one statewide prevention conference that invites all prevention entities to foster networking among community coalitions, prevention professionals and agencies.

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Attachment A: Prevention

Answer the following questions about the current year status of policies, procedures, and legislation in your State. Most of the questions are related to Healthy People 2010 (<http://www.healthypeople.gov/>) objectives. References to these objectives are provided for each application question. To respond, check the appropriate box or enter numbers on the blanks provided. After you have completed your answers, copy the attachment and submit it with your application.

1. Does your State conduct sobriety checkpoints on major and minor thoroughfares on a periodic basis? (HP 26-25)

Yes No Unknown

2. Does your State conduct or fund prevention/education activities aimed at preschool children? (HP 26-9)

Yes No Unknown

3. Does your State Alcohol and drug agency conduct or fund prevention/education activities in every school district aimed at youth grades K-12? (HP 26-9)

SAPT Block Grant	Other State Funds	Drug Free Schools
<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes
<input checked="" type="radio"/> No	<input checked="" type="radio"/> No	<input checked="" type="radio"/> No
<input type="radio"/> Unknown	<input type="radio"/> Unknown	<input type="radio"/> Unknown

4. Does your State have laws making it illegal to consume alcoholic beverages on the campuses of State colleges and universities? (HP 26-11)

Yes No Unknown

5. Does your State conduct prevention/education activities aimed at college students that include: (HP 26-11c)

Education Bureau? Yes No Unknown

Dissemination of materials? Yes No Unknown

Media campaigns? Yes No Unknown

Product pricing strategies? Yes No Unknown

Policy to limit access? Yes No Unknown

6. Does your State now have laws that provide for administrative suspension or revocation of drivers' licenses for those determined to have been driving under the influence of intoxication? (HP 26-24)

Yes No Unknown

7. Has the State enacted and enforced new policies in the last year to reduce access to alcoholic beverages by minors such as:

(HP 26-11c, 12, 23)

Restrictions at recreational and entertainment events at which youth made up a majority of participants/consumers: Yes No Unknown

New product pricing: Yes No Unknown

New taxes on alcoholic beverages: Yes No Unknown

New laws or enforcement of penalties and license revocation for sale of alcoholic beverages to minors: Yes No Unknown

Parental responsibility laws for a child's possession and use of alcoholic beverages: Yes No Unknown

8. Does your State provide training and assistance activities for parents regarding alcohol, tobacco, and other drug use by minors?

Yes No Unknown

9. What is the average age of first use for the following? (HP 26-9 and 27-4) (if available)

Age 0 - 5 Age 6 - 11 Age 12 - 14 Age 15 - 18

Cigarettes

Alcohol

Marijuana

10. What is your State's present legal alcohol concentration tolerance level for: (HP 26-25)

Motor vehicle drivers age 21 and older? 0.08

Motor vehicle drivers under age 21? 0.02

11. How many communities in your State have comprehensive, community-wide coalitions for alcohol and other drug abuse prevention? (HP 26-3)

Communities: 60

12. Has your State enacted statutes to restrict promotion of alcoholic beverages and tobacco that are focused principally on young audiences? (HP 26-11 and 26-16)

Yes No Unknown

Nebraska

Goal #3: Pregnant Women Services

GOAL # 3. An agreement to expend not less than an amount equal to the amount expended by the State for FY 1994 to establish new programs or expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children; and, directly or through arrangements with other public or nonprofit entities, to make available prenatal care to women receiving such treatment services, and, while the women are receiving services, child care (See 42 U.S.C. 300x-22(b)(1)(C) and 45 C.F.R. 96.124(c)(e)).

FY 2006 (Compliance):

FY 2008 (Progress):

FY 2009 (Intended Use):

GOAL # 3

-- An agreement to expend not less than an amount equal to the amount expended by the State for FFY 1994 to establish new programs or expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children; and, directly or through arrangements with other public or nonprofit entities, to make available prenatal care to women receiving such treatment services, and, while the women are receiving services, child care (See 42 U.S.C. 300x-22(c)(1)(C) and 45 C.F.R. 96.124(c)(e)).

FY 2006 (Compliance)

3.1 By September 30, 2006, expand Medicaid Option reimbursements to include women's specific services.

Payments for Substance Abuse Medicaid began to be made in July 2005 for Community Support, Halfway House, Therapeutic Community, Intensive Outpatient and Short term Residential.

3.2 By June 30, 2006, provide to regions allocations of women's specific funds from block grant sources.

Allocation for State Fiscal Year 2007 funds were made in April 2006 and included women's specific set aside funding

3.3 Continue staff involvement in the Women's Behavioral Health Coalition meetings.

Staff is assigned to the Women's Behavioral Health Coalition and when time permits attend meetings.

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GOAL # 3

-- An agreement to expend not less than an amount equal to the amount expended by the State for FFY 1994 to establish new programs or expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children; and, directly or through arrangements with other public or nonprofit entities, to make available prenatal care to women receiving such treatment services, and, while the women are receiving services, child care (See 42 U.S.C. 300x-22(c)(1)(C) and 45 C.F.R. 96.124(c)(e)).

FY 2008 (Progress):

3.1 Maintain Medicaid Option reimbursements to continue expanded treatment services, with women designated as a priority population.

Division of Behavioral Health and Division of Medicaid and Long Term Care have continued to work together on substance abuse waiver activities. Divisions have formed a work group to review service definitions of the combined service definitions issues in August 2006. Forty percent match funds expended by the Division of Behavioral Health has resulted in 60% federal match.

3.2 The Division of Behavioral Health Services engages as a partner in activities designed to promote prevention, screening, treatment and recovery-oriented follow-up services for women. Activities include:

- a) Continue active membership in the Women's Behavioral Health Coalition.

Membership in the Women's Behavioral Health Coalition has continued.

- b) Recognizing that women are disproportionately represented among those who have been sexually, physically, and psychologically abused, the Division of Behavioral Health Services strongly supports the Trauma-Informed Nebraska workgroup. This state-wide group collects data, provides training and consults on policy issues related to trauma-informed care.

Division of Behavioral Health continues to work with the Trauma Informed Nebraska work group to encourage agencies to include trauma events in assessments. The revised minimum data set for substance abuse agencies include questions on trauma history as prompts to agencies to include in assessments. The revised Administrative Service Organization placement guidelines also provide for prompts on trauma history.

- c) The Division of Behavioral Health Services supports and participates in an Advancing Recovery group to benefit those with substance use disorders. The group has identified two best practices they hope to

implement. One involves the promotion of total wellness and collaboration with primary care providers. This would impact pregnant women very directly, as immediate steps would be taken to make certain that each pregnant woman seeking substance abuse treatment has a "medical home" for quality prenatal care. Efforts are also underway to develop processes for health education related to pregnancy and use of substances. These interim services would be documented for each consumer individually, as well as through cooperative agreements with primary care facilities.

The Division of Behavioral Health made application for Brief Intervention and Referral Funds in the spring of 2008, and to Sept 1, 2008 has not heard of the status of the application. This grant if received will provide additional training funds for primary care workers to include substance abuse in their assessments.

- d) By April 15, 2008, provide to regions allocations of women's specific funds from block grant sources as a part of the allocation process.

State Fiscal Year 2008 allocations were provided to the Regions in late April 2008.

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GOAL # 3

-- An agreement to expend not less than an amount equal to the amount expended by the State for FFY 1994 to establish new programs or expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children; and, directly or through arrangements with other public or nonprofit entities, to make available prenatal care to women receiving such treatment services, and, while the women are receiving services, child care (See 42 U.S.C. 300x-22(c)(1)(C) and 45 C.F.R. 96.124(c)(e)).

FY 2009 (Intended Use Plan):

3.1 - Maintain Medicaid substance abuse waiver reimbursements to continue for treatment services, with women designated as a priority population.

3.2 - The Division of Behavioral Health Community Program director will participate in the Nebraska Women's Behavioral Health Coalition.

3.3 - Staff of the Division of Behavioral Health will participate in Block Grant 101 training in October 2008 and identify specific women's interim service needs in the state and provide additional training to behavioral health programs.

3.4 - The Division of Behavioral Health Services will work with the audit work group to review agency policies and procedures to ensure documentation of agencies providing interim services to women and their children.

3.5 - The Division of Behavioral Health Services will support the Trauma-Informed Nebraska workgroup and will continue to work with this group to include training resources to provider agencies and the ASO contractor.

3.6 - The Division will update it's policies and procedures to ensure that programs designated to serve women provide for prenatal care to women receiving treatment services, and, while the women are receiving services, child care.

3.7 - By April 15, 2009, provide to Regional Behavioral Health Authorities allocations of women's specific funds from revenue sources as a part of the allocation process.

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Nebraska

Attachment B: Programs for Women

Attachment B: Programs for Pregnant Women and Women with Dependent Children (See 42 U.S.C. 300x-22(b); 45 C.F.R. 96.124(c)(3); and 45 C.F.R. 96.122(f)(1)(viii))

For the fiscal year three years prior (FY 2006) to the fiscal year for which the State is applying for funds:

Refer back to your Substance Abuse Entity Inventory (Form 6). Identify those projects serving pregnant women and women with dependent children and the types of services provided in FY 2006. In a narrative of **up to two pages**, describe these funded projects.

Attachment B: Programs for Pregnant Women and Women with Dependent Children
(See 42 U.S.C. 300x-22(b); 45 C.F.R. 96.124(c)(3); and 45 C.F.R. 96.122(f)(1)(viii))

For the fiscal year three years prior (FY 2006) to the fiscal year for which the State is applying for funds:

Refer back to your Substance Abuse Entity Inventory (Form 6). Identify those projects serving pregnant women and women with dependent children and the types of services provided in FY 2006. In a narrative of **up to two pages**, describe these funded projects.

The PHS Act required the State to expend at least 5 percent of the FY 1993 and FY 1994 block grants to increase (relative to FY 1992 and FY 1993, respectively) the availability of treatment services designed for pregnant women and women with dependent children. In the case of a grant for any subsequent fiscal year, the State will expend for such services for such women not less than an amount equal to the amount expended by the State for fiscal year 1994.

In up to four pages, answer the following questions:

1. Identify the name, location (include sub-State planning area), Inventory of Substance Abuse Treatment Services (I-SATS) ID number (formerly the National Facility Register (NFR) number), level of care (refer to definitions in Section II.4), capacity, and amount of funds made available to each program designed to meet the needs of pregnant women and women with dependent children.
2. What did the State do to ensure compliance with 42 U.S.C. 300x-22(b)(1)(C) in spending FY 2006 block grant and/or State funds?
3. What special methods did the State use to **monitor** the adequacy of efforts to meet the special needs of pregnant women and women with dependent children?
4. What sources of data did the State use in estimating treatment capacity and utilization by pregnant women and women with dependent children?
5. What did the State do with FY 2006 block grant and/or State funds to establish new programs or expand the capacity of existing programs for pregnant women and women with dependent children?

Nebraska has funded the following qualifying programs to serve pregnant women and women with children:

A.-- Region II ARM in ARM program (NE 100985) provides a wrap-a-round model combining non-residential and community support services for serving pregnant women and women with children in a rural setting. The program includes access to primary medical care for women, referral for prenatal care, childcare, primary pediatric care, gender specific substance abuse and mental health treatment, other therapeutic interventions for women, therapeutic interventions for children, case management and transportation for women and children to access medical and therapeutic services.

B.-- Region III Women's Program is a collaborative effort between 4 agencies to serve pregnant women and women with children in a rural setting. Agencies involved are: Saint Francis Alcohol and Drug Counseling (NE900475), South Central Counseling (NE301708), the Bridge (NE900305), and Region III Regional Administration. The program includes access to primary medical care for women, including referral for prenatal care, childcare, primary pediatric care, gender specific substance abuse and mental health treatment, other therapeutic interventions for women, therapeutic interventions for children, case management and transportation for women and children to access medical and therapeutic services. Outpatient counseling services are provided to pregnant women and a woman with children and a weekend partial care program involves the women and children in counseling, education, and supportive services.

B1 -- Saint Francis Alcohol and Drug Counseling (NE900475), is a hospital sponsored treatment provider offering a series of residential and non-residential treatment options.

B2 -- South Central Behavioral Health Services (NE301708), offers non-residential treatment services and provides access to primary medical care for women, including referral for prenatal care, childcare, primary pediatric care, gender specific substance abuse and mental health treatment, other therapeutic interventions for women, therapeutic interventions for children, case management and transportation for women and children to access medical and therapeutic services

B3 -- The Bridge (NE900305) is a 9 bed long term residential treatment program with a length of stay varying from 6 to 12 months. The Bridge utilizes the therapeutic community model to offer women in recovery from alcohol or drug abuse a *secure* setting, gender specific counseling and referral to women's health care facilities.

C.-- St Monica's Project Mother and Child (NE100977)-- St. Monica's (PMC) is a residential treatment program for pregnant women and women with children. The program is located in Lincoln Nebraska and has a capacity to serve up to 8 women and 15 children. The program includes access to primary medical care for women, including referral for prenatal care, childcare, primary pediatric care, gender specific substance abuse and mental health treatment, other therapeutic interventions for women,

therapeutic interventions for children, case management and transportation for women and children to access medical and therapeutic services.

D.-- St. Monica's Outpatient and Partial Care programs (NE900038) provide non-residential substance abuse treatment to women. Children participate in childcare programs while mothers participate in treatment services. The non-residential and intensive non-residential program includes access to primary medical care for women, including referral for prenatal care, childcare, primary pediatric care, gender specific substance abuse and mental health treatment, other therapeutic interventions for women, therapeutic interventions for children, case management and transportation for women and children to access medical and therapeutic services.

E.-- Lincoln Medical Education Foundation (NE100415) Provides intervention and non-residential treatment services to young pregnant women through their family practice residency program. All pregnant women are screened for alcohol, tobacco and other drug use. Referrals or transfers are made to gender specific treatment services. Services are closely coordinated between prenatal care and substance abuse counseling. All qualifying program services are available directly through the Lincoln Medical Education Foundation or through affiliation agreements with agencies in the area.

(2.) The following agencies are women's specific providers but do not have all services (non-qualifying) for pregnant women and women with dependent children.

F.—Panhandle Mental Health Center (NE300205) provides non-residential substance abuse and mental health services and referral to women's medical services.

G.-- Human Services (NE 900699) is a four bed short term residential treatment service providing services to women and appropriate women's health referrals. Length of stay is limited to 30 days.

I. —The Well Link (NE100662) is a 9 bed residential treatment program offering gender specific counseling and access to women's health services.

J.—Santa Monica (NE750540) is a 12 bed residential treatment program offering gender specific counseling and access to women's health services.

**(1) -- Nebraska Pregnant Women's and Women with Children Service Summary
FFY 2007 Qualifying Programs**

Name	Location – City (Region)	NFR-ID	Type of Care	Capacity	FFY 2007 Federal Funds Made Available
Region II Arm in Arm	North Platte (2)	NE100985	Outpatient	Outpatient	\$83,366
Saint Francis Alcohol Drug Counseling	Grand Island (3)	NE900475	Outpatient	Outpatient	\$27874
The Bridge	Hastings (3)	NE900305	Residential	Residential	\$32785
South Central Behavioral Health	Kearney (3)	NE301708	Outpatient	Outpatient	\$37,574
St Monica Project Mother and Child	Lincoln (5)	NE100977	Long Term Residential	18	\$32,538
Lincoln Medical Education Foundation	Lincoln (5)	NE 100415	Outpatient	Outpatient	\$80,000
TOTAL					\$304,137

(2) – In a letter dated May 31, 1995, Nebraska declared a base FFY 1992 Women program set aside of \$247,044. Requirements in Block Grants for 1993 and 1994 added additional women's funding. The FFY 1993 Federal Block Grant (\$5,011,151 (\$250,558)) required the state to add 5% of the grant to the women's maintenance. Additionally 5% of the FFY 1994 Federal Block Grant (\$5,122,221 (\$256,111)) was required to be added. The total Women's maintenance of effort is \$753,713. These figures were confirmed in the revised core element review of the state block grant by JBS in the spring 2000 (page 30).

Non-Qualifying Women's Programs FFY 2007:

Name	Location – City (Region)	NFR-ID	Type of Care	Capacity	FFY 2007 Federal Funds Made Available
Panhandle Mental Health Center	Scottsbluff (1)	NE300205	Intensive Outpatient		\$0
Human Services	Alliance (1)	NE900699	Short Term Residential	1	\$0
Well Link	Norfolk (4)	NE100662	Halfway House	9	\$21157
Santa Monica	Omaha (6)	NE750540	Therapeutic Community	12	\$94,8500
TOTAL					\$116,007

Each year the state establishes minimum regional allocations of federal, state and local service funding. The specific set asides for federal funding must be met by the respective regions in women's services with special emphasis being directed toward building services which include access to primary medical care for women, including referral for prenatal care, childcare, primary pediatric care, gender specific substance abuse and mental health treatment, other therapeutic interventions for women, therapeutic interventions for children, case management and transportation for women and children to access medical and therapeutic services. During the period of FFY 2007 expenditures the state reemphasized the need for waiting list information and the need for programs to address the special needs of pregnant women and women with children, especially in detoxification programs. .

(3) -- The state monitors the adequacy of efforts by programs funded to serve pregnant women and women with children through reviews of budget plans with emphasis toward becoming a qualified program, monthly financial reports, registration, authorizations and continued care reviews through Magellan Health data system, and on-site technical assistance by division staff, through program site visits and the waiting list monitoring system.

(4) -- Nebraska utilizes Magellan Behavioral Health client data system to estimate capacity and utilization of services designed to serve pregnant women and women with children. The State has a waiting list monitoring system to determine any clients unable to access the system within 48 hours. The waiting list monitoring system specifically addresses pregnant women as a priority population. In the spring of 2007 the Division underwent a Core Technical Review by CSAT. That review identified weaknesses in monitoring and service utilization systems. A Corrective Action Plan has been

developed and following Block Grant 101 in the Fall 2008, Division staff will work with regions and programs to strengthen procedures.

(5) -- In Federal Fiscal Year 2007 Nebraska maintained funding in all Federal Set Aside programs. Special services for pregnant women and women with children were addressed in contract requirements. Each region was provided allocations of FFY 2007 block grant funds to establish and maintain programs which made available access to primary medical care for women, including referral for prenatal care, childcare, primary pediatric care, gender specific substance abuse and mental health treatment, other therapeutic interventions for women, therapeutic interventions for children, case management and transportation for women and children to access medical and therapeutic services.

State FY 2005 was the first year in which Women's service providers were given the opportunity to participate in Medicaid matching service reimbursement. The total number of federal Substance Abuse Block Grant dollars was significantly reduced as a result in this participation. Total reimbursement for Women's services given all reported funding sources in State Fiscal Year 2007 \$7,210,246 of that amount \$1,896,028 was from state sources, \$420,144 Federal Block Grant for Substance Abuse, \$40,000 Local Tax match and \$1,812,742 from Medicaid payments to providers.

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Nebraska

Attachment B: Programs for Women (contd.)

Title XIX, Part B, Subpart II, of the PHS Act required the State to expend at least 5 percent of the FY 1993 and FY 1994 block grants to increase (relative to FY 1992 and FY 1993, respectively) the availability of treatment services designed for pregnant women and women with dependent children. In the case of a grant for any subsequent fiscal year, the State will expend for such services for such women not less than an amount equal to the amount expended by the State for fiscal year 1994.

In up to four pages, answer the following questions:

1. Identify the name, location (include sub-State planning area), Inventory of Substance Abuse Treatment Services (I-SATS) ID number (formerly the National Facility Register (NFR) number), level of care (refer to definitions in Section II.4), capacity, and amount of funds made available to each program designed to meet the needs of pregnant women and women with dependent children.
2. What did the State do to ensure compliance with 42 U.S.C. 300x-22(b)(1)(C) in spending FY 2006 block grant and/or State funds?
3. What special methods did the State use to **monitor** the adequacy of efforts to meet the special needs of pregnant women and women with dependent children?
4. What sources of data did the State use in estimating treatment capacity and utilization by pregnant women and women with dependent children?
5. What did the State do with FY 2006 Block Grant and/or State funds to establish new programs or expand the capacity of existing programs for pregnant women and women with dependent children?

Attachment B: Programs for Pregnant Women and Women with Dependent Children
(See 42 U.S.C. 300x-22(b); 45 C.F.R. 96.124(c)(3); and 45 C.F.R. 96.122(f)(1)(viii))

For the fiscal year three years prior (FY 2006) to the fiscal year for which the State is applying for funds:

Refer back to your Substance Abuse Entity Inventory (Form 6). Identify those projects serving pregnant women and women with dependent children and the types of services provided in FY 2006. In a narrative of **up to two pages**, describe these funded projects.

The PHS Act required the State to expend at least 5 percent of the FY 1993 and FY 1994 block grants to increase (relative to FY 1992 and FY 1993, respectively) the availability of treatment services designed for pregnant women and women with dependent children. In the case of a grant for any subsequent fiscal year, the State will expend for such services for such women not less than an amount equal to the amount expended by the State for fiscal year 1994.

In up to four pages, answer the following questions:

1. Identify the name, location (include sub-State planning area), Inventory of Substance Abuse Treatment Services (I-SATS) ID number (formerly the National Facility Register (NFR) number), level of care (refer to definitions in Section II.4), capacity, and amount of funds made available to each program designed to meet the needs of pregnant women and women with dependent children.
2. What did the State do to ensure compliance with 42 U.S.C. 300x-22(b)(1)(C) in spending FY 2006 block grant and/or State funds?
3. What special methods did the State use to **monitor** the adequacy of efforts to meet the special needs of pregnant women and women with dependent children?
4. What sources of data did the State use in estimating treatment capacity and utilization by pregnant women and women with dependent children?
5. What did the State do with FY 2006 block grant and/or State funds to establish new programs or expand the capacity of existing programs for pregnant women and women with dependent children?

Nebraska has funded the following qualifying programs to serve pregnant women and women with children:

A.-- Region II ARM in ARM program (NE 100985) provides a wrap-a-round model combining non-residential and community support services for serving pregnant women and women with children in a rural setting. The program includes access to primary medical care for women, referral for prenatal care, childcare, primary pediatric care, gender specific substance abuse and mental health treatment, other therapeutic interventions for women, therapeutic interventions for children, case management and transportation for women and children to access medical and therapeutic services.

B.-- Region III Women's Program is a collaborative effort between 4 agencies to serve pregnant women and women with children in a rural setting. Agencies involved are: Saint Francis Alcohol and Drug Counseling (NE900475), South Central Counseling (NE301708), the Bridge (NE900305), and Region III Regional Administration. The program includes access to primary medical care for women, including referral for prenatal care, childcare, primary pediatric care, gender specific substance abuse and mental health treatment, other therapeutic interventions for women, therapeutic interventions for children, case management and transportation for women and children to access medical and therapeutic services. Outpatient counseling services are provided to pregnant women and a woman with children and a weekend partial care program involves the women and children in counseling, education, and supportive services.

B1 -- Saint Francis Alcohol and Drug Counseling (NE900475), is a hospital sponsored treatment provider offering a series of residential and non-residential treatment options.

B2 -- South Central Behavioral Health Services (NE301708), offers non-residential treatment services and provides access to primary medical care for women, including referral for prenatal care, childcare, primary pediatric care, gender specific substance abuse and mental health treatment, other therapeutic interventions for women, therapeutic interventions for children, case management and transportation for women and children to access medical and therapeutic services

B3 -- The Bridge (NE900305) is a 9 bed long term residential treatment program with a length of stay varying from 6 to 12 months. The Bridge utilizes the therapeutic community model to offer women in recovery from alcohol or drug abuse a *secure* setting, gender specific counseling and referral to women's health care facilities.

C.-- St Monica's Project Mother and Child (NE100977)-- St. Monica's (PMC) is a residential treatment program for pregnant women and women with children. The program is located in Lincoln Nebraska and has a capacity to serve up to 8 women and 15 children. The program includes access to primary medical care for women, including referral for prenatal care, childcare, primary pediatric care, gender specific substance abuse and mental health treatment, other therapeutic interventions for women,

therapeutic interventions for children, case management and transportation for women and children to access medical and therapeutic services.

D.-- St. Monica's Outpatient and Partial Care programs (NE900038) provide non-residential substance abuse treatment to women. Children participate in childcare programs while mothers participate in treatment services. The non-residential and intensive non-residential program includes access to primary medical care for women, including referral for prenatal care, childcare, primary pediatric care, gender specific substance abuse and mental health treatment, other therapeutic interventions for women, therapeutic interventions for children, case management and transportation for women and children to access medical and therapeutic services.

E.-- Lincoln Medical Education Foundation (NE100415) Provides intervention and non-residential treatment services to young pregnant women through their family practice residency program. All pregnant women are screened for alcohol, tobacco and other drug use. Referrals or transfers are made to gender specific treatment services. Services are closely coordinated between prenatal care and substance abuse counseling. All qualifying program services are available directly through the Lincoln Medical Education Foundation or through affiliation agreements with agencies in the area.

(2.) The following agencies are women's specific providers but do not have all services (non-qualifying) for pregnant women and women with dependent children.

F.—Panhandle Mental Health Center (NE300205) provides non-residential substance abuse and mental health services and referral to women's medical services.

G.-- Human Services (NE 900699) is a four bed short term residential treatment service providing services to women and appropriate women's health referrals. Length of stay is limited to 30 days.

I. —The Well Link (NE100662) is a 9 bed residential treatment program offering gender specific counseling and access to women's health services.

J.—Santa Monica (NE750540) is a 12 bed residential treatment program offering gender specific counseling and access to women's health services.

**(1) -- Nebraska Pregnant Women's and Women with Children Service Summary
FFY 2007 Qualifying Programs**

Name	Location – City (Region)	NFR-ID	Type of Care	Capacity	FFY 2007 Federal Funds Made Available
Region II Arm in Arm	North Platte (2)	NE100985	Outpatient	Outpatient	\$83,366
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Nebraska

Goal #4: IVDU Services

GOAL # 4. An agreement to provide treatment to intravenous drug abusers that fulfills the 90 percent capacity reporting, 14-120 day performance requirement, interim services, outreach activities and monitoring requirements (See 42 U.S.C. 300x-23 and 45 C.F.R. 96.126).

FY 2006 (Compliance):

FY 2008 (Progress):

FY 2009 (Intended Use):

GOAL # 4

-- An agreement to provide treatment to intravenous drug abusers that fulfills the 90 percent capacity reporting, 14-120 day performance requirement, interim services, outreach activities and monitoring requirements (See 42 U.S.C. 300x-23 and 45 C.F.R. 96.126).

FFY 2006 (Compliance):

Objective 4.1 -- Continue to include in regional contract requirements to fulfill the 14-120 day service performance requirements.

Contract language to fulfill 14-120 day requirements is located at Attachment E Section IV.

Objective 4.2 -- Include in contracts reference to protocols that outline monitoring and auditing standards that take into account the 14-120 day service performance requirements, participation in waiting list and 90 % reporting.

Contract language to fulfill 14-120 day requirements is located at Attachment E Section IV.

Objective 4.3 -- Continue the work of the fiscal manager's team and contract work group by revising auditing protocols and process of measuring performance results.

Fiscal Managers meet quarterly to discuss contract terms and auditing procedures. As a result of these meetings FY 07 contract has had several clarifying statements included and as of Sept 06 the Audit Workbook is requiring updating. New service definitions for Substance Abuse services that are funded in part through Medicaid were published in December 2005 and updated in August 2006.

Objective 4.4 -- Continue to provide authorizations to service population that meets financial and clinical eligibility criteria through Magellan Behavioral Health managed care initiative and to provide ancillary services as individual situations dictate.

Regional Network Managers continue to see that services are funded for a wide variety of populations in their regions. Service contracts were let for SFY 2007 funds in July 2006.

Objective 4.5 -- The state will continue to operate the waiting list system and will work with regions and agencies to enhance the waiting list and 90 % capacity reporting.

Weekly reports of service capacity and utilization as well as priority persons on wait lists are received on Tuesdays and Wednesdays from all regions. On average regions report over 85 percent of the time. Delays in reporting occur due to staff time,

vacations and equipment malfunctions.

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GOAL # 4

-- An agreement to provide treatment to intravenous drug abusers that fulfills the 90 percent capacity reporting, 14-120 day performance requirement, interim services, outreach activities and monitoring requirements (See 42 U.S.C. 300x-23 and 45 C.F.R. 96.126).

FFY 2008 (Progress):

4.1 – Continue to require that Regional contracts include the 14-120 day service performance requirements.

The Division received a report of the site visit conducted by the Center for Substance Abuse Treatment in November 2007. The report indicated that the Division was not out of compliance with Block Grant requirements, but regions and agencies were not aware of those requirements, even though they were included in the contract and audit requirements. Division staff worked to put together a corrective action plan and in February 2008 that plan was approved along with a technical assistance plan. The Technical assistance plan included a desk top review of all contract and block grant compliance issues by Federal consultant. The consults conveyance review revealed some weakness in the contract between the regions and the state. As of August 2008, Department legal staff and Division staff was reviewing the contract against consultant recommendations. The 14-120 day performance standard was among those items that were found in the contract and for which recommendations were advised. Those recommendations were to include specifics of the interim services to be provided during waiting.

4.2 – Continue to require that contracts include protocols for monitoring and auditing the following:

- a) Monitoring of the waiting list
- b) Interim services including referrals to primary care
- c) Outreach activities including health education

Legal staff of the Department of Health and Human Services will be working to strengthen the contract language based on the report of the consultant about the Division's conveyance documentation. Additionally, once the Division staff has been training through Block Grant 101, additional training will be made available to Regions and Service providers.

4.3 -- The fiscal managers team and contract work group will continue to review and revise auditing protocols. Desired outcomes will be identified, and performance will be measured through monitoring of outcomes.

Audit work group has met during the last year to discuss the results of the federal site visit by CSAT. That visit revealed weaknesses in documentation by programs of interim

services during wait periods. Compliance with the 14-120 day wait period requirements could not be fully determined. Division and Regional staff are to receive training in those requirements. Block Grant 101 is scheduled in late October 2008 for Division staff. Requirements will be fully outlined and staff will work to develop methods to document compliance at the program level.

4.4 – Continue to authorize services for consumers who meet the financial and clinical eligibility criteria through the Magellan Behavioral Health managed care initiative. Continue to provide ancillary services as individual situations dictate.

A new Administrative Service Contract was let to Magellan Behavioral Health Services, inc., in June 2008. That new contract included the conditions of award as expressed in the Administrative Service Organization Request for Proposal (RFP) let in January 2008. Under conditions of the RFP the ASO is to strengthen services to those who are on wait lists and to remind, encourage and assist programs in documentation and implementation of interim services to persons placed on wait lists.

4.5 -- The state will continue to manage the waiting list system, and will work with Behavioral Health Authorities (Regions) and providers to analyze and revise the process so that data collected is accurate, and can be used for system improvement.

The Network Management Team (administrators of the Department and Regions) are continuing to meet every other month. This requirement is included in the discussions. Once staff of the Division has received Block Grant 101 training more definitive suggests to programs regarding wait list creation and documentation of interim services will be made available. Block Grant 101 is scheduled for late October 2008.

4.6 – The State will work with Behavioral Health Authorities (Regions) and providers to improve the documentation of interim services to IV drug users who could not be served within the 14-120 day requirement.

Even before Block Grant 101 training the Audit work group has implemented as review of current practices of programs for documentation and made recommendations for improvements. Division staff will continue to work with the audit work group to review regional audit procedures and to establish review protocols on documentation.

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GOAL # 4

-- An agreement to provide treatment to intravenous drug abusers that fulfills the 90 percent capacity reporting, 14-120 day performance requirement, interim services, outreach activities and monitoring requirements (See 42 U.S.C. 300x-23 and 45 C.F.R. 96.126).

FFY 2009 (Intended Use):

4.1 - Division staff will attend Block Grant 101 Training in October 2008.

4.2 - By December 31, 2008, Division staff will have convened a meeting of the Audit Work Group to review agency reports of performance regarding services to Intravenous Drug Abusers.

4.3 – Work with Department of Health and Human Services Legal Section to revise Region – State contract in accord with recommendations of the Conveyance report received in June 2008 to continue to require that Regional contracts include the 14-120 day service performance requirements.

4.4 – Continue to require that contracts include protocols for monitoring and auditing the following:

- a) Monitoring of the waiting list
- b) Interim services including referrals to primary care
- c) Outreach activities including health education

4.5 – Continue to authorize services for consumers who meet the financial and clinical eligibility criteria through the Magellan Behavioral Health managed care initiative and review activities through Division and Magellan Quality Improvement Teams.

4.6 -- The state will continue to manage the waiting list system, and will work with Behavioral Health Authorities (Regions) and providers to analyze and revise the process so that data collected is accurate, and can be used for system improvement.

4.7 – The State will work with Behavioral Health Authorities (Regions) and providers to improve the documentation of interim services to IV drug users who could not be served within the 14-120 day requirement.

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Nebraska

Attachment C: Programs for IVDU

Attachment C: Programs for Intravenous Drug Users (IVDUs)

(See 42 U.S.C. 300x-23; 45 C.F.R. 96.126; and 45 C.F.R. 96.122(f)(1)(ix))

For the fiscal year three years prior (FY 2006) to the fiscal year for which the State is applying for funds:

1. How did the State define IVDUs in need of treatment services?
2. 42 U.S.C. 300x-23(a)(1) requires that any program receiving amounts from the grant to provide treatment for intravenous drug abuse notify the State when the program has reached 90 percent of its capacity. Describe how the State ensured that this was done. Please provide a list of all such programs that notified the State during FY 2006 and include the program's I-SATS ID number (See 45 C.F.R. 96.126(a)).
3. 42 U.S.C. 300x-23(a)(2)(A)(B) requires that an individual who requests and is in need of treatment for intravenous drug abuse is admitted to a program of such treatment within 14-120 days. Describe how the State ensured that such programs were in compliance with the 14-120 day performance requirement (See 45 C.F.R. 96.126(b)).
4. 42 U.S.C. 300x-23(b) requires any program receiving amounts from the grant to provide treatment for intravenous drug abuse to carry out activities to encourage individuals in need of such treatment to undergo treatment. Describe how the State ensured that outreach activities directed toward IVDUs was accomplished (See 45 C.F.R. 96.126(e)).

Attachment C: Programs for Intravenous Drug Users (IVDUs)

(See 42 U.S.C. 300x-23; 45 C.F.R. 96.126; and 45 C.F.R. 96.122(f)(1)(ix))

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3. 42 U.S.C. 300x-23(a)(2)(A)(B) requires that an individual who requests and is in need of treatment for intravenous drug abuse is admitted to a program of such treatment within 14-120 days. Describe how the State ensured that such programs were in compliance with the 14-120 day performance requirement (See 45 C.F.R. 96.126(b)).
4. 42 U.S.C. 300x-23(b) requires any program receiving amounts from the grant to provide treatment for intravenous drug abuse to carry out activities to encourage individuals in need of such treatment to undergo treatment. Describe how the State ensured that outreach activities directed toward IVDUs was accomplished (See 45 C.F.R. 96.126(e)).

FFY 2006 Compliance

(1) -- An individual is defined as being in need of services if the use of substances lead to significant social role impairment and the individual has a diagnosable substance abuse or addiction disorder with the usual route of admission through needles either intravenous or intramuscular. Most, if not all, of IVDU's would meet this requirement.

(2) -- Programs are required to report weekly to the state's capacity management system (96.126(a)). The reporting guidelines includes a report of the percentage of capacity. Programs report through their respective regions the capacity of the agency (in beds, slots or hours of counseling available), the current utilization, and percentage of utilization; and number of persons on wait lists are recorded by priority group. Each Tuesday the state receives reports from each region and programs within the regions. (Owing to staffing i.e. vacations, sick leave or training, programs may miss a week or two during the year). These reports are reviewed by State staff and maintained in file system for future use. In the Core Technical Review conducted in April 2007, CSAT staff observed that the Division staff made minimal use of the information contained in the Capacity/Management system. Recommendations for increased staffing were made to the Division by the consultants and in the final report of September 2007. As of

September 2008, the Division has authorization for a data and fiscal staff position.

(3) -- Contracts with regions stipulate regions must include a prohibition of the distribution of sterile needles (45 C.F.R. 96.135(a)(6)) in their contracts. This requirement is included in the subcontract from regions to agencies. Regions monitor implementation of the requirement in yearly program compliance reviews, and as a part of the A-131 Uniform Independent audit requirements.

(4) – The 90 percent capacity notification system (45 C.F.R. 96.126(a)) has been established. Regions contract with service providers and included in those subcontracts requirements for agencies to report weekly their current capacity, utilization, and counts of persons on waiting lists. Women, women with children, IVDU's and other priority population members are identified on the waiting list information. Where priority persons are listed who have been on the waiting list for close to allotted time Regions must make arrangements to find available treatment. Regions are authorized to make every effort to obtain treatment for priority populations. Magellan Behavioral Health has been helpful as Administrative Service Organization managed care entity in identifying persons needing treatment and those areas of the state with capacity to treat priority populations. Table below provides a list of all IV drug programs and their status in reporting 90 percent capacity.

(5) -- Agencies receiving SAPT Block Grant funds must provide services to IVDU's within 14-120 days of request (45 C.F.R. 96.126(b)). This performance measure is included in regional and regional subcontracts. Regions must monitor priority persons on waiting lists and seek program admissions as appropriate should agencies be unable to serve a priority person in the established time frames. To date, there are no reports of individuals who have exceeded the 14-120 day requirements. Interim services to IVDU's was identified as a weakness in the Core Technical Review conducted by CSAT representatives in April 2007. Documentation of interim services being offered was lacking in two programs visited by CSAT representatives. The State has recognized this challenge and has included a more thorough description of interim services in contract documents, and is requiring additional review of documentation by regions toward program. The Division staff will be attending Block Grant 101 training In October 2008. Block Grant 101 will provide the staff an opportunity to more fully flesh out the requirements for interim services, and provide specific guidance to agencies to fulfill these requirements. Block Grant 101 will be repeated for Regions and Agencies with detailed instructions from the state on how to meet the requirements. Additionally, the first of the Technical Assistance plan to be completed is a review of the contract conveyance documents. In that review additional suggestions for contract language have been made and as of August 2008, revisions are being proposed.

(6) -- Outreach activities include:

A. -- Program certification regulations and regional contracts and subcontracts require

programs to perform outreach activities.

- B. -- The Division funded a toll-free information line.
- C. -- The Governor's Office and the Nebraska Broadcasters Association have collaborated on the development of TV and radio spots.
- D. -- The Division in cooperation with the Department has presented training to counselors and other professionals concerning IVDU and HIV/AIDS.
- E. -- Programs are required by contract to screen for high-risk HIV/STD/TB individuals and to have agreements/arrangements for individuals at risk to receive testing.
- F. -- The Department of Health and Human Services, Division of Public Health continues a Health Promotion Unit, infectious Disease Section who provides training with emphasis toward IVDU populations.

Agencies Reporting Having Reached 90 Percent Capacity at any time during FFY 2006.

NFR Number	Agency	IV Users	Exceeded 90%
750904	Alegent Health, Inc.	YES	YES
750441	ARCH	YES	YES
301302	Behavioral Heath Specialists	YES	YES
750953	Blue Valley Mental Health Cen	YES	YES
100126	Catholic Charities - Columbus	YES	YES
100431	Catholic Charities - Omaha	YES	YES
301401	CenterPointe	YES	YES
901051	Chicano Awareness Center	YES	YES
100563	Child Guidance Center	YES	YES
	Community Mental Health	YES	
750938	Cente		YES
750250	Cornhusker Place	YES	YES
100613	Faith Regional Health Service	YES	YES
100280	Family Services - Lincoln	YES	YES
750151	Friendship House	YES	YES
100202	Good Samaritan Hospital	YES	YES
100279	Goodwill Industries of Greate	YES	YES
101553	Great Plains Medical Center	YES	YES
900491	Heartland Counseling Services	YES	YES

100103	Heartland Family Services	YES	YES
901242	Houses of Hope of Nebraska, I	YES	YES
900699	Human Services	YES	YES
900350	Lincoln Council on Alcoholism	YES	YES
100415	Lincoln Medical Education Par	YES	YES
	Lutheran Family Services	YES	
900962	(LNK)		YES
	Lutheran Family Services	YES	
101793	(OMA)		YES
	Lutheran Family Services	YES	
100278	(SBB)		YES
	Mary Lanning Memorial	YES	
100100	Hospital		YES
301500	Mid Plains Center for Behavio	YES	YES
101258	Milne Detoxification	YES	YES
101296	Nebraska Urban Indian Health	YES	YES
	North East Panhandle	YES	
100605	Substanc		YES
300072	NOVA	YES	YES
100381	Omaha Tribe of Nebraska	YES	YES
	Panhandle Mental Health	YES	
300205	Cente		YES
100779	Ponca Tribe of Nebraska	YES	YES
900566	Region 2 Human Services	YES	YES
101215	Region West Medical Center	YES	YES
100118	Richard Young Hospital	YES	YES
750540	Santa Monica	YES	YES
	Santee Sioux Tribe of	YES	
750607	Nebraska		YES
301708	South Central Behavioral Heal	YES	YES
900731	St Francis Alcohol-Drug Treat	YES	YES
900038	St. Monica's Behavioral Healt	YES	YES
900305	The Bridge	YES	YES
900418	The Link	YES	YES
101413	University of Nebraska Medica	YES	YES
100662	Well Link, Inc.	YES	YES
901374	Winnebago Tribe of Nebraska	YES	YES
000081	Touchstone	YES	YES

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Nebraska

Attachment D: Program Compliance Monitoring

Attachment D: Program Compliance Monitoring (See 45 C.F.R. 96.122(f)(3)(vii))

The Interim Final Rule (45 C.F.R. Part 96) requires effective strategies for monitoring programs' compliance with the following sections of Title XIX, Part B, Subpart II of the PHS Act: 42 U.S.C. 300x-23(a); 42 U.S.C. 300x-24(a); and 42 U.S.C. 300x-27(b).

For the fiscal year two years prior (FY 2007) to the fiscal year for which the State is applying for funds:

In **up to three pages** provide the following:

- A description of the strategies developed by the State for monitoring compliance with each of the sections identified below; and
- A description of the problems identified and corrective actions taken:

1. **Notification of Reaching Capacity** 42 U.S.C. 300x-23(a)
(See 45 C.F.R. 96.126(f) and 45 C.F.R. 96.122(f)(3)(vii));
2. **Tuberculosis Services** 42 U.S.C. 300x-24(a)
(See 45 C.F.R. 96.127(b) and 45 C.F.R. 96.122(f)(3)(vii)); and
3. **Treatment Services for Pregnant Women** 42 U.S.C. 300x-27(b)
(See 45 C.F.R. 96.131(f) and 45 C.F.R. 96.122(f)(3)(vii)).

Attachment D: Program Compliance Monitoring

(See 45 C.F.R. 96.122(f)(3)(vii))

The Interim Final Rule (45 C.F.R. Part 96) requires effective strategies for monitoring programs' compliance with the following sections of the PHS Act: 42 U.S.C. 300x-23(a); 42 U.S.C. 300x-24(a); and 42 U.S.C. 300x-27(b).

For the fiscal year two years prior (FY 2007) to the fiscal year for which the State is applying for funds:

In up to three pages provide the following:

- A description of the strategies developed by the State for monitoring compliance with each of the sections identified below; and
- A description of the problems identified and corrective actions taken:
 1. **Notification of Reaching Capacity** 42 U.S.C. 300x-23(a)
(See 45 C.F.R. 96.126(f) and 45 C.F.R. 96.122(f)(3)(vii));
 2. **Tuberculosis Services** 42 U.S.C. 300x-24(a)
(See 45 C.F.R. 96.127(b) and 45 C.F.R. 96.122(f)(3)(vii)); and
 3. **Treatment Services for Pregnant Women** 42 U.S.C. 300x-27(b)
(See 45 C.F.R. 96.131(f) and 45 C.F.R. 96.122(f)(3)(vii)).

FFY 2006 Compliance

A. Strategies and Activities Developed:

The requirements involving Block Grant capacity management, waiting lists, order of selection, and interim services were first included in the regional contracts for SFY93-4 and continued each year thereafter. All programs began reporting to the system in August of 1994, through their respective region, capacity, utilization and numbers of priority group members on waiting lists. Reports are made each Tuesday with compilations made by regions and set to the Division via FAX the same day. The system was reviewed at the Network Managers (Regions) meeting of October 1999, and all Regions agreed to review and update the reporting to include capacities based on the authorization process conducted by Magellan Health. Additional capacity information has been added to the FY 2004 Regional Plans of expenditures in an effort to capture agencies static capacity and to verify that against the capacity reported in the capacity reporting system both for the agencies as a whole and for services purchased by state contracts. Regional Plan capacity reports have not been added to the capacity

management system due to lack of staff.

1. Section 1923 (a): - 90 % capacity reporting

This section requires reporting capacity when it reaches 90 percent or greater. The requirement is met both in contracting language and in weekly reporting by programs to the respective regions. Regional contracts require agencies to indicate to regions when they achieve 90 percent level. The Division monitors each region on a weekly basis to determine if agencies are reporting and whether there are any persons listed seeking admission who are not otherwise being served. In the Core Technical Review of April 2007, CSAT consultants reviewed the staff activities related to capacity and wait list management system. It was their observation that the system was functioning, however there were not sufficient staff at the Division level to fully review these reports and make recommendations regarding client movement. In an effort to improve upon the wait list monitoring the Division has been given authority to hire a data person. This person will be responsible for all budget, and data elements of the Division and to make appropriate reports. As part of the Technical Assistance Plan that was created to address deficiencies within the Division, Block Grant 101 has been scheduled for late October 2008. This training is intended to provide Division staff with the knowledge to carry out the requirements of the Block Grant.

2. Section 1924 (a): TB Screening, Testing, and Treatment

Nebraska is a low incidence TB State (28 active cases as of 5/1/2001, 89 percent are foreign born.). The Division works cooperatively with the Division of Disease Control to facilitate networking with state and county TB screening sites. The Division has included, in contractual language, requirements that programs directly or through arrangements with public or non-profit private entities routinely make available TB services. Additionally, Division has distributed to all regions and programs TIP Number 11 Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases. Programs use this or an approved screening instrument. In the initial phase of developing the screening the Division provided a workshop in use of screening instruments in each of the six behavioral health authorities.

3. Section 1927 (b): Pregnant Women Preference:

The requirement to give preference to pregnant women in admission was included in the contracts between the Department and Regions and as a screening for authorizations and continued stay reviews by Magellan Health. Some women specific residential programs in the State are not funded for, nor have the capacity, to provide all of the required services of 45 CFR 96.131. A complete description of women's treatment providers is given as Attachment B of this application. Programs are required to contact the Division/Region within 48 hours if a pregnant or injecting woman is placed on a waiting list. The Region (Network Manager) then determines if another placement

would be available and attempts to secure appropriate treatment.

B. Problems Identified and Corrective Action:

The sensitive nature of the questions in the treatment improvement protocol has created difficulties at the agency level. The Division, in cooperation with, Regional administrators, and its training contractors have developed a training packet that aids programs in the administration of this or similar screening instruments.

As of late June 2005 many programs report greater than 90 percent utilization. Outpatient programs have reported that they can see priority group members on an emergency basis and can provide referral to interim services. Also, outpatient programs are unable to consistently and accurately pinpoint 90 percent capacity given the nature of the groups and family counseling.

The Division of Behavioral Health received a Core Technical Review in April 2007. As a result of the report on that visit received in October 2008, a corrective action plan was developed and approved in February 2008. Among the observations of the consultants representing the Center for Substance Abuse Treatment were that the staff was not routinely monitoring the capacity reports received by the Regional Behavioral Health Authorities. That while the system was operational, it could benefit from updating to an internet based system. Additionally, the consultants observed that the staff person assigned to carry out these data functions was a student intern. Division of Behavioral Health has been grant staffing authority to hire a Data Manager. That authority has been included in the Department of Health and Human Services personal service limitation. As of August 2008, the Division is working with Human Resources to create a job description.

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Nebraska

Goal #5: TB Services

GOAL # 5. An agreement, directly or through arrangements with other public or nonprofit private entities, to routinely make available tuberculosis services to each individual receiving treatment for substance abuse and to monitor such service delivery (See 42 U.S.C. 300x-24(a) and 45 C.F.R. 96.127).

FY 2006 (Compliance):

FY 2008 (Progress):

FY 2009 (Intended Use):

GOAL # 5. An agreement, directly or through arrangements with other public or nonprofit private entities, to routinely make available tuberculosis services to each individual receiving treatment for substance abuse and to monitor such service delivery (See 42 U.S.C. 300x-24(a) and 45 C.F.R. 96.127).

FFY 2006 (Compliance):

Objective 5.1 -- Continue to require by contract that agencies screen for high risk HIV/TB/STD.

Agreement requirements are in contract language in Attachment E.

Objective 5.2 -- Continue to require programs to maintain formal agreements with local health departments, and clinics to test for HIV/STD/TB.

Agreement requirements are in contract language in Attachment E.

Objective 5.3 -- Continue to monitor program compliance with requirements.

Program Audits are conducted by Regions annually.

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GOAL # 5. An agreement, directly or through arrangements with other public or nonprofit private entities, to routinely make available tuberculosis services to each individual receiving treatment for substance abuse and to monitor such service delivery (See 42 U.S.C. 300x-24(a) and 45 C.F.R. 96.127).

FFY 2008 (Progress):

5.1 -- Continue to require by contract that all providers screen for HIV/TB/STD. It is important to note that Nebraska has a low prevalence of TB, and skin-testing for TB is not mandated or widely performed. However, technical assistance will be offered to providers so that appropriate alternative screening methods can be developed and utilized.

The Division received a Core Review from the Center Of Substance Abuse Treatment in spring 2007. The Report of the review indicated the Division was weak in documentation of the performance of these requirements. A corrective action plan was prepared and approved in February 2008, which included technical assistance requests from the Federal Government. A part of the Technical assistance provided has been a desk top review of contract language from the state to regions and regions to service agencies. That conveyance review has resulted in a report received in June 2008 that includes suggested changes to contract language. Division of Behavioral Health is working with legal staff of the Department of Health and Human Services to include changes in contract language. Additional requirements for program documentation will be included in the Audit work group requirements.

5.2 -- Continue to require programs to maintain formal agreements with local health departments and primary care providers. Consumers deemed to be positive or at high risk for HIV/TB/STD must be referred for further testing and necessary treatment.

Audit work group is working with Division staff to review current audit procedures and to improve performance in this objective. Staff training on Block Grant 101 will be followed by service provider training once staff has worked to develop a model program.

5.3 -- Continue to monitor program compliance. Work with providers and Behavioral Health Authorities (Regions) to develop efficient, easily-used audit tools and processes.

The Division through the Network managers and audit work group is working to strengthen audit procedures. The Audit work group continues to meet quarterly. More information will be forthcoming to the audit work group after the staff has had time to review block grant 101 training materials.

GOAL # 5. An agreement, directly or through arrangements with other public or nonprofit private entities, to routinely make available tuberculosis services to each individual receiving treatment for substance abuse and to monitor such service delivery (See 42 U.S.C. 300x-24(a) and 45 C.F.R. 96.127).

FFY 2009 (Intended Use):

5.1 - Continue to require by contract that all providers screen for HIV/TB/STD.

5.2 - Division of Behavioral Health will work with Division of Public Health to train counselors on the sensitive nature of questions related to HIV/TB/STD, and to educate behavioral health workers on the importance this information might play in individuals recovery.

5.3 -- Continue to require programs to maintain formal agreements with local health departments and primary care providers. Consumers deemed to be positive or at high risk for HIV/TB/STD must be referred for further testing and necessary treatment.

5.4 -- Working through the Audit Work Group of the Division of Behavioral Health continue to monitor program compliance. Work with providers and Behavioral Health Authorities (Regions) to develop efficient, easily-used audit tools and processes.

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Nebraska

Goal #6: HIV Services

GOAL # 6. An agreement, by designated States, to provide treatment for persons with substance abuse problems with an emphasis on making available within existing programs early intervention services for HIV in areas of the State that have the greatest need for such services and to monitor such service delivery (See 42 U.S.C. 300x-24(b) and 45 C.F.R. 96.128).

FY 2006 (Compliance):

FY 2008 (Progress):

FY 2009 (Intended Use):

GOAL # 6

-- An agreement, by designated States, to provide treatment for persons with substance abuse problems with an emphasis on making available within existing programs early intervention services for HIV in areas of the State that have the greatest need for such services and to monitor such service delivery (See 42 U.S.C. 300x-24(b) and 45 C.F.R. 96.128).

FFY 2006 (Compliance):

Nebraska is not a designated State

18 rapid testing sites were operational from August 11, 2004 to June 30, 2005 and 921 tests were reported to have been given. Less than 1% of the tests showed positive results for HIV infection. Sites are located throughout the state and operated under contract with the HIV Prevention Program operated from the Department of Health and Human Services Regulation and Licensure.

FFY 2008 (Progress):

Nebraska is not a designated State

Nebraska does participate in the Rapid HIV testing through the Ryan White and HIV Prevention Program operated from the Department Of Health and Human Services Regulation and Licensure. Additional testing is available at local Health Departments.

FFY 2009 (Intended Use):

Nebraska is not a designated State

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GOAL # 6

-- *An agreement, by designated States, to provide treatment for persons with substance abuse problems with an emphasis on making available within existing programs early intervention services for HIV in areas of the State that have the greatest need for such services and to monitor such service delivery (See 42 U.S.C. 300x-24(b) and 45 C.F.R. 96.128).*

FFY 2006 (Compliance):

Nebraska is not a designated State

FFY 2008 (Progress):

Nebraska is not a designated State

FFY 2009 (Intended Use):

Nebraska is not a designated State

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GOAL # 6

-- *An agreement, by designated States, to provide treatment for persons with substance abuse problems with an emphasis on making available within existing programs early intervention services for HIV in areas of the State that have the greatest need for such services and to monitor such service delivery (See 42 U.S.C. 300x-24(b) and 45 C.F.R. 96.128).*

FFY 2006 (Compliance):

Nebraska is not a designated State

FFY 2008 (Progress):

Nebraska is not a designated State

FFY 2009 (Intended Use):

Nebraska is not a designated State

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Nebraska

Attachment E: TB and Early Intervention Svcs for HIV

Attachment E: Tuberculosis (TB) and Early Intervention Services for HIV (See 45 C.F.R. 96.122(f)(1)(x))

For the fiscal year three years prior (FY 2006) to the fiscal year for which the State is applying for funds:

Provide a description of the State's procedures and activities and the total funds expended (or obligated if expenditure data is not available) for tuberculosis services. If a "designated State," provide funds expended (or obligated), for early intervention services for HIV.

Examples of procedures include, but are not limited to:

- development of procedures (and any subsequent amendments), for tuberculosis services and, if a designated State, early intervention services for HIV, e.g., Qualified Services Organization Agreements (QSOA) and Memoranda of Understanding (MOU) ;
- the role of the single State authority (SSA) for substance abuse prevention and treatment; and
- the role of the single State authority for public health and communicable diseases.

Examples of **activities** include, but are not limited to:

- the type and amount of training made available to providers to ensure that tuberculosis services are routinely made available to each individual receiving treatment for substance abuse ;
- the number and geographic locations (include sub-State planning area) of projects delivering early intervention services for HIV ;
- the linkages between IVDU outreach (See 42 U.S.C. 300x-23(b) and 45 C.F.R. 96.126(e)) and the projects delivering early intervention services for HIV; and
- technical assistance.

Attachment E: Tuberculosis (TB) and Early Intervention Services for HIV
(See 45 C.F.R. 96.122(f)(1)(x))

For the fiscal year three years prior (FY 2006) to the fiscal year for which the State is applying for funds:

Provide a description of the State's procedures and activities and the total funds expended (or obligated if expenditure data is not available) for tuberculosis services. If a "designated State," provide funds expended (or obligated), for early intervention services for HIV.

Examples of **procedures** include, but are not limited to:

- development of procedures (and any subsequent amendments), for tuberculosis services and, if a designated State, early intervention services for HIV, e.g., Qualified Services Organization Agreements (QSOA) and Memoranda of Understanding (MOU);
- the role of the single State authority (SSA) for substance abuse prevention and treatment; and
- the role of the single State authority for public health and communicable diseases.

Examples of **activities** include, but are not limited to:

- the type and amount of training made available to providers to ensure that tuberculosis services are routinely made available to each individual receiving treatment for substance abuse;
- the number and geographic locations (include sub-State planning area) of projects delivering early intervention services for HIV;
- the linkages between IVDU outreach (See 42 U.S.C. 300x-23(b) and 45 C.F.R. 96.126(e)) and the projects delivering early intervention services for HIV; and
- technical assistance.

The Division of Behavioral Health has no specific financial set aside for HIV or TB services. Division draft regulations and current contracts require programs to have working relationships with local health departments and to screen all persons requesting services for communicable diseases including, HIV, TB, Sexually transmitted diseases and Hepatitis A, B and C. The occurrence of these diseases among the population is unknown as agencies heretofore have not required reporting to the Division of Behavioral Health their occurrences. Under the regulations for communicable diseases residential treatment centers are required to report new cases of communicable diseases to the Communicable Disease Section of the Division of Public Health.

Block grant funds are not used specifically for screening but are used for training efforts. One continuing education course on the presentation and sensitive nature of health questions is made available through the training contractor. Basic counselor education

course in clinical records and cultural sensitivity include the proper presentation and documentation of information gathered by the health history. Each agency health screenings are a part of the intake process and documentation of physician approval is required. Each year agencies receive notification of the requirements for health screenings, but in recent peer reviews, it was noted that such screenings are not always utilized and made a part of the clinical records. Therefore, as part of the new data collection effort under the revised Administrative Services Contract with Magellan Behavioral Health Services, signed in June 2008, additional questions as to the client's status in TB, HIV, and Hepatitis are being added along with questions related to medication. These additional questions are designed to be a reminder to agencies to include complete medical and social histories on persons accessing the treatment system. The additional questions are anticipated to be initiated by the end of calendar year 2008.

In State Fiscal Year 2007, the Department of Health and Human Services expended \$55,909 in State General Funds toward TB treatment services; and State Fiscal Year 2008, \$54,871 General Funds were used.

For Federal Fiscal Year 2006 Nebraska was not a designated state for HIV. No Substance Abuse Prevention and Treatment Block Grant funds are used to provide HIV treatment or referral.

Nebraska HIV/AIDS Case Rate Table

Calendar Year	Federal Block Grant Application Year	Rate/100,000
1999	2001	4.0
2000	2002	4.8
2001	2003	4.4
2002	2004	4.2
2003	2005	6.2
2004	2006	6.8
2005	2007	4.0
2006	2008	4.2
2007	2009	6.7

Source: Nebraska Department of health and Human Services, Disease Surveillance Section. *2007 Nebraska HIV/AIDS Epidemiological Profile*, 2007. Lincoln NE.

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Nebraska

Goal #7: Development of Group Homes

GOAL # 7. An agreement to continue to provide for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund (See 42 U.S.C. 300x-25). Effective FY 2001, the States may choose to maintain such a fund. If a State chooses to participate, reporting is required.

FY 2006 (Compliance): (Reporting REQUIRED if State chose to participate)

FY 2008 (Progress): (Reporting REQUIRED if State chose to participate)

FY 2009 (Intended Use): (State participation is OPTIONAL)

GOAL # 7. An agreement to continue to provide for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund (See 42 U.S.C. 300x-25 and 45 C.F.R. 96.129). Effective FY 2001, the States may choose to maintain such a fund. If a State chooses to participate, reporting is required.

FFY 2006 (Compliance): (participation OPTIONAL)

Objective 7.1 -- Maintain revolving loan fund during FFY 2006.

Two loans have been made in FY 2006.

Objective 7.2 -- Publicize availability of funds via public notice, bulletins, and presentations at local and state alcohol and drug abuse organizations and on the World Wide Web.

Information about the loan fund continues to be available on the State web site at <http://www.hhss.ne.gov/hew/sua/recvyexp.htm>

Objective 7.3 -- Provide technical assistance to individuals and organizations that make inquiry about the fund.

Information was provided to two groups during Fiscal Year 2006. One group made application.

Objective 7.4 – Seek Federal, State and Foundation support to continue building on the work of Oxford House Nebraska state workers to continue coordination and referral activities.

Also Oxford House Nebraska, Inc. has reorganized and closed a number of homes to more fully make use of limited resources.

Objective 7.5 – work with loan recipients to maintain payments and minimize loan losses due to non-payment

Oxford House Nebraska, Inc. has reorganized and closed several homes in Nebraska due to an overage of houses and inability to fill beds. Capacity is now approaching 80 percent in September 2006. Previous outreach workers had agreed to occupy homes that there were no way to fill and in which extensive repairs should have been made before additional bedrooms were installed in basements. Current organization continues to pay back loans through the group home process.

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GOAL # 7. An agreement to continue to provide for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund (See 42 U.S.C. 300x-25 and 45 C.F.R. 96.129). Effective FY 2001, the States may choose to maintain such a fund. If a State chooses to participate, reporting is required.

FFY 2008 (Progress): (participation OPTIONAL)

7.1 -- Maintain revolving loan fund during FFY 2008.

The revolving loan fund was maintained in Federal Fiscal Year 2008. One new loan was made. The Division has contracted with the Omaha Good Neighbor Foundation for support in carrying out the review of oxford houses. The Good Neighbor Foundation was established to provide assistance in development of housing alternatives for substance abuser and has been instrumental in the development of homes in Omaha and Lincoln. Funds for the support of this contract come from interest earned in the revolving loan account.

7.2 -- Publicize availability of funds via public notice, bulletins, and presentations at local and state alcohol and drug abuse organizations and on the World Wide Web.

Division continues to maintain a revolving loan application and explanation on its web page.

7.3 -- Provide technical assistance to individuals and organizations that make inquiry about the fund.

No inquiries have been made during fiscal year 2008.

7.4 – Seek Federal, State and Foundation support to continue building on the work of Oxford House Nebraska state workers to continue coordination and referral activities.

Division has supported efforts of foundation support through contract with the Omaha Good Neighbor Foundation. Additional efforts to gain community support for recovery homes had occurred through announcements made at regional network managers meetings and mental health housing meetings. Each regional housing coordinator is provided information on Oxford House model.

7.5 – Work with loan recipients to maintain payments and minimize loan losses due to non-payment

One of the stated purposes of the agreement between the Omaha Good Neighbor Foundation and Division of Behavioral Health is to maintain good repayment on

outstanding loans. With a person touching base with the houses on a continuous basis loan repayment may have a higher probability to be repaid. As a result of these activities, two homes significantly in arrears have begun making payments to the loan fund. The homes were trained on home operation and to establish a new set of officers in the house.

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GOAL # 7. An agreement to continue to provide for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund (See 42 U.S.C. 300x-25 and 45 C.F.R. 96.129). Effective FY 2001, the States may choose to maintain such a fund. If a State chooses to participate, reporting is required.

FFY 2009 (Intended Use): (participation OPTIONAL)

7.1 -- Maintain revolving loan fund during FFY 2009.

7.2 -- Publicize availability of funds via public notice, bulletins, and presentations at local and state alcohol and drug abuse organizations and on the World Wide Web.

7.3 -- Provide technical assistance to individuals and organizations that make inquiry about the fund.

7.4 – Seek Federal, State and Foundation support to continue building on the work of Oxford House Nebraska state workers to continue coordination and referral activities.

7.5 – Work with loan recipients to maintain payments and minimize loan losses due to non-payment.

7.6 - Train Regional Housing Coordinators in the Recovery Home model and encourage expansion throughout the state.

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Nebraska

Attachment F: Group Home Entities

Attachment F: Group Home Entities and Programs (See 42 U.S.C. 300x-25)

If the State has chosen in Fiscal Year 2006 to participate and continue to provide for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund then Attachment F must be completed.

Provide a list of all entities that have received loans from the revolving fund during FY 2006 to establish group homes for recovering substance abusers. In a narrative of **up to two pages**, describe the following:

- the number and amount of loans made available during the applicable fiscal years;
- the amount available in the fund throughout the fiscal year ;
- the source of funds used to establish and maintain the revolving fund ;
- the loan requirements, application procedures, the number of loans made, the number of repayments, and any repayment problems encountered ;
- the private, nonprofit entity selected to manage the fund ;
- any written agreement that may exist between the State and the managing entity ;
- how the State monitors fund and loan operations ; and
- any changes from previous years' operations.

Attachment F: Group Home Entities and Programs

(See 42 U.S.C. 300x-25)

If the State has chosen in fiscal year (FY) 2006 to participate and continue to provide for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund then Attachment F must be completed.

Provide a list of all entities that have received loans from the revolving fund during FY 2005 to establish group homes for recovering substance abusers. In a narrative of **up to two pages**, describe the following:

- the number and amount of loans made available during the applicable fiscal years;
- the amount available in the fund throughout the fiscal year;
- the source of funds used to establish and maintain the revolving fund;
- the loan requirements, application procedures, the number of loans made, the number of repayments, and any repayment problems encountered;
- the private, nonprofit entity selected to manage the fund;
- any written agreement that may exist between the State and the managing entity;
- how the State monitors fund and loan operations; and
- any changes from previous years' operations.

The following is a discussion of the loans made by Federal Fiscal Year.

For years before 2005 please see preceding block grant applications.

Federal Fiscal Year 2005

In September 2004 a new women's house opened up in Lincoln, NE, known as Parkview this house is home to 6 women.

September 2004 saw the establishment of Knox Place in Omaha, NE, for 8 men.

In February 2005, "E Street" house requested and received a loan for additional changes to the structure and addition of 2 new beds.

Several houses were closed in a reorganization of the Oxford House Nebraska Chapter in the spring of 2005. Loans were continued to be paid back, albeit payments were delayed during the reorganization and closure. Homes that were closed were agreed to have loan paid back through chapter dues from the six state chapters based the

assumed liability for all Oxford House loans by the statewide chapter. Payments of \$125 per month were agreed upon by each of the representative chapters. Not all chapters continue to pay this loan amount.

State staff continues to monitor repayment of loans. The state staff makes loan arrangements and disperses funds to the non-profit sponsoring organizations. Funds are paid back by each house on a monthly basis.

Date	Loan Fund Balance *
September 30, 2004	\$32,931
December 31, 2004	\$40,707
March 30, 2005	\$48,243
June 30, 2005	\$55,507

Federal Fiscal Year 2006

In September 2005 two loans were made to the Building Hero's Within, Inc., for recovery homes in the Omaha Area. Dorothy B's on Laurel and Fort Street were provided \$7,863 in loan funds for home development. Housing was to be provided for 7 men and 9 women.

Date	Loan Fund Balance *
September 30, 2005	\$66,100
December 31, 2005	\$63,670
March 30, 2006	\$66,592
June 30, 2006	\$71,822

Federal Fiscal Year 2007

2nd Chance House was provided a \$4,000.00 loan through the auspices of the Beacon of Light, Inc. Beacon of Light has had a good track record of loan repayment and funds were transferred to Beacon of Light in February 2007. 2nd Chance House was located in the 5400 block of Hickory in Omaha and housed 8 men.

The White Lion House was previously loaned funds to support the house operation. In May 2007 the building housing White Lion was sold and the residents requested and received \$2,000 in loan funds to support the move. The new house was occupied by 8 women.

Date	Loan Fund Balance *
September 30, 2006	\$73,267
December 31, 2006	\$75,717
March 30, 2007	\$74,653
June 30, 2007	\$75,653

Federal Fiscal Year 2008

In May 2008 a new Oxford House was established near 48th and Van Dorn Streets in Lincoln, NE. This house received a \$2,700 loan and is residence to 6 men.

In May 2008, the Division of Behavioral Health provided to the Good Neighbor Foundation, Inc., Omaha, NE \$24,000 toward support of their efforts to organize, assist and support Oxford House and Recovery Homes. With these funds the Good Neighbor Foundation is able to provide additional assistance to houses. Each recovery home in the Omaha, Lincoln and Grand Island were to receive at least one visit every 6 months. Good Neighbor Foundation staff was asked to pay special attention to those homes that have had a poor track record of loan repayments. The funding for this contract was derived from interest gained in the last 6 years of the loan fund. The contract is scheduled to end in June 2009.

Date	Loan Fund Balance *
September 30, 2007	\$77,543
December 31, 2007	\$78,949
March 30, 2008	\$80,714
June 30, 2008	\$78,913

The Revolving loan fund continues to be available. A copy of the loan application and procedures are available at <http://www.dhhs.ne.gov/hew/sua/recvyexp.htm>. The Division of Behavioral Health is the sole operator of the loan fund. The fund consists of the initial \$100,000 plus accrued interest less funds loaned and loss due to applicant default. The Division of Behavioral Health makes these loans and receives the loan payments directly from applicants. Payments are returned to the fund pool for future distribution. The Division staff does not become involved in the house operations. The Division is the single contact for loan fund application and payments.

Nebraska funds 10 to 15 Oxford Houses. Without these startup funds, it would be nearly impossible for Oxford Houses to start up. Housing has been identified in the preliminary results of the Substance Abuse Assessment conducted by the University of Nebraska - Lincoln, Public Policy Center as a critical issue. While not every Oxford House (or Recovery Home) is repaying their loan, the majority pay the agreed amount in a timely fashion.

** Funds identified are principle and interest payments by recovery homes and do not include earned interest on principle balance of the loan fund.*

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Nebraska

Goal #8: Tobacco Products

GOAL # 8.

An agreement to continue to have in effect a State law that makes it unlawful for any manufacturer, retailer, or distributor of tobacco products to sell or distribute any such product to any individual under the age of 18; and, to enforce such laws in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under age 18 (See 42 U.S.C. 300x-26, 45 C.F.R. 96.130 and 45 C.F.R. 96.122(d)).

- Is the State's FY 2009 Annual Synar Report included with the FY 2009 uniform application? (Yes/No)
- If No, please indicate when the State plans to submit the report: (mm/dd/2008)

Note: The statutory due date is December 31, 2008.

Is the State's FY 2009 Annual Synar Report included with the FY 2009 Uniform Application - No

Estimated date to Submit: October 30, 2008

Nebraska

Goal #9: Pregnant Women Preferences

GOAL # 9. An agreement to ensure that each pregnant woman be given preference in admission to treatment facilities; and, when the facility has insufficient capacity, to ensure that the pregnant woman be referred to the State, which will refer the woman to a facility that does have capacity to admit the woman, or if no such facility has the capacity to admit the woman, will make available interim services within 48 hours, including a referral for prenatal care (See 42 U.S.C. 300x-27 and 45 C.F.R. 96.131).

FY 2006 (Compliance):

FY 2008 (Progress):

FY 2009 (Intended Use):

GOAL # 9. *An agreement to ensure that each pregnant woman be given preference in admission to treatment facilities; and, when the facility has insufficient capacity, to ensure that the pregnant woman be referred to the State, which will refer the woman to a facility that does have capacity to admit the woman, or if no such facility has the capacity to admit the woman, will make available interim services within 48 hours, including a referral for prenatal care (See 42 U.S.C. 300x-27 and 45 C.F.R. 96.131).*

FFY 2006 (Compliance):

Objective 9.1: -- Continue to require through the regional and regional subcontracts that programs give priority in admissions in the order required by federal regulations including Women and Women with children as top priority.

Contracts continue to require priority for women through order of selection criteria outlined in Attachment E

Objective 9.2 -- Continue to require by contract participation in the Capacity Management, Waiting List System.

Attachment E requires participation in Capacity Management, and wait list system.

Objective 9.3 -- Continue to monitor Waiting List Management System reports to ensure compliance with admission priorities and provision of interim services.

Reports are received weekly by the Division from the several Regional Behavioral Health Authorities. Reports continue to show many agencies having 100 percent of capacity. Additional funds have been provided through Legislative intent to downsize state's psychiatric hospitals.

Objective 9.4. -- Continue to monitor implementation of managed care systems management function, ensure that pre-authorization of services complies with block grant requirements.

State contract with Magellan Behavioral Health, Inc. includes monthly contact to discuss operational issues. Magellan has been responsive to the Division needs relative to the order of selection and in fulfilling the Legislative mandate to downsize the state psychiatric hospitals.

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GOAL # 9. *An agreement to ensure that each pregnant woman be given preference in admission to treatment facilities; and, when the facility has insufficient capacity, to ensure that the pregnant woman be referred to the State, which will refer the woman to a facility that does have capacity to admit the woman, or if no such facility has the capacity to admit the woman, will make available interim services within 48 hours, including a referral for prenatal care (See 42 U.S.C. 300x-27 and 45 C.F.R. 96.131).*

FFY 2008 (Progress):

9.1: -- Continue to require through contracts with Regions and Regional subcontracts that programs give priority in admissions in the order required by federal regulations. Pregnant women and women with dependent children will remain top priorities.

The CSAT core review report received in November 2007 recommended the Division review its conveyance process and list of priorities. As a result of Behavioral Health Reform, committed persons had become a major focus and priority of the state. This did not leave out women but did place them "down" the order of priority. To correct this situation, Substance Abuse language of the Contract is being reviewed to again place women at the top of the priority for admission to treatment programs, and especially women with children.

9.2 -- The Capacity Management Waiting List System will continue, and Regions/providers will be required by contract to participate. Regions will manage the waiting lists among their own providers, making adjustments as needed to facilitate admissions as quickly as possible. When 90% capacity of contracted services has been reached, the Region will notify the Division of Behavioral Health. The Division will intervene as need to ensure communication and collaboration with other Regions who may have capacity available. The Division will also monitor ongoing reporting, and maintain a database of waitlist information. The system will evaluate the effectiveness of current procedures, and make changes as needed to gather accurate data. The data collected will be used to analyze methods of system improvement.

As notated in the Core Technical Review conducted in 2007, Division analysis of the capacity and wait list management systems has been sporadic. Anticipated as a result of Block Grant 101, will be added emphasis on the performance of the system and alterations on how data will be collected at the provider level.

9.3 -- Continue to monitor Waiting List Management System reports to ensure compliance with admission priorities and provision of interim services. This effort is being incorporated into state-wide auditing procedures.

Core Technical review indicted that little monitoring of the Waiting list management system was conducted by the Division. While information is collected on a weekly basis, it was not systematically reviewed by decision makers. The Division has scheduled Block Grant 101 training for staff in late October 2008. This training will emphasis the importance of the capacity and wait list systems.

9.4. -- Continue to monitor managed care systems, and ensure that pre-authorization of services complies with block grant requirements.

The Administrative Service Organization selected as a result of the Request for Proposal let in January 2008 was Magellan Behavioral Health Services, Inc. Magellan has had experience in complying with block grant requirements through established priorities for authorizations for residential services within the state. Authorizations for Pregnant and Post partum women will be highest priority followed by Women and Women with children.

9.5 – The State will monitor the service delivery system in order to identify gaps in access, and develop strategies to improve or change capacity in order to serve the priority population such as of pregnant women and women with dependent children. The Division will promote and support efforts by Regions and providers to achieve “qualified” status.

As of Fiscal Year 2008 all women designated service provides have achieved qualified status. In Omaha a major new player, courtesy of a discretionary grant from CSAT is Family Services. They have developed a new women's specific outpatient and residential program.

9.6 -- Provide technical assistance as appropriate to providers wishing to improve their referral, service and documentation processes. Particular attention will be paid to the provision of gender-specific, trauma-informed care.

Division has continued to provide technical assistance to women's programs and has reviewed the results of the Core Technical Review with Network managers (Regions) as a step toward adjusting priorities.

9.7 – Provide technical assistance as needed to Regional staff auditing programs for compliance with federal block grant requirements. Behavioral Health Authorities (Regions) must ensure that providers of services to women have agreements with accessible primary care providers, and that timely referrals to these primary care providers are documented in a systematic manner. This is being addressed through the state-wide Audit Committee, a body of representatives from all Regions and the Division of Behavioral Health who meet to discuss and improve auditing procedures.

As a result of the Core Technical Review the audit work group has identified documentation as a priority training effort to programs. Each region is working to strengthen documentation at provider levels and to emphasize Substance Abuse priority populations.

9.8 – The Regional contracts will be amended to include specific language related to

provision of interim services and including services to pregnant women and women with dependent children.

Amendments were made to include specific list of interim services for women and for pregnant women in 2008 Region/state contracts. In June 2008, under auspices of the technical assistance plan, consultants suggested additional conveyance changes and those are being reviewed by legal staff of the Department of Health and Human Services for inclusion in contract amendments scheduled for the first quarter of State Fiscal Year 2009.

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GOAL # 9. An agreement to ensure that each pregnant woman be given preference in admission to treatment facilities; and, when the facility has insufficient capacity, to ensure that the pregnant woman be referred to the State, which will refer the woman to a facility that does have capacity to admit the woman, or if no such facility has the capacity to admit the woman, will make available interim services within 48 hours, including a referral for prenatal care (See 42 U.S.C. 300x-27 and 45 C.F.R. 96.131).

FFY 2009 (Intended Use):

9.1: -- Continue to require through contracts with Regional Behavioral Health Authorities and Regional subcontracts that programs give priority in admissions in the order required by federal regulations. Pregnant women and women with dependent children will remain top priorities.

9.2 -- The Capacity Management Waiting List System will continue, and Regions/providers will be required by contract to participate. Division staff will monitor reporting on a weekly basis.

9.3 - Explore alternative methods to collect capacity and wait list information to comply with 14-120 wait list requirements.

9.4 -- Continue to monitor Waiting List Management System reports to ensure compliance with admission priorities and provision of interim services. This effort is being incorporated into state-wide auditing procedures.

9.5 -- Provide technical assistance as appropriate to providers wishing to improve their referral, service and documentation processes.

9.6 – By December 31, 2008, and after Substance Abuse Block Grant 101 training, train Regional Behavioral Health Authority staff auditing programs on compliance with federal block grant requirements.

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Nebraska

Attachment G: Capacity Management

Attachment G: Capacity Management and Waiting List Systems

(See 45 C.F.R. 96.122(f)(3)(vi))

For the fiscal year two years prior (FY 2007) to the fiscal year for which the State is applying for funds:

In **up to five pages**, provide a description of the State's procedures and activities undertaken, and the total amount of funds expended (or obligated if expenditure data is not available), to comply with the requirement to develop capacity management and waiting list systems for intravenous drug users and pregnant women (See 45 C.F.R. 96.126(c) and 45 C.F.R. 96.131(c), respectively). This report should include information regarding the utilization of these systems. Examples of **procedures** may include, but not be limited to:

- development of procedures (and any subsequent amendments) to reasonably implement a capacity management and waiting list system ;
- the role of the Single State Authority (SSA) for substance abuse prevention and treatment ;
- the role of intermediaries (county or regional entity), if applicable, and substance abuse treatment providers; and
- the use of technology, e.g., toll-free telephone numbers, automated reporting systems, etc.

Examples of **activities** may include, but not be limited to:

- how interim services are made available to individuals awaiting admission to treatment ;
- the mechanism(s) utilized by programs for maintaining contact with individuals awaiting admission to treatment; and
- technical assistance.

Attachment G: Capacity Management and Waiting List Systems
(See 45 C.F.R. 96.122(f)(3)(vi))

For the fiscal year two years prior (FY 2007) to the fiscal year for which the State is applying for funds:

In **up to five pages**, provide a description of the State's procedures and activities undertaken, and the total amount of funds expended (or obligated if expenditure data is not available), to comply with the requirement to develop capacity management and waiting list systems for intravenous drug users and pregnant women (See 45 C.F.R. 96.126(c) and 45 C.F.R. 96.131(c), respectively). This report should include information regarding the utilization of these systems. Examples of **procedures** may include, but not be limited to:

- development of procedures (and any subsequent amendments) to reasonably implement a capacity management and waiting list system;
- the role of the Single State Authority (SSA) for substance abuse prevention and treatment;
- the role of intermediaries (county or regional entity), if applicable, and substance abuse treatment providers; and
- the use of technology, e.g., toll-free telephone numbers, automated reporting systems, etc.

Examples of **activities** may include, but not be limited to:

- how interim services are made available to individuals awaiting admission to treatment;
- the mechanism(s) utilized by programs for maintaining contact with individuals awaiting admission to treatment; and
- technical assistance.

The Division of Behavioral Health has implemented, through its regional system, a capacity management and waiting list process. Programs report weekly on utilization and priority persons on waiting lists. Memoranda implementing the assessment, referral and capacity management system were issued in August 1995, to all regions and programs.

As originally designed, each agency reports the number of persons and percent of capacity to its respective regional authority on Monday or Tuesday of each week.

These reported capacities and utilization are forwarded to the Division of Behavioral Health on Tuesday PM. Division staff are assigned responsibility to review reports and to discuss with regions noted occurrences of extended priority populations on wait lists. The reporting instruments from each region vary slightly but all include the stated capacity of the agencies program, number of current enrollees and percent of capacity. Then each agency lists the number of persons on wait lists followed by the number of the priority populations on those wait lists. Addendum s are requested from each program on the current activities to support those priority persons made on behalf of the program including but not limited to, the provision of interim services, maintaining contact with the priority person and current location of the contact (at home awaiting treatment, in other treatment services, incarcerated etc.).

Review of procedures outlined in the April 2007 Core Technical Review site visit conducted by CSAT revealed weaknesses in the application of the procedures as outlined. First, nigher agency reviewed by the site visit team could outline the priority populations. Second one regional team was uncertain of the priorities among the priority populations listed. The survey team did note that contract documents between state and region and region to agency did list the priority populations in approximate federal order. That same team reviewed documentation of interim services at agencies and found significant weaknesses in agency documentation.

At the state level the Core Technical Review site visit team found that staff were not reviewing the reports made by the regions to the state. Also the site visit team indicated that there was not a clear line of authority between a designated staff member and the regions to process potential priority population members between regions if necessary.

In the Final report of the Core Technical Review CSAT recommended strengthening the contract language, by adding specific priority to each of the priority populations and by listing the interim services to be documented on behalf of the priority populations as those services are delivered. The Divisions Corrective Plan dated February 2008 and Technical Assistance Plan dated March 2008 each have specific actions the state will take to strengthen procedures and documentation toward these priority populations.

In the contract for State Fiscal Year 2009, additional wording was inserted specifically enumerating the interim services that a population member was to receive in light of their being placed on a wait list. These contract additions were reviewed in the Conveyance Technical Assistance provided by CSAT and reported to the State in May 2008, in accordance with the Technical Assistance Plan of March 2008. While there has not been resolution of the state staffing through Sept 2008, the states Regional program representatives have re prioritized the review of the weekly reports. Block Grant 101 training of the state staff is scheduled for late October 2008, again in accord with the Technical Assistance, and corrective action plans of earlier in 2008. This training will be followed up with agency/region training once state staff are able to redraft procedures for the implementation and documentation of the

capacity/management system. Agencies continue to work at documentation and regional review and audit procedures have been strengthened toward document review. Agencies continue to question the efficacy of "serving" a enrolled individual both ethically and liability wise.

Block Grant 101 training is scheduled to occur between regions and programs after that of the state staff. Meanwhile the regional staffs have been working to draft procedures while awaiting training of Block Grant 101. While this may seem slightly like the cart before the horse, the intent is to formulate questions that can be answered through attempted procedures in the training and to establish the best possible services to support recovery among all populations, not just the priority populations. Capacity to treat persons is significantly effected when priority population members request admittance. These populations must be reconciled against all persons seeking recovery orientated services.

To date there has not been a need for the state to step into a placement dispute between priority population members and others. Nor has the state had to require the movement of a population member among treatment providers between regions. As stated by the programs, brochures on prenatal care, TB services and referrals to health department have been provided to priority populations seeking treatment and placed on wait lists. In many cases populations are served in less restrictive levels of care (such as outpatient) when residential care is indicated by assessments. Because the state does not have a central assessment and intake process each provider has been made responsible for the provision of services to those seeking treatment.

Nebraska does not have a central assessment and intake process. Assessments are conducted at many non-residential provider locations, and by individuals authorized though the states licensing system. Assessments are conducted by approved providers through the criminal justice system through the process created in the early 2000's to address assessment shopping by those under court supervision. The "standardized model" identifies the types of information that are required of an assessment to be reviewed by the courts and how recommendations for treatment placement are to be addressed. Yet this does not preclude a person from being on several wait lists simultaneously.

Expenditures in support of these activities are absorbed through administrative funds for staffing and communications. No specific block grant funds are designated to administer these activities at the State, Region or agency levels.

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Nebraska

Goal #10: Process for Referring

GOAL # 10. An agreement to improve the process in the State for referring individuals to the treatment modality that is most appropriate for the individual (See 42 U.S.C. 300x-28(a) and 45 C.F.R. 96.132(a)).

FY 2006 (Compliance):

FY 2008 (Progress):

FY 2009 (Intended Use):

GOAL # 10. An agreement to improve the process in the State for referring individuals to the treatment modality that is most appropriate for the individual (See 42 U.S.C. 300x-28(a) and 45 C.F.R. 96.132(a)).

FFY 2006 (Compliance):

Objective 10.1 -- During FFY 2006 conduct monthly reviews with ASO contractor of patient placement process to determine refinements necessary.

Division staff met 10 of the 12 months with the Magellan Behavioral Health Services, Inc staff to review contract details including Reports package: Reviewed reports included:

- *Flow Chart and sample documents (screen shots, TADs, etc.)*
- *website training manual*
- *Resume RC LOC reports*
- *Review of EPC data comments*
- *August Reports package*
- *Status of NOMMS, SOMMS*
- *Magellan contract management*
- *Telecare*

Objective 10.2 -- During FFY 2006 Continue to train and update provider organizations in managed care system registry and authorization process.

Magellan continues to have staff available to train local service providers. Additionally in November 2005, Medicaid introduced American Society of Addiction Medicine Patient Placement Criteria to the Nebraska Substance Abuse providers. In April 2006, the Division issued joint service definitions with Medicaid that incorporated American Society of Addiction Medicine patient Placement Criteria.

Objective 10.3 -- During FFY 2006 provide training to providers on assessment criteria and admission/discharge criteria and the implementation of the Standardized Model to improve quality of assessments for Substance Abuse Offenders and Treatment placement decision.

New admission, continued stay and termination requirements have been implemented in some of the services. Training for all service providers was held via the internet on revised MRO guidelines and continues to be available at:
http://www.hhss.ne.gov/beh/New_Improved_MRO_Guide.pdf.

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GOAL # 10. An agreement to improve the process in the State for referring individuals to the treatment modality that is most appropriate for the individual (See 42 U.S.C. 300x-28(a) and 45 C.F.R. 96.132(a)).

FFY 2008 (Progress):

Objective 10.1 -- During FFY 2008 conduct bi-monthly reviews with ASO contractor to:

- a) Review quality of information
- b) Identify trends
- c) Determine need for further information
- d) Develop strategies for improvement

Bi Monthly meeting were held during Fiscal Year 2008.

The Division of Behavioral Health will also review information from a variety of other sources, such as state-wide and regional needs assessments, consumer and provider surveys, peer review processes and data supplied by professional groups and advisory committees.

Regional Network Management continues to use data systems of the regions to collect and analysis information at the regional level and to discuss at Network Management meetings held with the state on a bi-monthly basis.

Objective 10.2 -- During FFY 2008 Continue to train and update provider organizations in managed care system registry and authorization process.

The Providers have continued to be trained upon request to the Managed care Administrative Service Organization.

Objective 10.3 -- During FFY 2008 the Division of Behavioral Health will work with a variety of stakeholders including the Regions, the Substance Abuse Advisory Committee, consumers and providers to identify unified standards of care and related training needs. Training needs already identified include promotion of the Standardized Model, treatment planning that ensures continuity of care, trauma-informed services, cultural competence, specialized crimineogenics, and provision of interim services.

The Division has let a new Administrative Organization Request for Proposal in January 2008. Among requirements of the RFP, for which Magellan Behavioral Health Services, inch, was successful bidder, are trauma informed and recovery orientated services. The Division continues to work with Magellan on implementation.

Objective 10.4 -- During FFY 2008, the Division of Behavioral Health will be working with system partners to develop a comprehensive system of quality assurance that reflects the Strategic Plan, needs assessment data, individual Regional plans and

national accreditation standards. Once standards of care have been prioritized, comparable national benchmarks will be sought. As system will then be developed to measure progress against these benchmarks, as well as documentation of improved quality in areas of importance to stakeholders. Data will be collected to demonstrate active movement toward specific performance goals.

Under the new Administrative Service Organization contract a quality assurance system has been implemented that includes consumers, advocates, network managers, network providers and state personnel. This QI system will meet for review activities and to set performance measures beginning in October 2008.

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GOAL # 10. An agreement to improve the process in the State for referring individuals to the treatment modality that is most appropriate for the individual (See 42 U.S.C. 300x-28(a) and 45 C.F.R. 96.132(a)).

FFY 2009 (Intended Use):

10.1 – By February 1, 2009, work with Magellan Behavioral Health (Administrative Services Contractor) and Medicaid to update service admission, discharge and continued stay reviews to include standards of care, and American Society of Addiction Medicine (ASAM) patient placement criteria.

10.2 - Continue training for counselors on the Standardized Model for Criminal Justice referrals to the behavioral health system.

10.3 - Work with Division of Children and Family Services, Division of Medicaid and Long Term Care to train counselors on evidence based practices for Substance Abuse treatment.

10.4 - Work with the Division of Behavioral Health Quality Improvement Team to explore methods to test fidelity to evidence based practices.

10.5 -- During FFY 2009 the Division of Behavioral Health will work with a variety of stakeholders including the Regions, the Substance Abuse Advisory Committee, consumers and providers to identify unified standards of care and related training needs.

10.6 - Work with Regional Behavioral Health Authorities to review Division of Behavioral Health policies and procedures regarding placement of intravenous drug users and women in services as priority populations.

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Nebraska

Goal #11: Continuing Education

GOAL # 11. An agreement to provide continuing education for the employees of facilities which provide prevention activities or treatment services (or both as the case may be) (See 42 U.S.C. 300x-28(b) and 45 C.F.R. 96.132(b)).

FY 2006 (Compliance):

FY 2008 (Progress):

FY 2009 (Intended Use):

GOAL # 11. An agreement to provide continuing education for the employees of facilities which provide prevention activities or treatment services (or both as the case may be) (See 42 U.S.C. 300x-28(b) and 45 C.F.R. 96.132(b)).

FFY 2006 (Compliance):

Objective 11.1 -- The Division of Behavioral Health Services will contract with Lincoln Medical Education Partnership to provide core education course training throughout the state to prepare future counselors for meeting Nebraska's Certified Alcohol and Drug Abuse Counselor Certification Requirements.

Core education courses provided by Lincoln Medical Education Partnership were 19 classes for 645 hours of training.

Objective 11.2 -- The Division of Behavioral Health Services will include in the contract with LMEF a requirement to provide 72 hours of continuing education courses which advance the educational needs of employees working within the treatment services system.

Lincoln Medical Education provided 20 classes for 134 hours of service.

Objective 11.3 -- Division of Behavioral Health Services will contract with LMEF for continued activities to strengthen the fields understanding of the CASI and ASI tools within the context of the overall Model for Assessment of Criminal Justice Client.

In Fiscal Year 06 - 3 ASI and 3 CASI training classes were held for 60 hours of training each.

Objective 11.4 -- Division of Behavioral Health Services conduct at least one Nebraska Prevention Generalist Course for all persons working within the substance abuse prevention services system.

Division sponsored two Prevention Generalist trainings in State Fiscal Year 2006

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GOAL # 11. *An agreement to provide continuing education for the employees of facilities which provide prevention activities or treatment services (or both as the case may be) (See 42 U.S.C. 300x-28(b) and 45 C.F.R. 96.132(b)).*

FFY 2008 (Progress):

11.1 -- The Division of Behavioral Health Services will contract with Lincoln Medical Education Partnership to provide core education course training throughout the state to prepare future counselors for meeting Nebraska's Certified Alcohol and Drug Abuse Counselor Certification Requirements.

Lincoln Medical Education Partnership continued to supply core educational courses in 2008. During Fiscal Year 2008 19 Core Education Classes were provided with an average attendance of 17 persons.

11.2 -- The Division of Behavioral Health Services will include in the contract with LMEF a requirement to provide 72 hours of continuing education courses which advance the educational needs of employees working within the treatment services system.

Lincoln Medical Education Partnership continued to supply continuing educational courses in 2008. During Fiscal Year 2008 18 continuing education classes were providers with an average attendance of 19 individuals.

11.3 – The Division of Behavioral Health Services will contract with LMEF for continued activities to strengthen understanding of the CASI and ASI tools. This is especially important within the context of the overall Model for Assessment of Criminal Justice Clients.

Lincoln Medical Education Partnership continued to CASI and ASI courses in 2008. In FY 2008 4 additional ASI CASI training courses were provided with an average attendance of 21 people.

11.4 – The Division of Behavioral Health Services, working with the Division of Public Health, will make changes to the Nebraska Prevention Generalist Training manual to incorporate the Strategic Prevention Framework planning process.

This objective was not accomplished owing to training necessary to the Regional Prevention Coordinators to ready staffs to facilitate technical assistance to community coalitions in the Strategic Prevention Framework planning process.

11.5 – The Division of Behavioral Health Services will train Regional Prevention Coordinators to conduct Prevention Generalist Training.

No prevention generalist training was offered in 2008, as training was focused to

community coalitions. Generalist training is being reviewed given the re-emphasis of coalition building.

11.6 – The Division of Behavioral Health Services will provide training on recovery principles, and development of a recovery-oriented system of care.

Training on recovery orientated system of care is scheduled to occur with the training to implement the new Administrative Service Organization contract.

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GOAL # 11. *An agreement to provide continuing education for the employees of facilities which provide prevention activities or treatment services (or both as the case may be) (See 42 U.S.C. 300x-28(b) and 45 C.F.R. 96.132(b)).*

FFY 2009 (Intended Use):

11.1 -- The Division of Behavioral Health Services will contract with Lincoln Medical Education Partnership to provide core education course training for prospective counselors throughout the state to prepare future counselors for meeting Nebraska's licensure standards for Alcohol and Drug Abuse Counselor.

11.2 -- The Division of Behavioral Health Services will include in the contract with LMEF a requirement to provide 72 hours of continuing education courses which advance the educational needs of employees working within the treatment services system.

11.3 – The Division of Behavioral Health Services will contract with LMEF for continued activities to strengthen understanding of the CASI and ASI tools. This is especially important within the context of the overall Model for Assessment of Criminal Justice Clients.

11.4 – The Division of Behavioral Health Services will provide training on recovery principles, and development of a recovery-oriented system of care.

11.5 - The Division of Behavioral Health will work with Prevention Coordinators to identify community coalitions training needs and to continue to make funds available to support training and technical assistance to community coalitions.

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Nebraska

Goal #12: Coordinate Services

GOAL # 12. An agreement to coordinate ,prevention activities and treatment services with the provision of other appropriate services (See 42 U.S.C. 300x-28(c) and 45 C.F.R. 96.132(c)).

FY 2006 (Compliance):

FY 2008 (Progress):

FY 2009 (Intended Use):

GOAL # 12. An agreement to coordinate prevention activities and treatment services with the provision of other appropriate services (See 42 U.S.C. 300x-28(c) and 45 C.F.R. 96.132(c)).

FFY 2006 (Compliance)

Objective 12.1 -- During the fall of 2006 the Division of Behavioral Health Services will sponsor through its prevention and treatment training contractors a Leadership Institute that will bring national behavioral health researchers and policy makers together with State and community leaders to advance topics of importance for coordination of treatment and prevention services with other social and economic service systems.

Due to Behavioral Health Reform and the implementation of LB 1083, and Mental Health Commitment activities this event was not held.

Objective 12.2 -- During FFY2006 the Division of Behavioral Health Services Prevention Manager will continue to work with the Department of Education to manage implementation of the Safe and Drug-Free Schools and Communities program within Nebraska.

Coordinated effort with the Department of Education and the Governors office continues to implement the Safe and Drug-Free Schools and Communities program.

Objective 12.3 -- During FFY2006 the Division of Behavioral Health Services, the Division of Health Promotion and Education, the Nebraska State Patrol and the U.S. Attorney's Office will work cooperatively to ensure proper monitoring of SYNAR compliance monitoring in Nebraska.

SYNAR group met with Federal Representatives in May 2006 to review and discuss SYNAR implementation under the formal CSAP performance review. Final report on findings was received in August 2006, with one of the technical assistance recommendations being a thorough review of state tobacco laws, enforcement and comprehensive SYNAR programming at the state, and local level. Future years will report on this activity.

Objective 12.5 -- During FFY2006 the Division of Behavioral Health Services Prevention Program will work across organizational boundaries to provide leadership in creating a state behavioral health system that can support community efforts to reduce problems associated with substance abuse and related problems.

Under auspices of the SICA grant the Divisions Prevention Partnership continues to expand with the creation of an Epidemiological work group and funding for epidemiological work provided by CSAP. Staff developed profiles for counties and regions as well as the state as a whole using resources of many state departments.

Objective 12.6 -- During FFY2006 the Division of Behavioral Health Services Prevention Program Manager will meet with Network Managers bi-monthly to update them on prevention activities and encourage coordination of treatment and prevention activities in each region.

Network managers have met quarterly and prevention update have been either personally delivered or in writing from the prevention manager.

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GOAL # 12. *An agreement to coordinate prevention activities and treatment services with the provision of other appropriate services (See 42 U.S.C. 300x-28(c) and 45 C.F.R. 96.132(c)).*

FFY 2008 (Progress):

12.1 -- During FFY2008 the Division of Behavioral Health Services staff will work with the Department of Health and Human Services Public Health section to manage implementation of the Safe and Drug-Free Schools and Communities program within Nebraska.

Division of Public Health, Community Affairs is handling the Safe and Drug Free Schools and Communities program in cooperation of the Department of Education and Governors office. The Division of Behavioral Health, through the regional Prevention coordinators is involved in providing technical assistance to community coalitions selected to receive funding.

12.2 -- During FFY2008 the Division of Behavioral Health Services, the Division of Health Promotion and Education, the Nebraska State Patrol and the U.S. Attorney's Office will work cooperatively to ensure proper monitoring of SYNAR compliance monitoring in Nebraska.

Each of the agencies listed is working toward reduction of smoking. In Nebraska a statewide workplace smoking ban takes effect in 2009. Grand Island, Lincoln and Omaha have local workplace smoking bans.

12.3 – During FFY 2008 the Division will re initialize the request for technical assistance from CSAP on development of a more complete SYNAR program including tobacco law changes?

This request was not a priority in the legislative package suggest to Department of Health and Human Services officials in 2007 or 2008 and thus not implemented.

12.4 -- During FFY2008 the Division of Behavioral Health Services Prevention Program will continue work across organizational boundaries to provide leadership in creating a state behavioral health system that can support community efforts to diminish risk and increase protective factors within communities.

Through the efforts of the Nebraska Partners in Prevention, priorities were established for SPF-sig and other grant funds to communities. The belief is that a few priority areas with concentrated effort will result in improvement in national outcomes toward diminish risk and increased protective factors. The Strategic Prevention Framework assists communities in establishing their priorities based on the model implemented by the State.

12.5-- During FFY2008 the Division of Behavioral Health Services staff will meet with regional prevention coordinators bi-monthly to update them on prevention activities and encourage coordination of treatment and prevention activities in each region.

Meeting have been held monthly either through teleconferencing or face to face meetings to further the goal of coordinated effort between Department of Health and Human Services Divisions and Regional Prevention coordinators.

12.6 - During FFY 2008, the Division of Behavioral Health will contract with an outside entity to perform a comprehensive needs assessment that includes meaningful participation by consumers, providers, Behavioral Health Authority staff, advisory committees and community health and prevention advocates.

The needs assessment process has functioned in collaboration with the Division of Public Health, and has utilized data from the Nebraska State-Wide Epidemiological Survey. The survey identified the following as priorities for prevention:

- *Prevent alcohol use among persons 17 and younger*
- *Reduce binge drinking among 18-25 year olds*
- *Reduce alcohol impaired driving across all ages.*

Similar priorities are being established for treatment services. These priorities have reflected stakeholder input, as well as established best/evidence-based practices. Standards and practices will be developed that integrate prevention and treatment efforts. Community partners have been identified, such as the DHHS Division of Public Health, community primary care providers, mental health care providers, educational systems, consumer advocacy groups and coalitions promoting cultural and linguistic competency. These partners will collaborate to provide services such as early screening in primary care settings, referral to a variety of health resources for rapid, brief intervention, and the promotion of physical/emotional/spiritual wellness.

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GOAL # 12. *An agreement to coordinate prevention activities and treatment services with the provision of other appropriate services (See 42 U.S.C. 300x-28(c) and 45 C.F.R. 96.132(c)).*

FFY 2009 (Intended Use)

12.1 - During FFY2009 the Division of Behavioral Health Services Prevention Program will continue work across organizational boundaries to provide leadership in creating a state behavioral health system that can support community efforts to diminish risk and increase protective factors within communities.

12.2 - The Division will work with other entities of the Department of Health and Human Services to gain knowledge of model programs, coordinate activities between agencies and to coordinate services to individuals.

12.3 - The Division of Behavioral Health will continue to work with the Criminal Justice Advisory Committee to review the Standardized Model for Assessing Individuals in the Criminal Justice System, and to work toward creating a similar model for mental health and compulsive gambling programs.

12.4 - During FFY2009 the Division of Behavioral Health Services staff will meet with regional prevention coordinators monthly to update them on prevention activities and encourage coordination of treatment and prevention activities in each region.

12.5 - Through the Administrative Services Organization (Magellan Behavioral Health) work with Medicaid and Children and Family Services to integrate care to children, families and individuals including adequate support services such as housing and employment opportunities.

12.6 - By February 1, 2009, The Division of Behavioral Health will work with the Department of Education to issue a Request for Proposals to continue Student Assistance Program training and implementation in the school districts of the state through a statewide contractor.

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Nebraska

Goal #13: Assessment of Need

GOAL # 13. An agreement to submit an assessment of the need for both treatment and prevention in the State for authorized activities, both by locality and by the State in general (See 42 U.S.C. 300x-29 and 45 C.F.R. 96.133).

FY 2006 (Compliance):

FY 2008 (Progress):

FY 2009 (Intended Use):

GOAL # 13. An agreement to submit an assessment of the need for both treatment and prevention in the State for authorized activities, both by locality and by the State in general (See 42 U.S.C. 300x-29 and 45 C.F.R. 96.133).

FFY 2006 (Compliance):

Objective 13.1 -- Examine statewide incidence and prevalence of alcohol, tobacco and other drug use to assess programming shifts within prevention that may be needed to improve local effectiveness of prevention efforts.

Due to SICA grant staff changes this objective has not been accomplished. As part of the Epidemiological research grant received from CSAP, this objective is forwarded to FY 2007.

Objective 13.2 – Continue to review work of the long term funding work group to review the comprehensive strategy to effectively use treatment needs assessment information and to use state estimates from the National Household Survey of Drug Use and Health to determine changes in patterns of substance use at the county and Regional levels and to make additional estimates of minority populations substance abuse.

National household survey information has been included into the formula for substance abuse funding distribution outside of the Behavioral Health Reform effort. Behavioral Health Reform has taken up much of the staff time to assist Regional Center staff's to understand the need to shift from an institutional setting to community programming for persons who have been otherwise committed to regional centers for substance abuse problems.

Objective 13.3 – By September June 30, 2006, develop a plan for an array of behavioral health services that meets the requirements of LB 1083 -2004.

Working with Medicare, the Division released service definitions for the Substance Abuse MRO service array in December 2005 that were updated in August 2006.

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GOAL # 13. *An agreement to submit an assessment of the need for both treatment and prevention in the State for authorized activities, both by locality and by the State in general (See 42 U.S.C. 300x-29 and 45 C.F.R. 96.133).*

FFY 2008 (Progress):

13.1 – Coordinate assessment efforts with the Needs Assessment Grant received through CSAP with information that may be needed for Treatment Needs Assessment.

Nebraska Public Policy center received a contract with the Division of behavioral Health to conduct a Needs assessment process to garner perceptions of needs from community stakeholders. At least two town hall meetings were held in each of the six behavioral health regions during the period May through July 2008. Additionally an internet based survey was conducted asking perception of system needs in localities of the state. Over 700 respondents were recorded to the internet based survey. These data are being used by the epidemiological work group and network providers to further establish prevention and treatment priorities of the state.

13.2 – Together with the Nebraska Partners In Prevention Epidemiological Work Group work with other state agencies to foster a single source for Substance Abuse Prevention and Treatment Needs assessment information within the Department of Health and Human Services.

This is an ongoing work effort. To date no single departmental site has been able to be established.

13.3– Using county by county estimates of Substance Abuse population in Need generated in conjunction with the Western Interstate Commission on Higher Education (WICHE) - generate estimates for each of the Regions of state target population for substance abuse services. Compare against National Drug Use and Health Survey by Region which are the same as Nebraska's Regional Behavioral Health Organizations (sub state entities)

This effort is scheduled for contract in Fiscal year 2009 through the University of Nebraska Medical Center Epidemiological Department. A small area study using social indicators will be conducted and build on the efforts of the 2001 survey results.

13.4 – Legislation has mandated that priority be given to persons exiting the State Regional Centers. Continue the ongoing assessment of community services needed to promote successful recovery. Promote use of Medicaid payments to fund such services for qualified individuals.

Division continues to work with the Medicaid Division to promote additional Substance Abuse services to be paid for by Medicaid using match funds from the Davison. In total

9 services are now funded including Medical Detoxification occurring at hospitals for qualified individuals.

13.5 – By June 2008 Explore with Nebraska Annual Social Indicators Survey possibilities of replicating National Survey on Drug Use and Health toward estimating by region subpopulation prevalence rates for national outcome measures.

This effort was not addressed in 2008 owing to epidemiological studies by the Public Policy center.

13.8 – By June 30, 2008 work with the Regional Behavioral Health Authorities, consumers and other stakeholders to:

- Identify gaps in services and/or barriers to recovery.
- Prioritize geographic areas of greatest need.
- Prioritize service areas of greatest need.
- Identify potential resources.
- Develop a strategic planning process that involves the Division of Behavioral Health Services, Behavioral Health Authorities, consumers, providers and other stakeholders.
- Utilize annual plans of expenditures fill gaps identified.

This effort was incorporated into the effort to conduct the statewide needs assessment through the University of Nebraska Public Policy Center.

13.9 - During FFY 2008 the Division of Behavioral Health will work with the Division of Public Health to schedule a Treatment Needs Assessment process and to implement the findings of the NEPIP based on the Prevention Needs Assessment's priorities identified by NEPIP as:

- Prevent alcohol use among persons 17 and younger
- Reduce binge drinking among 18-25 year olds
- Reduce alcohol impaired driving across all ages.

Regional Prevention Coordinators are charged with coordination of effort in their region toward these three listed goals. All efforts are moving community coalitions toward concentrating efforts to implement community based programs focused at these three priorities.

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GOAL # 13. *An agreement to submit an assessment of the need for both treatment and prevention in the State for authorized activities, both by locality and by the State in general (See 42 U.S.C. 300x-29 and 45 C.F.R. 96.133).*

FFY 2009 (Intended Use):

13.1 – Coordinate assessment efforts with the Needs Assessment Grant received through CSAP with information that may be needed for Treatment Needs Assessment.

13.2 - During FFY 2009 the Division of Behavioral Health will continue to work with the Division of Public Health on the Epidemiological work group to identify areas of critical need within the state and to target resources to those need areas.

13.3 – Together with the Nebraska Partners In Prevention Epidemiological Work Group work with other state agencies to foster a single source for Substance Abuse Prevention and Treatment Needs assessment information within the Department of Health and Human Services.

13.4 – Contract with University of Nebraska Medical center to develop a statistical method to update treatment needs assessment for the state utilizing the work of the 2001 Needs Assessment Grant, social indicators and small area estimation procedures.

13.5 - Continue working with the University of Nebraska - Lincoln, Public Policy Center to review treatment needs as identified in the small group discussions and internet survey conducted in summer 2008.

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Nebraska

Goal #14: Hypodermic Needle Program

GOAL # 14. An agreement to ensure that no program funded through the block grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs (See 42 U.S.C. 300x-31(a)(1)(F) and 45 C.F.R. 96.135(a)(6)).

FY 2006 (Compliance):

FY 2008 (Progress):

FY 2009 (Intended Use):

GOAL # 14

-- *An agreement to ensure that no program funded through the block grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs (See 42 U.S.C. 300x-31(a)(1)(F) and 45 C.F.R. 96.135(a)(6)).*

FFY 2006 (Compliance):

Objective 14.1 -- Include restrictions on the use of funds for this purpose in all Regional and Direct contracts.

Restriction included in contract section Attachment E.

Objective 14.2 -- Work with contract work group and fiscal managers work team to include appropriate policies and monitoring guidelines for network managers to check program compliance with restriction.

Restriction is included in the Audit workbook.

Objective 14.3 -- Check program compliance with this restriction during monitoring visits of programs by regions and state staff.

No reports of violations of this provision have been documented in Fiscal Year 2006.

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GOAL # 14

-- An agreement to ensure that no program funded through the block grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs (See 42 U.S.C. 300x-31(a)(1)(F) and 45 C.F.R. 96.135(a)(6)).

FFY 2008 (Progress):

14.1 -- Include restrictions on the use of funds for this purpose in all Regional and Direct contracts.

Included in regional contracts.

14.2 -- Work with contract work group and fiscal managers work team to include appropriate policies and monitoring guidelines for network managers to check program compliance with restriction.

Restrictions are in place and regions monitor activities. Core technical review conducted in 2007 by CSAT did not find concerns regarding these policies.

14.3 -- Check program compliance with this restriction during monitoring visits of programs by regions and state staff.

Core Technical Review conducted in 2007 by CSAT indicated that state must take a greater responsibility for contract compliance monitoring regarding block grant requirement, in that effort, Division of Behavioral Health staff will attend Block Grant 101 training in October 2008.

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GOAL # 14

-- An agreement to ensure that no program funded through the block grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs (See 42 U.S.C. 300x-31(a)(1)(F) and 45 C.F.R. 96.135(a)(6)).

FFY 2009 (Intended Use):

14.1 -- Include restrictions on the use of funds for this purpose in all Regional and Direct contracts.

14.2 -- Work with contract work group, fiscal managers and audit work teams to include appropriate policies and monitoring guidelines for network managers to check program compliance with restriction.

14.3 -- Check program compliance with this restriction during monitoring visits of programs by regions and state staff.

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Nebraska

Goal #15: Independent Peer Review

GOAL # 15. An agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers that receive funds from the block grant (See 42 U.S.C. 300x-53(a) and 45 C.F.R. 96.136).

FY 2006 (Compliance):

FY 2008 (Progress):

FY 2009 (Intended Use):

GOAL # 15

-- An agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers that receive funds from the block grant (See 42 U.S.C. 300x-53(a) and 45 C.F.R. 96.136).

FFY 2006 (Compliance)

Objective 15.1 -- Contract with the treatment providers association to conduct peer reviews during FFY 2006.

Peer review contract was signed in July of 2006.

Under the terms of this contract, the Peer Review team (Nebraska Association of Behavioral Health Organizations) is awarded a total of \$17,000 to conduct reviews for Mental Health and Substance Abuse providers.

July to September 2006- A new peer review committee was identified and a meeting was held to review any potential material/manual revisions.

Objective 15.2 -- Monitor contractor performance of peer reviews.

Staff member is working with the Nebraska Association of Behavioral Health Organizations to review activities and reviews conducted.

Objective 15.3 -- Review reports of peer review activities during FFY 2006 and develop any needed technical assistance plans stemming from the reviews.

October-December 2006- Final locations of the site reviews were determined; 3 Mental Health site and 3 Substance Abuse sites with a total of 12 reviews.

Reports were received in July of 2007 and indicated that the peer review sites chosen offered representation from various service levels and to provide a mix of rural and urban programs. All six programs were in compliance. Among the improvements that were suggested, several best practices and major strengths were identified. Some of these included a TIER system (Totally Integrated Electronic records), adherence to CARF guidelines and Strategic planning, as well as CQI work reduction in medication error. Suggested improvements highlighted a need for continued problem solving with the agency wait list and better access to grievance forms for consumers.

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GOAL # 15

-- An agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers that receive funds from the block grant (See 42 U.S.C. 300x-53(a) and 45 C.F.R. 96.136).

FFY 2009 (Intended Use):

15.1 – Determine number of agencies that have received national accreditation that will be reviewed in the fiscal year and explore integration of national accreditation into the peer review process.

15.2 – Work with the Nebraska Association of Behavioral Health Organizations to gather consumer opinions in the Peer review process at agencies identified, including the potential use of consumers and families in the review process.

15.3 – Along with current identified treatment standards, make certain peer review addresses:

- Interim services
- Consumer and family inclusion in all aspects of treatment
- Activities to promote long-term recovery as well as acute treatment

15.4 - Work with the Nebraska Association of Behavioral Health Organizations to report peer review activities to the State Advisory Committee on Substance Abuse Services, and to develop appropriate training in areas identified in the peer review process.

15.5 – By June 30 have explore development of Consumer Advisory Teams at the regional level to provide oversight of peer review activities for Mental Health and Substance Abuse.

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GOAL # 15

-- An agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers that receive funds from the block grant (See 42 U.S.C. 300x-53(a) and 45 C.F.R. 96.136).

FFY 2009 (Intended Use):

15.1 – Determine number of agencies that have received national accreditation that will be reviewed in the fiscal year and explore integration of national accreditation into the peer review process.

15.2 – Work with the Nebraska Association of Behavioral Health Organizations to gather consumer opinions in the Peer review process at agencies identified, including the potential use of consumers and families in the review process.

15.3 – Along with current identified treatment standards, make certain peer review addresses:

- Interim services
- Consumer and family inclusion in all aspects of treatment
- Activities to promote long-term recovery as well as acute treatment

15.4 - Work with the Nebraska Association of Behavioral Health Organizations to report peer review activities to the State Advisory Committee on Substance Abuse Services, and to develop appropriate training in areas identified in the peer review process.

15.5 – By June 30 have explore development of Consumer Advisory Teams at the regional level to provide oversight of peer review activities for Mental Health and Substance Abuse.

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Nebraska

Attachment H: Independent Peer Review

Attachment H: Independent Peer Review (See 45 C.F.R. 96.122(f)(3)(v))

In **up to three pages** provide a description of the State's procedures and activities undertaken to comply with the requirement to conduct independent peer review during FY 2007 (See 42 U.S.C. 300x-53(a)(1) and 45 C.F.R. 96.136).

Examples of **procedures** may include, but not be limited to:

- the role of the Single State Agency(SSA) for substance abuse prevention activities and treatment services in the development of operational procedures implementing independent peer review ;
- the role of the State Medical Director for Substance Abuse Services in the development of such procedures ;
- the role of the independent peer reviewers; and
- the role of the entity(ies) reviewed.

Examples of **activities** may include, but not be limited to:

- the number of entities reviewed during the applicable fiscal year ;
- technical assistance made available to the entity(ies) reviewed; and
- technical assistance made available to the reviewers, if applicable.

Attachment H: Independent Peer Review (See 45 C.F.R. 96.122(f)(3)(v))

In **up to three pages** provide a description of the State's procedures and activities undertaken to comply with the requirement to conduct independent peer review during FY 2006 (See 42 U.S.C. 300x-53(a)(1) and 45 C.F.R. 96.136).

Examples of **procedures** may include, but not be limited to:

- the role of the Single State Authority (SSA) for substance abuse prevention activities and treatment services in the development of operational procedures implementing independent peer review;
- the role of the State Medical Director for Substance Abuse Services in the development of such procedures;
- the role of the independent peer reviewers; and
- the role of the entity(ies) reviewed.

Examples of **activities** may include, but not be limited to:

- the number of entities reviewed during the applicable fiscal year;
- technical assistance made available to the entity(ies) reviewed; and
- technical assistance made available to the reviewers, if applicable.

Peer review activities have been carried on by the Nebraska Association of Behavioral Health Organizations (NABHO). Initially a protocol for only substance abuse organizations was negotiated and implemented. That protocol included a sampling of 5% of organizations receiving funds from the Division for Substance Abuse prevention or treatment. Beginning in 2001 a mental health protocol was also developed and implemented in community organizations receiving funds from the Division of Behavioral Health Services. The goal is to conduct five reviews annually and to submit reports to the Division.

In the spring 2001 CSAT provided technical assistance to Nebraska on the Peer Review process. In the recommendations consultants made the following statement: "the recommendations to follow are not significant and should not require major adjustments to the design of the current system."

Consultant recommendations made include:

1. Provide more explicit detail regarding who comprises the NABHO Peer Review Committee, how committee members are selected (and by whom), and how long they serve.
2. Before reports are considered final, fortify the report submission process by initially submitting reports to programs as drafts, conducting a formal debrief between teams and programs after the drafts are submitted, and being more explicit about how differences of opinion are rectified and the circumstances under which reports are revised.
3. Develop a mechanism for aggregating peer review data at the end of the year to highlight themes regarding best practices, innovative approaches, and system wide opportunities for improvement.
4. Have the State Medical Director for Substance Abuse sign the peer review policies and procedures to make it evident that the policies and procedures are developed in consultation with the medical director.
5. Be more explicit about the number of programs that need to be selected each year and the selection process.
6. Further clarify the level and type of experience required of reviewers.
7. Include a specific sampling method that peer reviewers should use when selecting client records.

Protocol has been revised to incorporate the observation of the consultant and is specific in what information is to be included in the peer review the role of the peer

NABHO peer reviewers conducted on site reviews at selected agencies. Agencies are selected randomly. Based on the types of programs conducted by selected agencies volunteer peer reviewers are requested. Reviewers are counselors from agencies throughout the state with similar programs. The on site review is intended to provide technical assistance and training to the staff of the agency being visited and to facilitate cross training in the state overall.

Agency staffs are expected to assist the peer reviewers in determining the compliance of the agency in various aspects of clinical records management, program quality assurance, clinical appropriateness and overall documentation. During the course of the review staff of the agency will meet with and work along side the peer reviewer in a cooperative effort to strengthen the agencies overall efforts and to share with the peer reviewer superior efforts. Results of all the reviews conducted by NABHO in each Calendar year are submitted in a single report to the Division.

In discussions with NABHO representatives training of new reviewers and the durability of the process have become an issue. NABHO has asked for a process that provides CEU's for continuing education for reviewers. This is being reviewed by the state in the revision of the counselor certification regulations. Additional concerns include the amount of time necessary for reviewers. It is at least two days out of a reviewers schedule to conduct reviews and additional time to write a report on findings.

Major issues from reviews in the last few years include:

Calendar year 2006 – In January 2006 An offer was made to the Nebraska Association of Behavioral Health Organizations who accepted and a contract was let in August 2006. The training protocol to be used will be the same as that protocol developed previously. Training of counselor/reviewers were conducted late October 06. The report of activities of the reviewers was received in July 2007. That report acknowledged difficulties in scheduling reviews, especially in agencies undergoing national accreditation reviews. Some agencies has other reasons for not partaking of the reviews.

In recent national training, staff of the Division of Behavioral Health heard how other states had incorporated national accreditation into the peer review process. State staff will be exploring this alternative.

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Nebraska

Goal #16: Disclosure of Patient Records

GOAL # 16. An agreement to ensure that the State has in effect a system to protect patient records from inappropriate disclosure (See 42 U.S.C. 300x-53(b), 45 C.F.R. 96.132(e), and 42 C.F.R. part 2).

FY 2006 (Compliance):

FY 2008 (Progress):

FY 2009 (Intended Use):

GOAL # 16. An agreement to ensure that the State has in effect a system to protect patient records from inappropriate disclosure (See 42 U.S.C. 300x-53(b), 45 C.F.R. 96.132(e), and 42 C.F.R. part 2).

FFY 2006 (Compliance)

Objective 16.1 -- As part of ongoing monitoring and certification of programs, ensure compliance with existing rules and regulations on client confidentiality.

Confidentiality guidelines have been reviewed with providers. A technical Assistance telephone conversation was held in the Spring 2006 to review Substance Abuse requirements relative to Behavioral Health Reform and the sharing of clinical information for placement purposes with Regions for those persons discharged from Regional Centers (State Psychiatric Hospitals) into community programs. Subsequent communications between Regional Centers, Regions and Community Programs resulted in agreements to obtain releases of information.

Objective 16.2 -- Through contracts with an appropriate training provider, provide at least one workshop on confidentiality of client records.

One training was provided by Lincoln Medical Education Partnership on Confidentiality as a part of the continuing education courses offered and one training was provided as a part of the core course curriculum.

Objective 16.3 -- Provide technical assistance (including TIPS) to programs regarding inquiries concerning confidentiality of Alcohol Drug Abuse client records and protected health information related to HIPAA

Agencies have continued to collect and share information on HIPAA and 42 CFR through regional provider meetings.

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GOAL # 16. *An agreement to ensure that the State has in effect a system to protect patient records from inappropriate disclosure (See 42 U.S.C. 300x-53(b), 45 C.F.R. 96.132(e), and 42 C.F.R. part 2).*

FFY 2008 (Progress)

16.1 -- As part of ongoing monitoring and certification of programs, ensure compliance with existing rules and regulations on client confidentiality.

Programs are audited every year by the regions and this is one of the audit reviews. No specific incidents of client confidentiality violations have been noted.

16.2 -- Through contracts with an appropriate training provider, provide at least one workshop on confidentiality of client records.

Lincoln Medical Education Foundation has continued to offer a client confidentiality refresher course.

16.3 -- Provide technical assistance (including TIPS) to programs regarding inquiries concerning confidentiality of Alcohol Drug Abuse client records and protected health information related to HIPAA

No inquiries were made regarding confidentiality guidelines in 2008

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GOAL # 16. *An agreement to ensure that the State has in effect a system to protect patient records from inappropriate disclosure (See 42 U.S.C. 300x-53(b), 45 C.F.R. 96.132(e), and 42 C.F.R. part 2).*

FFY 2009 (Intended Use)

16.1 -- As part of ongoing monitoring and certification of programs, ensure compliance with existing rules and regulations on client confidentiality.

16.2 -- Through contracts with an appropriate training provider, provide at least one workshop on confidentiality of client records.

16.3 -- Provide technical assistance (including TIPS) to programs regarding inquiries concerning confidentiality of Alcohol Drug Abuse client records and protected health information related to HIPAA

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Nebraska

Goal #17: Charitable Choice

GOAL # 17. An agreement to ensure that the State has in effect a system to comply with services provided by non-governmental organizations (See 42 U.S.C. 300x-65 and 42 C.F.R. part 54 (See 42 C.F.R. 54.8(b) and 54.8(c)(4), Charitable Choice Provisions; Final Rule (68 FR 189, pp. 56430-56449, September 30, 2003).

FY 2006 (Compliance):
FY 2008 (Progress):
FY 2009 (Intended Use):

Goal # 17: An agreement to ensure that the State has in effect a system to comply with 42 U.S.C. 300x-65 and 42 C.F.R. part 54 (See 42 C.F.R. 54.8(c)(4) and 54.8(b), Charitable Choice Provisions and Regulations.

FY 2006 (Compliance):

Objective 17.1 Continue to work with NEBHANDS to facilitate provision of Behavioral Health Services alternative services through community and faith based organizations meeting state regulatory requirements.

Nebhands did not receive additional monies and ceased to provide the level of training after June 30, 2006, as was previously experienced. The number of participants in NEBHANDS training continued to be strong until funding ended.

Objective 17.2: By April 1, 2006, State will review contract provisions with Regional Governing Boards and where necessary provide wording to be included in contracts and subcontracts.

The Division did not change contract language. All service providers must comply with state regulations regarding licensure to provide services in the Nebraska Behavioral Health Network. On November 1, 2006, the division sent to all regions information on the provisions of Charitable Choice and requested a count of persons who might have "opted out" from service providers.

Objective 17.3: By June 30, 2006 determine if the State of Nebraska can comply with the "alternative provider" counting provisions.

Until late October 2006, The Division received no comments regarding the provisions of charitable choice from federal, state or local programs. Federal representatives alerted the Division of the need to construct a reporting system for those persons who "opt out."

The division requested from providers and regions the known number of times persons have opted out under the provisions of Charitable Choice in Late October 2006. Beginning November 1, weekly capacity and utilization reports included the provision of counts from agencies of individuals opting out. Regions reported zero incidents of opting out, and have requested further clarification of the provisions and implementation guidelines.

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Goal # 17: *An agreement to ensure that the State has in effect a system to comply with 42 U.S.C. 300x-65 and 42 C.F.R. part 54 (See 42 C.F.R. 54.8(c)(4) and 54.8(b), Charitable Choice Provisions and Regulations.*

FY 2008 (Progress):

17.1 - Continue reporting of Charitable Choice provisions in weekly capacity and wait list reporting system.

Agencies report on the Capacity reporting system any charitable choice requests - No incidents have been recorded in 2008.

17.2 - Review with Regional Network Managers Charitable Choice provision and to answer questions as they arise.

Division staff continue to review requirements with the Regions and field questions.

17.3 Programs are unsure of what constitutes a identifiable event under charitable choice. Technical assistance from federal representatives will be requested in FY 2008.

Block Grant 101 has been requested as a result of the Core Technical Review Technical Assistance Plan finalized in March 2008. Block Grant 101 will be held for Division staff in October 2008.

17.4 Work with Regional Behavioral Health Authorities to identify providers that may be affected by this provision - Currently the state does business with 7 entities: Catholic Charities, (Region 4 and 6), Lutheran Family Services (Statewide), St. Monica's (Lincoln), Santa Monica's (Omaha), Faith Regional Hospital (Region 4), and Interchurch Ministries (Statewide)

All providers may be affected and regions have been notified of this requirement both through e-mail and in contract language. Block Grant 101 is being scheduled in October 2008, and this training will be carried forward to Regional Behavioral Health Authorities with revised policies and procedures from the state to implement Charitable Choice provisions.

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Goal # 17: *An agreement to ensure that the State has in effect a system to comply with 42 U.S.C. 300x-65 and 42 C.F.R. part 54 (See 42 C.F.R. 54.8(c)(4) and 54.8(b), Charitable Choice Provisions and Regulations.*

FY 2009 (Intended Use):

17.1 - The Division of Behavioral Health will continue requiring agencies to report Charitable Choice provisions in weekly capacity and wait list reporting system.

17.2 - Staff will attend Block Grant 101 and review Charitable Choice provisions.

17.3 - Review with Regional Network Managers Charitable Choice provision and provide technical assistance to Regional Networks and programs

17.4 As the result of Block Grant 101 training work with the Audit Work Group to strengthen the provision of charitable choice in the state through provider training.

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Attachment I: Charitable Choice

Under Charitable Choice, States, local governments, and religious organizations, each as SAMHSA grant recipients, must: (1) ensure that religious organizations that are providers provide notice of their right to alternative services to all potential and actual program beneficiaries (services recipients); (2) ensure that religious organizations that are providers refer program beneficiaries to alternative services; and (3) fund and/or provide alternative services. The term "alternative services" means services determined by the State to be accessible and comparable and provided within a reasonable period of time from another substance abuse provider ("alternative provider") to which the program beneficiary ("services recipient") has no religious objection.

The purpose of Attachment I is to document how your State is complying with these provisions.

For the fiscal year prior (FY 2008) to the fiscal year for which the State is applying for funds check the appropriate box(es) that describe the State's procedures and activities undertaken to comply with the provisions.

Notice to Program Beneficiaries -Check all that Apply

- Used model notice provided in final regulations
- Used notice developed by State (Please attach a copy in Appendix A)
- State has disseminated notice to religious organizations that are providers
- State requires these religious organizations to give notice to all potential beneficiaries

Referrals to Alternative Services -Check all that Apply

- State has developed specific referral system for this requirement
- State has incorporated this requirement into existing referral system(s)
- SAMHSA's Treatment Facility Locator is used to help identify providers
- Other networks and information systems are used to help identify providers
- State maintains record of referrals made by religious organizations that are providers
- 0 Enter total number of referrals necessitated by religious objection to other substance abuse providers ("alternative providers"), as defined above, made in previous fiscal year. Provide total only; no information on specific referrals required.

Brief description (one paragraph) of any training for local governments and faith-based and community organizations on these requirements.

Direct service contracts are let through the Regional Governing Boards who have the statutory authority to contract for local service provision. In many areas of the state the only provider is a traditional faith based service provider who can meet the regulatory requirements for service provision as an individual or organization through the Department of Health and Human Services Regulation and Licensure. The State of Nebraska requires all service providers to be licensed as an individual or organization that receive state or federal funding for Substance Abuse Treatment Services or ancillary services such as child care, transportation, etc. Nebraska began collecting Charitable Choice "opt out" information from the Regional Behavioral Health Authorities on November 1, 2006 as an additional weekly report added on to the Capacity management wait list information. All Regions were provided direct access to the Charitable Choice regulations on the SAMHSA web site on November 3, (<http://www.samhsa.gov/FBCI/charchoice.aspx>). When programs were surveyed about the number of persons who may have opted out in early November for the previous year, programs reported none. No reports of persons opting out have been received through September 2008. Programs are unsure of what constitutes a identifiable event under charitable choice. Technical assistance in the form of Block Grant 101 from federal representatives has been requested in FY 2009.

Attachment J

If your State plans to apply for any of the following waivers, check the appropriate box and submit the request for a waiver at the earliest possible date.

- To expend not less than an amount equal to the amount expended by the State for FY 1994 to establish new programs or expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children (See 42 U.S.C. 300x-22(b)(2) and 45 C.F.R. 96.124(d)).
- Rural area early intervention services HIV requirements (See 42 U.S.C. 300x-24(b)(5)(B) and 45 C.F.R. 96.128(d))
- Improvement of process for appropriate referrals for treatment, continuing education, or coordination of various activities and services (See 42 U.S.C. 300x-28(d) and 45 C.F.R. 96.132(d))
- Statewide maintenance of effort (MOE) expenditure levels (See 42 U.S.C. 300x-30(c) and 45 C.F.R. 96.134(b))
- Construction/rehabilitation (See 42 U.S.C. 300x-31(c) and 45 C.F.R. 96.135(d))

If your State proposes to request a waiver at this time for one or more of the above provisions, include the waiver request as an attachment to the application, if possible. The Interim Final Rule, 45 C.F.R. 96.124(d), 96.128(d), 96.132(d), 96.134(b), and 96.135(d), contains information regarding the criteria for each waiver, respectively. A formal waiver request must be submitted to SAMHSA at some point in time if not included as an attachment to the application.

Nebraska

Attachment J: Waivers

Attachment J: Waivers

If your State proposes to request a waiver at this time for one or more of the above provisions, include the waiver request as an attachment to the application, if possible. The Interim Final Rule, 45 C.F.R. 96.124(d), 96.128(d), 96.132(d), 96.134(b), and 96.135(d), contains information regarding the criteria for each waiver, respectively. A formal waiver request must be submitted to SAMHSA at some point in time if not included as an attachment to the application.

Nebraska does not seek any of the waivers indicated in Attachment J.

SUBSTANCE ABUSE STATE AGENCY SPENDING REPORT

State: Nebraska

Dates of State Expenditure Period: From: 7/1/2006 To: 6/30/2007

Activity	Source of Funds					
	A.SAPT Block Grant FY 2006 Award (Spent)	B.Medicaid (Federal, State and Local)	C.Other Federal Funds (e.g., Medicare, other public welfare)	D.State Funds	E.Local Funds (excluding local Medicaid)	F.Other
Substance Abuse Prevention* and Treatment	\$ 5,900,151	\$	\$	\$ 16,860,611	\$ 376,061	\$
Primary Prevention	\$ 1,570,566		\$ 2,979,993	\$ 254,676	\$	\$
Tuberculosis Services	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0
HIV Early Intervention Services	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0
Administration: Excluding Program/Provider	\$ 393,196		\$	\$	\$	\$
Column Total	\$7,863,913	\$0	\$2,979,993	\$17,115,287	\$376,061	\$0

*Prevention other than Primary Prevention

- Foot Notes

State Expenditures are not available by specific classification of Prevention and Treatment - Nebraska Information System is not yet set up to code specific expenditures in the most recent completed State Fiscal Year. As part of the Stat's Corrective Action Plan, Prevention set aside, and Women's set aside is being requested to be encoded. As of August 2008 such coding has not yet occurred. Expenditure listed on Form 4 are derived from the Report of Actual Expenditures of the Regional Behavioral Health Authorities presented to the State in September 2007 for State Fiscal Year 2007 those reports do indicate Prevention and Women's set asides.

Form 4ab

State: Nebraska

Form 4a. Primary Prevention Expenditures Checklist

Activity	SAPT Block Grant FY 2006	Other Federal	State Funds	Local Funds	Other
Information Dissemination	\$ 124,025	\$	\$	\$	\$
Education	\$ 39,469	\$	\$	\$	\$
Alternatives	\$ 199,117	\$	\$ 254,676	\$	\$
Problem Identification & Referral	\$ 173,932	\$	\$	\$	\$
Community Based Process	\$ 240,164	\$	\$	\$	\$
Environmental	\$ 733,859	\$ 2,979,993	\$	\$	\$
Other	\$	\$	\$	\$	\$
Section 1926 - Tobacco	\$ 60,000	\$	\$	\$	\$
Column Total	\$1,570,566	\$2,979,993	\$254,676	\$0	\$0

Form 4b. Primary Prevention Expenditures Checklist

Activity	SAPT Block Grant FY 2006	Other Federal	State Funds	Local Funds	Other
Universal Indirect	\$	\$	\$	\$	\$
Universal Direct	\$	\$	\$	\$	\$
Selective	\$	\$	\$	\$	\$
Indicated	\$	\$	\$	\$	\$
Column Total	\$0	\$0	\$0	\$0	\$0

- Foot Notes

Nebraska is in the process of developing a prevention data collection system for Block Grant, SPF-SIG, Drug Free Schools and Communities and Drug Free Communities grantees in the State. Region 6 Behavioral Health Authority began Beta testing of the new information system Nebraska Prevention Information Reporting System (NPIRS) in August 2008 at <http://www.npirs.org>. Information derived for this report period is for the Six Strategies.

Funding Sources for State Fiscal Year 2007 - State Incentive Cooperative Act (SICA) as other federal.

Resource Development Expenditure Checklist

State: Nebraska

Did your State fund resource development activities from the FY 2006 SAPT Block Grant?

Yes No

Expenditures on Resource Development Activities are:				
<input checked="" type="radio"/> Actual <input type="radio"/> Estimated				
Activity	Column 1 Treatment	Column 2 Prevention	Column 3 Additional Combined	Total
Planning, Coordination and Needs Assessment	\$	\$	\$	\$
Quality Assurance	\$	\$	\$	\$
Training (post-employment)	\$ 65,000	\$	\$	\$ 65,000
Education (pre-employment)	\$ 65,000	\$	\$	\$ 65,000
Program Development	\$	\$	\$	\$
Research and Evaluation	\$	\$	\$	\$
Information Systems	\$	\$	\$	\$
Column Total	\$130,000	\$0	\$0	\$130,000

SUBSTANCE ABUSE ENTITY INVENTORY

State: Nebraska

1. Entity Number	2. I-SATS ID [X] if no I-SATS ID	3. Area Served	4. State Funds (Spent during State expenditure period)	FISCAL YEAR 2006			
				5. SAPT Block Grant Funds for Substance Abuse Prevention and Treatment Services (other than primary prevention)	5a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children	6. SAPT Block Grant Funds for Primary Prevention	7. SAPT Block Grant Funds for Early Intervention Services for HIV (if applicable)
100103	100103	North East	\$119,299	\$160,472	\$0	\$188,693	\$0
100126	100126	North East	\$368,527	\$36,814	\$0	\$0	\$0
100279	100279	South Central	\$40,467	\$13,194	\$0	\$0	\$0
100407	100407	South East	\$0	\$0	\$0	\$15,612	\$0
100415	100415	South East	\$29,320	\$98,546	\$80,000	\$30,025	\$0
100431	100431	Omaha Metro	\$493,645	\$604,683	\$0	\$0	\$0
100563	100563	South East	\$44,867	\$53,060	\$0	\$9,897	\$0
100605	100605	Panhandle	\$74,120	\$455,650	\$0	\$0	\$0
100621	100621	North East	\$0	\$0	\$0	\$204,335	\$0
100622	100622	North East	\$138,653	\$0	\$21,157	\$0	\$0
100811	100811	North East	\$460	\$0	\$0	\$16,243	\$0
100829	100829	South East	\$6,351	\$0	\$0	\$195,428	\$0
100837	100837	Omaha Metro	\$1,555	\$0	\$0	\$148,011	\$0
101041	101041	South Central	\$625	\$0	\$0	\$19,240	\$0
101258	101258	South Central	\$81,584	\$84,338	\$0	\$0	\$0
101296	101296	Omaha Metro	\$43,694	\$2,143	\$0	\$0	\$0
101413	101413	Omaha Metro	\$139,253	\$956,502	\$0	\$0	\$0
101793	101793	Omaha Metro	\$119,858	\$242,032	\$0	\$0	\$0
300072	30072	Omaha Metro	\$257,002	\$88,062	\$0	\$0	\$0
300205	300205	Panhandle	\$90,214	\$266,813	\$0	\$0	\$0
301302	301302	North East	\$811,297	\$436,785	\$0	\$0	\$0
301401	301401	South East	\$83,642	\$142,468	\$0	\$0	\$0
301500	301500	South Central	\$30,877	\$10,300	\$0	\$0	\$0
301708	301708	South Central	\$326,111	\$213,753	\$37,574	\$0	\$0
750144	750144	South Central	\$2,596	\$0	\$0	\$79,846	\$0
750151	750151	South Central	\$123,073	\$54,978	\$0	\$0	\$0
750250	750250	South East	\$175,245	\$550,186	\$0	\$0	\$0
750441	750441	Omaha Metro	\$179,762	\$25,679			
750540	750540	South East	\$174,172	\$0	\$94,850	\$0	\$0
750904	750904	Omaha Metro	\$89,498	\$22,944	\$0	\$0	\$0
750953	750953	South East	\$79,529	\$153,133	\$0	\$54,000	\$0
900038	900038	South East	\$1,030,222	\$0	\$32,538	\$0	\$0

900305	900305	South Central	\$71,448	\$0	\$32,785	\$0	\$0
900350	900350	South East	\$5,408	\$0	\$0	\$166,405	\$0
900418	900418	North East	\$124,013	\$193,465	\$0	\$0	\$0
900491	900491	North East	\$9,662	\$1,195	\$0	\$0	\$0
900566	900566	Southwest	\$368,473	\$69,459	\$83,366	\$25,408	\$0
900699	900699	Panhandle	\$67,508	\$112,725	\$0	\$0	\$0
900731	900731	South Central	\$719,789	\$366,757	\$37,874	\$0	\$0
900863	900863	Panhandle	\$317	\$0	\$0	\$9,750	\$0
900921	900921	South Central	\$1,736	\$0	\$0	\$53,422	\$0
900941	900941	North East	\$30,186	\$6,308	\$0	\$0	\$0
900962	900962	South East	\$83,040	\$24,000	\$0	\$0	\$0
901242	901242	South East	\$484,962	\$33,563	\$0	\$0	\$0
NE0002	NE0002	Statewide (optional)	\$0	\$0	\$0	\$28,574	\$0
NE0003	NE0003	Statewide (optional)	\$19,500	\$0	\$0	\$10,000	\$0
NE0005	NE0005	Statewide (optional)	\$0	\$0	\$0	\$56,782	\$0
NE0006	NE0006	Statewide (optional)	\$0	\$0	\$0	\$65,000	\$0
NE0007	NE0007	Statewide (optional)	\$0	\$0	\$0	\$2,000	\$0
NE100803	NE100803	South Central	\$29,631	\$0	\$0	\$45,528	\$0
NE900830	NE900830	Omaha Metro	\$0	\$0	\$0	\$146,367	\$0
Totals:			\$7,171,191	\$5,480,007	\$420,144	\$1,570,566	\$0

Form6 - Foot Notes

State Expenditures are not available by specific classification of Prevention and Treatment - Nebraska Information System is not yet set up to code specific expenditures in the most recent completed State Fiscal Year. As part of the Stat's Corrective Action Plan, Prevention set aside, and Women's set aside is being requested to be encoded. As of August 2008 such coding has not yet occurred. Expenditure listed on Form 4 are derived from the Report of Actual Expenditures of the Regional Behavioral Health Authorities presented to the State in September 2007 for State Fiscal Year 2007 those reports do indicate Prevention and Women's set asides.

PROVIDER ADDRESS TABLE

State: Nebraska

Provider ID	Description	Provider Address
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- Foot Notes

Provider addresses with the NE symbol in the ISSATS number are on record from previous block grant applications.

Form 6a

State: Nebraska

Prevention Strategy Report

Column A (Risks)	Column B (Strategies)	Column C (Providers)
No Risk Category Assigned [-99]	Clearinghouse/information resources centers [1]	2
	Media campaigns [3]	1
	Speaking engagements [6]	2
	Information lines/Hot lines [8]	3
	A/V Material Disseminated,Printed Material Disseminated,Curricula Disseminated,Newsletters Disseminated,Original Printed Material Developed [9]	6
	Parenting and family management [11]	1
	Ongoing classroom and/or small group sessions [12]	2
	Systematic planning [42]	1
	Community team-building [44]	2
	Accessing services and funding [45]	2
	Technical Assistance Services Attendees [46]	1
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	1
	Children of Substance Abusers [1]	Parenting and family management [11]
Community team-building [44]		2
Pregnant Women/Teens [2]	A/V Material Disseminated,Printed Material Disseminated,Curricula Disseminated,Newsletters Disseminated,Original Printed Material Developed [9]	1
	Ongoing classroom and/or small group sessions [12]	3
Violent and Delinquent Behavior [4]	Clearinghouse/information resources centers [1]	1
	A/V Material Disseminated,Printed Material Disseminated,Curricula Disseminated,Newsletters Disseminated,Original Printed Material Developed [9]	2
	Parenting and family management [11]	1
	Ongoing classroom and/or small group sessions [12]	2
	Systematic planning [42]	1
	Accessing services and funding [45]	1
	Information lines/Hot lines [8]	2
Mental Health Problems [5]	A/V Material Disseminated,Printed Material Disseminated,Curricula Disseminated,Newsletters Disseminated,Original Printed Material Developed [9]	3
	Ongoing classroom and/or small group sessions [12]	1
	Prevention Assessment and Referral Attendees [34]	1
	A/V Material Disseminated,Printed Material Disseminated,Curricula Disseminated,Newsletters Disseminated,Original Printed Material Developed [9]	1
Economically Disadvantaged [6]	A/V Material Disseminated,Printed Material Disseminated,Curricula Disseminated,Newsletters Disseminated,Original Printed Material Developed [9]	1

	[9]	
	Parenting and family management [11]	1
	Prevention Assessment and Referral Attendees [34]	1
	Systematic planning [42]	1
Physically Disabled [7]	Information lines/Hot lines [8]	2
Already Using Substances [9]	Media campaigns [3]	1
	Information lines/Hot lines [8]	5
	A/V Material Disseminated,Printed Material Disseminated,Curricula Disseminated,Newsletters Disseminated,Original Printed Material Developed [9]	10
	Parenting and family management [11]	1
	Ongoing classroom and/or small group sessions [12]	4
	Driving while under the influence/driving while intoxicated education programs [33]	4
	Prevention Assessment and Referral Attendees [34]	2
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	1
	Systematic planning [42]	1
	Technical Assistance Services Attendees [46]	1
Homeless and/or Run away Youth [10]	Information lines/Hot lines [8]	1
	Technical Assistance Services Attendees [46]	1
Business and Industry [11]	Clearinghouse/information resources centers [1]	1
	Resources directories [2]	1
	Media campaigns [3]	1
	Speaking engagements [6]	1
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	3
	Information lines/Hot lines [8]	5
	A/V Material Disseminated,Printed Material Disseminated,Curricula Disseminated,Newsletters Disseminated,Original Printed Material Developed [9]	9
	Parenting and family management [11]	1
	Peer leader/helper programs [13]	1
	Employee Assistance Programs [31]	1
	Prevention Assessment and Referral Attendees [34]	1
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	1
	Systematic planning [42]	1
	Community team-building [44]	2
	Accessing services and funding [45]	1
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	4
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	1

	Preventing Underage Sales of Tobacco and Tobacco Products-Synar Amendment [55]	1
Civic Groups/Coalitions [12]	Clearinghouse/information resources centers [1]	1
	Speaking engagements [6]	1
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	1
	Information lines/Hot lines [8]	3
	A/V Material Disseminated,Printed Material Disseminated,Curricula Disseminated,Newsletters Disseminated,Original Printed Material Developed [9]	0
	Youth/adult leadership activities [22]	1
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	2
	Systematic planning [42]	8
	Community team-building [44]	8
	Accessing services and funding [45]	6
	Technical Assistance Services Attendees [46]	14
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	5
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	3
	Preventing Underage Sales of Tobacco and Tobacco Products-Synar Amendment [55]	1
College Students [13]	Clearinghouse/information resources centers [1]	1
	Resources directories [2]	1
	Speaking engagements [6]	3
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	1
	Information lines/Hot lines [8]	5
	A/V Material Disseminated,Printed Material Disseminated,Curricula Disseminated,Newsletters Disseminated,Original Printed Material Developed [9]	9
	Parenting and family management [11]	1
	Ongoing classroom and/or small group sessions [12]	3
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	2
	Systematic planning [42]	1
	Community team-building [44]	2
	Technical Assistance Services Attendees [46]	4
Older Adults [14]	Speaking engagements [6]	2
	Information lines/Hot lines [8]	2
	Ongoing classroom and/or small group sessions [12]	1
	Employee Assistance Programs [31]	1
	Prevention Assessment and Referral Attendees [34]	1
	Community and volunteer training, e.g., neighborhood action training, impactor training,	1

	staff/officials training [41]	
	Community team-building [44]	1
Governmental/Elected Officials [15]	Clearinghouse/information resources centers [1]	1
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	1
	Information lines/Hot lines [8]	1
	A/V Material Disseminated,Printed Material Disseminated,Curricula Disseminated,Newsletters Disseminated,Original Printed Material Developed [9]	3
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	1
	Systematic planning [42]	2
	Community team-building [44]	3
	Accessing services and funding [45]	2
	Technical Assistance Services Attendees [46]	4
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	4
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	3
	Preventing Underage Sales of Tobacco and Tobacco Products-Synar Amendment [55]	1
Elementary School Students [16]	Clearinghouse/information resources centers [1]	1
	Speaking engagements [6]	2
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	1
	Information lines/Hot lines [8]	3
	Ongoing classroom and/or small group sessions [12]	4
	Peer leader/helper programs [13]	1
	Education programs for youth groups [14]	2
	Drug free dances and parties [21]	2
	Technical Assistance Services Attendees [46]	1
General Population [17]	Clearinghouse/information resources centers [1]	1
	Resources directories [2]	1
	Media campaigns [3]	2
	Speaking engagements [6]	4
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	5
	Information lines/Hot lines [8]	5
	A/V Material Disseminated,Printed Material Disseminated,Curricula Disseminated,Newsletters Disseminated,Original Printed Material Developed [9]	25
	Ongoing classroom and/or small group sessions [12]	3
	Youth/adult leadership activities [22]	1
	Employee Assistance Programs [31]	1
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	1

	Systematic planning [42]	2
	Community team-building [44]	5
	Accessing services and funding [45]	3
	Technical Assistance Services Attendees [46]	4
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	2
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	1
Health Professionals [18]	Clearinghouse/information resources centers [1]	1
	Speaking engagements [6]	2
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	1
	Information lines/Hot lines [8]	3
	A/V Material Disseminated,Printed Material Disseminated,Curricula Disseminated,Newsletters Disseminated,Original Printed Material Developed [9]	10
	Ongoing classroom and/or small group sessions [12]	1
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	1
	Systematic planning [42]	2
	Community team-building [44]	1
	Accessing services and funding [45]	1
	Technical Assistance Services Attendees [46]	4
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	1
High School Students [19]	Clearinghouse/information resources centers [1]	1
	Speaking engagements [6]	4
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	3
	Information lines/Hot lines [8]	5
	A/V Material Disseminated,Printed Material Disseminated,Curricula Disseminated,Newsletters Disseminated,Original Printed Material Developed [9]	9
	Ongoing classroom and/or small group sessions [12]	6
	Peer leader/helper programs [13]	2
	Education programs for youth groups [14]	3
	Youth/adult leadership activities [22]	2
	Community service activities [24]	1
	Recreation activities [26]	3
	Driving while under the influence/driving while intoxicated education programs [33]	1
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	1
	Systematic planning [42]	2
	Community team-building [44]	2
	Accessing services and funding [45]	1

	Technical Assistance Services Attendees [46]	2
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	2
Middle/Junior High School Students [20]	Clearinghouse/information resources centers [1]	1
	Speaking engagements [6]	2
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	1
	Information lines/Hot lines [8]	1
	A/V Material Disseminated,Printed Material Disseminated,Curricula Disseminated,Newsletters Disseminated,Original Printed Material Developed [9]	6
	Ongoing classroom and/or small group sessions [12]	4
	Education programs for youth groups [14]	3
	Youth/adult leadership activities [22]	1
	Recreation activities [26]	5
	Systematic planning [42]	1
	Community team-building [44]	2
	Accessing services and funding [45]	1
	Technical Assistance Services Attendees [46]	2
Parents/Families [21]	Clearinghouse/information resources centers [1]	3
	Media campaigns [3]	1
	Speaking engagements [6]	4
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	5
	Information lines/Hot lines [8]	5
	A/V Material Disseminated,Printed Material Disseminated,Curricula Disseminated,Newsletters Disseminated,Original Printed Material Developed [9]	13
	Parenting and family management [11]	6
	Ongoing classroom and/or small group sessions [12]	5
	Peer leader/helper programs [13]	1
	Education programs for youth groups [14]	3
	Recreation activities [26]	2
	Employee Assistance Programs [31]	1
	Student Assistance Programs [32]	1
	Driving while under the influence/driving while intoxicated education programs [33]	2
	Prevention Assessment and Referral Attendees [34]	1
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	1
	Systematic planning [42]	2
	Community team-building [44]	8
	Accessing services and funding [45]	2
	Technical Assistance Services Attendees [46]	5
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	1

Preschool Students [22]	Ongoing classroom and/or small group sessions [12]	2
	Recreation activities [26]	1
Prevention/Treatment Professionals [23]	Clearinghouse/information resources centers [1]	1
	Resources directories [2]	1
	Media campaigns [3]	1
	Speaking engagements [6]	3
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	1
	Information lines/Hot lines [8]	3
	A/V Material Disseminated,Printed Material Disseminated,Curricula Disseminated,Newsletters Disseminated,Original Printed Material Developed [9]	13
	Parenting and family management [11]	1
	Ongoing classroom and/or small group sessions [12]	4
	Peer leader/helper programs [13]	1
	Employee Assistance Programs [31]	1
	Prevention Assessment and Referral Attendees [34]	2
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	3
	Systematic planning [42]	5
	Community team-building [44]	9
	Accessing services and funding [45]	7
	Technical Assistance Services Attendees [46]	6
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	3
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	2
	Preventing Underage Sales of Tobacco and Tobacco Products-Synar Amendment [55]	0
Religious Groups [24]	Clearinghouse/information resources centers [1]	1
	Resources directories [2]	1
	Speaking engagements [6]	2
	Information lines/Hot lines [8]	5
	A/V Material Disseminated,Printed Material Disseminated,Curricula Disseminated,Newsletters Disseminated,Original Printed Material Developed [9]	6
	Ongoing classroom and/or small group sessions [12]	1
	Community drop-in centers [23]	1
	Systematic planning [42]	1
	Technical Assistance Services Attendees [46]	1
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	1
Teachers/Administrators/Counselors [25]	Clearinghouse/information resources centers [1]	1
	Resources directories [2]	1
	Speaking engagements [6]	4

	Information lines/Hot lines [8]	6
	A/V Material Disseminated,Printed Material Disseminated,Curricula Disseminated,Newsletters Disseminated,Original Printed Material Developed [9]	17
	Ongoing classroom and/or small group sessions [12]	3
	Student Assistance Programs [32]	2
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	4
	Systematic planning [42]	2
	Community team-building [44]	3
	Accessing services and funding [45]	3
	Technical Assistance Services Attendees [46]	7
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	3
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	1
Youth/Minors [26]	Clearinghouse/information resources centers [1]	1
	Speaking engagements [6]	1
	Information lines/Hot lines [8]	3
	A/V Material Disseminated,Printed Material Disseminated,Curricula Disseminated,Newsletters Disseminated,Original Printed Material Developed [9]	5
	Ongoing classroom and/or small group sessions [12]	4
	Education programs for youth groups [14]	1
	Youth/adult leadership activities [22]	1
	Community service activities [24]	1
	Driving while under the influence/driving while intoxicated education programs [33]	2
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	1
	Systematic planning [42]	1
	Community team-building [44]	1
	Accessing services and funding [45]	2
	Technical Assistance Services Attendees [46]	2
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	1
	Preventing Underage Sales of Tobacco and Tobacco Products-Synar Amendment [55]	1
Law Enforcement/Military [27]	Clearinghouse/information resources centers [1]	1
	Speaking engagements [6]	1
	Information lines/Hot lines [8]	3
	A/V Material Disseminated,Printed Material Disseminated,Curricula Disseminated,Newsletters Disseminated,Original Printed Material Developed [9]	4
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	1

	Systematic planning [42]	1
	Community team-building [44]	1
	Accessing services and funding [45]	1
	Technical Assistance Services Attendees [46]	2
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	1
	Preventing Underage Sales of Tobacco and Tobacco Products-Synar Amendment [55]	1
Gays/Lesbians [28]	Information lines/Hot lines [8]	1

TREATMENT UTILIZATION MATRIX

State: Nebraska

Dates of State Expenditure Period: From: 7/1/2006 To: 6/30/2007

Level of Care	Number of Admissions ≥ Number of Persons		Costs per Person		
	A.Number of Admissions	B.Number of Persons	C.Mean Cost of Services per Person	D.Median Cost of Services per Person	E.Standard Deviation of Cost per Person
Detoxification (24-Hour Care)					
Hospital Inpatient (Detox)			\$	\$	\$
Free-standing Residential			\$	\$	\$
Rehabilitation / Residential					
Hospital Inpatient (Rehabilitation)			\$	\$	\$
Short-term (up to 30 days)			\$	\$	\$
Long-term (over 30 days)			\$	\$	\$
Ambulatory (Outpatient)					
Outpatient			\$	\$	\$
Intensive Outpatient			\$	\$	\$
Detoxification			\$	\$	\$
Opioid Replacement Therapy (ORT)					
Opioid Replacement Therapy			\$	\$	\$

- Foot Notes

Nebraska does not have the ability to complete this form as presented.

Form 7b

Number of Persons Served (Unduplicated Count) for alcohol and other drug use in state-funded services by age, sex, and race/ethnicity

State: Nebraska

Age	A. Total	B. White		C. Black or African American		D. Native Hawaiian / Other Pacific Islander		E. Asian		F. American Indian / Alaska Native		G. More than one race reported		H. Unknown		I. Not Hispanic or Latino		J. Hispanic or Latino	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
1. 17 and under	4365	2096	1166	367	173	0	1	15	5	136	133	0	0	209	64	2535	1428	247	89
2. 18-24	5338	2993	1498	191	69	4	3	21	13	95	76	2	2	271	100	3259	1651	318	112
3. 25-44	9529	4588	2713	633	290	9	7	34	10	279	224	1	1	570	170	5496	3210	618	205
4. 45-64	3109	1623	751	305	100	2	2	6	5	83	49	1	0	154	28	2026	901	148	34
5. 65 and over	101	66	17	8	0	0	0	0	0	7	0	0	0	2	1	80	18	3	0
6. Total	22442	11366	6145	1504	632	15	13	76	33	600	482	4	3	1206	363	13396	7208	1334	440
7. Pregnant Women	256		195		18		0		0		25		0	18		238			18

Did the values reported by your State on Forms 7a and 7b come from a client-based system(s) with unique client identifiers? Yes No

Numbers of Persons Served who were admitted in a period prior to the 12 month reporting period.

- Foot Notes

Source: Nebraska Community Based Progrzms, Magellan Behavioral Health Data Set Extract July 24, 2008, Nebraska Department of Health and Human Services, Division of Behavioral Health, Lincoln, NE August 2008

Nebraska

Description of Calculations

Description of Calculations

If revisions or changes are necessary to prior years' description of the following, please provide: a brief narrative describing the amounts and methods used to calculate the following: (a) the base for services to pregnant women and women with dependent children as required by 42 U.S.C. 300x-22(b) (1); and, for 1994 and subsequent fiscal years report the Federal and State expenditures for such services; (b) the base and Maintenance of Effort (MOE) for tuberculosis services as required by 42 U.S.C. 300x-24(d); and, (c) for designated States, the base and MOE for HIV early intervention services as required by 42 U.S.C. 300x-24(d) (See 45 C.F.R. 96.122(f)(5)(ii)(A)(B)(C)).

Description of Calculations:

In a brief narrative, provide a description of the amounts and methods used to calculate the following: (a) the base for services to pregnant women and women with dependent children as required by section 1922(c)(1); and, for 1994 and subsequent fiscal years report the Federal and State expenditures for such services; (b) the base and Maintenance of Effort (MOE) for tuberculosis services as required by section 1924(d); and, (c) for designated States, the base and MOE for HIV early intervention services as required by section 1924(d) (See 42 U.S.C. 300x-52 and 45 C.F.R. 96.122(f)(5)(ii)(A)(B)(C)).

NARRATIVE DESCRIPTION OF BASE CALCULATIONS:

Narrative description of the amounts and methods used to calculate the base for A) service to pregnant women and women with children, B). Tuberculosis services and, C) HIV early intervention.

A: WOMEN'S BASE:

On May 31, 1995, Nebraska submitted detailed information to Lisa Schekel describing the amount of base dollars Nebraska declared as part of the pregnant women/women with children set aside. Nebraska declared \$247,044 (\$225,432 Block Grant and \$21,612 State General) as its base funding with the understanding that none of the programs funded with the base provide all five of the new minimum criteria. All programs do provide gender specific services. The base for pregnant women/women with children was determined by comparing total admissions in FY 1992 with admissions for pregnant women/women with children in programs funded with the women's set aside. The resulting percentage was then taken as a percentage of their total budget to determine the base funding. The original declaration was for non-qualifying programs (programs not containing all the required women's services).

With the initial allocation plus the five percent set asides in each of the fiscal year 1993 and 1994 the total set aside for women's programming was set at \$753,713. The total amount of Block Grant funds required under the two 5 percent allocations is \$506,669, or a combined FFY 1994 and subsequent years base of \$753,713. (Nebraska Technical Review Report, July 2000, Page 30; Nebraska Technical Review Report, May 1998, Page 34). Expenditures reported on SABG for FY 1994 were \$781,126.

As identified in the Nebraska Technical Review Report (July 2000 and November 2007) Nebraska is not able to track the set aside using the state accounting system. Allocation of funds to the regions is given in each regional contract with specific funding targets for the State Fiscal Year. In 1995 and subsequent years expenditures are recorded as a result of the reported actual expenditures of funds for federal and state funds from each of the six regional governing boards and direct contracts to providers

by the Office.

**Women's funding by Source
State Fiscal Years 2007**

State Fiscal Year	Federal Block	Other Federal	State General	Other State	Local Tax Match	Total
2007	420,144	1,812,742	1,263,179	632,849	40,000	4,168,914

Source: Annual report of Regions Expenditures (preliminary results) September 2007.

Initial expenditures reports from the Regions for State Fiscal Year 2007 provide the use of funds in support of women's programming from Tobacco Settlement, Federal Block Grant, and State Funds. The Division has moved federal block grant fund previously used to support women's programs to other programs and has begun to match Substance Abuse Waiver services under Medicaid within women's programming. These Match funds are from state general funds. In SFY 2007 \$1.2 million in state funds generated an additional \$1.8 Million in federal funds. These figures are taken from the annual report of expenditures (unaudited) filed by the Regional Governing Authorities. In the Core Technical Review conducted by CSAT in the spring 2007 it was noted that the state does not have a method to track set aside amounts in the automated Nebraska Information System (official state accounting system). The Division is working with Support Services of the Department of Health and Human Services to resolve this deficiency.

B: TUBERCULOSIS BASE:

The Division does not use State or Federal Substance Abuse funds to provide TB services. Programs are required to screen for HIV/STD/TB and to refer clients at risk to local health departments for testing and treatment if needed. The base and MOE expenditures are shown in TABLE II of this application and represent state general funds spent by the Nebraska Department of Health and Human Services Regulation and Licensure, for TB testing, counseling and treatment. Of the 26 active TB cases in the state 3 were substance abusers or 11.5 % of the cases. In state fiscal year 2007 Nebraska Department of Health and Human Services spent \$55,909.15 in general funds for TB medications and services. .

C: HIV DESIGNATION.

In Fiscal Year 2006 (this applications update year) Nebraska was not a designated state for HIV early intervention. The Table below provides a review of the most recent information on HIV/AIDS infection per 100,000 population.

HIV/AIDS CASE RATE TABLE

Calendar Year	Federal Block Grant Application Year	Rate/100,000
1991	1993	4.0
1992	1994	3.8
1993	1995	11.4
1994	1996	3.8
1995	1997	4.0
1996	1998	6.0
1997	1999	5.5
1998	2000	5.2
1999	2001	4.0
2000	2002	4.8
2001	2003	4.4
2002	2004	4.2
2003	2005	6.2
2004	2006	6.8
2005	2007	4.0
2006	2008	4.2
2007	2009	6.7

Source: Nebraska Department of Health and Human Services, Office of Preventive Health and Public Wellness, Disease Prevention and Control Section.

In 2007 definition includes the combined rate of HIV/AIDS.

H:\My Documents\BLOC2009\FY2009Resp\Compliance\Attachments-etc\NE_APP_09_Calcs.doc

SSA (MOE TABLE I)

State: Nebraska

Total Single State Agency (SSA) Expenditures for Substance Abuse (Table I)

PERIOD (A)	EXPENDITURES (B)	B1(2006) + B2(2007) ----- 2 (C)
SFY 2006 (1)	\$13,089,224	\$15,102,256
SFY 2007 (2)	\$17,115,287	
SFY 2008 (3)	\$ 25,232,950	

Are the expenditure amounts reported in Column B "actual" expenditures for the State fiscal years involved?

FY 2006 Yes No

FY 2007 Yes No

FY 2008 Yes No

If estimated expenditures are provided, please indicate when "actual" expenditure data will be submitted to SAMHSA (mm/dd/yyyy):

The MOE for State fiscal year(SFY) 2008 is met if the amount in Box B3 is greater than or equal to the amount in Box C2 assuming the State complied with MOE Requirements in these previous years.

The State may request an exclusion of certain non-recurring expenditures for a singular purpose from the calculation of the MOE, provided it meets CSAT approval based on review of the following information:

Did the State have any non-recurring expenditures for a specific purpose which were not included in the MOE calculation?

Yes No If yes, specify the amount and the State fiscal year: \$, (SFY)

Did the State include these funds in previous year MOE calculations?

Yes No

When did the State submit an official request to the SAMHSA Administrator to exclude these funds from the MOE calculations? (Date)

TB (MOE TABLE II)

State: Nebraska

Statewide Non-Federal Expenditures for Tuberculosis Services to Substance Abusers in Treatment (Table II)

(BASE TABLE)

Period	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment (B)	Total State Funds Spent on Clients who were Substance Abusers in Treatment A X B (C)	Average of Columns C1 and C2 C1 + C2 ----- 2 (D)
SFY 1991 (1)	\$ 26,611	1.21 %	\$ 322	\$ 336
SFY 1992 (2)	\$ 28,910	1.21 %	\$ 350	

(MAINTENANCE TABLE)

Period	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment (B)	Total State Funds Spent on Clients who were Substance Abusers in Treatment A X B (C)
SFY 2008 (3)	\$ 54,871	5 %	\$ 2,744

- Foot Notes

Expenditures for TB are of the Nebraska Department of Health and Human Services, Division of Public Health, Disease Prevention Section, state general funds for the State Fiscal Year stated. No Substance Abuse state general funds or Substance Abuse Federal Block Grant funds are used for TB services other than as a part of the disease assessment conducted by agencies as a part of the Health History in the general assessment of clients seeking treatment.

HIV (MOE TABLE III)

State: Nebraska

**Statewide Non-Federal Expenditures for HIV Early Intervention Services to Substance Abusers in Treatment
(Table III)**

(BASE TABLE)

Period	Total of All State Funds Spent on Early Intervention Services for HIV (A)	Average of Columns A1 and A2 A1 + A2 ----- 2 (B)
SFY 1993 (1)	\$ 0	\$ 0
SFY 1994 (2)	\$ 0	

(MAINTENANCE TABLE)

Period	Total of All State Funds Spent on Early Intervention Services for HIV* (A)
SFY 2008 (3)	\$ 0

* Provided to substance abusers at the site at which they receive substance abuse treatment

Womens (MOE TABLE IV)

State: Nebraska

Expenditures for Services to Pregnant Women and Women with Dependent Children (Table IV)

(MAINTENANCE TABLE)

Period	Total Women's Base (A)	Total Expenditures (B)
1994	\$753,713	
2006		\$2,975,000
2007		\$3,100,000
2008		\$ 2,751,469

Enter the amount the State plans to expend in FY 2009 for services for pregnant women and women with dependent children (amount entered must be not less than amount entered in Table IV Maintenance - Box A {1994}): \$ 2,800,000

- Foot Notes

State Expenditures are not available by specific classification of Prevention and Treatment - Nebraska Information System is not yet set up to code specific expenditures in the most recent completed State Fiscal Year. As part of the Stat's Corrective Action Plan, Prevention set aside, and Women's set aside is being requested to be encoded. As of August 2008 such coding has not yet occurred. Expenditure listed on Form 4 are derived from the Report of Actual Expenditures of the Regional Behavioral Health Authorities presented to the State in September 2007 for State Fiscal Year 2007 those reports do indicate Prevention and Women's set asides.

Nebraska

1. Planning

1. Planning

This item addresses compliance of the State's planning procedures with several statutory requirements. It requires completion of narratives and a checklist.

These are the statutory requirements:

- 42 U.S.C. 300x-29, 45 C.F.R. 96.133 and 45 C.F.R. 96.122(g)(13) require the State to submit a Statewide assessment of need for both treatment and prevention.

In a narrative of **up to three pages**, describe how your State carries out sub-State area planning and determines which areas have the highest incidence, prevalence, and greatest need. Include a definition of your State's sub-State planning areas. Identify what data is collected, how it is collected, and how it is used in making these decisions. If there is a State, regional, or local advisory council, describe their composition and their role in the planning process. Describe the monitoring process the State will use to assure that funded programs serve communities with the highest prevalence and need. Those States that have a State Epidemiological Workgroup or a State Epidemiological Outcomes Workgroup, must describe its composition and its contribution to needs assessment, planning, and evaluation processes for primary prevention and treatment planning. States are encouraged to utilize the epidemiological analyses and profiles to establish substance abuse prevention and treatment goals at the State level.

- 42 U.S.C. 300x-51 and 45 C.F.R. 96.123(a)(13) require the State to make the State plan public in such a manner as to facilitate public comment from any person during the development of the plan.

In a narrative of **up to two pages**, describe the process your State used to facilitate public comment in developing the State's plan and its FY 2009 application for SAPT Block Grant funds.

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- 42 U.S.C. 300x-51 and 45 C.F. R. 96.23(a)(13) require the State to make the State plan public in such a manner as to facilitate public comment from any person during the development of the plan.

In a narrative of **up to two pages**, describe the process your State used to facilitate public comment in developing the State's plan and its FY 2009 application for SAPT Block Grant funds.

Needs Assessment (Section 1929)

State Planning

By Statute, Nebraska is divided into six sub-state planning regions. Table 1 depicts the states Behavioral Health Authorities and the Counties served. Also contained in the table are the Target Population for Substance Abuse services and those persons estimated to be served in a given year. Estimates are taken from the local planning estimates produced by Regional Governing Authorities.

Table 1: Behavioral Health Authorities – Counties, Target Population and Number of Persons to be Served			
Behavioral Health Authority	Counties Served	Target Population	
1 (Panhandle)	Banner, Box Butte, Cheyenne, Dawes, Deuel, Garden, Kimball, Morrill, Scotts Bluff, Sheridan, Sioux	7,276	
2 (Southwest)	Arthur, Chase, Dawson, Dundy, Frontier, Gosper, Grant, Hayes, Hitchcock, Hooker, Keith, Lincoln, Logan, MacPherson, Perkins, Red Willow, Thomas	8,228	
3 (South Central)	Adams, Blaine, Buffalo, Clay, Custer, Franklin, Furnas, Garfield, Greeley, Hall, Hamilton, Harlan, Howard, Kearney, Loup, Merrick, Nuckolls, Phelps, Sherman, Valley, Webster, Wheeler	18,279	
4 (North)	Antelope, Boone, Boyd, Brown, Burt, Cedar, Cherry, Colfax, Cuming, Dakota, Dixon, Holt, Keya Paha, Knox, Madison, Nance, Pierce, Platte, Rock, Stanton, Thurston, Wayne	17,912	
5 (Southeast)	Butler, Fillmore, Gage, Jefferson, Johnson, Lancaster, Nemaha, Otoe, Pawnee, Polk, Richardson, Saline, Saunders, Seward, Thayer, York	32,871	
6 (Omaha Metro)	Cass, Dodge, Douglas, Sarpy, Washington	50,946	
	Total	135,512	

Each region has a similar structure. Regional Governing Board is the oversight with one elected representative from each county within the region. The Regional Governing Board hires the Regional Administrator. That administrator hires staff to support the monitoring, planning and oversight functions designated by state law and Office regulations.

Each region also has a Behavioral Health committee. This committee is made of many varied persons who have an interest in the Behavioral Health System. Each Regions committee meets to review the Regional Budget Plan (often containing specific recommendations for programs and services to be funded in each program) and to review planning and service utilization figures. While each Region has varying procedures in "planning" for services each does estimate the number of services they intend to concentrate on in the next year and an estimate of the persons to be served. Those estimates are given in Table 1 of this section.

Data available to assist in the budget and planning process include client information collected by the Division of Behavioral Health Services or its managed care contractor, historical program capacity and utilization, fund expenditures, waiting list data and Prevention Minimum Data Set. Nebraska has also recently received an estimate of the number of persons below 200 percent of poverty who may be most likely to access the Nebraska Behavioral Health System through a contract with the Western Interstate Commission on Higher Education. This study is the product of research of the University of Texas that is funded by SAMHSA. Table 2 depicts the estimate of the number of Substance Abusers likely to access the system.

Table 2: Prevalence Estimates of SUD For Nebraska Adults by State Region

Population	Region						Total
	I.	II.	III.	IV.	V.	VI.	
Total (HH, Inst., Group)	2,583	2,786	6,675	6,028	13,744	18,796	50,612
% of PGT	5%	6%	13%	12%	27%	37%	100%
Total Households	2,375	2,636	6,020	5,624	11,791	17,698	46,144
% of PGT	5%	6%	13%	12%	26%	38%	100%
HH <300% Poverty	1,693	1,825	4,196	3,646	7,450	9,763	28,573
% of PGT	6%	6%	15%	13%	26%	34%	100%
HH <200%	1,251	1,294	3,012	2,570	5,122	6,120	19,366

Poverty								9
% of PGT	6%	7%	16%	13%	26%	32%	100%	
HH <100% Poverty	525	438	1,159	1,071	2,211	2,463	7,867	
% of PGT	6%	6%	15%	14%	28%	31%	100%	
Total	8,427	8,979	21,062	18,939	40,318	54,840	152,565	
%	6%	6%	14%	12%	26%	36%	100%	

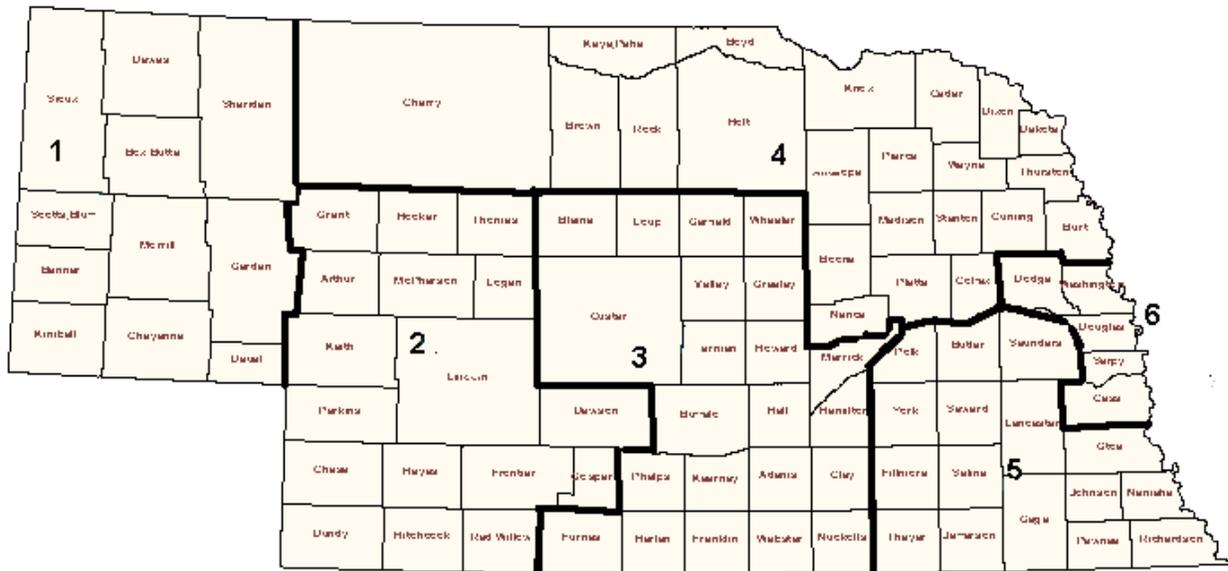
Source: Table 27: Prevalence Estimates of SUD For Nebraska Adults by State Region; Nebraska Prevalence Estimates for Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED); Western Interstate Commission on Higher Education, January 2007. Specific estimates by county are available from the study web site: http://psy.utmb.edu/estimation/index_html/Nebraska.htm

County level data are given at the study web site
[Http://psy.utmb.edu/estimations/index_html/Nebraska.htm](http://psy.utmb.edu/estimations/index_html/Nebraska.htm).

Estimates by Region from the national Household Survey on Drug Use and Health are given to the regions and available on the web at:
<http://oas.samhsa.gov/substate2k6/HTML/NE.htm>. The estimates vary widely. WICHE report is for persons having a poverty level of less than 300% of poverty. The national survey is for the state as a whole regardless of income and suggest more than 136,000 persons may be in need of substance abuse services.

Projected for State Fiscal Year 2009 is the completion of Tables 8 and 9 of the Block Grant application using social indicators data in combination with the National Household Survey on Drug Use and Health. There is proposed by researchers at the University of Nebraska Medical Center – Omaha, College of Public Health Epidemiological Department. Contracting has yet to be accomplished. Researchers have expressed interest in completing this statistical part of the needs assessment process, and to provide for continued support to update the social indicators.

Map 1 Nebraska Substance Abuse Regions



Nebraska Mental Health and Substance Abuse Regions

State Epidemiology Work Group:

As a part of the reorganization of the Department of Health and Human Services, the Epidemiological studies to be conducted for preparation of the State Strategic Prevention Framework - State Incentive Grant. An epidemiological work group has been convened and includes

Pamela Ashley, Extension Assistant Washington County Extension Office	Annemarie Bailey Fowler Research Coordinator Voices for Children in Nebraska
Debora Barnes-Josiah, Project Coordinator Office of Family Health Division of Public Health Nebraska Dept of Health & Human Services	Bob Beecham, Administrator Education Support Services Nebraska Department of Education
Robert Bussard, Program Specialist Division of Behavioral Health Nebraska Dept of Health & Human Services	Janet Hanna, Extension Educator UNL Northeast Research & Extension Center
Dan R Hoyt, Chair and Professor Department of Sociology University of Nebraska-Lincoln	Steve King Planning/Rsch/Accreditation Administrator Public Information Office

	NE Department of Correctional Services
Linda Major Director, Student Involvement NU Directions University of Nebraska-Lincoln	Lazarous Mbulo Health Surveillance Specialist Tobacco Free Nebraska Program Disease Prevention & Health Promotion Division of Public Health Nebraska Dept of Health & Human Services
Sandy Morrisey, Prevention Director Region V Systems	Kathy Nordby, Health Director Elkhorn Logan Valley Public Health Dept
Michael Overton Chief, Information Services Division Nebraska Crime Commission	John Penn, Executive Director Omaha Nation Community Response Team
Ming Qu Injury Epidemiologist/Nebraska CODES Administrator Health Assurance Division of Public Health Nebraska Dept of Health & Human Services	Michael Shambaugh-Miller Assistant Professor Health Services Research/Administration Div College of Public Health University of Nebraska Medical Center
Corey Smith Northern Plains Tribal Epidemiology Prog Aberdeen Area Tribal Chairman's Health Bd	Maya Chilese, Program Manager Division of Behavioral Health Nebraska Dept of Health & Human Services
Larry Voegelé, Program Manager Native American Health Liaison Office of Minority Health Division of Public Health Nebraska Dept of Health & Human Services	Fred Zwonechek, Administrator Nebraska Office of Highway Safety Nebraska Department of Motor Vehicles

Meetings have been held during the spring and summer of 2007 to narrow the number of indicators for prevention to use to fund future projects under the SPF-SIG process. Originally, nearly 50 indicators were identified. It is the goal for the work group to narrow indicators to fewer than 5. The Nebraska partners in Prevention committee (the steering committee for the SPF-SIG process) will be charged with final priority selection. This process is estimated to be from 6 to 8 months behind schedule owing to the reorganization of the State Department of Health and Human Services, and the late start resulting from that reorganization.

A part of the reorganization of the prevention system funded by the Division of Behavioral Health includes disbanding the Regional Prevention Centers, replacing those

with Regional Prevention Coordinators, defunding service agencies and taking 50% of the Federal dollars to fund coalitions for community programming. Regions are working with their advisory committees to strengthen the community coalitions and to develop measures of success. Those success measures are anticipated to include those selected from Nebraska Partners in Prevention along with local priorities. The priorities expressed for the Strategic Prevention Framework – SIG grantees were set by the Nebraska Partners in Prevention (NePIP) as:

- Underage drinking
- Binge Drinking in the 18-25 year old age group
- Impaired driving – all age groups

Public Review (Section 1941)

The Substance Abuse Performance Partnership Block Grant application is a document that results from a public participation process that defines the general direction of the Nebraska Behavioral Health System. This public participation process includes the Nebraska legislature, Behavioral Health Oversight Committee, State Substance Abuse Advisory Committee, Nebraska Partners in Prevention, Regional Behavioral Health Advisory Committees, general public, network managers, program participants and staff of the Division of Behavioral Health Services.

Nebraska Legislature:

The Unicameral (unique to Nebraska is the one house state legislature) provides guidance to the Division of Behavioral Health through the laws enacted. Those laws are enacted after considerable public input including committee meetings, bill hearings and legislative discussion. The Nebraska Behavioral Health Oversight Committee of the Legislature was sunset in June 2008. This committee reviewed the actions of the Division of Behavioral Health to implement Behavioral Health Reform in Nebraska. That reform effort resulted in the closure of one state psychiatric hospital and realignment of two others. Over \$30 million in new community program funds resulted that was split between mental health and substance abuse services. Regional Behavioral Health Authorities conducted extensive public meetings to accept comments on the area needs for services and to establish priorities for the phased in funds over four state fiscal years. Between 2004 and 2008 every region increased the amount of funds spent on substance abuse services and developed additional capacity in community based programs – either through local program development or through contracts with programs in other parts of the state.

Behavioral Health Oversight Committee

State law was changed in 2008 and the Legislature approved an Oversight Committee

to replace the legislative committee with one operated by the Division of Behavioral Health. LB 928 established the Behavioral Health Oversight Committee under the authority of the Director of The Division of Behavioral Health and tasked that committee for its one year term to formulate a direction for the Division of Behavioral Health through a strategic plan process. The committee members include:

Summary of Scot Adams Comments to the Behavioral Health Oversight Commission of the Legislature Final Meeting on June 20, 2008.

- In FY1955, the census at the three Regional Centers reached an all-time high of 4,746.
- 1995: The Division initiated a major redesign effort focused on providing behavioral health services when/where needed, building up community alternatives, and reducing reliance on Regional Centers.
- LB 1354 (1998): A Task Force examined the delivery and financing of services for adults with mental illnesses or addictions, and efforts to redesign Nebraska's behavioral health system.
- LB 692 (2001): \$8 M annually in new funding for community-based behavioral health services.
- LB 724 (2003): A road map for reform that included better services and outcomes for consumers, state leadership, Regional Governance, community-based services, integrated funding, and Legislative Oversight.
- LB 1083 (2004)

New or enhanced services created through LB 1083 include

Mental Health	Substance Abuse	Dual Disorder / Both MH & SA
Assertive Community Treatment	Community Support-SA	Dual Disorder Residential
Community Support-MH	Halfway House SA	Support Employment
Emergency Community Support	Intermediate Res SA	
Crisis Assessment	Methadone Maintenance	
Crisis Stabilization	Outpatient-SA	
Day Rehab	Short Term Residential (Enhanced)	
Day Treatment	Short Term Residential	
Intensive Community Services-MH	Social Detox	
Outpatient-MH	Therapeutic Community SA	
Psych Res Rehab MH		
Transitional Res MH		

Mental Health	Substance Abuse	Dual Disorder / Both MH & SA
Urgent Med Management		
Urgent Outpatient		
Housing Related Assistance		

Highlights – Regional Centers include:

- Hastings’ adult beds closed.
- NRC has a new mission.
- Low readmission rate.
-

Division of Behavioral Health Oversight Commission

Under LB 928 (2008), section 18 establishes the Behavioral Health Oversight Commission. The Behavioral Health Oversight Commission officially began on July 1, 2008 and will terminate on June 30, 2009. The first meeting was on July 24, 2008 and the second on August 11, 2008.

The commission consists of twelve members appointed by the Governor as follows:

- (i) One consumer of behavioral health services,
- (ii) one consumer advocate of behavioral health services,
- (iii) three providers of community-based behavioral health services, including one representative from each congressional district,
- (iv) three regional behavioral health authority administrators, including one from each congressional district,
- (v) one representative of the Norfolk Regional Center,
- (vi) one representative of the Lincoln Regional Center,
- (vii) one representative of the city of Norfolk, and
- (viii) one representative of the city of Hastings.

The Behavioral Health Oversight Commission Charter Statement (Adopted on August 11, 2008)

The Behavioral Health Oversight Commission shall be responsible to the Division of Behavioral Health (DBH) and shall oversee and support implementation of the Nebraska Behavioral Health Services Act. The Commission will provide advice and assistance to DBH regarding promotion of: (i) the interests of consumers and their families; (ii) both individual and systemic recovery; and, (iii) consumer involvement in all aspects of implementation of the Nebraska Behavioral Health Services Act. This Commission will provide a strategic vision for behavioral health for the State of Nebraska recognizing limited resource availability, and the importance of an environment of recovery for all behavioral health consumers.

State Substance Abuse Advisory Committee –

Established by LB 1083 in 2004, and a predecessor to the State Advisory Committee on Substance Abuse Services the State Substance Abuse Advisory Committee is charged with advising the Division of Behavioral Health on Substance Abuse Related matters. Similar committees exist for Mental Health and Compulsive Gambling. Section 71-815 of state law provides for the charge of the committee:

Section 71-815 - (1) The State Advisory Committee on Substance Abuse Services is created. Members of the committee shall have a demonstrated interest and commitment and specialized knowledge, experience, or expertise relating to the provision of substance abuse services in the State of Nebraska. The committee shall consist of twelve members appointed by the Governor and shall include at least three consumers of substance abuse services.

(2) The committee shall be responsible to the division and shall (a) conduct regular meetings, (b) provide advice and assistance to the division relating to the provision of substance abuse services in the State of Nebraska, (c) promote the interests of consumers and their families, (d) provide reports as requested by the division, and (e) engage in such other activities as directed or authorized by the division.

In its August 2007 meeting, the State Substance Abuse Advisory Committee reviewed the Block Grant application. The committee record indicates that the committees concerns and issues have been incorporated into the application.

Nebraska Partners in Prevention (NePIP)

This committee is an advisory committee established for the Strategic Prevention Framework – State Incentive Grant. This committee is staffed by the Division of Public Health and includes members from many parts of the Department of Health and Human Services, State Legislative Aids, members of the public, special population groups, and preventionists from across the state. The group has meet to review the epidemiological profile and to set the priorities for the SPF-SIG funds for applicants in 2008.

- Underage drinking
- Binge Drinking in the 18-25 year old age group
- Impaired driving – all age groups

Review of this application is accomplished through posting on the internet and inclusion of objectives in the State Substance Abuse Advisory Committee. The application is posted at: <http://www.dhhs.ne.gov/beh/Reports.htm>

Legislative review of the application is completed in each unicameral session through the public review of all documents of the Department of Health and Human Services. As a part of the yearly appropriations process, a public hearing is held which includes mention and availability of all federal and state applications for assistance.

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Planning Checklist

State: Nebraska

Criteria for Allocating Funds

Use the following checklist to indicate the criteria your State will use how to allocate FY 2009 Block Grant funds. Mark all criteria that apply. Indicate the priority of the criteria by placing numbers in the boxes. For example, if the most important criterion is 'incidence and prevalence levels', put a '1' in the box beside that option. If two or more criteria are equal, assign them the same number.

3 Population levels, Specify formula:

Household Income

4 Incidence and prevalence levels

Problem levels as estimated by alcohol/drug-related crime statistics

5 Problem levels as estimated by alcohol/drug-related health statistics

Problem levels as estimated by social indicator data

Problem levels as estimated by expert opinion

Resource levels as determined by (specify method)

2 Size of gaps between resources (as measured by)

Funds Per Capita

and needs (as estimated by)

1 Other (specify method)

Current Funding Level

Form 8

State: Nebraska

Treatment Needs Assessment Summary Matrix

Calendar Year: 2003

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: Liquor Laws	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Panhandle	90410	14963	2017	123	20	6434	929	850	362	899	0	0	0

Calendar Year: 2003

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: Liquor Laws	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Southwest	102311	17117	2297	284	45	7360	1020	616	443	579	0	0	0

Calendar Year: 2003

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: Liquor Laws	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
South Central	223143	26944	4933	300	48	15886	2554	1293	114	1193	0	0	0

Calendar Year: 2003

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: Liquor Laws	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000

North East	216388	35488	4026	727	43	15262	2101	1553	529	1811	1	0	0
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Calendar Year: 2003

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: Liquor Laws	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
South East	413553	38350	91330	1939	210	29347	4210	2592	2295	3858	1	2	1

Calendar Year: 2003

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: Liquor Laws	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Omaha Metro	685454	106814	14452	2197	351	45930	660	5187	6463	4887	2	8	2

Calendar Year: 2003

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: Liquor Laws	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
State Total	1711263	380551	37588	5115	817	118219	17145	12091	11206	13027	8	4	2

- Foot Notes

Nebraska has a corrective action plan to perform small area estimation of Substance Abuse Needs in Fiscal Year 2009. The information Presented in this document are from the latest estimates of need using a small area estimation process conducted with the Needs Assessment Study of 2001.

Form 9

State: Nebraska

Substate Planning Area [95]: State Total

Treatment Needs by Age, Sex, and Race/ Ethnicity

AGE GROUP	A. Total	B. White		C. Black or African American		D. Native Hawaiian / Other Pacific Islander		E. Asian		F. American Indian / Alaska Native		G. More than one race reported		H. Unknown		I. Not Hispanic Or Latino		J. Hispanic Or Latino	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
17 Years Old and Under	47,796	20,561	19,544	1,355	1,312	13	11	319	323	331	318	773	786	1,090	1,060	22,151	21,184	2,291	2,181
18 - 24 Years Old	28,576	12,493	12,167	685	641	18	10	262	259	150	148	246	248	729	520	13,270	13,008	1,312	985
25 - 44 Years Old	80,004	35,603	35,033	1,868	1,718	27	24	682	698	340	369	459	415	1,632	1,136	37,489	37,227	2,922	2,163
45 - 64 Years Old	60,053	27,880	28,427	890	944	9	10	257	343	166	167	163	183	296	318	28,927	29,689	833	723
65 and Over	38,039	15,152	21,644	288	435	1	2	57	84	44	63	54	71	70	74	15,461	22,146	206	227
Total	254,468	111,689	116,815	5,086	5,050	68	57	1,577	1,707	1,031	1,065	1,695	1,703	3,817	3,108	117,298	123,254	7,564	6,279

- Foot Notes

As a part of the Nebraska Corrective Action Plan resulting from the Technical Core Review of April 2007, Nebraska will be contracting with the University of Nebraska - Medical Center, School of Public Health, Department of Epidemiology to conduct small area estimation study to include estimates of the service population based on social indicators. The Study is currently scheduled to begin in November 2008 and be concluded in detail for FFY 2010 Block Grant application. Estimates presented on Form 9 are from the Needs Assessment estimates generated in 2001.

Nebraska

How your State determined the estimates for Form 8 and Form 9

How your State determined the estimates for Form 8 and Form 9

Under 42 U.S.C. 300x-29 and 45 C.F.R. 96.133, States are required to submit annually a needs assessment. This requirement is not contingent on the receipt of Federal needs assessment resources. States are required to use the best available data. Using **up to three pages**, explain what methods your State used to estimate the numbers of people in need of substance abuse treatment services, the biases of the data, and how the State intends to improve the reliability and validity of the data. Also indicate the sources and dates or timeframes for the data used in making these estimates reported in both Forms 8 and 9. In addition, provide any necessary explanation of the way your State records data or interprets the indices in columns 6 and 7, Form 8.

2. Needs assessment summary

These items involve completion of the Treatment Needs Assessment Summary Matrix (Form 8), the Needs by Age, Sex and Race/Ethnicity (Form 9), and a narrative explaining how the State arrived at the numbers entered on these forms, the biases of the data, and how the State intends to improve the reliability and validity of its data. This information is required by statute and regulation (See 42 U.S.C. 300x-29 and 45 C.F.R. 96.133).

3. Needs by age, sex, and race/ethnicity (Form 9)

Form 9's intent is to capture in column A the Total number of persons in need of treatment and then have this disaggregated among age, gender and race-ethnicity. The total of columns B through H should equal the total reported in column A (this total should also equal the sum of columns I and J).

These data aggregations by race and ethnicity are the categories required by the October 30, 1997 revision of *OMB Statistical Policy Directive No. 15: Race and Ethnic Standards for Federal Statistics and Administrative Reporting* (<http://www.whitehouse.gov/omb/fedreg/ombdir15.html>)

Needs Assessment Summary

How State Determined Numbers of the Matrix.

The Division of Mental Health, Substance Abuse and Addiction Services has received two treatment needs assessment study grants from CSAT. One grant was received in 1993, with another being awarded in 1998. These two grants have assisted the Division in understanding the Treatment needs of the State of Nebraska population. The Division has received no Prevention Needs Assessment support from CSAP. Data for the forms 8 and 9 are derived from the Treatment Needs Assessment grants. The State Incentive Cooperative Agreement for Prevention has among its objectives a prevention needs assessment and that is anticipated to be completed during State Fiscal Year 2007. Treatment numbers are a compilation of the Assessment grant information and information gathered from the Regions and 2001 study on estimated demand for Substance Abuse and Mental Health services conducted by the Western Interstate Commission on Higher Education (WICHE) and Dr. Charles Holzer of the University of Texas Medical branch (http://psy.utmb.edu/estimation/index_htm/Nebraska.htm). An updates estimate of Substance Use Disorders was received in January 2007 from the University of Texas. The Division of Behavioral Health continues to study this estimates against the National Household Survey of Drug Use and Health. The data in the matrix represent data from previous studies prepared under agreements of the State Needs Assessment grant process.

As identified in the Core Technical Review, and state's plan of correction, the most

recent needs assessment was some time ago. In the course of the last six or more years the Division has continued to require the Regional Behavioral Health Authorities to conduct local planning and needs assessment. The State has not heretofore summarized those efforts. In March 2008, the Division met with the University of Nebraska – Lincoln, Public Policy Center and agreed to conduct, with the Public Policy Center, a needs assessment. That contract was signed in April 2008. Contractually the Public Policy Center was to conduct public forums in each of the 6 regions and to develop a web based questionnaire. As reported in the July 2007, State Substance Abuse Advisory Committee meeting more than 20 public forums were held throughout the state and nearly 700 questionnaires were completed. Survey results are being analyzed by staff of the Public Policy Center and invited public participants.

A statistical estimation of the need for substance abuse services will be the second phase of the needs assessment studies to be completed in Fiscal Year 2009. This second phase is scheduled to be contracted with the University of Nebraska Medical Center – School of Public Health, Department of Epidemiology. Utilizing social indicators data (much of which has been gathered by the Epidemiology Work Group for the SPF-SIG planning process) small area estimates will be made. The small area estimates will also take into consideration the work of the University of Texas Medical School identified below, and the Epidemiological Work Group efforts. Tables 8 and 9 are scheduled to be completed using this estimation process. Until then Tables 8 and 9 continue to use the synthetic estimates made from the 2001 report of the State Needs Assessment Grant.

Needs by Age, Sex and Race/Ethnicity

The information presented on Form 9, related to need and demand represents efforts of the Department in collecting and analyzing data as a result of the Needs Assessment grant. Form 9 is derived by using Logistic Regression Analysis that estimates, using probability statistics, statewide from census data by region. Because of the relatively low incidence in each of the regional cells the estimating procedure comes up with a different number than the statewide estimates given in Table 8. In Table 9, the statewide total is an additive total of the various regional cells.

The breakdown of persons by age, gender and race given by the University of Texas is continuing to be studied. It is not presented in table on Form 8 and 9. Completed analysis is dependent upon the prevention needs assessment that is between 6 -9 months delayed due to the changes in staffing and departmental organizational structure.

Table 29: Adults in Total Population with SUD by Region and Demographic Variables

Demographics	Region						Total	% of Total Adult Population
	I.	II.	III.	IV.	V.	VI.		
Age								
18-20	455	463	1,144	1,004	2,403	2,632	8,101	16%
21-24	489	454	1,406	1,093	3,457	3,775	10,674	21%
25-34	695	832	1,899	1,724	3,851	6,259	15,260	30%
35-44	603	670	1,448	1,430	2,656	4,193	11,000	22%
45-54	244	262	547	552	1,027	1,483	4,115	8%
55-64	62	69	141	133	219	302	926	2%
65+	35	36	90	92	131	152	536	1%
Sex								
Female	782	778	1,924	1,689	3,849	5,594	14,616	29%
Male	1,801	2,008	4,751	4,339	9,895	13,202	35,996	71%
Race/Ethnicity								
White	2,099	2,308	5,863	4,997	12,370	15,030	42,667	84%
African Am	6	7	18	21	187	1,098	1,337	3%
Asian	8	7	48	36	341	427	867	2%
Pacific I	3	0	4	3	11	30	51	0%
Native	81	17	32	225	113	144	612	1%
Other	4	1	9	7	20	29	70	0%
Multi	20	16	38	37	176	315	602	1%
Hispanic	362	430	663	702	526	1,723	4,406	9%
Total	2,583	2,786	6,675	6,028	13,744	18,796	50,612	100%

Source: WICHE Mental Health Program contact Scott Adams, Psy.D. or Jenny Shaw sadams@wiche.edu or jshaw@wiche.edu In collaboration with Charles Holzer, PhD, University of Texas Medical Branch in Nebraska "Prevalence Estimates for Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED), January 2007.

Prevention Assessment

Results of the 2003, 2005 and 2007 Risk and Protective Factor Survey are analyzed at the local and statewide levels. These results are instrumental in the development of local planning for prevention efforts conducted by coalitions across the state. Under the direction of the Statewide Cooperative Agreement for Prevention, the Director of Prevention and her staff of consultants and students have worked hard to train local substance abuse coalitions in the development of local plans using data from the Risk and Protective Factors Survey of 2003 and are continuing to work with coalitions around the state to understand the results of the 2005 and 2007 survey (results were released in the Spring 2006 and 2008.) Under the State Incentive Cooperative Agreement funding from SAMHSA-CSAP (SICA) Funding for coalitions was dependent upon coalitions using data from the Risk and Protective Factors Surveys and information from local and state sources. In 2005 and 6 Thirty six grantees were funded from the federal funds. Block grant funded programs were among some of those programs who were successful in development of local strategies using science based scientifically valid best practices. With SPF-SIG the Nebraska partners in Prevention (NePIP) established state priorities including:

- Reduce Underaged Drinking.
- Reduce Binge Drinking 18-25 year age group.
- Reduce Impaired driving in all age groups.

SPF-SIG applications were made in May 2008 with funding released to 18 community coalitions in September 2008 after the NEPIP meeting of August 2008. All communities agreed to conducting the 5 step SPF model and to incorporate activities to address the 3 state priorities.

Treatment Assessment

Regional Network Managers utilized the information from the 1995 needs assessment studies to develop regional estimates of treatment needs. Those data were updated in 2001 when new census figures were made available. Regional authorities then worked with local planning bodies to estimate the number of treatment options that were needed to satisfy all treatment needs of the Behavioral Health system. These data were compiled into a white paper presented to the Legislature in 2001.

Data of the CSAT needs assessment grant funded in 1998 were made available to the regional bodies in spring 2001. These data confirmed the level of need previously estimated and assisted in documenting the more narrow need of substance abuse dependency. The data shown in tables 8 and 9 reflect a broader substance abuse definition.

FORM 8 – and Form 9 sources

Source: Division of Behavioral Health Services, Nebraska Department of Health and Human Services, Needs Assessment Study July 2001.

Criminal Activity: Uniform Crime Reports, Nebraska Commission on Law Enforcement and Criminal Justice, Lincoln, Dec 2007

Communicable Diseases: Nebraska Department of Health and Human Services, Health Surveillance Division.

National Survey on Drug Use and Health, 2005-06 State Estimates. US Department of Health and Human Services, Office of Applied Science, Substance Abuse and Mental Health Services Administration (SAMHSA) April 2008.

State Treatment And Prevention Needs Assessment information developed from National Survey on Drug Use and Health, 2005-06 State Estimates utilizes Regional Behavioral Health Authority boundaries described in the planning effort pages with the exception that regions 1 and 2 are combined. The combination of Region 1 and 2 is a result of the low population base on which to make meaningful estimates. These estimates suggest Nebraska has upwards of 130,000 persons in need of treatment services, of which only about 1/3 will actually access the service system (42,900). Prevention estimates continue to be generated from the Epidemiological workgroup and from community coalitions funded by block grant, SPF-SIG, Drug Free Communities, Drug Free Schools and Community grantees.

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Form 11**State: Nebraska****INTENDED USE PLAN**

(Include ONLY Funds to be spent by the agency administering the block grant. Estimated data are acceptable on this form)

SOURCE OF FUNDS

Activity	(24 Month Projections)					
	A.SAPT Block Grant FY 2009 Award	B.Medicaid (Federal, State and Local)	C.Other Federal Funds (e.g., Medicare, other public welfare)	D.State Funds	E.Local Funds (excluding local Medicaid)	F.Other
Substance Abuse Prevention* and Treatment	\$ 5,899,275	\$ 0	\$ 0	\$ 24,857,483	\$ 423,500	\$ 0
Primary Prevention	\$ 1,573,140		\$ 0	\$ 375,467	\$ 0	\$ 0
Tuberculosis Services	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0
HIV Early Intervention Services	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0
Administration: (Excluding Program/Provider Lvl)	\$ 393,285		\$ 0	\$	\$	\$
Column Total	\$7,865,700	\$0	\$0	\$25,232,950	\$423,500	\$0

Form 11ab

State: Nebraska

Form 11a. Primary Prevention Planned Expenditures Checklist

Activity	Block Grant FY 2009	Other Federal	State Funds	Local Funds	Other
Information Dissemination	\$	\$	\$	\$	\$
Education	\$	\$	\$	\$	\$
Alternatives	\$	\$	\$	\$	\$
Problem Identification & Referral	\$	\$	\$	\$	\$
Community Based Process	\$ 756,570	\$	\$	\$ 187,734	\$
Environmental	\$ 756,570	\$	\$	\$ 187,733	\$
Other	\$	\$	\$	\$	\$
Section 1926 - Tobacco	\$ 60,000	\$	\$	\$	\$ 60,000
Column Total	\$1,573,140	\$0	\$0	\$375,467	\$60,000

Form 11b. Primary Prevention Planned Expenditures Checklist

Activity	Block Grant FY 2009	Other Federal	State Funds	Local Funds	Other
Universal Direct	\$	\$	\$	\$	\$
Universal Indirect	\$	\$	\$	\$	\$
Selective	\$	\$	\$	\$	\$
Indicated	\$	\$	\$	\$	\$
Column Total	\$0	\$0	\$0	\$0	\$0

Resource Development Planned Expenditure Checklist

State: Nebraska

Did your State plan to fund resource development activities with FY 2009 funds?

Yes **No**

Activity	Treatment	Prevention	Additional Combined	Total
Planning, Coordination and Needs Assessment	\$ 45,000	\$	\$	\$ 45,000
Quality Assurance	\$	\$	\$	\$
Training (post-employment)	\$ 75,000	\$	\$	\$ 75,000
Education (pre-employment)	\$ 75,000	\$	\$	\$ 75,000
Program Development	\$	\$	\$	\$
Research and Evaluation	\$	\$	\$	\$
Information Systems	\$ 35,000	\$	\$	\$ 35,000
Column Total	\$230,000	\$0	\$0	\$230,000

Form 12

State: Nebraska

TREATMENT CAPACITY MATRIX

This form contains data covering a 24- month projection for the period during which your principal agency of the State is permitted to spend the FY 2009 block grant award.

Level of Care	A.Number of Admissions	B.Number of Persons
Detoxification (24-Hour Care)		
Hospital Inpatient (Detox)	0	
Free-standing Residential	5,300	4,000
Rehabilitation / Residential		
Hospital Inpatient (Rehabilitation)	0	0
Short-term (up to 30 days)	2,100	2,100
Long-term (over 30 days)	2,500	1,850
Ambulatory (Outpatient)		
Outpatient	11,700	9,875
Intensive Outpatient	1,250	1,200
Detoxification	0	0
Opioid Replacement Therapy (ORT)		
Opioid Replacement Therapy	0	0

Purchasing Services

This item requires completing two checklists.

Methods for Purchasing

There are many methods the State can use to purchase substance abuse services. Use the following checklist to describe how your State will purchase services with the FY 2009 block grant award. Indicate the proportion of funding that is expended through the applicable procurement mechanism.

- | | |
|---|--------------------------|
| <input type="checkbox"/> Competitive grants | Percent of Expense: % |
| <input checked="" type="checkbox"/> Competitive contracts | Percent of Expense: 2 % |
| <input checked="" type="checkbox"/> Non-competitive grants | Percent of Expense: 8 % |
| <input type="checkbox"/> Non-competitive contracts | Percent of Expense: 5 % |
| <input checked="" type="checkbox"/> Statutory or regulatory allocation to governmental agencies serving as umbrella agencies that purchase or directly operate services | Percent of Expense: 85 % |
| <input type="checkbox"/> Other | Percent of Expense: % |

(The total for the above categories should equal 100 percent.)

- | | |
|---|-----------------------|
| <input type="checkbox"/> According to county or regional priorities | Percent of Expense: % |
|---|-----------------------|
-

Methods for Determining Prices

There are also alternative ways a State can decide how much it will pay for services. Use the following checklist to describe how your State pays for services. Complete any that apply. In addressing a State's allocation of resources through various payment methods, a State may choose to report either the proportion of expenditures or proportion of clients served through these payment methods. Estimated proportions are acceptable.

- | | |
|--|---------------------------------|
| <input checked="" type="checkbox"/> Line item program budget | Percent of Clients Served: 10 % |
| | Percent of Expenditures: 20 % |

- | | |
|---|------------------------------|
| <input type="checkbox"/> Price per slot | Percent of Clients Served: % |
| | Percent of Expenditures: % |

Rate: \$	Type of slot:
Rate: \$	Type of slot:
Rate: \$	Type of slot:

- | | |
|--|------------------------------|
| <input type="checkbox"/> Price per unit of service | Percent of Clients Served: % |
| | Percent of Expenditures: % |

Unit:	Rate: \$
Unit:	Rate: \$

Unit:

Rate: \$

Per capita allocation (Formula:)

Percent of Clients Served: %

Percent of Expenditures: %

Price per episode of care

Percent of Clients Served: %

Percent of Expenditures: %

Rate: \$

Diagnostic Group:

Rate: \$

Diagnostic Group:

Rate: \$

Diagnostic Group:

Program Performance Monitoring

On-site inspections

Frequency for treatment: EVERY TWO YEARS

Frequency for prevention: OTHER

Activity Reports

Frequency for treatment: QUARTERLY

Frequency for prevention: QUARTERLY

Management Information System

Patient/participant data reporting system

Frequency for treatment: MONTHLY

Frequency for prevention: QUARTERLY

Performance Contracts

Cost reports

Independent Peer Review

Licensure standards - programs and facilities

Frequency for treatment: EVERY TWO YEARS

Frequency for prevention: NONE SELECTED

Licensure standards - personnel

Frequency for treatment: EVERY TWO YEARS

Frequency for prevention: NONE SELECTED

Other:

Specify:

Form T1

State: **Nebraska**

Performance Measure Data Collection Interim Standard – Change in Employment Status (from Admission to Discharge)

GOAL To improve the employment status of persons treated in the State's substance abuse treatment system.

MEASURE The change in *all clients receiving treatment* who reported being employed (including part-time) at discharge.

DEFINITIONS Change in *all clients receiving treatment* who reported being employed (including part-time) at admission and discharge.

Most recent year for which data are available  From: To:

Employment Status – Clients employed (full-time and part-time) (prior 30 days) at admission vs. discharge	Admission Clients (T ₁)	Discharge Clients (T ₂)
Number of clients employed (full-time and part-time) [numerator]	<input type="text" value="6381"/>	<input type="text" value="7965"/>
Total number of clients with non-missing values on employment status [denominator]	<input type="text" value="17953"/>	<input type="text" value="17953"/>
Percent of clients employed (full-time and part-time)	35.54%	44.37%
Percent of clients employed (full-time and part-time) at discharge minus percent of clients employed at admission. (Positive percent change values indicate increased employment)	Absolute Change [%T ₂ -%T ₁] 8.83% / 24.82%	

State Description of Employment Status Data Collection (Form T1)

STATE CONFORMANCE TO INTERIM STANDARD	<p>States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described</p> <p>Information Collected at Admission and at Discharge from reporting agencies. The following parameters are used to determine the numbers of individual records to be reported in National performance measures. Records not included in any of the T - Treatment Performance measure: All Emergency, Crisis or Urgent services; any Civil Protective Custody, Assessments, Diagnostic Interviews, IPPC, Pre-Auth, or Self-Help/Peer Services; and if the information related to the performance measure is blank at discharge. Nebraska matches discharge records to admission records but is not able to match episodes of care in the Data Integration Grant (DIG) data sets used for this reporting.</p>
DATA SOURCE	<p>What is the source of data for table T1? (Select all that apply)</p> <p><input checked="" type="checkbox"/> Client Self Report</p>

Client self-report confirmed by another source:

Collateral source

Administrative data source

Other: Specify

EPISODE OF CARE

How is the admission/discharge basis defined for table T1? (Select one)

Admission is on the first date of service, prior to which no service has been received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days

Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit

Other, Specify:

DISCHARGE DATA COLLECTION

How was discharge data collected for table T1? (Select all that apply)

Not applicable, data reported on form is collected at time period other than discharge

Specify:

In-Treatment data days post admission

Follow-up data months post

Other, Specify:

Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment

Discharge data is collected for a sample of all clients who were admitted to treatment

Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment

Discharge records are not collected for approximately % of clients who were admitted for treatment

RECORD LINKING

Was the admission and discharge data linked for table T1? (Select all that apply)

Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID)

Select type of UCID:

Master Client Index or Master Patient Index, centrally assigned

Social Security Number (SSN)

Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.)

Some other Statewide unique ID

Provider-entity-specific unique ID

No, State Management Information System does not utilize UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohorts basis) or State relied on other data sources for post admission data

No, admission and discharge records were matched using probabilistic record matching

IF DATA IS UNAVAILABLE

If data is not reported, why is State unable to report? (Select all that apply)

- Information is not collected at admission
- Information is not collected at discharge
- Information is not collected by the categories requested
- State collects information on the indicator area but utilizes a different measure.

DATA PLANS IF DATA IS NOT AVAILABLE

State must provide time-framed plans for capturing employment status data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.

Currently working with Managed Care contractor to report TEDS Admission and Discharge information. Information reported here is from the number of admissions and number of discharges for selected services without linking records. Services do not include Detoxification, Civil Protective Custody, Assessment only, Crisis Services, Urgent or Emergency services.

Form T2

State: **Nebraska**

Performance Measure Data Collection Interim Standard – Number of Clients and Change in Homelessness (Living Status)

GOAL To improve living conditions of persons treated in the State's substance abuse treatment system.

MEASURE The change in *all clients receiving treatment* who reported being homeless at discharge.

DEFINITIONS Change in *all clients receiving treatment* who reported being homeless at discharge equals the clients reporting being homeless at admission subtracted from the clients reporting being homeless at discharge.

Most recent year for which data are available  From: To:

Homelessness – Clients homeless (prior 30 days) at admission vs. discharge	Admission Clients (T ₁)	Discharge Clients (T ₂)
Number of clients homeless [numerator]	<input type="text" value="1503"/>	<input type="text" value="833"/>
Total number of clients with non-missing values on living arrangements [denominator]	<input type="text" value="14953"/>	<input type="text" value="17953"/>
Percent of clients homeless	10.05%	4.64%
Percent of clients homeless at discharge minus percent of clients homeless at admission. (Negative percent change values indicate reduced homelessness)	Absolute Change [%T ₂ -%T ₁] -5.41% / -53.84%	

State Description of Homelessness (Living Status) Data Collection (Form T2)

STATE CONFORMANCE TO INTERIM STANDARD	<p>States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described</p> <p>Information collected at admission and at discharge from reporting agencies. The following parameters are used to determine the numbers of individual records to be reported in National performance measures. Records not included in any of the T - Treatment Performance measure: All Emergency, Crisis or Urgent services; any Civil Protective Custody, Assessments, Diagnostic Interviews, IPPC, Pre-Auth, or Self-Help/Peer Services; and if the information related to the performance measure is blank at discharge. Nebraska matches discharge records to admission records but is not able to match episodes of care in the Data Integration Grant (DIG) data sets used for this reporting.</p>
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DATA SOURCE	<p>What is the source of data for table T2? (Select all that apply)</p> <p><input checked="" type="checkbox"/> Client Self Report</p>
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Client self-report confirmed by another source:

- Collateral source
- Administrative data source

Other: Specify

EPISODE OF CARE

How is the admission/discharge basis defined for table T2? (Select one)

- Admission is on the first date of service, prior to which no service has been received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days
- Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit
- Other, Specify:

DISCHARGE DATA COLLECTION

How was discharge data collected for table T2? (Select all that apply)

- Not applicable, data reported on form is collected at time period other than discharge
Specify:
 - In-Treatment data days post admission
 - Follow-up data months post
 - Other, Specify:
- Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
- Discharge data is collected for a sample of all clients who were admitted to treatment
- Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
- Discharge records are not collected for approximately % of clients who were admitted for treatment

RECORD LINKING

Was the admission and discharge data linked for table T2? (Select all that apply)

- Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID)
Select type of UCID:
 - Master Client Index or Master Patient Index, centrally assigned
 - Social Security Number (SSN)
 - Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.)
 - Some other Statewide unique ID
 - Provider-entity-specific unique ID
- No, State Management Information System does not utilize UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohorts basis) or State relied on other data sources for post admission data
- No, admission and discharge records were matched using probabilistic record matching

IF DATA IS
UNAVAILABLE

If data is not reported, why is State unable to report? (Select all that apply)

- Information is not collected at admission
- Information is not collected at discharge
- Information is not collected by the categories requested
- State collects information on the indicator area but utilizes a different measure.

DATA PLANS IF DATA IS
NOT AVAILABLE

State must provide time-framed plans for capturing living status data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.

Currently working with Managed care contractor to report TEDS admission and Discharge information. Information reported here is from the number of admissions and number of discharges for selected services without linking records. Services do not include detoxification, Civil Protective Custody, Assessment only, Crisis Services, Urgent or Emergency services.

Form T3

State: **Nebraska**

Performance Measure Data Collection Interim Standard – Change of Persons Arrested

GOAL To reduce the criminal justice involvement of persons treated in the State's substance abuse treatment system.

MEASURE The change in persons arrested in the last 30 days at discharge for *all clients receiving treatment*.

DEFINITIONS Change in persons arrested in the last 30 days at discharge for *all clients receiving treatment* equals clients who were arrested in the 30 days prior to admission subtracted from clients who were arrested in the last 30 days at discharge. An arrest is any arrest.

Most recent year for which data are available  From: To:

Arrests – Clients arrested (any charge) (prior 30 days) at admission vs. discharge	Admission Clients (T ₁)	Discharge Clients (T ₂)
Number of Clients arrested [numerator]	<input type="text" value="6706"/>	<input type="text" value="3446"/>
Total number of clients with non-missing values on arrests [denominator]	<input type="text" value="17953"/>	<input type="text" value="17953"/>
Percent of clients arrested	37.35%	19.19%
Percent of clients arrested at discharge minus percent of clients arrested at admission. (Negative percent change values indicate reduced arrests)	Absolute Change [%T ₂ -%T ₁] -18.16% / -48.61%	

State Description of Number of Arrests Data Collection (Form T3)

STATE CONFORMANCE TO INTERIM STANDARD	<p>States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described</p> <p>The following parameters are used to determine the numbers of individual records to be reported in National performance measures. Records not included in any of the T - Treatment Performance measure: All Emergency, Crisis or Urgent services; any Civil Protective Custody, Assessments, Diagnostic Interviews, IPPC, Pre-Auth, or Self-Help/Peer Services; and if the information related to the performance measure is blank at discharge. Nebraska matches discharge records to admission records but is not able to match episodes of care in the Data Integration Grant (DIG) data sets used for this reporting.</p>
DATA SOURCE	<p>What is the source of data for table T3? (Select all that apply)</p> <p><input checked="" type="checkbox"/> Client Self Report</p>

Client self-report confirmed by another source:

- Collateral source
- Administrative data source

Other: Specify

EPISODE OF CARE

How is the admission/discharge basis defined for table T3? (Select one)

- Admission is on the first date of service, prior to which no service has been received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days
- Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit
- Other, Specify:

DISCHARGE DATA COLLECTION

How was discharge data collected for table T3? (Select all that apply)

- Not applicable, data reported on form is collected at time period other than discharge
Specify:
 - In-Treatment data days post admission
 - Follow-up data months post
 - Other, Specify:
- Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
- Discharge data is collected for a sample of all clients who were admitted to treatment
- Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
- Discharge records are not collected for approximately % of clients who were admitted for treatment

RECORD LINKING

Was the admission and discharge data linked for table T3? (Select all that apply)

- Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID)
Select type of UCID:
 - Master Client Index or Master Patient Index, centrally assigned
 - Social Security Number (SSN)
 - Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.)
 - Some other Statewide unique ID
 - Provider-entity-specific unique ID
- No, State Management Information System does not utilize UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohorts basis) or State relied on other data sources for post admission data
- No, admission and discharge records were matched using probabilistic record matching

IF DATA IS
UNAVAILABLE

If data is not reported, why is State unable to report? (Select all that apply)

- Information is not collected at admission
- Information is not collected at discharge
- Information is not collected by the categories requested
- State collects information on the indicator area but utilizes a different measure.

DATA PLANS IF DATA IS
NOT AVAILABLE

State must provide time-framed plans for capturing arrest data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.

Currently working with Managed care contractor to report TEDS admission and Discharge information. Information reported here is from the number of admissions and number of discharges for selected services without linking records. Services do not include detoxification, Civil Protective Custody, Assessment only, Crisis Services, Urgent or Emergency services.

Form T4

State: **Nebraska**

Performance Measure Data Collection Interim Standard – Percentage Point Change in Abstinence - Alcohol Use

GOAL To reduce substance abuse to protect the health, safety, and quality of life for all.

MEASURE The change in *all clients receiving treatment* who reported abstinence at discharge.

DEFINITIONS Change in *all clients receiving treatment* who reported abstinence at discharge equals clients reporting abstinence at admission subtracted from clients reporting abstinence at discharge.

Most recent year for which data are available  From: To:

Alcohol Abstinence – Clients with no alcohol use (all clients regardless of primary problem) (use Alcohol Use in last 30 days field) at admission vs. discharge.	Admission Clients (T ₁)	Discharge Clients (T ₂)
Number of clients abstinent from alcohol [numerator]	<input type="text" value="3727"/>	<input type="text" value="4200"/>
Total number of clients with non-missing values on "used any alcohol" variable [denominator]	<input type="text" value="9448"/>	<input type="text" value="9448"/>
Percent of clients abstinent from alcohol	39.45%	44.45%
Percent of clients abstinent from alcohol at discharge minus percent of clients abstinent from alcohol at admission. (Positive percent change values indicate increased alcohol abstinence)	Absolute Change [%T ₂ -%T ₁] 5.00% / 12.69%	
(1) If State does not have a "used any alcohol" variable, calculate instead using frequency of use variables for all primary, secondary, or tertiary problem codes in which the coded problem is Alcohol (e.g., TEDS Code 02)		

State Description of Alcohol Use Data Collection (Form T4)

STATE CONFORMANCE TO INTERIM STANDARD	<p>States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described</p> <p>Information collected at admission and at discharge from reporting agencies. The following parameters are used to determine the numbers of individual records to be reported in National performance measures. Records not included in any of the T - Treatment Performance measure: All Emergency, Crisis or Urgent services; any Civil Protective Custody, Assessments, Diagnostic Interviews, IPPC, Pre-Auth, or Self-Help/Peer Services; and if the information related to the performance measure is blank at discharge. Nebraska matches discharge records to admission records but is not able to match episodes of care in the Data Integration Grant (DIG) data sets used for this reporting.</p>
DATA SOURCE	

What is the source of data for table T4? (Select all that apply)

Client Self Report

Client self-report confirmed by another source:

Collateral source

Administrative data source

Other: Specify

EPISODE OF CARE

How is the admission/discharge basis defined for table T4? (Select one)

Admission is on the first date of service, prior to which no service has been received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days

Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit

Other, Specify:

All admission records and all discharge records from certain program types

DISCHARGE DATA COLLECTION

How was discharge data collected for table T4? (Select all that apply)

Not applicable, data reported on form is collected at time period other than discharge
Specify:

In-Treatment data days post admission

Follow-up data months post admission

Other, Specify:

Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment

Discharge data is collected for a sample of all clients who were admitted to treatment

Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment

Discharge records are not collected for approximately % of clients who were admitted for treatment

RECORD LINKING

Was the admission and discharge data linked for table T4? (Select all that apply)

Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID)
Select type of UCID:

Master Client Index or Master Patient Index, centrally assigned

Social Security Number (SSN)

Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.)

Some other Statewide unique ID

Provider-entity-specific unique ID

No, State Management Information System does not utilize UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohorts basis) or State relied on other data

sources for post admission data

- No, admission and discharge records were matched using probabilistic record matching

IF DATA IS
UNAVAILABLE

If data is not reported, why is State unable to report? (Select all that apply)

- Information is not collected at admission
- Information is not collected at discharge
- Information is not collected by the categories requested
- State collects information on the indicator area but utilizes a different measure.

DATA PLANS IF DATA IS
NOT AVAILABLE

State must provide time-framed plans for capturing alcohol abstinence data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.

Currently working with Managed care contractor to report TEDS admission and Discharge information. Information reported here is from the number of admissions and number of discharges for selected services without linking records. Services do not include detoxification, Civil Protective Custody, Assessment only, Crisis Services, Urgent or Emergency services.

Form T5

State: **Nebraska**

Performance Measure Data Collection Interim Standard – Percentage Point Change in Abstinence - Other Drug Use

GOAL To reduce substance abuse to protect the health, safety, and quality of life for all.

MEASURE The change in *all clients receiving treatment* who reported abstinence at discharge.

DEFINITIONS Change in *all clients receiving treatment* who reported abstinence at discharge equals clients reporting abstinence at admission subtracted from clients reporting abstinence at discharge.

Most recent year for which data are available  From: To:

Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) (use Any Drug Use in last 30 days field) at admission vs. discharge.	Admission Clients (T ₁)	Discharge Clients (T ₂)
Number of Clients abstinent from illegal drugs [numerator]	<input type="text" value="3780"/>	<input type="text" value="3708"/>
Total number of clients with non-missing values on "used any drug" variable [denominator]	<input type="text" value="8103"/>	<input type="text" value="8103"/>
Percent of clients abstinent from drugs	46.65%	45.76%
Percent of clients abstinent from drugs at discharge minus percent of clients abstinent from drugs at admission. (Positive percent change values indicate increased drug abstinence)	Absolute Change [%T ₂ -%T ₁] -0.89% / -1.90%	
(2) If State does not have a "used any drug" variable, calculate instead using frequency of use variables for all primary, secondary, or tertiary problem codes in which the coded problem is Drugs (e.g., TEDS Codes 03-20)		

State Description of Other Drug Use Data Collection (Form T5)

STATE CONFORMANCE TO INTERIM STANDARD	<p>States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described</p> <p>The following parameters are used to determine the numbers of individual records to be reported in National performance measures. Records not included in any of the T - Treatment Performance measure: All Emergency, Crisis or Urgent services; any Civil Protective Custody, Assessments, Diagnostic Interviews, IPPC, Pre-Auth, or Self-Help/Peer Services; and if the information related to the performance measure is blank at discharge. Nebraska matches discharge records to admission records but is not able to match episodes of care in the Data Integration Grant (DIG) data sets used for this reporting.</p>
DATA SOURCE	<p>What is the source of data for table T5? (Select all that apply)</p>

Client Self Report

Client self-report confirmed by another source:

Collateral source

Administrative data source

Other: Specify

EPISODE OF CARE

How is the admission/discharge basis defined for table T5? (Select one)

- Admission is on the first date of service, prior to which no service has been received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days
- Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit
- Other, Specify:

All admission records and all discharge records from certain program types

DISCHARGE DATA COLLECTION

How was discharge data collected for table T5? (Select all that apply)

Not applicable, data reported on form is collected at time period other than discharge
Specify:

In-Treatment data days post admission

Follow-up data months post

Other, Specify:

- Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
- Discharge data is collected for a sample of all clients who were admitted to treatment
- Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
- Discharge records are not collected for approximately % of clients who were admitted for treatment

RECORD LINKING

Was the admission and discharge data linked for table T5? (Select all that apply)

Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID)
Select type of UCID:

Master Client Index or Master Patient Index, centrally assigned

Social Security Number (SSN)

Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.)

Some other Statewide unique ID

Provider-entity-specific unique ID

No, State Management Information System does not utilize UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohorts basis) or State relied on other data sources for post admission data

No, admission and discharge records were matched using probabilistic record matching

IF DATA IS
UNAVAILABLE

If data is not reported, why is State unable to report? (Select all that apply)

- Information is not collected at admission
- Information is not collected at discharge
- Information is not collected by the categories requested
- State collects information on the indicator area but utilizes a different measure.

DATA PLANS IF DATA IS
NOT AVAILABLE

State must provide time-framed plans for capturing drug abstinence data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.

Currently working with Managed care contractor to report TEDS admission and Discharge information. Information reported here is from the number of admissions and number of discharges for selected services without linking records. Services do not include detoxification, Civil Protective Custody, Assessment only, Crisis Services, Urgent or Emergency services.

Form T6

State: **Nebraska**

Performance Measure Data Collection Interim Standard – Percentage Point Change in Social Support of Recovery

GOAL To improve clients' participation in social support of recovery activities to reduce substance abuse to protect the health, safety, and quality of life for all.

MEASURE The change in *all clients receiving treatment* who reported participation in one or more social and or recovery support activity at discharge.

DEFINITIONS Change in *all clients receiving treatment* who reported participation in one or more social and recovery support activities at discharge equals clients reporting participation at admission subtracted from clients reporting participation at discharge.

Most recent year for which data are available  From: To:

Social Support of Recovery – Clients participating in self-help groups, support groups (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge	Admission Clients (T ₁)	Discharge Clients (T ₂)
Number of clients with one or more such activities (AA NA meetings attended, etc.) [numerator]	<input type="text" value="0"/>	<input type="text" value="0"/>
Total number of Admission and Discharge clients with non-missing values on social support activities [denominator]	<input type="text" value="0"/>	<input type="text" value="0"/>
Percent of clients participating in social support activities		
Percent of clients participating in social support of recovery activities in prior 30 days at discharge minus percent of clients participating in social support of recovery activities in prior 30 days at admission. (Positive percent change values indicate increased participation in social support of recovery activities.)	Absolute Change [%T ₂ -%T ₁] 0 / 0.00%	

State Description of Social Support of Recovery Data Collection (Form T6)

STATE CONFORMANCE TO INTERIM STANDARD	<p>States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described</p> <p>Information is not collected. Corrective Action Plan submitted and accepted in February 2008 includes addition of Social Connectiveness question on data gathering instruments. Magellan Behavioral Health has plans to include social support question on data system modifications scheduled in November 2008 upgrade. The following parameters are used to determine the numbers of individual records to be reported in National performance measures. Records not included in any of the T - Treatment Performance measure: All Emergency, Crisis or Urgent services; any Civil Protective Custody, Assessments, Diagnostic Interviews, IPPC, Pre-Auth, or Self-Help/Peer Services; and if the information related to the performance measure is blank at discharge. Nebraska matches discharge records to admission records but is not able to match episodes of care in the Data Integration Grant (DIG) data sets used for this reporting.</p>
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DATA SOURCE	<p>What is the source of data for table T6? (Select all that apply)</p> <p><input type="checkbox"/> Client Self Report</p> <p>Client self-report confirmed by another source:</p> <p style="margin-left: 20px;"><input type="checkbox"/> Collateral source</p> <p style="margin-left: 20px;"><input type="checkbox"/> Administrative data source</p> <p><input type="checkbox"/> Other: Specify <input style="width: 150px;" type="text"/></p>
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EPISODE OF CARE	<p>How is the admission/discharge basis defined for table T6? (Select one)</p> <p><input type="radio"/> Admission is on the first date of service, prior to which no service has been received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days</p> <p><input type="radio"/> Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit</p> <p><input type="radio"/> Other, Specify:</p> <p><input style="width: 250px;" type="text"/></p>
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DISCHARGE DATA COLLECTION	<p>How was discharge data collected for table T6? (Select all that apply)</p> <div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> <p><input type="checkbox"/> Not applicable, data reported on form is collected at time period other than discharge</p> <p>Specify:</p> <p style="margin-left: 20px;"><input type="radio"/> In-Treatment data <input style="width: 50px;" type="text"/> days post admission</p> <p style="margin-left: 20px;"><input type="radio"/> Follow-up data <input style="width: 50px;" type="text"/> months post <input style="width: 80px;" type="text" value="admission"/></p> <p style="margin-left: 20px;"><input type="radio"/> Other, Specify: <input style="width: 200px;" type="text"/></p> </div> <p><input type="checkbox"/> Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment</p> <p><input type="checkbox"/> Discharge data is collected for a sample of all clients who were admitted to treatment</p> <p><input type="checkbox"/> Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment</p> <p><input type="checkbox"/> Discharge records are not collected for approximately <input style="width: 50px;" type="text"/> % of clients who were admitted for treatment</p>
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RECORD LINKING	<p>Was the admission and discharge data linked for table T6? (Select all that apply)</p> <div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> <p><input type="checkbox"/> Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID)</p> <p>Select type of UCID:</p> <p style="margin-left: 20px;"><input type="radio"/> Master Client Index or Master Patient Index, centrally assigned</p> <p style="margin-left: 20px;"><input type="radio"/> Social Security Number (SSN)</p> <p style="margin-left: 20px;"><input type="radio"/> Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.)</p> <p style="margin-left: 20px;"><input type="radio"/> Some other Statewide unique ID</p> <p style="margin-left: 20px;"><input type="radio"/> Provider-entity-specific unique ID</p> </div> <p><input type="checkbox"/> No, State Management Information System does not utilize UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohorts basis) or State relied on other data</p>
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sources for post admission data

No, admission and discharge records were matched using probabilistic record matching

IF DATA IS
UNAVAILABLE

If data is not reported, why is State unable to report? (Select all that apply)

- Information is not collected at admission
- Information is not collected at discharge
- Information is not collected by the categories requested
- State collects information on the indicator area but utilizes a different measure.

DATA PLANS IF DATA IS
NOT AVAILABLE

State must provide time-framed plans for capturing social support of recovery data data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.

Form T7

State: **Nebraska**

Form T7 was pre-populated with the following Data Source: Discharges in CY 2007

Length of Stay (in Days) of All Discharges

Level of Care	Length of Stay (in Days)			
	Average (Mean)	25th Percentile	50th Percentile (Median)	75th Percentile
Detoxification (24-Hour Care)				
1. Hospital Inpatient				
2. Free-standing Residential	3	1	1	1
Rehabilitation / Residential				
3. Hospital Inpatient				
4. Short-term (up to 30 days)	32	25	28	35
5. Long-term (over 30 days)	111	29	82	155
Ambulatory (Outpatient)				
6. Outpatient	161	35	100	212
7. Intensive Outpatient	77	41	52	76
8. Detoxification				
Opioid Replacement Therapy (ORT)				
9. Opioid Replacement therapy	2	2	2	2
10. ORT Outpatient	507	212	367	805

Notes:		
Level of Care	2006 TEDS discharge record count	
	Discharges submitted	Discharges linked to an admission
Total count, all levels of care	9,623	9,252
1. Hospital Inpatient-Detoxification (24-Hour Care)	0	0
2. Free-standing Residential-Detoxification (24-Hour Care)	4,652	4,569
3. Hospital Inpatient-Rehabilitation / Residential	0	0
4. Short-term (up to 30 days)-Rehabilitation / Residential	796	786
5. Long-term (over 30 days)-Rehabilitation /		

Residential	560	541
6. Outpatient-Ambulatory (Outpatient)	508	449
7. Intensive Outpatient-Ambulatory (Outpatient)	3,107	2,843
8. Detoxification-Ambulatory (Outpatient)	0	0
9. Opioid Replacement therapy-Opioid Replacement Therapy (ORT)		1
10. ORT Outpatient-Opioid Replacement Therapy (ORT)		63
Source: SAMHSA/OAS TEDS CY 2007 linked discharge file [Records received through 05/27/2008]		

Nebraska

INSERT OVERALL NARRATIVE:

INSERT OVERALL NARRATIVE:

The State should address as many of these questions as possible and may provide other relevant information if so desired. Responses to questions that are already provided in other sections of the application (e.g., planning, needs assessment) should be referenced whenever possible.

State Performance Management and Leadership

Describe the Single State Agency's capacity and capability to make data driven decisions based on performance measures. Describe any potential barriers and necessary changes that would enhance the SSA's leadership role in this capacity.

Describe the types of regular and ad hoc reports generated by the State and identify to whom they are distributed and how.

If the State sets benchmarks, performance targets or quantified objectives, what methods are used by the State in setting these values?

What actions does the State take as a result of analyzing performance management data?

Has the State developed evidence-based practices (EBPs) or programs and, if so, does the State require that providers use these EBPs?

Provider Involvement

What actions does the State expect the provider or intermediary to take as a result of analyzing performance management data?

If the SSA has a regular training program for State and provider staff that collect and report client information, describe the training program, its participants and frequency. Do workforce development plans address NOMs implementation and performance-based management practices? Does the State require providers to supply information about the intensity or number of services received?

State Performance Management and Leadership

Describe the Single State Agency's capacity and capability to make data driven decisions based on performance measures. Describe any potential barriers and necessary changes that would enhance the SSA's leadership role in this capacity. Describe the types of regular and ad hoc reports generated by the State and identify to whom they are distributed and how.

Limited Capabilities to conduct Data Orientated Decision Making:

Beginning in FY 2008 and continuing into FY 2009, two items will affect this observation. The Division is in the process of funding a new Prevention Data System built on the models of other prevention system to collect information to support block grant reporting and decision making at the State and sub-state levels. Beta testing began in late August 2008 for the Nebraska Prevention Information Reporting System (NPIRS) that is an internet based system built and managed with the expertise of the staff at Region 6 Behavioral Health Authority. NPIRS began capturing community coalition level performance information. This community level information will be reported through the Regional Behavioral Health Authorities, to the state and into grant applications. Coalitions, providers and Regional Behavioral Health Authorities have been working with the State to implement the NPIRS over the design and development stages that began in October 2007. The Web address for NPIRS is: <http://www.npirs.org>.

On the treatment side, a series of revisions was included in the Administrative Service Organizations (ASO) request for proposal let in February 2008. These strengthened data sets include full National Outcome Measures and reporting requirements for the State Outcomes Monitoring and Measurement System (SOMMS). The Successful bidder to the State's request for proposal was the same organization that previously held the administrative services organization contract (Magellan Behavioral Health, Inc.). Toward an effort to comply with the new contract details the first SOMMS data transfer by the ASO contractor occurred in August 2008. Calendar Year 2007 data, as well as the First and Second quarter 2008 data were transferred to the Federal Contractor for SOMMS. Because of programming errors Arrests in Prior 30 days, Detailed Not in Labor Force, and Social Connectedness measures were not properly included. . Corrections to the reporting system are being made and the October 2008 SOMMS transfer is scheduled to include these data items.

As a part of the ASO bid process in February 2008, more reporting to programs and Regional Behavioral Health Authorities has been required. The Division is working to make available monthly, quarterly, and fiscal year reports meaningful to sub-state entities and programs include SOMMS variables. .

Noted in the Core Technical Review Report was the inability of staff within the Division to manage data. The report indicated staff was able to review the data but there were not sufficient staff to compile reports and to analyze the data. A new position for data manager has been approved, and as of August, 2008 the Department wide Personal

Service Limitation includes this position. As of August 2008, position description had been drafted and submitted to the Personal section of the Departments' Support Services. An additional position within the Division to support the data manager is also being considered. This will affectively limit the number of interns and other staff who have to be cobbled together to manage the information from the data system, analyze that information and make recommendations to management.

If the State sets benchmarks, performance targets or quantified objectives, what methods are used by the State in setting these values?

Nebraska has not set benchmarks, performance targets or quantified objectives.

What actions does the State take as a result of analyzing performance management data?

Nebraska does not have performance management data system.

Has the State developed evidence-based practices (EBPs) or programs and, if so, does the State require that providers use these EBPs?

Nebraska has not established Evidence Base Practices nor does it currently require agencies to use such in the Treatment area. Prevention is based in large part with the SPF-SIG model planning process and community coalition building using effective strategies and programs.

Provider Involvement

What actions does the State expect the provider or intermediary to take as a result of analyzing performance management data?

Provider management is the providers responsibility. The State SSA has not heretofore imposed sanctions for performance deficiencies.

If the SSA has a regular training program for State and provider staff that collect and report client information, describe the training program, its participants and frequency.

No regular training program is currently available. The Division of Behavioral Health is working with the Administrative Services Organization to begin a continuous quality improvement process to the ASO contract and with provider level reporting.

Do workforce development plans address NOMs implementation and performance-based management practices?

Nebraska has no workforce development plan. Continuous Quality Assurance planning is beginning with Division staff and within the Magellan Behavioral Health Administrative Service Organization contract initiated in June 2008.

Does the State require providers to supply information about the intensity or number of services received?

Nebraska is a modified managed care state - Agencies are paid through contracts for units of service for authorized clients and on a reimbursement for expenses for persons served as registered clients. Client data is requested of the providers through the Administrative Services Organization web site. Client authorizations are given by the ASO. The ASO is Magellan Behavioral Health, Inc. Clients are admitted to a service and terminated from services. Clients may be enrolled in several services at the same time from an appropriate array of providers. Concurrent enrollment in outpatient services is not uncommon,. Residential programs are authorized, and dual enrollment in more than one residential program is unusual. Agencies report on authorized clients numbers of units of service provided. No similar reporting on registered clients currently exists.

Nebraska

Treatment Corrective Action Plan (submit upon request)

1. Describe the corrective action plan, including critical steps and actions the State and its providers will employ to collect and report the National Outcome Measures data.
2. Discuss the timeframes for the State's corrective action plan detailing the planned milestones and other measures of progress the State has incorporated into its corrective action plan.
3. Describe the State's corrective action plan implementation monitoring activities including interventions or adjustments the State will employ when timeframes or milestones are not achieved.

Form P1

State: Nebraska

NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use Measure: 30-Day Use

A. Measure	B. Question/Response	C. Pre-Populated Data	D. Approved Substitute Data	
1. 30-day Alcohol Use	Source Survey Item: NSDUH Questionnaire. "Think specifically about the past 30 days, that is, from [DATEFILL] through today. During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?" [Response option: Write in a number between 0 and 30.] Outcome Reported: Percent who reported having used alcohol during the past 30 days.	Ages 12-17 - FFY 2006	34.50	
		Ages 18+ - FFY 2006	57.50	
2. 30-day Cigarette Use	Source Survey Item: NSDUH Questionnaire: "During the past 30 days, that is, since [DATEFILL], on how many days did you smoke part or all of a cigarette?" [Response option: Write in a number between 0 and 30.]	Ages 12-17 - FFY 2006	11.20	
		Ages 18+ - FFY 2006	27.20	
3. 30-day Use of Other Tobacco Product	Source Survey Item: NSDUH Questionnaire: "During the past 30 days, that is, since [DATEFILL], on how many days did you use [other tobacco products] † ?" [Response option: Write in a number between 0 and 30.] Outcome Reported: Percent who reported having used a tobacco product other than cigarettes during the past 30 days,	Ages 12-17 - FFY 2006	6.60	
		Ages 18+ - FFY 2006	10	
4. 30-day Use of Marijuana	Source Survey Item: NSDUH Questionnaire: "Think specifically about the past 30 days, from [DATEFILL] up to and including today. During the past 30 days, on how many days did you use marijuana or hashish?" [Response option: Write in a number between 0 and 30.] Outcome Reported: Percent who reported having used marijuana or hashish during the past 30 days.	Ages 12-17 - FFY 2006	4.70	
		Ages 18+ - FFY 2006	4.50	
5. 30-day Use of Illegal Drugs Other Than Marijuana	Source Survey Item: NSDUH Questionnaire: "Think specifically about the past 30 days, from [DATEFILL] up to and including today. During the past 30 days, on how many days did you use [any other illegal drug] ‡ ?" Outcome Reported: Percent who reported having used illegal drugs other than marijuana or hashish during the past 30 days, calculated by combining responses to questions about individual drugs (heroin, cocaine, stimulants, hallucinogens, inhalants, prescription drugs used without doctors' orders).	Ages 12-17 - FFY 2006	5.60	
		Ages 18+ - FFY 2006	2.40	

((s)) Suppressed due to insufficient or non-comparable data

† NSDUH asks separate questions for each tobacco product. The number provided combines responses to all questions about tobacco products other than cigarettes.

‡ NSDUH asks separate questions for each illegal drug. The number provided combines responses to all questions about illegal drugs other than marijuana or hashish.

Form P2

State: Nebraska

NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use Measure: Perception of Risk/Harm of Use

A. Measure	B. Question/Response	C. Pre- Populated Data	D. Approved Substitute Data
1. Perception of Risk From Cigarette	Source Survey Item: NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke one or more packs of cigarettes per day?" [Response options: No risk, slight risk, moderate risk, great risk] Outcome Reported: Percent reporting moderate or great risk.	Ages 12–17 - FFY 2006 94.80	
		Ages 18+ - FFY 2006 95.30	
1. Perception of Risk From Cigarettes	Source Survey Item: NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?" [Response options: No risk, slight risk, moderate risk, great risk] Outcome Reported: Percent reporting moderate or great risk.	Ages 12–17 - FFY 2006 77.50	
		Ages 18+ - FFY 2006 77	
3. Perception of Risk From Marijuana	Source Survey Item: NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke marijuana once or twice a week?" [Response options: No risk, slight risk, moderate risk, great risk] Outcome Reported: Percent reporting moderate or great risk.	Ages 12–17 - FFY 2006 85.60	
		Ages 18+ - FFY 2006 79.70	

((s)) Suppressed due to insufficient or non-comparable data

Form P3

State: Nebraska

NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use Measure: Age of First Use

A. Measure	B. Question/Response	C. Pre-Populated Data	D. Approved Substitute Data
1. Age at First Use of Alcohol	Source Survey Item: NSDUH Questionnaire: "Think about the first time you had a drink of an alcoholic beverage. How old were you the first time you had a drink of an alcoholic beverage? Please do not include any time when you only had a sip or two from a drink." [Response option: Write in age at first use.] Outcome Reported: Average age at first use of alcohol.	Ages 12–17 - FFY 2006 <input type="text" value="13"/>	<input type="text"/>
		Ages 18+ - FFY 2006 <input type="text" value="16.90"/>	<input type="text"/>
2. Age at First Use of Cigarettes	Source Survey Item: NSDUH Questionnaire: "How old were you the first time you smoked part or all of a cigarette?" [Response option: Write in age at first use.] Outcome Reported: Average age at first use of cigarettes.	Ages 12–17 - FFY 2006 <input type="text" value="12.60"/>	<input type="text"/>
		Ages 18+ - FFY 2006 <input type="text" value="15.50"/>	<input type="text"/>
3. Age at First Use of Tobacco Products Other Than Cigarettes	Source Survey Item: NSDUH Questionnaire: "How old were you the first time you used [any other tobacco product] † ?" [Response option: Write in age at first use.] Outcome Reported: Average age at first use of tobacco products other than cigarettes.	Ages 12–17 - FFY 2006 <input type="text" value="13.50"/>	<input type="text"/>
		Ages 18+ - FFY 2006 <input type="text" value="18.30"/>	<input type="text"/>
4. Age at First Use of Marijuana or Hashish	Source Survey Item: NSDUH Questionnaire: "How old were you the first time you used marijuana or hashish?" [Response option: Write in age at first use.] Outcome Reported: Average age at first use of marijuana or hashish.	Ages 12–17 - FFY 2006 <input type="text" value="13.60"/>	<input type="text"/>
		Ages 18+ - FFY 2006 <input type="text" value="17.80"/>	<input type="text"/>
5. Age at First Use of Illegal Drugs Other Than Marijuana or Hashish	Source Survey Item: NSDUH Questionnaire: "How old were you the first time you used [other illegal drugs] ‡ ?" [Response option: Write in age at first use.] Outcome Reported: Average age at first use of other illegal drugs.	Ages 12–17 - FFY 2006 <input type="text" value="12.40"/>	<input type="text"/>
		Ages 18+ - FFY 2006 <input type="text" value="19.60"/>	<input type="text"/>

((s)) Suppressed due to insufficient or non-comparable data

† The question was asked about each tobacco product separately, and the youngest age at first use was taken as the measure.

‡ The question was asked about each drug in this category separately, and the youngest age at first use was taken as the measure.

Form P4

State: Nebraska

NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use Measure: Perception of Disapproval/Attitudes

A. Measure	B. Question/Response	C. Pre- Populated Data	D. Approved Substitute Data
1. Disapproval of Cigarettes	<p>Source Survey Item: NSDUH Questionnaire: "How do you feel about someone your age smoking one or more packs of cigarettes a day?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]</p> <p>Outcome Reported: Percent somewhat or strongly disapproving.</p>	89.50	
2. Perception of Disapproval of Cigarettes	<p>Source Survey Item: NSDUH Questionnaire: "How do you think your close friends would feel about you smoking one or more packs of cigarettes a day?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]</p> <p>Outcome Reported: Percent reporting that their friends would somewhat or strongly disapprove.</p>	88.80	
3. Disapproval of Using Marijuana Experimentally	<p>Source Survey Item: NSDUH Questionnaire: "How do you feel about someone your age trying marijuana or hashish once or twice?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]</p> <p>Outcome Reported: Percent somewhat or strongly disapproving.</p>	85.50	
4. Disapproval of Using Marijuana Regularly	<p>Source Survey Item: NSDUH Questionnaire: "How do you feel about someone your age using marijuana once a month or more?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]</p> <p>Outcome Reported: Percent somewhat or strongly disapproving.</p>	86.10	
5. Disapproval of Alcohol	<p>Source Survey Item: NSDUH Questionnaire: "How do you feel about someone your age having one or two drinks of an alcoholic beverage nearly every day?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]</p> <p>Outcome Reported: Percent somewhat or strongly disapproving.</p>	86.20	

((s)) Suppressed due to insufficient or non-comparable data

Form P5

State: Nebraska

NOMs Domain: Employment/Education
Measure: Perception of Workplace Policy

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Perception of Workplace Policy	<p>Source Survey Item: NSDUH Questionnaire: "Would you be more or less likely to want to work for an employer that tests its employees for drug or alcohol use on a random basis? Would you say more likely, less likely, or would it make no difference to you?" [Response options: More likely, less likely, would make no difference]</p> <p>Outcome Reported: Percent reporting that they would be more likely to work for an employer conducting random drug and alcohol tests.</p>		Ages 15-17 - FFY 2006 30.30	
			Ages 18+ - FFY 2006 45.10	

((s)) Suppressed due to insufficient or non-comparable data

Form P7

State: Nebraska

NOMs Domain: Employment/Education
Measure: Average Daily School Attendance Rate

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Average Daily School Attendance Rate	<p>Source: National Center for Education Statistics, Common Core of Data: The National Public Education Finance Survey available for download at http://nces.ed.gov/ccd/stfis.asp</p> <p>Measure calculation: Average daily attendance (NCES defined) divided by total enrollment and multiplied by 100.</p>	FFY 2006	91.20	

((s)) Suppressed due to insufficient or non-comparable data

Form P8

State: Nebraska

NOMs Domain: Crime and Criminal Justice Measure: Alcohol-Related Traffic Fatalities

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Alcohol-Related Traffic Fatalities	Source: National Highway Traffic Safety Administration Fatality Analysis Reporting System Measure calculation: The number of alcohol-related traffic fatalities divided by the total number of traffic fatalities and multiplied by 100.	FFY 2006	33.10	

((s)) Suppressed due to insufficient or non-comparable data

Form P9

State: Nebraska

NOMs Domain: Crime and Criminal Justice Measure: Alcohol- and Drug-Related Arrests

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Alcohol- and Drug-Related Arrests	<p>Source: Federal Bureau of Investigation Uniform Crime Reports</p> <p>Measure calculation: The number of alcohol- and drug-related arrests divided by the total number of arrests and multiplied by 100.</p>	FFY 2006	105.50	

((s)) Suppressed due to insufficient or non-comparable data

Form P10

State: Nebraska

NOMs Domain: Social Connectedness Measure: Family Communications Around Drug and Alcohol Use

A. Measure	B. Question/Response	C. Pre-Populated Data	D. Approved Substitute Data
1. Family Communications Around Drug and Alcohol Use (Parents of children aged 12-17)	<p>Source Survey Item: NSDUH Questionnaire: "Now think about the past 12 months, that is, from [DATEFILL] through today. During the past 12 months, have you talked with at least one of your parents about the dangers of tobacco, alcohol, or drug use? By parents, we mean either your biological parents, adoptive parents, stepparents, or adult guardians, whether or not they live with you." [Response options: Yes, No] Outcome Reported: Percent reporting having talked with a parent.</p>	Ages 12-17 - FFY 2006 <input type="text" value="61.80"/>	<input type="text"/>
2. Family Communications Around Drug and Alcohol Use (Parents of children aged 12-17)	<p>Source Survey Item: NSDUH Questionnaire: "During the past 12 months, how many times have you talked with your child about the dangers or problems associated with the use of tobacco, alcohol, or other drugs?" † [Response options: 0 times, 1 to 2 times, a few times, many times] Outcome Reported: Percent of parents reporting that they have talked to their child.</p>	Ages 18+ - FFY 2006 <input type="text" value="87.50"/>	<input type="text"/>

((s)) Suppressed due to insufficient or non-comparable data

† NSDUH does not ask this question of all sampled parents. It is a validation question posed to parents of 12- to 17-year-old survey respondents. Therefore, the responses are not representative of the population of parents in a State. The sample sizes are often too small for valid reporting.

Form P11

State: Nebraska

NOMs Domain: Retention

Measure: Percentage of Youth Seeing, Reading, Watching, or Listening to a Prevention Message

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Exposure to Prevention Messages	<p>Source Survey Item: NSDUH Questionnaire: "During the past 12 months, do you recall [hearing, reading, or watching an advertisement about the prevention of substance use] † ?" Outcome Reported: Percent reporting having been exposed to prevention message.</p>	Ages 12-17 - FFY 2006	92.90	

((s)) Suppressed due to insufficient or non-comparable data

† This is a summary of four separate NSDUH questions each asking about a specific type of prevention message delivered within a specific context.

Form P12A

State: Nebraska

Programs and Strategies—Number of Persons Served by Age, Gender, Race, and Ethnicity

Question 1: Describe the data collection system you used to collect the NOMs data (e.g., MDS, DbB, KIT Solutions, manual process).

Question 2: Describe how your State’s data collection and reporting processes record a participant’s race, specifically for participants who are more than one race. Indicate whether the State added those participants to the number for each applicable racial category or whether the State added all those participants to the More Than One Race subcategory.

Category	Description	Total Served
A. Age	1. 0-4	1320
	2. 5-11	5310
	3. 12-14	8464
	4. 15-17	9152
	5. 18-20	10485
	6. 21-24	21339
	7. 25-44	162960
	8. 45-64	197112
	9. 65 And Over	191236
B. Gender	Male	300877
	Female	306501
C. Race	White	313939
	Black or African American	96872
	Native Hawaiian/Other Pacific Islander	19186
	Asian	19353

	More Than One Race (not OMB required)	20653
	Race Not Known or Other (not OMB required)	38045
D. Ethnicity	Hispanic or Latino	99330
	Not Hispanic or Latino	508048

Form P12B

State: Nebraska

Population-Based Programs and Strategies—Number of Persons Served by Age, Gender, Race, and Ethnicity

Category	Description	Total Served
A. Age	1. 0-4	0
	2. 5-11	0
	3. 12-14	25
	4. 15-17	1073
	5. 18-20	27
	6. 21-24	151
	7. 25-44	2163
	8. 45-64	1706
	9. 65 And Over	39
	10. Age Not Known	
B. Gender	Male	2390
	Female	2794
	Gender Unknown	
C. Race	White	3918
	Black or African American	541
	Native Hawaiian/Other Pacific Islander	233
	Asian	112
	American indian/Alaska Native	

	More Than One Race (not OMB required)	49
	Race Not Known or Other (not OMB required)	
D. Ethnicity	Hispanic or Latino	331
	Not Hispanic or Latino	4853

Form P13

State: Nebraska

Number of Persons Served by Type of Intervention

Intervention Type	Number of Persons Served by Individual- or Population-Based Program or Strategy	
	A. Individual-Based Programs and Strategies	B. Population-Based Programs and Strategies
1. Universal Direct	605809	N/A
2. Universal Indirect	N/A	5184
3. Selective	1514	N/A
4. Indicated	55	N/A
5. Total	607378	5184

Form P14

State: Nebraska

Evidence-Based Programs and Strategies by Type of Intervention

NOMs Domain: Retention

NOMs Domain: Evidence-Based Programs and Strategies

Measure: Number of Evidence-Based Programs and Strategies

Definition of Evidence-Based Programs and Strategies: The guidance document for the Strategic Prevention Framework State Incentive Grant, Identifying and Selecting Evidence-based Interventions, provides the following definition for evidence-based programs:

- Inclusion in a Federal List or Registry of evidence-based interventions
- Being reported (with positive effects) in a peer-reviewed journal
- Documentation of effectiveness based on the following guidelines:
 - Guideline 1: The intervention is based on a solid theory or theoretical perspective that has validated research, and
 - Guideline 2: The intervention is supported by a documented body of knowledge—a converging of empirical evidence of effectiveness—generated from similar or related interventions that indicate effectiveness, and
 - Guideline 3: The intervention is judged by informed experts to be effective (i.e., reflects and documents consensus among informed experts based on their knowledge that combines theory, research, and practice experience). “Informed experts” may include key community prevention leaders, and elders or other respected leaders within indigenous cultures.

1. Describe the process the State will use to implement the guidelines included in the above definition.

2. Describe how the State collected data on the number of programs and strategies. What is the source of the data?

Number of Evidence-Based Programs and Strategies by Type of Intervention

	A. Universal Direct	B. Universal Indirect	C. Universal Total	D. Selected	E. Indicated	F. Total
1. Number of Evidence-Based Programs and Strategies Funded	3327	342	3669	117	16	133
2. Total number of Programs and Strategies Funded	7460	342	7792	546	22	568
3. Percent of Evidence-Based Programs and Strategies	44.60%	100.00%	47.09%	21.43%	72.73%	23.42%

Form P15

State: Nebraska

Services Provided Within Cost Bands

Type of Intervention	A. Number of Programs and Strategies	B. Number of Programs and Strategies Falling Within Cost Bands	C. Percent of Programs and Strategies Falling Within Cost Bands
1. Universal Direct Programs and Strategies	<input type="text"/>	<input type="text"/>	<input type="text"/> %
2. Universal Indirect Programs and Strategies	<input type="text"/>	<input type="text"/>	<input type="text"/> %
3. Subtotal Universal Programs	0	0	%
4. Selective Programs and Strategies	<input type="text"/>	<input type="text"/>	<input type="text"/> %
5. Indicated Programs and Strategies	<input type="text"/>	<input type="text"/>	<input type="text"/> %
6. Total All Programs	0	0	%

- Foot Notes

Cost and participant count information collected using spreadsheets is not reliable. Nebraska has begun using a beta test site for the Nebraska Prevention Information Reporting System as of August 2008. Full reporting is anticipated to begin October 1, 2008. NPIRS is a coordinated effort funded by the Division of Behavioral Health with the participation of the Nebraska Department of Health and Human Services, Division of Public Health, the Six Regional Behavioral Health Authorities and the SPF-SIG, and Block Grant funded community coalitions.

Nebraska

Prevention Corrective Action Plan (submit upon request)

1. Describe the corrective action plan, including critical steps and actions the State and its providers will employ to collect and report the National Outcome Measures data.
2. Discuss the timeframes for the State's corrective action plan detailing the planned milestones and other measures of progress the State has incorporated into its corrective action plan.
3. Describe the State's corrective action plan implementation monitoring activities including interventions or adjustments the State will employ when timeframes or milestones are not achieved.

Prevention Attachments A, B, and C (optional)

State:
Nebraska

Approved Substitute Data Submission Form

Substitute data has not been submitted for prevention forms.

State: Nebraska

**Prevention Attachment D:
2005 Block Grant Subrecipient Cost Band Worksheet**

Subrecipient Name: _____

Date Form Completed: _____

Name of Contact Person: _____

Phone: _____ **E-mail Address:** _____

Table 1: Program Detail

1	2	3	4	5	6
Program Name	Number of Participants	Number of Program Hours Received	Total Cost of the Program	Average Cost Per Participant (Col 4/Col 2)	Average Cost Per Participant Falls Within 2005 Cost Bands (Yes=1 No=0)
Universal Direct Programs					Universal Direct: \$58.01–\$693.98
1.					
2.					
3.					
4.					
Universal Indirect Programs					Universal Indirect \$1.05–\$82.26
1.					
2.					
3.					
4.					
Selective Programs					Selective \$151.88–\$6,409.29
1.					
2.					
3.					
4.					
Indicated Programs					Indicated \$510.47–\$4,888.44
1.					
2.					
3.					
4.					

Table 2: Subrecipient Cost Band Summary

	1	2
Program Type	Number of Programs	Number of Programs Falling Within Cost Bands
Universal Direct		
Universal Indirect		
Selective		
Indicated		
Total		

Instructions for Completing the 2005 Block Grant Subrecipient Cost Band Worksheet

The 2005 Block Grant Subrecipient Cost Band Worksheet is an optional tool that States may use for their providers to record the number of program participants, the number of hours received, the cost of each program, the average cost per program participant, and the number of programs whose average participant costs fall within the 2005 cost bands. Data should be based on total cost of program not only the funding from CSAP. States may use an alternative approach to obtain data used to report the aggregate cost band data in Form P15 of the SAPT Block Grant Application. These worksheets are not required as part of that submission.

1. Subrecipient Information

Grant Information. At the top of the page, enter the name of the subrecipient, the contact information for the person completing this form, and the date on which the form was completed.

2. Table 1: Program Detail

Column 1: Program Name. In column 1, list the names of all programs that were funded in whole or in part with Block Grant funds during Federal fiscal year (FY) 2005. Add additional rows if necessary.

A program is defined as an activity, a strategy, or an approach intended to prevent an outcome or to alter the course of an existing condition. In substance abuse prevention, interventions may be used to prevent or lower the rate of substance use or substance abuse-related risk factors.

Separate table sections are provided for programs that are defined as Universal Direct, Universal Indirect, Selective, and indicated. Universal indirect services are defined as services that support prevention activities, such as population-based activities, and the provision of information and technical assistance. Universal direct, selective, and indicated services are defined as prevention program interventions that directly serve participants.

- **Universal.** Activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk.
- **Universal Direct.** Interventions directly serve an identifiable group of participants but who have not been identified on the basis of individual risk (e.g., school curriculum, afterschool program, parenting class). This also could include interventions involving interpersonal and ongoing/repeated contact (e.g., coalitions).
- **Universal Indirect.** Interventions support population-based programs and environmental strategies (e.g., establishing ATOD policies, modifying ATOD advertising practices). This also could include interventions involving programs and policies implemented by coalitions.
- **Selective.** Activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- **Indicated.** Activities targeted to individuals identified as having minimal but detectable signs or symptoms foreshadowing disorder or having biological markers indicating predisposition for disorder but not yet meeting diagnostic levels.

Column 2: Number of Participants. In this column, specify the number of participants who took part in the preventive program during FY 2005. If this intervention was delivered to multiple groups, combine all groups and report the total. If it is an indirect program, use the estimated number of people reached during the reporting year.

Column 3: Number of Program Hours Received. In this column, report the number of hours that program participants received over the course of the program.

Column 4: Total Cost of This Program. In this column, report the total of all costs expended on the program during the reporting year. This should include all costs associated with the program, such as staff training, staff time, and materials, during the year.

Column 5: Average Cost Per Participant. Report the average cost per participant. Calculate the average cost by dividing the Block Grant dollars expended on each program (column 4) by the number of participants served (column 2).

Column 6: Average Cost Per Participant Falls Within Cost Bands. Compare the average cost per participant (column 5) with the 2005 cost bands for each program type. If the average cost per participant falls within the specified interval, record a “1” in column 5. If the average cost is either higher or lower than the cost band interval, enter a zero in column 5.

3. Table 2: Subrecipient Cost Band Summary

Table 2 summarizes information recorded in Table 1.

Column 1: Number of Programs. In column 1, enter the total number of programs on which you reported in Table 1, by program types (Universal Direct, Universal Indirect, Selective, and Indicated). Total the number of programs in the last row.

Column 2: Number of Programs Falling Within Cost Bands. For each program type, enter the total number of programs that fell within the cost bands for that program type (i.e., programs that were coded “1” in Table 1, column 5).

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Nebraska

Appendix A - Additional Supporting Documents (Optional)

Appendix A - Additional Supporting Documents (Optional)

No additional documentation is required to complete your application, besides those referenced in other sections. This area is strictly optional. However, if you wish to add extra documents to support your application, please attach it (them) here. If you have multiple documents, please 'zip' them together and attach here.