

Nebraska System of Care

Strategic Planning Project

July 2013 – July 2014

Nebraska Department of Health and Human Services
Division of Behavioral Health
Lincoln, NE



Nebraska System of Care Planning Project
Planning for Transformation through Partnerships

Table of Contents

Executive Summary..... 1



Population of Focus..... 4

Context and History of System of Care in Nebraska 4

Vision, Mission and Values 10

Nebraska System of Care Planning Process 11

 Structure and Approach..... 11

 Training and Technical Assistance..... 13

 Participation in Planning..... 14

 Key Findings from Assessment 14

 Plan Development 15

 Youth Engagement..... 16

 Reviewing and Refining the Plan 17

Logic Model: Transforming Nebraska’s System of Care for Children, Youth and their Families. 18

Strategic Plan 26

 Goals..... 26

 Framework 27

 Strategies..... 27

Social Marketing and Communication Plan 42

Appendix A: Logic Model and Strategic Plan Development Tool 46

Appendix B: Definitions and Acronyms 63

Appendix C: Governance Diagram 70

Acknowledgements..... 71

Nebraska System of Care Strategic Planning Project

Forward

A Family Perspective on the System of Care Planning Process

“As a parent being asked to share my voice as a representative of the voice of so many others families, having spent sleepless nights considering the best path for my child with behavioral health needs, balancing my family’s needs with that of getting my child the help she needed, fearing the unknown and celebrating the successes, my moment of arrival in a room full of professionals was daunting, at best. However, I had been encouraged, prepared, educated and supported to get to that room with years of my own lived experience as a parent coupled with the tools I had gained by listening and learning from other parents in similar situations that had also sought out support from my local family-run organization. As I tiptoed into the conference room, head lowered, hands clasped, I feared judgment and reprisal and felt small and insignificant despite the preparation.

Something miraculous happened in that large room in Nebraska that day. A professional came to my side and offered her hand and an introduction. Soon we were drinking coffee and discussing our children, and I learned that this professional, like apparently many, were also family members and had lived experience of their own in addition to their professional expertise. It was that professional that listened to me and prodded me to speak about my experiences with the behavioral health system that day. By day’s end my chin was held firm, my shoulders broad and my hands were often found to be clasped by this woman who reminded me that my voice as a parent was vital to system improvement. I will continue to share my story with other parents that are launching their parent leadership campaign as encouragement and with other professionals that are unsure how to engage or interact with family members.”

A Nebraska Parent

Families, parents and youth involved with family-run organizations across Nebraska benefit from the diverse and collaborative partnerships that have defined the System of Care planning for children’s behavioral health services and supports. Family and Youth Leaders were afforded opportunities to share their voices about how systems personally impacted them during the multi-phased SOC planning cycle.

From a philosophical stand point, it was vital for the professional system partners, parent partners and youth partners to come together to identify various perspectives, commonalities and agreement on priorities. In some situations that union benefited from some very honest,

real and often difficult discussions about what it means to truly involve families and youth as opposed to just inviting them to meetings.

System partners identified that launching and sustaining system change requires meaningful participation of families as partners, as much as other public and private child and family serving agencies and other stakeholders. Inclusion, as it was referred to in the planning phases, meant: acknowledging families as experts on their own needs; ensuring an active and meaningful role for family members in a variety of areas; and providing diverse opportunities for family members to participate in shared decision-making.

In the initial planning stages, the core SOC Management Team focused on developing capacity for family inclusion at the family, peer and system level by utilizing the SAMHSA statewide Family Network contract with Nebraska Federation of Families and the affiliate local family-run organizations. This created various opportunities for parent education on SOC, as well as preparation and involvement in various meetings and work groups that allowed parents and youth to share their views in an accepting and open atmosphere focused on cohesion and system improvement.

The parent and youth role in the planning process focused on:

- Leveraging parent's and youth's lived experience in policy, law and financing;
- Continuous reiteration of the values and principles of family-driven care in service delivery, support and processes that directly (and indirectly) impact youth and families;
- Identification of gaps, barriers, theories and wording that is not congruent with parent and youth partnership values in a System of Care model;
- Cultural and linguistic diversity, intelligence and cohesive focus on related standards;
- Identification, value and necessity of partnerships at all levels.

Vast empowerment of parents and youth catapulted the movement to establish further structure around Parent and Youth Leadership programming and a Native American Peer Support project through coordinated efforts with Nebraska Federation of Families for Children's Mental Health and the affiliate family organizations. Though the work was sometimes difficult, it was also a catalyst for hope that the future for families and youth might include necessary changes to improve outcomes.

Sara S. Nicholson
Chief Operating Officer
Nebraska Federation of Families for Children's Mental Health

NEBRASKA SYSTEM OF CARE
Strategic Planning Project
Planning for Transformation through Partnerships

EXECUTIVE SUMMARY

Nebraska's System of Care Strategic Plan, when implemented, will build on partnerships, include full participation of youth and families, and create a broad, integrated process across all of Nebraska's child-serving systems to achieve positive outcomes for children and youth with serious emotional and behavioral health needs and their families.

Vision: *All Nebraska children, youth and families reach their full potential.*

Mission: *Nebraska will improve the lives of children, youth and families by working within partnerships to transform Nebraska System of Care.*

Return on Investment (ROI):

States and communities that have implemented the system of care approach have reported changes in service utilization patterns. Such changes have resulted in a "return on investment" for the public systems that serve children with serious mental health conditions and their families. Examples include:

- Decreased use of inpatient psychiatric and residential treatment,
- Decreased use of juvenile correction and other out-of-home placements, and
- Decreased use of physical health services and emergency rooms.¹

The following return on investments were realized through the System of Care approach implemented in Nebraska's Behavioral Health Region III serving 22 counties in central Nebraska.

- From 2001 to 2009, the Central Nebraska region successfully returned youth to the community from high levels of care that were provided in restrictive settings outside of the community. These youth were then served with the system of care approach. Savings of \$500,000 in 2001 later grew to \$900,000 which were reinvested to serve additional youth and families.
- The average cost per family served with the system of care approach using wraparound was 60% less than the cost of those served through the child welfare or juvenile justice system.
- In 2012, 90% of youth at risk of entering child welfare or juvenile justice who were served with the system of care approach by six behavioral health authorities remained with their families.²

Capitalizing on initial infrastructure currently in place including the support and involvement of leaders across the state's many child-serving systems, Nebraska can expect to realize similar if not significant return on investment as the System of Care is implemented statewide.

¹ Stroul, Beth A. M.Ed., Pires, Sheila A., M.P.A., *Return on Investment in Systems of Care for Children with Behavioral Health Challenges*, National Technical Assistance Center for Children's Mental Health, April 2014

² Baxter, Beth, 2013; Nebraska Behavioral Health Services, Region III, 2000; Stroul et al., 2009

Nebraska's Assessment of Need for System of Care:

A statewide readiness assessment for System of Care, conducted by UNL Public Policy Center, among 1105 families, youth, service providers and other stakeholders, identified clear priority areas to be addressed:

- Expanding the array of services and supports.
- Enhancing the cultural and linguistic appropriateness of services to match family needs.
- Improving access to services and supports.
- Maximizing use of all funding sources, especially federal.
- Inclusion of trauma-informed service options.
- Expanding family and youth involvement and leadership.
- Systems to monitor quality and outcomes.

Stakeholders across the state were clear in their expectation that state leaders provide the framework, data and resources for local implementation of system of care, including increased opportunities for system level involvement for youth and families.

Planning Structure and Approach:

The planning project involved a comprehensive, highly participatory statewide process featuring more than 260 youth, family members and system representatives. Planning centered around eleven (11) planning groups that were formed and facilitated beginning in December 2013 and extending through April 2014. These groups include ten (10) Core Strategy Teams and an overarching Project Management Team. In addition to system representatives, all teams included youth and family members as an essential element of the planning process.

The Core Strategy Teams (CST) were organized around ten (10) content areas resulting in ten (10) sets of content-specific recommendations for enhancing System of Care. The resulting strategic plan includes goals and culturally and regionally relevant and sustainable strategies organized around the following core areas:

- Implementing Policy, Administrative and Regulatory Changes
- Developing Services and Supports Based on the SOC Approach
- Creating Financing Mechanisms
- Providing Training, TA and Coaching
- Generating Support for the System of Care Approach among system partners, providers and clients.

Positive Outcomes:

Positive outcomes associated with System of Care implementation include:

- Improvements in the lives of children and youth, such as decreased behavioral and emotional problems, suicide rates, substance use, and juvenile justice involvement. Systems of care also increase strengths, school attendance and grades, and stability of living situation.
- Improvements in the lives of families, such as reduced caregiver strain and improved family functioning. Families also receive increased education, support services, and peer support.

- Improvements in service delivery systems, such as an extensive array of home and community-based services and supports, individualization of services, increased family and youth involvement in services, and increased use of evidence-based practices.
- Improvements in the cost and quality of care, including decreased utilization of inpatient and residential services, increased cross-system collaboration, and improved use of Medicaid and other resources.³

Nebraska’s System of Care, when implemented, will provide meaningful benefits and measurable outcomes to children and youth as experienced in the context of everyday living. A full list of process and functional outcomes can be accessed in the Strategic Plan on pages 18 and 25.

In order to infuse System of Care and the power of partnerships across Nebraska, the strategies as described beginning on page 28 of the Plan should be implemented. Many of these strategies would be low or no-cost thus supporting the “return on Investment” as previously described.

For Additional Information:

- Quick reference - Strategic Plan Goals and Strategies: See **Strategic Plan** pages 26-41
- Nebraska System of Care, Strategic Planning Project, Full Document:
<http://www.dhhs.ne.gov/soc>
- Grant planning process: See **Strategic Plan** pages 11-17
- Core Strategy Teams products - Development Tool: See **Appendix A** pages 46-62
- Required grant deliverables reported to SAMHSA:
 - Logic Model: See page 18
 - Plan goals and strategies: See pages 26-41
 - Social Marketing and Communication Plan: See pages 42-45
- Statewide Needs Assessment – Final Report: <http://www.dhhs.ne.gov/soc>
- Suggested Outcome Measures and Indicators: See **Strategic Plan** pages 18 and 25
- Youth engagement in plan development: See pages 16-17
 - Youth Focus Groups – Full Report: <http://www.dhhs.ne.gov/soc>

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³ Stroul, Beth A. M.Ed., Pires, Sheila A., M.P.A., *Return on Investment in Systems of Care for Children with Behavioral Health Challenges*, National Technical Assistance Center for Children’s Mental Health, April 2014

Nebraska System of Care Planning Project

July 2013 – July 2014

Population of Focus

The population of focus for Nebraska’s System of Care (SOC) planning efforts is defined, inclusively, as: *Children and youth with serious emotional and behavioral health needs and their families across all of Nebraska’s child-serving systems.*

Context and History of System of Care in Nebraska

The Nebraska Department of Health and Human Services (DHHS) Division of Behavioral Health (DBH) serves as the chief behavioral authority for the State of Nebraska as dictated in Neb. Rev. Stat. §71-806. In relationship to Nebraska’s SOC, DHHS DBH has the authority and responsibility to direct and coordinate the public behavioral health system, including integration and coordination of the system; comprehensive statewide planning for the provision of an appropriate array of community-based behavioral health services and continuum of care; development and management of data and information systems; prioritization and approval of all expenditures of funds received and administered by the division; and promotion of activities in research and education to improve the quality of behavioral health services, recruitment and retention of behavioral health professionals, and access to behavioral health programs and services. DHHS DBH works in partnership with six Regional Behavioral Health Authorities (RBHA) to carry out its charge.

Nebraska organized its mental health system in six regions in 1974. (See Figure 1) In 2004, LB 1083, the Nebraska Behavioral Health Services Act, was passed, establishing the regions as RBHAs. Neb. Rev. Stat. §71-803 outlines that RBHAs ensure: (1) the public safety and the health and safety of persons with behavioral health disorders; (2) statewide access to behavioral health services, including, but not limited to, (a) adequate availability of behavioral health professionals, programs, and facilities, (b) an appropriate array of community-based services and continuum of care, and (c) integration and coordination of behavioral health services with primary health care services; (3) high quality behavioral health services, including, but not limited to, (a) services that are research-based and consumer-focused, (b) services that emphasize beneficial treatment outcomes and recovery, with appropriate treatment planning, case management, community support, and consumer peer support, (c) appropriate regulation of behavioral health professionals, programs, and facilities, and (d) consumer involvement as a priority in all aspects of service planning and delivery; and (4) cost-effective behavioral health services, including, but not limited to, (a) services that are efficiently managed and supported with appropriate planning and information, (b) services that emphasize prevention, early detection, and early intervention, (c) services that are provided in the least restrictive

environment consistent with the consumer's clinical diagnosis and plan of treatment, and (d) funding that is fully integrated and allocated to support the consumer and his or her plan of treatment.

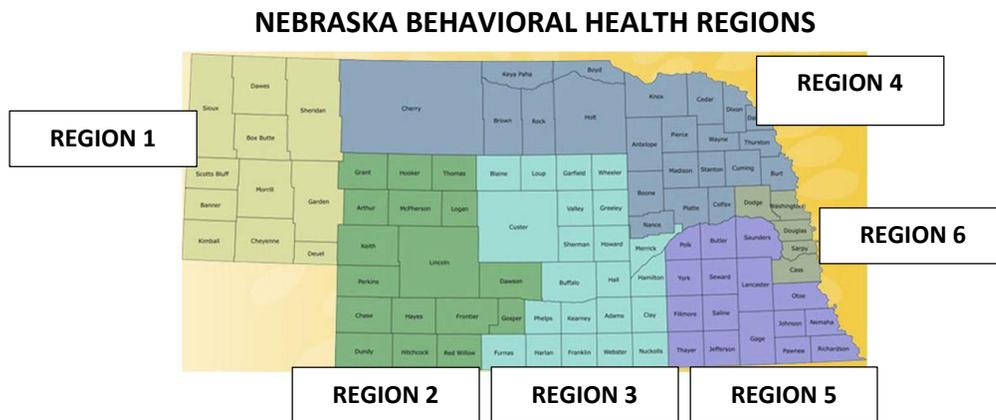


Figure 1

RBHAs develop local systems of care across the state responsive to local needs and building upon the unique strengths and communities of each region, forging partnerships with youth, families, providers, DHHS agencies (inclusive of Division of Behavioral Health (DBH), Children and Family Services (CFS), and Medicaid and Long-Term Care), county leaders (counties provide a 1:3 match for state funding), local system stakeholders, and community leaders and members. RBHA funding is intended to serve individuals who are not Medicaid eligible or do not have insurance coverage. The RBHAs include: Region 1 (11 counties) in western Nebraska with headquarters in Scottsbluff; Region 2 (17 counties) in southwestern Nebraska with headquarters in North Platte; Region 3 (22 counties) in central Nebraska with headquarters in Kearney; Region 4 (22 counties) in northern Nebraska with headquarters in Norfolk; Region 5 (16 counties) in southeastern Nebraska with headquarters in Lincoln; and Region 6 (5 counties) in eastern Nebraska with headquarters in Omaha.

Each RBHA braids funding from state, federal, and local county sources to develop local networks of providers to provide an array of non-traditional supports not covered by Medicaid, ranging from emergency to resiliency-oriented supports to wraparound. System coordination is central to their purpose, coordinating the local behavioral health system in the region through strategic strengths-based/recovery-focused processes that empower individuals and communities to assure that network providers, system partners and the many stakeholders of the behavioral health system work in a coordinated manner that supports individuals across the life span to promote resiliency and achieve recovery. Each RBHA has established multi-stakeholder collaborative structures to coordinate efforts in formal functional areas for Consumers (including youth) and Family Involvement and Inclusion, Network Management, Emergency Services System, Prevention Services System, and Youth System of Care (YSC). Each

RBHA has implemented since 1995 a Professional Partner Program (PPP) using a fidelity-based version of the wraparound care coordination model to support services to families who have children with serious emotional disorders and to ensure that youth and families have a voice and ownership in developing an accessible, comprehensive, individualized family support plan. DBH is currently contracting with TriWest Group to update the wraparound fidelity and outcome evaluation approach of the PPP, as well as its cost methodology. The YSC and PPP infrastructure facilitate the involvement of youth, families, and system partners at the regional (YSC) and individual family (PPP) levels. Over time, specialty PPP has developed within the RBHAs, including transition-age PPP teams and rapid response PPP teams developed as a proactive strategy to reduce the number of individuals and families seeking out-of-home care and services via county attorneys and county/district courts. (See Figure 2). CFS has also identified prevention PPP as part of its Alternative Response strategy to reduce the number of individuals that receive out-of-home care and to decrease the number of youth coming under the custody of the court.

Nebraska Judicial Districts - District Courts

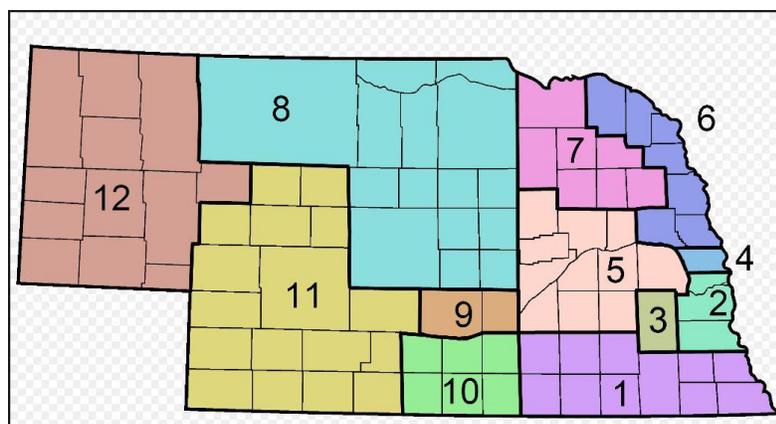


Figure 2

The YSC and PPP structures in each RBHA, alongside parallel structures for child welfare through the CFS’s five Service Areas (SAs) (see Figure 3), are long-standing and provide a key component of the foundation upon which the SOC strategic plan implementation efforts are built. While their geographic boundaries are not fully aligned, there is much overlap and each RBHA works with assigned SAs. This enhanced regional alignment is key to sustainability, as both RBHAs and SAs have established networks among SOC stakeholders in each region.

Nebraska’s past SOC efforts, generated in Behavioral Health Regions 3 and 5, served as the state’s barometer for moving forward with a SOC on a statewide basis. These efforts allowed Nebraska to capitalize on regional successes and incorporate lessons learned in the development of this SOC strategic plan.

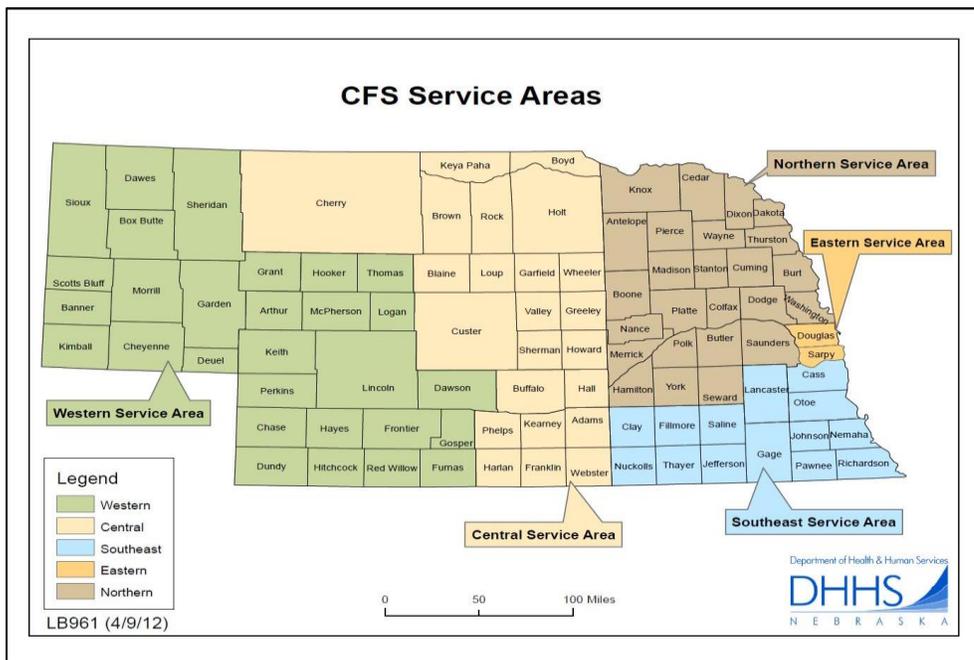


Figure 3

The timing to support System of Care (SOC) development at the state level in Nebraska is in a state of unprecedented readiness. Critical developments in 2011 solidified two directions for the state central to SOC development. First, Legislative Bill (LB) 821 established the Nebraska Children’s Commission (Commission), a 26-member body charged with creating a statewide strategic plan to reform child welfare programs and services, including children’s behavioral health. The Commission is comprised of representatives of the three branches of state government and members of the general public, including: guardians ad litem, prosecuting attorneys, foster and biological parents, children’s services providers, child advocacy organizations, foster care review board members, court-appointed special advocate volunteers, and youth currently or previously in foster care. This Commission serves as a permanent forum for collaboration among state, local community, public and private stakeholders across child-serving programs and services. The intent of the Legislature in creating the Commission was to establish the group as a high-level leadership body with membership from the legislative, executive and judicial branches, along with system stakeholders, to improve the safety and well-being of children and families in Nebraska.

Just as importantly for children with SED, in May 2012 the directors of DBH and CFS issued Administrative Memo #17-2012 defining a process for the two divisions to collaborate in new ways to improve outcomes for every youth involved in the child welfare system with a mental health and/or substance abuse disorder. The Transition Aged Youth Referral and Coordination Process developed through this memo set into motion a renewed spirit of shared responsibility in helping youth with behavioral health challenges access the full array of services and supports

available to them. Then, to set the stage for the recent Title IV-E Waiver application, Administrative Memo #2-2012 in January 2013 identified shared statutory goals for CFS to: 1) increase permanency for all infants, children, and youth by reducing the time in foster placements when possible and promoting a successful transition to adulthood for older youth, 2) increase positive outcomes for infants, children, youth, and families in their homes and communities, including tribal communities, and improve the safety and well-being of infants, children, and youth, and 3) prevent child abuse and neglect and the re-entry of infants, children, and youth into foster care. The memo was promulgated among staff to assure that when a child needs to be removed from their home due to safety concerns, non-custodial parents should be the first person considered for placement, followed by other people the children know and who care about them in order to reduce trauma to the child.

The goals reinforced the need for a Title IV-E Waiver application to develop an Alternative Response Model to reduce Nebraska's exceptionally high rate of foster care placement. With aligned support of DHHS, the Governor and the Legislature to pursue the waiver and carry out the mandate of LB 821, the SOC strategic plan builds on multiple prior initiatives to enable even higher levels of collaboration, including:

- In 2012, Nebraska explored and planned for the launch of an Alternative Response (AR) Model within CFS to allow families an opportunity to address issues prompting the child abuse/neglect reporting without removing children at low risk of harm from their natural environment. An AR stakeholder group has been formed with members including DBH, CFS, RBHAs, CFS's Service Administrators, the Federation of Families, and others. LB 853 allows the statutory change to current investigations and make way for pilots of the AR Model, to begin in State Fiscal Year 2015, in a limited and evaluative manner. AR is an effort to change further the state's culture away from thinking that the safety of a child can only be achieved through removal from the family home. The focus of the pilot is more on enhancing the family's protective factors while maintaining the child's safety. As such, communities enrolled in the pilot are collaborating in ways that inform and strengthen the System of Care.
- Beginning in 2012, DBH and CFS have been working in collaboration on a framework for trauma-informed care (TIC). DBH established Trauma Informed Nebraska in 2005 to guide TIC policy, provide trauma screening and training, gather data, and develop trauma-specific services statewide. All DBH-funded providers must complete a baseline agency assessment using the Harris and Falot TIC tool (Falot & Harris, 2009), and DBH has completed this tool for the state central office. CFS is currently working on a TIC Self-Assessment in order to develop a strategic plan moving forward. DBH and CFS completed training on the use of Results-Based Accountability™ ("RBA") to measure the outcomes achieved through services for children and families. RBA is also incorporated as part of the Title IV-E Waiver demonstration project interventions.

- The 2013 Legislative Session also included numerous bills that impacted the building of services and supports for children. There was legislation introduced to expand Medicaid state plan services to children ages 4-21 with SED who have been diverted or deinstitutionalized (LB270); expand telehealth services for schools (LB556) and juvenile youth (LB605); extend Title IV foster care eligibility until age 21 (LB216); change Foster Care Licensures and Kinship Home/Relative Home provisions to support permanency with kin and relatives (LB265); expand funding for counseling, mental health treatment and supportive services to improve child and caretaker well-being without having to remove children from their homes (LB425); and increase the number of juvenile court judges and specialized courts (LB463). LB 216, 265 and 556 were subsequently passed into law.
- A final, critical opportunity that makes this effort particularly timely involves Medicaid funding. In 2011 and 2012, the Medicaid system addressed multiple issues relating to residential treatment (Psychiatric Residential Treatment Facilities) and reestablishment of the children's mental health benefit within the state plan, as well as a request for proposal process to implement an at-risk behavioral health benefit in September 2013. Health services funding more broadly is also in a state of transition as the health insurance exchange, MHPAEA requirements for Medicaid services, and questions regarding Medicaid expansion will shape the structure of public and private health care in Nebraska that will guide us for years to come.

It is critical that SOC development be a central theme to help structure and influence those decisions, and the SOC Strategic Plan offers the people of Nebraska that opportunity.

Vision, Mission and Values

Partners agreed to a vision, mission and values for developing and implementing a system of Care. The following represents the final products coming from the highly participatory process.

Vision

Nebraska's vision describes our hopes and intentions for system of care for children and youth and their families in the next three to five years – our vision reminds us why this effort is important.

Vision: *Nebraska children, youth and families of all cultures are able to access an integrated system of care that supports them to reach their full potential holistically (health, home, purpose and community), while in school, living in a home and community that supports strong family connections, and in their transition to adulthood.*

Simply Said: *All Nebraska children, youth and families reach their full potential.*

Mission

The Mission of the Nebraska System of Care Partnership guides our efforts by describing (1) what the system of care does; (2) who it serves; and (3) how it functions.

Mission: *Nebraska's child and family serving system of care will improve access to appropriate and timely community-based care that is family-driven and youth-guided; embodies the cultural and linguistic values of the individuals and families being served and improves their clinical, behavioral, social, and educational outcomes; and eliminates fragmented approaches to meeting need. Child and family-serving systems will achieve this change through transparent system collaboration with partnerships and shared ownership involving individuals and families as full partners.*

Simply Said: *Nebraska will improve the lives of children, youth and families by working within partnerships to transform the Nebraska System of Care.*

Values

Our values and principles are the foundation for our system of care; everything we do can be measured against these core values.

Values: *Youth-guided; family-driven; individualized; culturally and linguistically competent; accessible; cost-effective, trusted partnerships.*

Nebraska System of Care Planning Process

Structure and Approach

Planning for Nebraska’s System of Care involved a comprehensive, highly participatory statewide process, featuring youth, family members and system partners. Planning centered around eleven (11) groups that were formed and facilitated beginning in December 2013 and extending through April 2014. These groups include 10 Core Strategy Teams and an overarching Project Management Team. All teams included system, youth and family partners working together. The Core Strategy Teams (CSTs) were organized around content areas and the Project Management Team (PMT) was responsible for project oversight and development of this consolidated statewide plan based on recommendations from each of the other planning groups. While this participatory process was highly intensive in terms of complexity and overall level of effort, this model was chosen in order to promote wide-ranging participation and ownership of identified issues. Our participatory planning process emphasized culturally and regionally relevant and sustainable strategies, and engagement of local experts (including those with lived experience), resources and supports instead of reliance on centralized experts, resources or efforts leading to top-down, generic strategies.

The 10 CSTs were facilitated by planning co-chairs (see the third column in Figure 5 for CST list). The co-chairs for each CST included a system partner and a family partner, who were recruited based on their experience with the topic area systems and stakeholders as well as their willingness to serve as co-facilitator. The CST structure resulted in 10 sets of content-specific recommendations for enhancing System of Care. The Project Management Team then reviewed, analyzed and consolidated these recommendations. This comprehensive statewide plan and logic model is the product of our planning model. Please refer to **figures 4 and 5** for a graphic depiction of the statewide planning process. Note that Phase 4 timelines were compressed to facilitate internal deadlines.

Overview of Timeline and Sequence of Planning Process

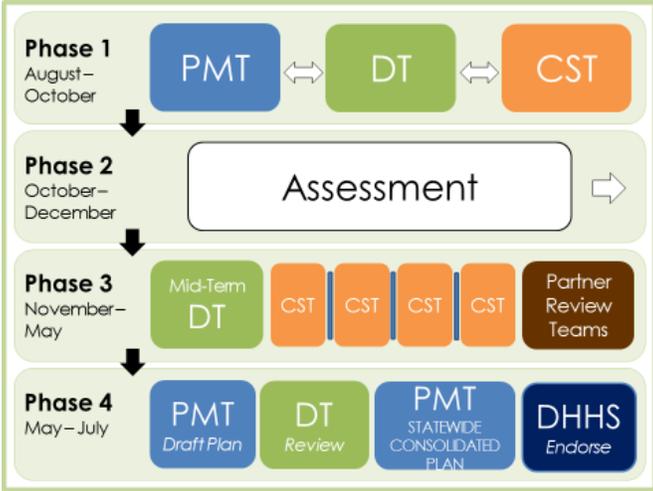


Figure 4

Overview of Planning Group Composition

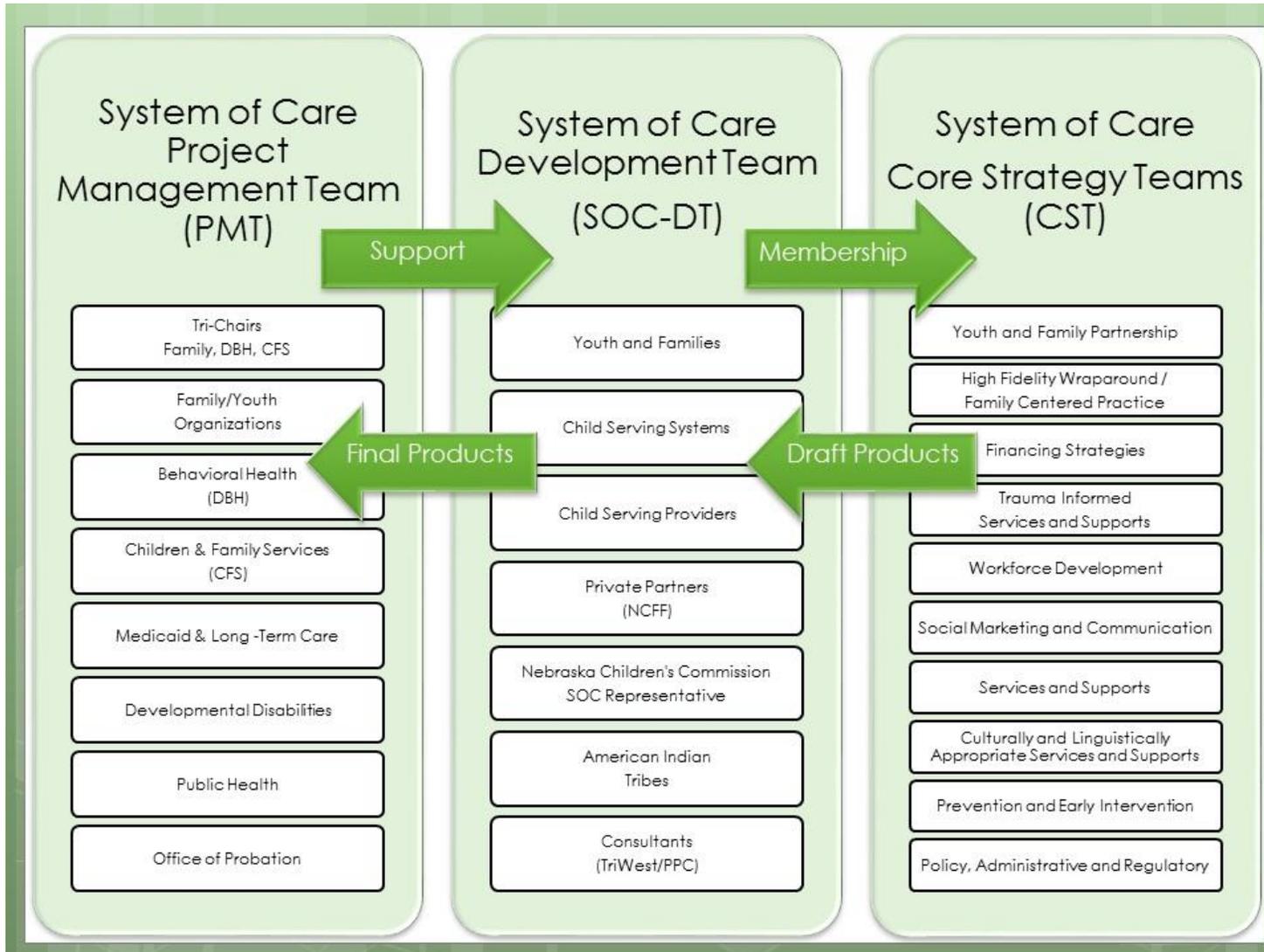


Figure 5

An essential element of our strategic plan planning processes was the involvement of family and youth. Two Nebraska organizations spearheaded the coordination -the Nebraska Federation of Families for Children’s Mental Health (NFF) and Nebraska Children and Family Foundation (NCF). Utilizing grant funding for this critical effort, these organizations assisted throughout the planning by successfully: organizing and gathering the voice of youth and family focus in the readiness assessment and strategic plan review phases; recruiting family and youth for involvement in the CSTs; facilitating CSTs; facilitating family and youth attendance at the kick-off and planning sessions; developing the communication plan; and participating in the final stages of the completion of the strategic plan. Because of these two organizations and their tremendous contribution to the strategic planning process, Nebraska has a strong SOC strategic plan based on an abundance of youth and family engagement.

Training and Technical Assistance

To maximize the intended effectiveness and outcomes of the 10 Core Strategy Teams (CST), two training sessions were provided to all CST co-chairs prior to the initiation of their first CST meeting. Training consisted of an overview of the CST process (review of team charge, logistics, team membership, etc.), and expected outcomes and meeting facilitation tips and techniques. A large portion of the training discussion was focused on how CST chairs could embed and implement the system of care philosophy and principles throughout the planning process as well as growing the understanding and implementation of equal partnership. Continued coaching was provided by the Project Coordinator to CST co-chairs through bi-weekly phone conferenced during the months the CSTs were convened. The phone conferences provided CST co-chairs an opportunity to ask questions and address and resolve issues specific to their individual CST content area and work products.

Central to the success of Nebraska’s SOC Planning Project is adherence to the National Standards for Culturally and Linguistically Appropriate Services (CLAS). A key focus of the planning process was to promulgate and increase commitment to the CLAS standards across all levels of planning and the subsequent strategic plan. To meet this objective one of the 10 Core Strategy Teams was dedicated to identifying and developing strategies to infuse Cultural and Linguistic Competence (CLC) and CLAS principles, practices and standards across all 10 CST content areas. Technical Assistance in the form of an all-day workshop specific to CLC/CLAS was offered to all CST members as well as members of the Project Management Team, project leadership and key staff of system partners. Vivian Jackson, Ph.D., National Center for Cultural Competence, Georgetown University Center for Child and Human Development, presided over the day’s agenda which included topics specific to clarity of concepts and elements of CLC. Application/implementation exercises for CLC and CLAS, adaptable to individual spheres of influence, were offered to participants. We appreciated Dr. Jackson’s time and consultation outside of the workshop to review and improve the plan. Blanca Ramirez-Salazar, Tribal Liaison, DHHS Office of Health Disparities and Health Equity, assisted during final plan

development in reviewing and providing her recommendations for the draft language specific to CLC/CLAS.

Participation in Planning

Statewide Readiness Assessment

The University of Nebraska Public Policy Center conducted a statewide self-assessment of readiness for expanding system of care in Nebraska during November 2013. The self-assessment consisted of a survey of 786 families, youth, service providers and other stakeholders, and 42 discussion forums with 319 participants in all six behavioral health regions. Listed below is participant primary role as reported in the survey and discussion groups.

Primary Role	Number
Judiciary	8
Youth	38
Foster Parent/Guardian	12
Advocate	38
Supervisor	60
Parent/Family Member (past or present)	171
Teacher	99
Administrator	116
Direct Service Provider	141
Service System	206
Other*	216

*Other included service providers such as counselors, school counselors, guidance counselors, nurses and school nurses.

Key Findings from Assessment

The statewide readiness assessment indicated a widely held sense that system of care components were lacking both at the state and community level. Clear priority areas from the readiness assessment included: 1) expanding the array of services and support; 2) enhancing the cultural and linguistic appropriateness of services to better match family needs; 3) improving access to services and support; 4) maximizing use of all funding sources, especially federal; 5) inclusion of trauma-informed service options; 6) expanding family and youth involvement and leadership; and 6) systems to monitor quality and outcomes.

Interestingly, stakeholders across the state were clear in their expectation that state leaders provide the framework, data and resources for local implementation of system of care. Participants thought youth and family partnership components were lacking across the state. Families indicated they want to be recognized as equal partners on child and family teams. Increasing opportunities for system level involvement for youth and families, and equipping them with the skills to participate effectively in policy development, appear to be a clear area of need.

Stakeholders noted that workforce development components are lacking in consistency and continuity at the community and state levels. Training the workforce is considered a state and community strength as well as a priority need. There was recognition that Nebraska has a shortage of behavioral health professionals, particularly in rural areas. Survey and focus group participant suggestions include better utilization of other system professionals, such as school social workers; enhancing compensation for behavioral health providers to increase recruitment and retention; and improving the skills of the workforce through training on topics such as trauma-informed care, evidence-based practices, social and emotional development, high-fidelity wraparound, and cultural and linguistic competency.

An essential system partner in the strategic planning process related to workforce development was the University of Nebraska Medical Center (UNMC). By state statute, UNMC's Behavioral Health Education Center of Nebraska's (BHECN) mission is to:

To enhance the behavioral health of the people of Nebraska by improving the numbers, accessibility and competence of the Nebraska Behavioral Health Workforce through the collaboration of academic institutions, providers, governmental agencies and the community.

Along with the Executive Director of a Nebraska Federation of Family organization, BHECN's Associate Director chaired the CST that addressed SOC workforce development, which produced a multitude of strategies to improve Nebraska's behavioral health workforce providing services and supports to children, youth and families. BHECN has pledged to continue to be a central force in the implementation of Nebraska's SOC Strategic Plan.

Plan Development

Core Strategy Teams: Participation = 262

Listed on the next page is SOC partner participation by role on ten core strategy teams. The numbers were compiled from the attendance sheets of the individual CST breakout sessions during two statewide meetings (October 2013 and January 2014) and individual CST meeting in February and March 2014. Numbers listed reflect attendance at one or more (but not necessarily all) CST meetings beginning October 2013 through March 2014. During this period

of time, corresponding to Phase 3 in the planning structure (see Figure 4), CSTs developed the basic content and strategies for the plan.

In spite of recruitment efforts and a moderate level of family and youth participation, Nebraska must pay special attention to building a solid foundation for equal partnership in the SOC.

CST	System Partners	Family Partners	Youth Partners
CLAS	12	2	3
Finance	17	No Volunteers	No Volunteers
High Fidelity Wraparound	18	2	2
Policy, Administration	28	3	1
Prevention/Early Intervention	29	9	1
Services and Supports	38	7	1
Social Marketing	4	3	4
Trauma-Informed Care	19	8	2
Workforce Development	23	2	1
Youth/Family Partnership	19	2	2
TOTAL	207	38	17

Youth Engagement

Focus Groups: Youth Participation = 143

The voice of youth who were experiencing or had experienced Nebraska’s behavioral health system and other child serving systems was of particular interest in this process. Central to accomplishing the collection of youth voice was the partnership of NCFE and Project Everlast. (See the organization’s link at: <http://www.projecteverlast.org/>.) Through the leadership of NCFE’s Cassy Rockwell, youth voice was included in the planning process by way of a developed plan to conduct youth focus groups with youth organizations around the state. In total, 14 youth-serving organizations hosted youth focus groups across Nebraska (during February and March 2014). NCFE conducted a second round of focus groups in June in order to gather youth input into the developing system of care strategic plan. All groups ranged from one to 17 participants. There was representation from: juvenile justice facilities, child welfare current and former wards, behavioral health, independent living/transitional programs, and Native youth. One hundred forty-three (143) youth participated and 115 provided demographic information.

Of the youth that provided demographic information, 89% reported having received services from a child serving system in Nebraska. Listed below are the types of agencies from which youth had received services.

System/Agency	Number of Youth
Child Welfare	32
Developmental Disability	11
Early Childhood	13
Education	27
Health care	30
Mental Health	48
Substance Abuse	31
Vocational Rehabilitation	23
Juvenile Justice/Probation	54
Other*	13

*Other: Foster Care (4), Region 3 (2), NYLC (2), Boys Town (1), Project Everlast (1), Team Mates (1), shelters (1) and unspecified (1))

Reviewing and Refining the Plan

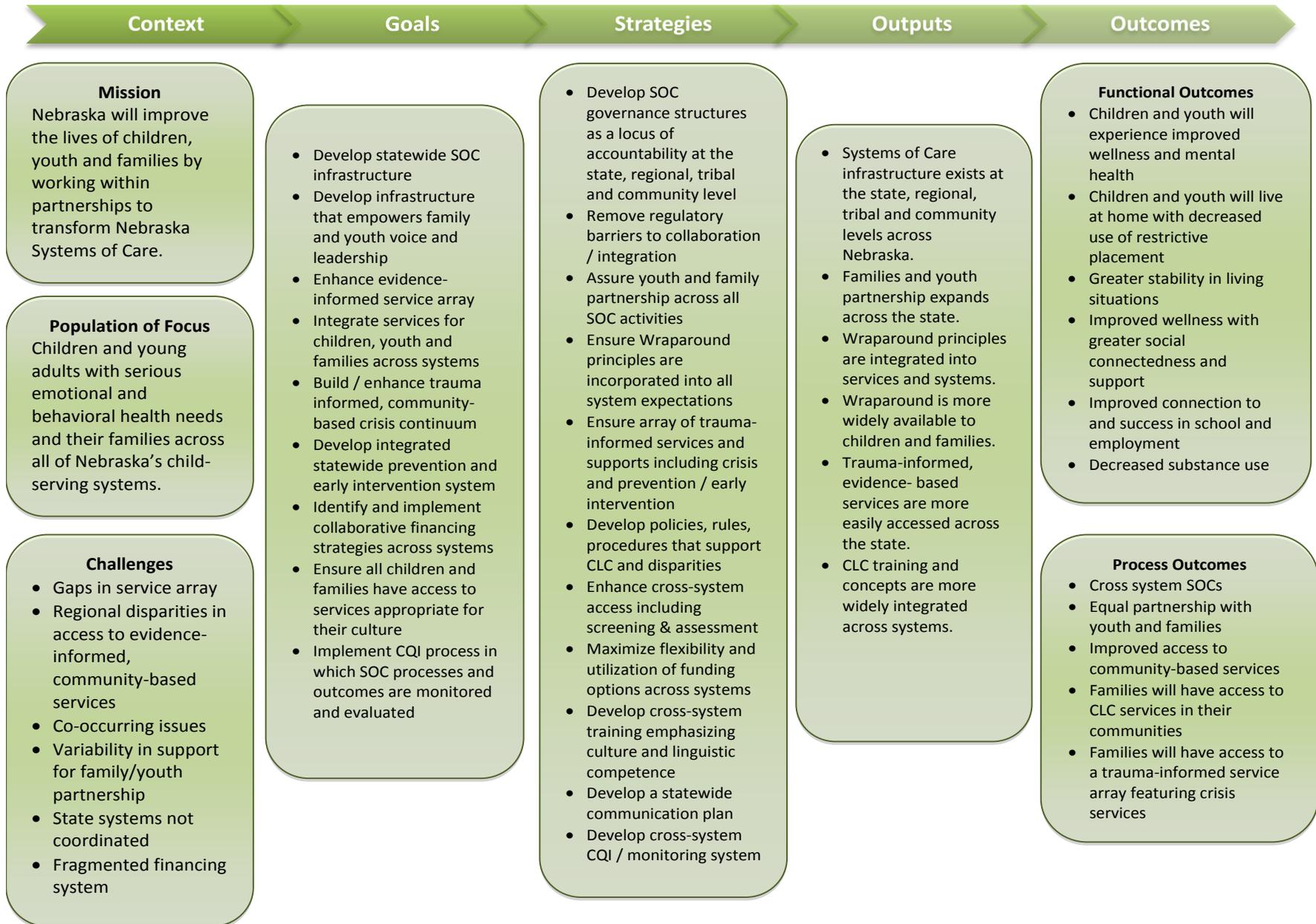
Plan Review and Revision: Participation = 262

The PMT adopted a logic model (page 18). They chose to include an expanded logic model which was an aggregate of the CST work plans. The strategic plan (page 26) was then organized into the nationally recommended format. After the initial logic model and strategic plan were drafted, we conducted a participatory review process during the months of April, May and June. The process included statewide town hall-style meetings as well as a series of youth focus groups, a family survey process and a special effort to ensure feedback from Native Americans in Nebraska. During this period, planning participants were asked to reflect on the priorities, goals and strategies reflected in the plan. The participatory review process resulted in significant revisions to ensure the plan truly reflects the systems and people of Nebraska.

Another activity in the participatory review process was to periodically present the draft plan and core strategies to the Nebraska Commission for Children for their review and support. Going forward, the Commission will use this strategic plan as a foundation for the development of their future priorities for Nebraska’s SOC.

Finally, the PMT and representatives of all Nebraska Family Organizations completed final edits and this document was reviewed and approved by DHHS leadership.

Logic Model: Transforming Nebraska's System of Care for Children, Youth and their Families



Expanded Logic Model

<ul style="list-style-type: none"> • Vision: Nebraska children, youth and families of all cultures are able to access an integrated system of care that supports them to reach their full potential holistically (health, home, purpose and community) while in school, living in a home and community that supports strong family connections, and in their transition to adulthood. • Mission: Nebraska’s child and family serving system of care will improve access to appropriate and timely community-based care that is family-driven and youth-guided; embodies the cultural and linguistic values of the individuals and families being served and improves their clinical, behavioral, social, and educational outcomes; and eliminates fragmented approaches to meeting need. Child and family-serving systems will achieve this change through transparent system collaboration with partnerships and shared ownership involving individuals and families as full partners.
<p>Values: Youth-guided; family-driven; individualized; culturally and linguistically competent;; accessible; cost-effective; trusted partnerships.</p>
<p>Population of Focus: Children and youth with serious emotional and behavioral health needs and their families across all of Nebraska’s child-serving systems.</p>

Strengths & Resources →	Context, Needs, Challenges →	Goals →	Strategies and Sub-Strategies →
<ul style="list-style-type: none"> • Systems (JJ; BH; PH; CFS, Ed.) recognize the importance of, and are beginning to work towards, partnership with family and youth. • Growing understanding that early, community-based care is an effective strategy. • Growing commitment, at the state level, to partnership among youth, family and system partners. 	<ul style="list-style-type: none"> • Change is difficult and requires great persistence. Policies and practices inhibit youth and family-centered work and involvement. • Gaps in service array, in some areas of the state, with limited access to evidence-informed, community-based interventions. • Skepticism and limited awareness and/or support for family leadership in some parts of the state. 	<ul style="list-style-type: none"> • Develop, implement and sustain System of Care (SOC) infrastructure, inclusive of legislation, policy, regulatory and financing, at regional, tribal and community levels. • Build a sustainable statewide infrastructure to empower children, youth and family voice outreach, education, advocacy and leadership opportunities. 	<p>Implementing Policy, Administrative, and Regulatory Changes</p> <ul style="list-style-type: none"> • Develop a SOC governance structure for a locus of accountability at the state level and support the implementation of the strategic plan by the SOC Leadership Team • The SOC Leadership Team will support the formation of regional, tribal and community SOC Leadership Teams that build upon current local strengths, and assume locus of accountability for SOC efforts at the local level. • Identify and review regulations or other barriers that prevent effective collaboration and/or development of a single services plan for youth and families across systems. • Ensure wraparound principles are incorporated into expectations for service provision across systems including contractual language to promote accountability

Strengths & Resources →	Context, Needs, Challenges →	Goals →	Strategies and Sub-Strategies →
<ul style="list-style-type: none"> Juvenile justice, child welfare, behavioral health and education systems actively participating in SOC planning. 	<ul style="list-style-type: none"> Lack of consistency, common definition of wraparound and family-driven practice. Many of the children and youth with the highest needs are involved in multiple systems. State systems (DBH, CFS, DD, MLTC) are not coordinated in engaging providers, resulting in inefficient use of scarce resources. Regional differences across the state require flexibility and locally tailored strategies for successful implementation. State-funding of fidelity-based wraparound maximizes flexibility, but is limited in terms of funding streams. Fragmented financing system for behavioral health. Need cross-system screening and assessment for trauma. Limited services and supports across the age range (e.g., 0-8 years; TAY). Partnerships with schools vary across the state. Generational, deep-seated BH stigma. 	<ul style="list-style-type: none"> Provide a culturally responsive, evidence-based and promising practices service array, featuring wraparound principles/philosophy and peer-to-peer support, to children, youth and families. Integrate children, youth and family services across systems. Build, or enhance a culturally responsive, trauma-informed and community-based crisis continuum across systems. Develop an integrated statewide prevention and early intervention system for children, youth and their families that emphasizes mental health promotion, suicide prevention, resilience, and trauma-informed practices. Utilize collaborative financing strategies across systems that are consistent with SOC values and principles. 	<ul style="list-style-type: none"> Assure that youth, family members and system partners will be involved in meaningful partnership in state and regional planning, evaluation, training, social marketing, CLC/CLAS and all other SOC implementation activities. Develop a statewide, cross-system “competency worksheet” for organizations to incorporate into training and evaluation practices. Identify and agree upon a shared screening, assessment and evaluation framework in the context of across system collaboration to support understanding of appropriateness of level of care determinations and service utilization. Identify and establish mechanisms for regional, tribal and community SOC teams to identify and monitor effectiveness of services provided to children and youth involved in multiple systems. Obtain formal commitment across systems to SOC values and principles including contribution of funds for system redesign through a signed Memorandum of Commitment document. Ensure that recruitment, hiring and retention practices result in High Fidelity Wraparound (HFW), regional and state staff that are culturally and linguistically representative of the communities being served. Assure that data regarding outreach, access, outcomes and disparities among culturally and linguistically diverse groups is used in making policy, administrative and regulatory changes. Integrate SOC principles with state and local policy decisions. Develop policies, rules and procedures that support CLC, implement CLAS standards, and address disparities. Coordinate across DBH, CFS, DD and MLTC-funded networks. <p>Developing Services and Supports based on the SOC Approach</p> <ul style="list-style-type: none"> Develop definitions, principles and practices for “no wrong door access” and a single services plan for children, youth and families across systems. Assist regional, tribal and community SOC leadership teams to explore ways to integrate strategies across systems at the local level.

Strengths & Resources →	Context, Needs, Challenges →	Goals →	Strategies and Sub-Strategies →
	<ul style="list-style-type: none"> • Policies, procedures & funding streams are barriers to flexibility in pooling resources or creativity. • Inconsistent family involvement – "expert" mentality; not valuing youth and family input. 	<ul style="list-style-type: none"> • All children, youth and families will have access to services that respect and are appropriate for their culture. • Implement a participatory Continuous Quality Improvement (CQI) process in which all SOC intended outcomes are systematically monitored and evaluated. 	<ul style="list-style-type: none"> • Promote and support the development of children, youth and family organizations within regions, tribes and communities. • Explore school-based and school-linked services including behavioral health screening, assessment, evaluation and referral protocols at the local level, including behavioral health screening, assessment, evaluation and referral protocols at the local level. • Ensure children and youth have access to wraparound, person-centered and family-driven planning leading to the delivery of evidence-based, promising practices and peer-to-peer services and support. • Identify and agree upon a shared screening, assessment and evaluation framework in the context of across system collaboration to support understanding of appropriateness of level of care determinations and service utilization. • Identify opportunities to promote coordination and eliminate duplication of services and processes across systems. • Facilitate the development and support of an integrated health information exchange (HIE) across systems. • Build a statewide crisis continuum that includes brief out-of-home options for children and youth in crisis such as crisis residential, respite, therapeutic foster care, and emergency shelter options. • Develop an integrated prevention and early intervention system based on primary, secondary and tertiary prevention components and includes efforts to increase parent/caregiver education, resources, integration with primary care, safe out-of-school programs, in-home services, and informal and formal supports. • Provide education/training to youth, family and system partners on accessing and using SOC funding. • Provide support to providers to develop the capacity to deliver services which are evidence-based and or promising practices to children, youth and their families and engage in on-going fidelity monitoring of such services.

Strengths & Resources →	Context, Needs, Challenges →	Goals →	Strategies and Sub-Strategies →
			<ul style="list-style-type: none"> • Support the development and promotion of resource materials necessary to meet unmet needs of cultural and linguistic populations in Nebraska. • Develop/build on standards to ensure that all service plans developed with children, youth and families are individualized to their unique culture, beliefs and values. • Encourage the development and implementation of monitoring strategies for services and supports. • Explore the implementation of accountability standards for providers and state partners across systems. <p>Creating Financing Mechanisms</p> <ul style="list-style-type: none"> • Explore policy and administrative options to support the development and use of evidence-based and promising practices across funding streams and increase flexibility across funding streams. • Pursue funding mechanisms for youth and family peer support. • Identify funding, incentives and other options for providers to participate in individualized children, youth and family team meetings and activities as related to the individualized service plan. • Identify and develop strategies to increase flexibility within funding streams. • Develop strategies to access flexible service funds designed to support children, youth and their families for items or activities identified in their individualized wraparound service plan or as emergent needs arise. • Develop and implement a pilot project to track the needs of and service provision to children, youth and families who are high-frequency consumers of services across systems and initiate a data-driven management system. • Develop flexible funding options for expenses such as transportation and child care to support youth and family participation and involvement at all levels. • Complete financial scan (financial resource matrix, Children’s Commission Cross System Analysis Report).

Strengths & Resources →	Context, Needs, Challenges →	Goals →	Strategies and Sub-Strategies →
			<ul style="list-style-type: none"> • Identify options for braided funding approaches to support a culturally responsive, trauma-informed and community-based crisis continuum across systems. • Identify budget allocations to include resources for translation and interpretation services and Culturally and Linguistically Appropriate Services (CLAS) implementation. <p>Providing Training, TA, and Coaching</p> <ul style="list-style-type: none"> • Coordinate efforts of all child serving systems to establish joint curricula and training that supports cross system work and ensure dissemination of that training. • Develop and implement culturally appropriate leadership training for interested youth and families. • Develop state-level family and youth leader position(s) to serve as a liaison between state agencies/systems and the youth and family network(s). • Facilitate the development of statewide training, education and technical assistance for the SOC workforce that utilizes youth and families as trainers. • Develop standards for state best practices for youth-guided and family-driven services. • Develop a competency training/education inventory to be used across systems and inclusive of the following eight domains: trauma informed/capable care; child and adolescent development; cultural and linguistic competence; children and youth with developmental disabilities and behavioral health needs; screening/assessment/evaluation/referral; family and person-centered practice; treatment planning/interventions/service delivery; quality improvement/professionalism and ethics. • Provide education/training for youth, family and system partners in evidence-based and promising practices related to mental health promotion, suicide prevention, resilience, and trauma-informed practices. • Develop a statewide, cross-system “competency worksheet” for organizations to incorporate into training, coaching and evaluation practices.

Strengths & Resources →	Context, Needs, Challenges →	Goals →	Strategies and Sub-Strategies →
			<ul style="list-style-type: none"> • Develop and/or enhance the formation of local continuous quality improvement (CQI) teams /workgroups and data-informed decision-making. <p>Generating Support/Social Marketing</p> <ul style="list-style-type: none"> • Assure that all children, youth, family and system partners are informed and knowledgeable about the SOC philosophy and HFW. • Inform youth, families and other key stakeholders of the value of youth and family voice and the opportunity for youth and family partnership and leadership at the state, county and individual levels. • Ensure communications plan provides information to the public about how to gain access to a community-based crisis continuum. • Develop and implement a communications plan that increases the awareness of prevention and early intervention resources including a clearinghouse of funded evidence-based and promising practices and availability of services and community resources. • Ensure communications are appropriate across counties with diverse linguistic characteristics, including their primary language, literacy skills and disability status. • Develop CLC component to social marketing and communications plan to include understanding of the cultural issues related to services and include linguistic ability to communicate. • Ensure messaging campaigns consider the cultural communities’ preferred language, medium, messenger and style.

Outcomes

Functional Outcomes and Indicators

- Children and youth will experience improved wellness and mental health.
- Children and youth will live at home.
 - Decrease utilization of long-term out-of-home placements.
 - Increase use of residential alternatives such as High Fidelity Wraparound, short term crisis, respite, and related supports.
 - Children and youth will experience improved stability in living situation.
- Children, youth and families exhibit well-being.
 - Improved coping skills.
 - Improved social connectedness.
 - Increased ability to overcome behavioral health needs.
- Children and youth will function successfully in the community.
 - Attend school and graduate.
 - Succeed in employment.
 - Engage in pro-social activities.
 - Experience more positive relationships with family, friends and others.
 - Establish effective support networks.
 - Experience decreased substance use.
- Costs for out-of-home care will decrease.

Process Outcomes

- Nebraska child and family serving agencies/systems partner and collaborate.
 - Engage in the implementation of coordinated and integrated system of care.
 - Efficiently and effectively deploy services and supports as determined by wraparound teams.
 - Implement culturally and linguistically appropriate and trauma-informed practice in all phases of interacting with children, youth and families.
 - Create an integrated system with “no wrong door” access.
 - Engage in equal partnership with families and youth in developing improved system of care.
 - Agree to, and implement, a common set of functional outcomes and work toward them together.
 - Have access to flexible funding to ensure individualized service delivery.
 - Be evaluated on implementation of family-centered practice within the agency/system.
- Nebraska children, youth and families
 - Have access to services in their home community.
 - Understand the systems and services they are involved in and know how to access information and get questions answered.
- Policies and funding for behavioral health in Nebraska will place a greater emphasis on prevention and early identification/intervention.

Nebraska System of Care Strategic Plan



Goals

The Project Management Team (PMT) considered all of the input from the planning process described previously and early on identified the following nine (9) goals that will organize our plan to enhance system of care for children, youth and their families across Nebraska:

1. Develop, implement and sustain system of care (SOC) infrastructure, inclusive of legislation, policy, regulatory and financing, at regional, tribal and community levels.
2. Build a sustainable statewide infrastructure to empower children, youth and family voice, outreach, education, advocacy and leadership opportunities.
3. Provide a culturally responsive, evidence-based and promising practices service array, featuring wraparound principles/philosophy and peer-to-peer support, to children, youth and families.
4. Integrate children, youth and family services across systems.
5. Build or enhance a culturally responsive, trauma-informed and community-based crisis continuum across systems.
6. Develop an integrated statewide prevention and early intervention system for children, youth and their families that emphasizes mental health promotion, suicide prevention, resilience, and trauma-informed practices.
7. Utilize collaborative financing strategies across systems that are consistent with SOC values and principles.
8. All children, youth and families will have access to services that respect and are appropriate for their culture.
9. Implement a participatory continuous quality improvement (CQI) process in which all SOC-intended outcomes are systematically monitored and evaluated.

Framework

Nebraska adopted the overarching framework of five core areas of focus identified by Beth Stroul and Robert Friedman (2011)⁴ as a way to organize the system of care strategic plan. They are:

1. Implementing Policy, Administrative, and Regulatory Changes
2. Developing Services and Supports based on the SOC Approach
3. Creating Financing Mechanisms
4. Providing Training, TA, and Coaching
5. Generating Support

Strategies

Nebraska is a diverse and complex state; the strategies that follow on pages 28-41 reflect this diversity as many strategies and activities require state, regional, tribal and local level actions that need to be addressed. Like any strategic plan, these strategies are a work in progress and subject to continuous review and improvement.



⁴ Stroul, B. A., & Friedman, R. M. (2011). Issue brief: Strategies for expanding the system of care approach. Washington, DC: Technical Assistance Partnership for Child and Family Mental Health.

NEBRASKA SYSTEM OF CARE (SOC) STRATEGIC PLAN

GOALS	Strategies Needed to Complete Goals				
	(A) Implementing Policy, Administrative, and Regulatory Changes	(B) Developing Services and Supports Based on the SOC Approach	(C) Creating Financing Mechanisms	(D) Providing Training, TA, and Coaching	(E) Generating Support
	Strategies	Strategies	Strategies	Strategies	Strategies
<p>GOAL # 1</p> <p>Develop, implement and sustain System of Care (SOC) infrastructure, inclusive of legislation, policy, regulatory and financing, at regional, tribal and community levels.</p>	<p>1. A.1. DHHS leadership will develop a SOC governance structure for a locus of accountability at the state level and support the implementation of the strategic plan by the SOC Leadership Team.</p> <p>1. A.2. The SOC Leadership Team, inclusive of equal representation of youth, family, and system partners will be formed and charged with pursuing dissemination and implementation of this strategic plan.</p>	<p>1. B.1. The SOC Leadership Team will develop definitions, principles and practices for “no wrong door access” and a single services plan for children, youth and families across systems.</p> <p>1. B.2. The SOC Leadership Team will assist regional, tribal, community and AR SOC leadership teams to explore ways to integrate strategies across systems at the local level, as identified in the SOC strategic plan.</p> <p>1. B.3 The SOC Leadership Team will identify and implement collaborative opportunities with AR Pilot Communities.</p>	<p>1. C.1. The SOC Leadership Team will develop funding stream options such as braided funding approaches across systems, and private and foundation contributions to develop alternatives to higher levels of care for children and youth.</p> <p>1. C.2. The SOC Leadership Team will develop standards for supporting equal partnership for children, youth and family participation in SOC activities, including financial support needed to fully participate in SOC activities.</p>	<p>1. D.1. The SOC Leadership Team will support the development of SOC principles and practices education/training for the system workforce and identify resources to disseminate education/training throughout the state.</p>	<p>1. E.1. The SOC Leadership Team will develop a communication plan that will inform children, youth, family and system partners about the Nebraska SOC.</p>

NEBRASKA SYSTEM OF CARE (SOC) STRATEGIC PLAN

GOALS	Strategies Needed to Complete Goals				
	(A) Implementing Policy, Administrative, and Regulatory Changes	(B) Developing Services and Supports Based on the SOC Approach	(C) Creating Financing Mechanisms	(D) Providing Training, TA, and Coaching	(E) Generating Support
	Strategies	Strategies	Strategies	Strategies	Strategies
GOAL #1 Continued	<p>1. A.3. The SOC Leadership Team will support the formation of regional, tribal, community and AR SOC Leadership Teams that build upon current local strengths, and assume locus of accountability for SOC efforts at the local level.</p> <p>1. A.4. The SOC Leadership Team will develop a method to track behavioral health disparities and develop and implement strategies to address accordingly.</p>				

NEBRASKA SYSTEM OF CARE (SOC) STRATEGIC PLAN

GOALS	Strategies Needed to Complete Goals				
	(A) Implementing Policy, Administrative, and Regulatory Changes	(B) Developing Services and Supports Based on the SOC Approach	(C) Creating Financing Mechanisms	(D) Providing Training, TA, and Coaching	(E) Generating Support
	Strategies	Strategies	Strategies	Strategies	Strategies
<p>GOAL # 2</p> <p>Build a sustainable statewide infrastructure to empower children, youth and family voice, outreach, education, advocacy and leadership opportunities.</p>	<p>2. A.1. (Same as 1.A.2.) The SOC Leadership Team, inclusive of equal representation of youth, family, and system partners, will be formed and charged with pursuing dissemination and implementation of this strategic plan.</p> <p>2. A.2. The SOC Leadership Team will identify strategies and resources to fund and sustain children, youth and family equal partnerships.</p>	<p>2. B.1. The SOC Leadership Team will promote and support the development of children, youth and family organizations within regions, tribes and communities.</p>	<p>2. C.1. The SOC Leadership Team will pursue funding mechanisms for youth and family peer support.</p>	<p>2. D.1. The SOC Leadership Team will identify youth and family, culturally appropriate leadership education/training opportunities throughout the state.</p> <p>2. D.2. The SOC Leadership Team will develop state-level family and youth leader position(s) to serve as a liaison between state agencies/systems and the youth and family network(s).</p> <p>2. D.3. The SOC Leadership Team will facilitate the development of statewide training, education and technical assistance for the SOC workforce that utilizes youth and families as trainers.</p> <p>2. D.4. The SOC Leadership Team will develop standards for state best practices for youth-guided and family-driven services.</p>	<p>2. E.1. The SOC Leadership Team will develop and implement a statewide communications plan that incorporates and promotes the value of youth and family partnership and leadership.</p>

NEBRASKA SYSTEM OF CARE (SOC) STRATEGIC PLAN

GOALS	Strategies Needed to Complete Goals				
	(A) Implementing Policy, Administrative, and Regulatory Changes	(B) Developing Services and Supports Based on the SOC Approach	(C) Creating Financing Mechanisms	(D) Providing Training, TA, and Coaching	(E) Generating Support
	Strategies	Strategies	Strategies	Strategies	Strategies
<p>GOAL # 3</p> <p>Provide a culturally responsive, evidence-based and promising practices service array, featuring wraparound principles, philosophy and peer-to-peer support, to children, youth and families.</p>	<p>3. A.1. (Same as 1.A.3.) The SOC Leadership Team will support the formation of regional, tribal and community SOC Leadership Teams that build upon current local strengths, and assume locus of accountability for SOC efforts at the local level.</p> <p>3. A.2. The SOC Leadership Team will identify regulations, barriers and gaps that prevent effective collaboration and/or development of a single services plan for children, youth and families across systems.</p>	<p>3. B.1. The SOC Leadership Team will support exploration of school-based and school-linked services including behavioral health screening, assessment, evaluation and referral protocols at the local level.</p> <p>3. B.2. The SOC Leadership Team will ensure children and youth have access to wraparound, person-centered and family-driven planning leading to the delivery of evidence based, promising practices and peer-to-peer services and supports.</p> <p>3. B.3 The SOC Leadership Team will identify and address disparities and inequalities in service outcomes.</p>	<p>3. C.1. The SOC Leadership Team will explore policy and administrative options to support the development and use of evidence-based and promising practices across funding streams.</p> <p>3. C.2. The SOC Leadership Team will explore policy and administrative options to increase flexibility across funding streams.</p> <p>3. C.3. (Same as 2.C.1.) The SOC Leadership Team will pursue funding mechanisms for youth and family peer support.</p>	<p>3. D.1. The SOC Leadership Team will develop a competency training/education inventory to be used across systems and inclusive of the following eight domains: trauma-informed/capable care; child and adolescent development; cultural and linguistic competence; children and youth with developmental disabilities and behavioral health needs; screening/assessment/evaluation/referral; family and person-centered practice; treatment planning/interventions/service delivery; quality improvement/professionalism and ethics.</p>	<p>3. E.1. The SOC Leadership Team will develop and implement a communications plan to inform system partners and key stakeholders about SOC; evidence-based and promising practices; peer-to-peer services and supports; and wraparound principles.</p>

NEBRASKA SYSTEM OF CARE (SOC) STRATEGIC PLAN

GOALS	Strategies Needed to Complete Goals				
	(A) Implementing Policy, Administrative, and Regulatory Changes	(B) Developing Services and Supports Based on the SOC Approach	(C) Creating Financing Mechanisms	(D) Providing Training, TA, and Coaching	(E) Generating Support
	Strategies	Strategies	Strategies	Strategies	Strategies
GOAL #3 Continued	<p>3. A.3. The SOC Leadership will ensure wraparound principles are incorporated into expectations for service provision across systems including contractual language to promote accountability.</p> <p>3. A.4. The SOC Leadership Team system partners will identify and agree upon a shared screening, assessment and evaluation framework in the context of across system collaboration to support understanding of appropriateness of level of care determinations and service utilization.</p>	<p>3. B.4. The SOC Leadership Team will identify mechanisms to Integrate diverse prevention services in many community-level and family-serving settings such as Early Childhood and evidence-based home visiting programs.</p>	<p>3. C.4. The SOC Leadership Team will identify funding, incentives and other options for providers to participate in individualized children, youth and family team meetings and activities as related to the individualized service plan.</p>	<p>3. D.2. The SOC Leadership Team will ensure the children and youth workforce, across systems, demonstrates proficiency in the eight domains (see 3.D.1.) as well as the wraparound principles and High Fidelity Wraparound.</p>	

NEBRASKA SYSTEM OF CARE (SOC) STRATEGIC PLAN

NEBRASKA SYSTEM OF CARE (SOC) STRATEGIC PLAN					
GOALS	Strategies Needed to Complete Goals				
	(A) Implementing Policy, Administrative, and Regulatory Changes	(B) Developing Services and Supports Based on the SOC Approach	(C) Creating Financing Mechanisms	(D) Providing Training, TA, and Coaching	(E) Generating Support
	Strategies	Strategies	Strategies	Strategies	Strategies
<p style="text-align: center;">GOAL # 4</p> <p>Integrate children, youth and family services across systems.</p>	<p>4. A.1. The SOC Leadership Team will identify and develop strategies to address requirements regarding confidentiality issues that inhibit collaboration and integration across systems.</p> <p>4. A.2. The SOC Leadership Team will identify and establish mechanisms for regional, tribal and community SOC teams to identify and monitor effectiveness of services provided to children and youth involved in multiple systems.</p>	<p>4. B.1. (Same as 3.A.4.) The SOC Leadership Team system partners will identify and agree upon a shared screening, assessment and evaluation framework in the context of across system collaboration to support understanding of appropriateness of level of care determinations and service utilization.</p> <p>4. B.2. The SOC Leadership Team will identify opportunities to promote coordination and eliminate duplication of services and processes across systems.</p> <p>4. B.3. The SOC Leadership Team will facilitate the development and support of an integrated health information exchange (HIE) across systems.</p>	<p>4. C.1. The SOC Leadership Team will identify and develop strategies to increase flexibility within funding streams.</p> <p>4. C.2. The SOC Leadership Team will develop strategies to access flexible service funds designed to support children, youth and their families for items or activities identified in their individualized wraparound service plan or as emergent needs arise.</p>	<p>4. D.1. The SOC Leadership Team will establish joint curricula based on eight identified domains (see 3.D.1.) and identify opportunities to coordinate education/training activities across systems.</p> <p>4. D.2 The SOC Leadership Team will engage/retain DHHS Division of Behavioral Health to lead and facilitate training and technical assistance across systems.</p>	<p>4. E.1. (Same as 3.E.1.) The SOC Leadership Team will develop and implement a communications plan to inform system partners and key stakeholders about SOC; evidence-based and promising practices; peer-to-peer services and supports; and wraparound principles.</p>

NEBRASKA SYSTEM OF CARE (SOC) STRATEGIC PLAN

GOALS	Strategies Needed to Complete Goals				
	(A) Implementing Policy, Administrative, and Regulatory Changes	(B) Developing Services and Supports Based on the SOC Approach	(C) Creating Financing Mechanisms	(D) Providing Training, TA, and Coaching	(E) Generating Support
	Strategies	Strategies	Strategies	Strategies	Strategies
GOAL #4 Continued		<p>4. B.4. (Same as 1.B.1.) The SOC Leadership Team will develop definitions, principles and practices for “no wrong door access” and a single services plan for children, youth and families across systems.</p>	<p>4. C.3. The SOC Leadership Team will develop and implement a pilot project to track the needs of and service provision to children, youth and families who are high-frequency consumers of services across systems and initiate a data-driven management system.</p> <p>4. C.4. The SOC Leadership Team will develop flexible funding options for expenses such as transportation and child care to support youth and family participation and involvement at all levels.</p>		

NEBRASKA SYSTEM OF CARE (SOC) STRATEGIC PLAN

GOALS	Strategies Needed to Complete Goals				
	(A) Implementing Policy, Administrative, and Regulatory Changes	(B) Developing Services and Supports Based on the SOC Approach	(C) Creating Financing Mechanisms	(D) Providing Training, TA, and Coaching	(E) Generating Support
	Strategies	Strategies	Strategies	Strategies	Strategies
GOAL # 5 Build, or enhance a culturally responsive, trauma-informed and community-based crisis continuum across systems.	5. A.1. The SOC Leadership Team will identify and coordinate regulations, licensing and policy requirements that are relevant to the development of a culturally responsive, trauma-informed and community-based crisis continuum across systems.	5. B.1. The SOC Leadership Team will explore and identify requirements necessary to build a culturally responsive, trauma-informed and community-based crisis continuum across systems that includes a dedicated on-call team, in-home services and brief out-of-home options for children and youth in crisis, such as crisis residential, respite, therapeutic foster care, and emergency shelter.	5. C.1. The SOC Leadership Team will identify options for braided funding approaches to support a culturally responsive, trauma-informed and community-based crisis continuum across systems.		5 .E.1. The SOC Leadership Team will develop and implement a communications plan that provides information to the public about how to gain access to a community-based crisis continuum.

NEBRASKA SYSTEM OF CARE (SOC) STRATEGIC PLAN

GOALS	Strategies Needed to Complete Goals				
	(A) Implementing Policy, Administrative, and Regulatory Changes	(B) Developing Services and Supports Based on the SOC Approach	(C) Creating Financing Mechanisms	(D) Providing Training, TA, and Coaching	(E) Generating Support
	Strategies	Strategies	Strategies	Strategies	Strategies
<p>GOAL # 6 Develop an integrated statewide prevention and early intervention system for children, youth and their families that emphasizes mental health promotion, suicide prevention, resilience, and trauma-informed practices.</p>	<p>6. A.1. The SOC Leadership Team will map current children, youth and family-guided prevention and early intervention efforts, and create shared definitions, processes, performance measures and policies across systems to support community and state partnerships in the development of an integrated statewide prevention and early intervention system.</p>	<p>6. B.1. The SOC Leadership Team will develop an integrated prevention and early intervention system based on universal, selective and indicated prevention components (Behavioral Health) and primary, secondary and tertiary prevention components (Public Health) and includes efforts to increase parent/caregiver education, resources, integration with primary care, safe out-of-school programs, in-home services, and informal and formal supports.</p> <p>6. B.2 The SOC Leadership team will develop and/or align services and supports to address identified risk and protective factors.</p>	<p>6. C.1. The SOC Leadership Team will identify funding for technical assistance and prevention/early intervention education/training for youth, family and system partners and support local prevention and early intervention efforts through partnerships across systems.</p>	<p>6. D.1. The SOC Leadership Team will provide education/training for youth, family and system partners in evidence-based and promising practices related to mental health promotion, suicide prevention, resilience, and trauma-informed practices.</p> <p>6. D.2. The SOC Leadership Team will provide child care providers with professional development opportunities related to early childhood behavioral health.</p> <p>6. D.3. The SOC Leadership Team will provide parent educators with education/training on parenting/care giver curricula that utilizes evidence-based and promising practices.</p>	<p>6. E.1. The SOC Leadership Team will develop and implement a communications plan that increases the awareness of prevention and early intervention resources, including a clearinghouse of funded evidence-based and promising practices and availability of services and community resources.</p>

NEBRASKA SYSTEM OF CARE (SOC) STRATEGIC PLAN

GOALS	Strategies Needed to Complete Goals				
	(A) Implementing Policy, Administrative, and Regulatory Changes	(B) Developing Services and Supports Based on the SOC Approach	(C) Creating Financing Mechanisms	(D) Providing Training, TA, and Coaching	(E) Generating Support
	Strategies	Strategies	Strategies	Strategies	Strategies
<p>GOAL # 7</p> <p>Utilize collaborative financing strategies across systems that are consistent with SOC values and principles.</p>	<p>7. A.1. The SOC Leadership Team will obtain formal commitment across systems to SOC values and principles including contribution of funds for system redesign through a signed Memorandum of Commitment document.</p> <p>7. A.2. The SOC Leadership Team will identify and pursue financial resources to support the implementation of the System of Care strategic plan.</p> <p>7. A.3. The SOC Leadership Team will map current children and youth service and support opportunities, eligibility requirements, funding sources, and relevant policies, practices, and regulations across systems.</p>	<p>7. B.1. The SOC Leadership Team will provide education/training to youth, family and system partners on accessing and using SOC funding.</p> <p>7. B.2. The SOC Leadership Team will provide support to providers to develop the capacity to deliver services which are evidence-based and/or promising practices to children, youth and their families and engage in on-going fidelity monitoring of such services.</p>	<p>7. C.1. The SOC Leadership Team will complete a financial investment blueprint of children and youth services and supports available across systems.</p> <p>7. C.2. (Same as 1.C.1.) The SOC Leadership Team will develop funding stream options such as braided funding approaches across systems, and private and foundation contributions to develop alternatives to higher levels of care for children and youth.</p> <p>7. C.3. (Same as 4.C.4.) The SOC Leadership Team will develop flexible funding options for expenses such as transportation and child care to support youth and family participation and involvement at all levels.</p>		

NEBRASKA SYSTEM OF CARE (SOC) STRATEGIC PLAN

GOALS	Strategies Needed to Complete Goals				
	(A) Implementing Policy, Administrative, and Regulatory Changes	(B) Developing Services and Supports Based on the SOC Approach	(C) Creating Financing Mechanisms	(D) Providing Training, TA, and Coaching	(E) Generating Support
	Strategies	Strategies	Strategies	Strategies	Strategies
GOAL #7 Continued			<p>7. C.4. The SOC Leadership Team will develop an interactive data system to perform necessary analytics.</p> <p>7. C.5. The SOC Leadership Team will develop budget allocations to include resources for translation and interpretation services and Culturally and Linguistically Appropriate Services (CLAS) implementation.</p> <p>7. C.6. (Same as 4.C.3.) The SOC Leadership Team will develop and implement a pilot project to track the needs of and service provision to children, youth and their families who are high-frequency consumers of services across systems and initiate a data driven management system.</p>		

NEBRASKA SYSTEM OF CARE (SOC) STRATEGIC PLAN

GOALS	Strategies Needed to Complete Goals				
	(A) Implementing Policy, Administrative, and Regulatory Changes	(B) Developing Services and Supports Based on the SOC Approach	(C) Creating Financing Mechanisms	(D) Providing Training, TA, and Coaching	(E) Generating Support
	Strategies	Strategies	Strategies	Strategies	Strategies
<p style="text-align: center;">GOAL # 8</p> <p>All children, youth and families will have access to services that respect and are appropriate for their culture.</p>	<p>8. A.1. The SOC Leadership Team will review and make recommendations regarding recruitment, hiring and retention practices to ensure a workforce that is culturally and linguistically representative of the communities and populations being served.</p> <p>8. A.2. The SOC Leadership Team will ensure that data regarding outreach, access, outcomes and disparities among culturally and linguistically diverse groups are used in making policy, administrative and regulatory decisions.</p>	<p>8. B.1. The SOC Leadership Team will review current practice and make recommendations regarding the use of culturally and linguistically relevant outreach materials, services and supports.</p> <p>8. B.2. The SOC Leadership Team will develop/build on standards to ensure that all service plans developed with children, youth and families are individualized to their unique culture, beliefs and values.</p>	<p>8. C.1. The SOC Leadership Team will identify opportunities with each system (local, county, state, tribal, private, and federal partner) for increasing flexibility within funding streams in order to fund and sustain SOC, wraparound, youth and family development, initiatives.</p> <p>8. C.2. (Same as 1.C.1.) The SOC Leadership Team will develop funding stream options such as braided funding approaches across systems, and private and foundation contributions to develop alternatives to higher levels of care for children and youth.</p>	<p>8. D.1. The SOC Leadership Team will develop and implement education/training opportunities for system partners on Cultural and Linguistic Competence (CLC) and Culturally and Linguistically Appropriate Services (CLAS).</p> <p>8. D.2. The SOC Leadership Team will develop communication and training tools to understand challenges based on status as a child, youth, or family member and challenges related to membership in a marginalized cultural group (e.g. race, ethnicity, immigration status, sexual orientation, socioeconomic class, rural/urban).</p>	<p>8. E.1. The SOC Leadership Team will ensure communications to populations with diverse linguistic characteristics are appropriate, including primary languages, literacy skills and disability status.</p> <p>8. E.2. The SOC Leadership Team will develop and implement a Cultural and Linguistic Competence (CLC) and Culturally and Linguistically Appropriate Services (CLAS) component to the communications plan to emphasize understanding of the cultural issues related to services, including the linguistic ability to communicate.</p> <p>8. E.3. The SOC Leadership Team will ensure messaging campaigns consider the cultural communities' preferred language, medium, messenger and style.</p>

NEBRASKA SYSTEM OF CARE (SOC) STRATEGIC PLAN

GOALS	Strategies Needed to Complete Goals				
	(A) Implementing Policy, Administrative, and Regulatory Changes	(B) Developing Services and Supports Based on the SOC Approach	(C) Creating Financing Mechanisms	(D) Providing Training, TA, and Coaching	(E) Generating Support
	Strategies	Strategies	Strategies	Strategies	Strategies
GOAL #8 Continued	<p>8. A.3 The SOC Leadership Team will develop policies, rules and procedures that support Cultural and Linguistic Competence (CLC) and implement Culturally and Linguistically Appropriate Services (CLAS) standards, and address disparities.</p>				

NEBRASKA SYSTEM OF CARE (SOC) STRATEGIC PLAN

GOALS	Strategies Needed to Complete Goals				
	(A) Implementing Policy, Administrative, and Regulatory Changes	(B) Developing Services and Supports Based on the SOC Approach	(C) Creating Financing Mechanisms	(D) Providing Training, TA, and Coaching	(E) Generating Support
	Strategies	Strategies	Strategies	Strategies	Strategies
<p>GOAL # 9</p> <p>Implement a participatory Continuous Quality Improvement (CQI) process in which all SOC intended outcomes are systematically monitored and evaluated.</p>	<p>9. A.1. The SOC Leadership Team will engage regional, tribal and community entities to participate in the development and implementation of monitoring and evaluation activities.</p> <p>9. A.2. The SOC Leadership Team will incorporate measurement and evaluation of SOC outcomes across systems including provider contracts and regional/tribal/community processes, e.g., procurement, training, and implementation of services and supports.</p> <p>9. A.3 The SOC Leadership Team will identify a common Quality Improvement (QI) process that supports monitoring, evaluation and outcome measures and can be used across systems.</p>	<p>9. B.1. The SOC Leadership Team will encourage the development and implementation of monitoring strategies for services and supports.</p> <p>9. B.2. The SOC Leadership Team will explore the implementation of accountability standards for providers and state partners across systems.</p> <p>9. B.3 The SOC Leadership Team will identify and address disparities and inequalities in outcomes among youth and families.</p>	<p>9. C.1. The SOC Leadership Team will identify funding options for fiscally sustaining evaluation activities.</p>	<p>9. D.1. The SOC Leadership Team will develop and/or enhance the formation of local continuous quality improvement (CQI) teams/workgroups and support training and technical assistance as necessary.</p> <p>9. D.2. The SOC Leadership Team will educate/train partners about how data can be effectively used to guide decision-making.</p>	<p>9. E.1. The SOC Leadership Team will utilize data in the communications plan.</p>

Social Marketing and Communications Plan

The purpose of the Social Marketing and Communications Proposal is to provide a messaging and channel strategy designed to change the behaviors of those involved in the behavioral health system in the state of Nebraska. Whether consumer, parent or provider, referring educator or concerned classmate, virtually any Nebraskan can play a role in how mental health care is accessed and perceived. This breadth of scope comes with serious challenges and remarkable opportunities.

Vision

The social marketing and communication plan moves Nebraska to become a place where children, youth and families of any cultural or ethnic background feel comfortable asking for help, and know where to access high quality behavioral health care without worrying about feeling judged.

In order to bring us closer to reality, the social marketing plan must work to change the perceptions of key audiences that are involved in mental health care – namely:

- Children and youth who need and/or are receiving services;
- Parents striving to get their children and youth the services they need;
- Educators who are working with children and youth every day;
- Behavioral health care providers who are serving consumers; and
- Policymakers and system partners who impact the delivery and availability of services.

Goals

The social marketing plan should achieve the following goals over a four-year implementation period:

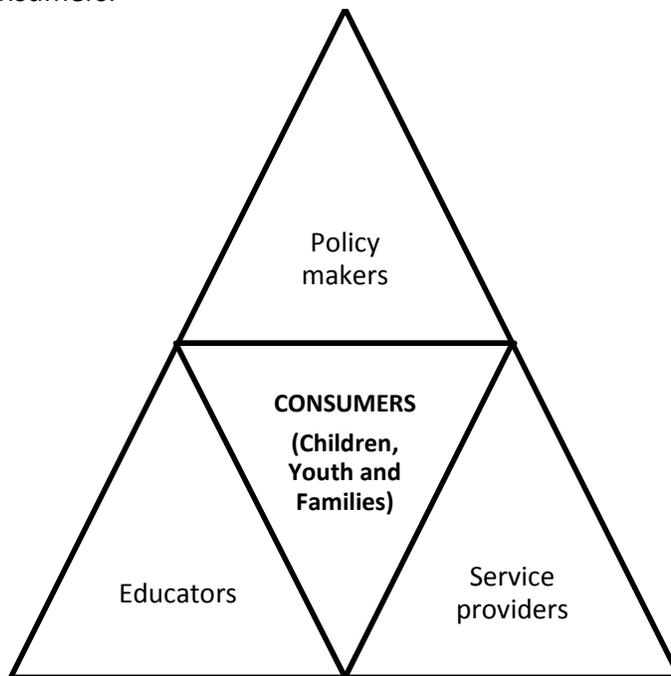
- A general understanding among prospective consumers regarding how to access mental health care;
- A lessening of a feeling of stigmatization or marginalization of children, youth and families who need mental health care services;
- A clearly communicated process and set of best practices for educators to refer students and families into the system of care;
- A more sensitive care-giving environment (with regard to diagnosis, family dynamics and trauma, and linguistic and cultural considerations) within the system of care, where consumers and their families feel supported without judgment;
- A more educated population of policymakers with a complete understanding of the costs associated with poor behavioral health care and the societal benefits associated with the system of care; and
- Prevention and recovery reflected in improved outcomes due to early identification and intervention as a result of expanding awareness.

AUDIENCES

As shown in the audience matrix, the social marketing plan reaches several audiences. The primary audience is the consumers – the children, youth and families who need and/or are receiving services through the system.

Other audiences – educators, service providers, policymakers and system partners – are secondary audiences. It is imperative these audiences receive information, as the most critical roles of these audiences are to understand and work toward the purpose of the grant and to act as a conduit of information to the consumer audiences.

Because the educators and policymakers act as communication channels to our primary consumer audiences, the resulting approach is one that puts the consumer audiences at the core, surrounded by the educators, service providers and policymakers that directly impact services and provide information to consumers.



Primary Audience 1: Families

The families are the action takers when it comes to moving a child who needs services into the system. They are often referred into the system by a physician, other health care provider or educator. Some parents, however, will seek out information on their own. For this audience, making information about the system of care easily accessible and supportive in tone is critical to bringing them into the system poised for a positive experience.

Communicating with families who speak English as a second language will be of critical importance, as this population is susceptible to the social isolation and service unavailability that can cause long-term issues for those needing behavioral health care. The same is true for Nebraska's tribal families.

Teachers and providers will play a critical role in identifying those who need access to the system of

care within these populations, and to help ensure their entry into the system is handled with sensitivity.

Primary Audience 2: Children/youth

Younger children and youth who need to access the system of care will do so via a parent or guardian. While the message of how to access the system will reach young people through parents and secondary audiences, they must also be receiving the message of support, non-judgment and comfort. Older youth may access the system through their own initiative. They too must be receiving a message of support, non-judgment and comfort.

Secondary Audiences: Educators/Service Providers

Working intensively on communicating with educators, health care and behavioral health service providers will focus the messaging on those often responsible for referring families into the system of care and serving families once they're in the system. By nature of the roles they play in the system, these audiences act as powerful word-of-mouth conduits for the messaging of the social marketing plan. Resources spent communicating with these groups will support, bolster and serve as the foundation of communications with the primary audiences. Educators must also carry through the message to all students about treating their peers with behavioral health issues compassionately.

Other Secondary Audiences: Policymakers, System Partners and Internal Teams

The social marketing plan calls for communicating directly with policymakers about the impact a system of care could make on the state's economy and the lives of their constituents. System partners can also bolster their influence as their services intersect. The goal of these communications will be to directly affect policy discussions and swing both legislative and administrative policy in favor of children, youth, and families and a more comprehensive and well-functioning system of care. The decisions made here will directly affect the primary and secondary audiences, so the plan will actively promote feedback mechanisms so that families, youth, educators and service providers can ensure that policymakers are hearing their concerns and experiences.

The Internal audience consists of the other core strategy teams working to build the system of care in Nebraska.

With this audience model in mind, the social marketing and communication plan is created around channels that are focused on reaching the primary audiences, with the intent of simultaneously capturing them through direct message interaction and through the secondary audiences.

Communication Channels

In order to reach all audiences in the most context- and channel-appropriate, cost-efficient and effective way, the social marketing plan uses a variety of strategies. At its center is a new, user-friendly website that will be targeted to serve all audiences. The website will serve as the content foundation and rallying point that all other communication channels reference, promote and reinforce.

In all four years of the social marketing plan, the user-friendly website is an evolving resource for all audiences.

YEAR 1: Year 1 will focus on content and message development based on best practice, results of two or more focus groups, and information gathered through other SOC strategy teams. In addition, stories from families who have children and/or youth with behavioral health challenges and educators/providers who have worked with such children, youth and families will be collected, vetted and edited for use in several communication channels.

Identified needs will drive the development, content and design of a new, user-friendly, interactive website and collateral materials that drive people to the website. Collateral materials will be targeted to specific audiences, to include social media, radio and television PSAs, billboards, printed materials, print advertisements, and other channels. Research will determine the materials to be available in Spanish and specific to Nebraska Tribes.

YEAR 2: The beginning of Year 2 will see the website launched and collateral information distributed. A news release, news conference and pitched stories with press kits will be part of the launch.

This will be a promotional year focused on driving families, educators and service providers across the state to the website. In addition to distributing the collateral materials developed in Year 1, outreach strategies will include meeting with parent groups, professional associations, and attending community events to discuss resources available on the website. Because the website is the focal point of information for key audiences, attention will be given to modifications according to feedback. During this year paid print, TV and radio buys will begin, including in Spanish.

YEAR 3: Development will begin on the creation of short video documentaries based on the stories that have continued to be collected. Documentaries will feature children, youth, families, educators and provider perspectives. When complete, these will be placed on the website and the agency's YouTube channel and will be promoted via a news conference, news release and promotional efforts with system partners. All other social marketing and communication efforts will continue.

During this year, follow-up focus groups will be conducted to identify saturation and understanding of intended messages to primary and secondary audiences. The effectiveness of current efforts will be evaluated to determine what strategies and messages need to be freshened or changed for Year 4 and beyond.

YEAR 4: This year, the website, select collateral materials and outreach strategies will be retooled based on feedback from the focus groups. This will position the social marketing and communications efforts to continue throughout and after Year 4 of the grant.

Appendix A: Logic Model and Strategic Plan Development Tool

The following pages represent a working document organized according to the 10 Core Strategy Teams (CSTs) described earlier. Each section summarizes, in bulleted form, the work of each CST. This content formed the foundation of the logic model and strategic plan.

Logic Model and Strategic Plan Development Tool

Population of Focus: Children and youth with serious emotional and behavioral health needs and their families across all of Nebraska’s child-serving systems.

Youth and Family Partnership			
Vision Statement: Families and youth are partners on all levels within the System of Care.			
Strengths & Resources ➡	Context, Needs, Challenges ➡	Goals ➡	Strategies and Sub-Strategies ➡
<ul style="list-style-type: none"> • Systems (JJ; BH; CPS) recognize the importance of family/youth voice 	<ul style="list-style-type: none"> • Communication/ Awareness – Youth, family and system partners need to know how to give and receive information; speak common language. • Need for training: for professionals, to increase youth and family engagement; for families, to understand systems. • Partnership and engagement – needs to be equal, equitable partnership, needs to be youth and family friendly. • There are policies and practices that prevent /inhibit youth- and family-driven work and involvement. 	<ul style="list-style-type: none"> • Ensure a sustainable, well-funded statewide infrastructure for a youth network and family network representative of the population of Nebraska to empower all youth and family voice, outreach, education, advocacy and leadership opportunities. • Ensure that youth and families involved in the behavioral health system of care have opportunities to be meaningfully involved in all levels of planning, policy development, quality improvement and the evaluating/monitoring of programs within Nebraska. 	<ul style="list-style-type: none"> • Create a statewide infrastructure for Youth Network and expansion of Family Network in order to build involvement and leadership opportunities. • Identify funding opportunities to support development and maintenance of Youth / Family Networks (YFN) and develop guidelines for reimbursement across agencies. • Provide training to youth and families to serve as trainers and evaluators of systems and providers. • Educational resources for youth and families to understand system(s) and utilize their voice for self-advocacy. • Increase capacity to alleviate transportation as a barrier to utilizing voice. • Increase the number of Family Peer Specialists and establish Youth Peer Specialists through a standardized certification process. • Provide TA and other support utilizing best practices to community coalitions and other interested parties to establish family/peer support organizations. • Develop training and resources for system professionals on how to listen and communicate with youth and families provided by youth and families. • Create state-level family and youth leader position(s) that serves as a liaison between state systems and the youth and family network(s). • Develop training and TA system to support family engagement/involvement that includes youth and families as participants and trainers alongside professionals. • Develop guidelines for best practices for youth involvement, leadership and youth-driven services.

Youth and Family Partnership			
Vision Statement: Families and youth are partners on all levels within the System of Care.			
Strengths & Resources ➡	Context, Needs, Challenges ➡	Goals ➡	Strategies and Sub-Strategies ➡
			<ul style="list-style-type: none"> • Create a formal, standardized approach that utilizes youth and family networks for review of policies, practices and procedures that impact youth and families.

High Fidelity Wraparound/Family Centered Practice			
Vision Statement: "All children, youth and families consistently experience family-centered practice. Your voice and choice in all decisions."			
Strengths & Resources ➡	Context, Needs, Challenges ➡	Goals ➡	Strategies and Sub-Strategies ➡
<ul style="list-style-type: none"> • Service providers have training in Family Centered Practice (FCP) models – some have fidelity models • Family organizations are strong statewide/regionally • Legislative Bills LB 464, LB561 and LB216 • Data is routinely collected • Readiness to change • Youth voice is increasing/youth are at the table 	<ul style="list-style-type: none"> • Interagency Collaboration /Communication – lack of equal partnership, tendency to blame instead of true collaboration • Fidelity training – lack of consistency, common definition of wraparound and FCP • Developing a FCP culture across all systems – value worker, develop expectations 	<ul style="list-style-type: none"> • Promote information and resource sharing and reduce barriers for all families and system partners to include foster families and team members. • Ensuring Fidelity of HFW and FCP models. • Implementation of wraparound/FCP training for all system partners. • Increase funding available for FCP practice models across the state. • FCP culture is infused throughout all child serving systems in Nebraska. 	<ul style="list-style-type: none"> • Media coverage to let families know their voice counts and should be heard. • Handbook/brochures in multiple languages. • Support groups. • Communications plan with all agencies involved in the system to roll out plan, address barriers – tag on 1184 meetings (each region could decide best way to accomplish this). • Training for all system partners (training should occur locally). • Look at creating a flexible funding pool across systems for individualized service delivery. • Collect base line – team meeting observation and family voice survey. • Overall Training through core training teams in each region for trainers, workers, youth, foster families, families, tribes, minorities, interpreters. Training teams include youth and families and are culturally diverse. • Gather/develop specific stand-alone training/tools as system partners learn areas that need improvement. • Develop follow-up plan to ensure progress continues. • Select a set of tools to use across all systems.

High Fidelity Wraparound/Family Centered Practice			
Vision Statement: "All children, youth and families consistently experience family-centered practice. Your voice and choice in all decisions."			
Strengths & Resources ➡	Context, Needs, Challenges ➡	Goals ➡	Strategies and Sub-Strategies ➡
			<ul style="list-style-type: none"> • Design system to use data at state-region-local levels. • Explore funding available to provide training (explore cross-system collaborative training hub). • Provide stipends, food, transportation for youth and families. • Look at available national/state/county/foundation funding and funding models for cost efficiency. • Develop regional plans for expanding wraparound facilitation (such as PPP) to expand to populations not currently served. • Identify/recruit system champions.

Financing Strategies			
Vision Statement: Nebraska's child and family-serving system of care partners will commit to improve youth, family, and system outcomes utilizing coordinated financing strategies that are consistent with system of care values and principles.			
Strengths & Resources ➡	Context, Needs, Challenges ➡	Goals ➡	Strategies and Sub-Strategies ➡
<p>Available funding for services:</p> <ul style="list-style-type: none"> • Peer-to-peer support (family organization funded) • Housing/advocacy/peers • Juvenile Justice services for pre-adjudication and post-adjudication/predisposition youth. 	<p>Limited funding:</p> <ul style="list-style-type: none"> • <i>Everyone</i> is payer of last resort • Funding decisions based on short-term outcomes (need chronic/persistent illness management approach) • Some reimbursement rates inadequate • Affordable Care Act challenges <p>Access and eligibility:</p> <ul style="list-style-type: none"> • Waiting lists • Cross system eligibility 	<ul style="list-style-type: none"> • Develop Memorandum of Commitment for all systems to sign as commitment to SOC values and to hold each other accountable during the process of system transformation. 	<ul style="list-style-type: none"> • Develop Memorandum of Commitment document. • Memorandum signatories include DBH, CFS, MLTC, PH, probation, education, DD, judicial, county and regional representatives, RBHAs, and private funders. • Identify all financial resources and eligibility requirements. • Develop interactive data system to perform necessary analytics. • Complete financial investment scan (financial resource matrix, Children's Commission Cross System Analysis Report). • Initiate data-driven management system through pilot project of highest service users.

Financing Strategies			
<p>Vision Statement: Nebraska's child and family-serving system of care partners will commit to improve youth, family, and system outcomes utilizing coordinated financing strategies that are consistent with system of care values and principles.</p>			
Strengths & Resources ➔	Context, Needs, Challenges ➔	Goals ➔	Strategies and Sub-Strategies ➔
<ul style="list-style-type: none"> • Cost reimbursement / regional system 	<ul style="list-style-type: none"> • Must be at “rock bottom” to qualify Limited workforce: <ul style="list-style-type: none"> • Workers at capacity • Providers unwilling to serve difficult-to-serve individuals • Fragmented funding system • No infrastructure to fix this (e.g. data system to show the overlaps) • Rural/urban differences 	<ul style="list-style-type: none"> • Ensure data-driven decision-making, including finance, which will result in reduced utilization of intensive, restrictive, and high-end services and promote prevention and earlier intervention. 	<ul style="list-style-type: none"> • Prioritize financial needs through pilot project (statewide high-end users payment toward behavioral health services across service systems). • All system partners agree to contribute funds to redesign the system during pilot project. • Explore other financial options to develop alternatives to higher levels of care (1% financing shift [high intensity to prevention], 1915b waiver, wraparound, peer support, etc.). • Assure that appropriations also address and support youth and family participation/involvement at all levels (transportation, child care, etc.). • Ensure that all budget allocations include resources for translation and interpretation and CLAS implementation.

Trauma Informed Services and Supports			
<p>Vision Statement: A trauma-informed Nebraska is aware that trauma is a lifespan issue that meets this challenge with sensitivity, training, support and follow-up regardless of location. Nebraska strives to be trauma-informed as well as trauma-capable in providing services to all residents.</p>			
Strengths & Resources ➔	Context, Needs, Challenges ➔	Goals ➔	Strategies and Sub-Strategies ➔
<ul style="list-style-type: none"> • Free training – TF-CBT, Kids for Keeps; online parenting curriculum (available to families through Family Orgs.) Training Academy, Right Turn, workshops, WRAP; foster parents 	<ul style="list-style-type: none"> • Better utilization of existing services • Knowledge among providers/consumers of service array • Uniform screening for trauma 	<ul style="list-style-type: none"> • Provide training for all systems to become trauma-informed and trauma-capable. • Develop statewide definitions of trauma, trauma-informed care and trauma-informed systems. 	<ul style="list-style-type: none"> • Reduce barriers to attend training, including cost and travel time. • Provide basic training and follow-up support to all. • Ensure providers are cross-trained in early intervention and trauma. • Bring more awareness to the topic of vicarious trauma and compassion fatigue to ensure that all members are supported.

Trauma Informed Services and Supports

Vision Statement: A trauma-informed Nebraska is aware that trauma is a lifespan issue that meets this challenge with sensitivity, training, support and follow-up regardless of location. Nebraska strives to be trauma-informed as well as trauma-capable in providing services to all residents.

Strengths & Resources ➡	Context, Needs, Challenges ➡	Goals ➡	Strategies and Sub-Strategies ➡
<ul style="list-style-type: none"> receive specialized training • Common language among partners • Panhandle Partnership • Cedars youth programs • Project Everlast 	<ul style="list-style-type: none"> • Intake processes for youth can be traumatizing • Transitions for youth can be traumatizing • Family voice/choice in therapeutic needs • Transportation • TIC training across all systems • Early childhood intervention 	<ul style="list-style-type: none"> • Consider the impact of trauma on early childhood and the role of providing early intervention and prevention services. • Explore use of common trauma assessments and screenings. 	<ul style="list-style-type: none"> • Resource lists will include whether provider offers trauma-informed services.

Workforce Development			
Vision Statement: “A behavioral health workforce that is family- and person-centered, competent and supported at all levels”.			
Strengths & Resources ➡	Context, Needs, Challenges ➡	Goals ➡	Strategies and Sub-Strategies ➡
<ul style="list-style-type: none"> • Commitment by systems to develop a competent workforce. • Different educational backgrounds provide array of well-rounded workforce. • Face-to-face work allowing for detailed explanation and guidance. • Project Everlast provides youth with ability and opportunity to express youth voice. • Training and technical assistance capacity and expertise of the Behavioral Health Education Center of Nebraska and University of Nebraska at Lincoln, Omaha and Kearney as it relates to SOC. 	<ul style="list-style-type: none"> • Turnover; burnout is abundant. • Lack of competency among system partners working with youth and family partners. • “Family team” meetings inconsistent and not to fidelity (focused on negatives, some family members aren’t present at meetings, non-compassionate system partners). • Prevention services are not widely available. 	<ul style="list-style-type: none"> • The workforce will demonstrate proficiency in the following eight (8) domains: trauma-informed/capable; child and adolescent development; cultural and linguistic competence; child and adolescents with developmental disabilities and behavioral health; screening/assessment/evaluation/referral; family and person-centered practice; treatment planning /interventions/service delivery; quality improvement/professionalism and ethics. • Guidelines to be used for recruitment and retention efforts of a competent and culturally diverse workforce. 	<ul style="list-style-type: none"> • Develop a statewide, cross-system “competency worksheet” for organizations to incorporate into training and evaluation practices. • Develop guidelines that assist leadership and organizations with recruitment and retention of the workforce. • Develop guidelines for leaders and organizations that support the workforce, themselves and other agencies. • Address staff turnover issues within the services field. Turnover of staff compromises trust. Encourage retention strategies. Wellness incentives (employer provided “fit bits” to employees, reduced gym memberships, on site wellness programs).

Social Marketing and Communication

Vision Statement: Nebraskans value preventive behavioral health care so anyone can access help easily and the general public holds no stigma and supports policy changes that create an integrated system of care.

Strengths & Resources ➡	Context, Needs, Challenges ➡	Goals ➡	Strategies and Sub-Strategies ➡
<ul style="list-style-type: none"> • Family Partners are facilitating communication. • Nebraska Family Helpline 	<ul style="list-style-type: none"> • Generational, deep-seated stigma • Negative experiences with the system • Weakness-based model • Diagnoses as label 	<ul style="list-style-type: none"> • Stigma surrounding behavioral health or system involvement will no longer be a barrier to accessing support. • No fear about discussing trauma. • You are an individual, not your case file. • Build public will for improvement. • Prevention is positive: services are available to families before the extremes happen. 	<p>Story telling: “de-stigmatize”:</p> <ul style="list-style-type: none"> • Book/video/website: Stories and resources (check out UNL page on mental health) • Panels • Sharing via social media • Directory • Central access referral • Messaging around benefits of prevention • Story sharing website – youth-centered – with linkage to resources • Put the hotline online for youth – make it youth oriented • Training of professionals who interact with families, children & youth • Uniform • Strengths-based • Youth-driven and centered • Frequently updated • Ensure messaging campaigns consider the cultural communities’ preferred language, medium, messenger and style.

Services and Supports

Vision Statement: In the state of Nebraska, needed services and supports are accessible through inquiry at any and all service delivery agencies and through a common statewide service inquiry access point. Services are available to all persons in need, regardless of income, age, or demographics. Services are consumer-driven, consumer-informed, and consumer-based in delivery and must be provided by qualified, and well-trained staff or peers.

Strengths & Resources ➔	Context, Needs, Challenges ➔	Goals ➔	Strategies and Sub-Strategies ➔
<ul style="list-style-type: none"> • Alternative Response Collaborations. • Collaboration among agencies • Greater openness to family/youth partnership • Culture moving away from traditional services • Understanding that community based care is better for youth vs. residential care • Beginning focus on trauma-informed care • Better access to services for juvenile justice clients • Advocacy groups' growth and expansion • High Fidelity Wraparound • Home visitation programs • Programs for youth 4-8 	<ul style="list-style-type: none"> • Accessibility • Providers are walled-in – more interested in preserving turf • Lack of one plan, “no wrong door” • No incentives to improve integration • Limited financing to set up and maintain service delivery structures • Policies, procedures & funding streams are barriers to flexibility in pooling resources or creativity • Waiting lists of programs are long • Limited family voice system/program planning efforts • Little trust among service agencies/systems • Disparities in access across the state 	<ul style="list-style-type: none"> • Families are able to access needed service/support. • Families have consistency in their service provision across service systems. • Full service arrays (consisting of quality services) are available to children and families across the state of Nebraska. • All public and private service provision entities understand the importance of collaboration and actively work to improve service provision across service systems. • Expand current efforts of grass roots/community organizations to empower communities to create services/supports. 	<ul style="list-style-type: none"> • Use Alternative Response and NCFE's (Nebraska Children and Family Foundation) existing efforts to involve communities in the creation of their own services/supports array. • Nebraska commits to the “no wrong door” model for access. Any point at which a child or family requests/requires services/supports becomes the entry point. Providers work behind the scenes electronically to make the necessary connections to all needed services/supports from that point forward. • Helplines are staffed with skilled, knowledgeable professionals who are able to provide “warm transfers” to other entities. • Creation of Family Review Panels that would make recommendations to Nebraska’s Children Commission and seek approval specific to program content and needed services/supports prior to funding and implementation. • Online access by families and children to their own file information through the use of a confidential access code. Families/children retrieve information but also are able to directly enter their own comments, feedback, requests into case files. • Use existing tele-medicine technology to expand access to services and supports. • Co-location of therapists, psychiatric/psychological providers, medical providers in schools across the state.

Services and Supports

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Strengths & Resources ➔	Context, Needs, Challenges ➔	Goals ➔	Strategies and Sub-Strategies ➔
			<ul style="list-style-type: none"> • Messaging and information are critical to “no wrong door” model. Churches, schools, community centers, neighborhood groups, libraries, newspapers, cultural centers, Twitter, Facebook, etc. need to be involved in the bringing the information to families in need. • Peer-to-peer service provision and supports are funded and integrated into all aspects of service delivery. • Creation of System Navigators that would be assigned at the outset and stay with the family throughout the time the family has service needs. • Recommend that Nebraska fill the gaps of services that exist to children diagnosed on the Autism spectrum. • People who are deaf and hard of hearing have effective/qualified service providers able to communicate but also knowledgeable of the cultural aspects of the hearing impaired community. • Build a crisis continuum including community-based and residential components. • Build a robust para-professional network of service providers. • Explore use of community-based and natural supports accepted by different cultural groups. • Explore school-based and school-linked services. School services typically include 1) screening, assessment, evaluation and referral protocols with local mental health providers; and 2) comprehensive whole school environmental interventions such as the Positive Behavioral Interventions and Supports (PBIS) model.

Services and Supports

Vision Statement: In the state of Nebraska, needed services and supports are accessible through inquiry at any and all service delivery agencies and through a common statewide service inquiry access point. Services are available to all persons in need, regardless of income, age, or demographics. Services are consumer-driven, consumer-informed, and consumer-based in delivery and must be provided by qualified, and well-trained staff or peers.

Strengths & Resources ➔	Context, Needs, Challenges ➔	Goals ➔	Strategies and Sub-Strategies ➔
			<ul style="list-style-type: none"> • Explore flex funding pools of money needed to be created to ensure the creativity we need. Fully funded peer to peer/ service and support delivery created and maintained. • Office of Consumer Protection and Advocacy created and staffed appropriately to address service delivery issues in a formal manner. • Post treatment family survey information reviewed for helpful information in creating services.

Culturally and Linguistically Appropriate Services and Supports

Vision Statement: In a culturally and linguistically appropriate System of Care the following are available: 1) Culturally and linguistically competent organizations and systems that support a workforce that embodies the cultural and linguistic values of the families being served and have the knowledge and skills to be effective; and 2) A statewide tool that assesses cultural, linguistic socioeconomic information that can be written, telecommunicated or collected appropriately that assists in developing service plans for youth and their families.

Strengths & Resources ➔	Context, Needs, Challenges ➔	Goals ➔	Strategies and Sub-Strategies ➔
<ul style="list-style-type: none"> • School-based medical, mental health one-stop shop occurring in some areas <ul style="list-style-type: none"> ○ Medicaid in public schools (billing for services) ○ Interdisciplinary teams • CASA/GAL/Justice = CLAS Navigator PALS • Assessment = Road Map to Wellness = Culture 	<ul style="list-style-type: none"> • Treating others the way we want to be treated (Golden Rule) • Training impact – measurement, time • Empower youth who are in the throes – Navigator paired with peer support • Medicaid support – “Family of One” concept • Training (with accountability) <ul style="list-style-type: none"> ○ Hiring practices ○ Qualitative survey of consumer 	<ul style="list-style-type: none"> • All children, youth and their families will access services that respect, and are appropriate for, their culture. • All activities involving families and youth are inclusive of the cultural diversity of the families who are eligible for services. • Workforce (providers) in child- and family-serving systems will represent the range of diversity in populations eligible to be served. • Planning and budget allocations across systems will include translation and interpretation, standardized data collection, etc. 	<ul style="list-style-type: none"> • Identify all cultural groups that are eligible but may not be accessing services and understand the reasons why they are not accessing these services. • Develop CLC component to social marketing and communication plan to include understanding of the cultural issues related to service and include linguistic ability to communicate. • Develop communication and training tools to understand challenges based on status as a “family member” or “child / youth” AND challenges related to membership in a marginalized cultural group (e.g., race, ethnicity, immigration status, sexual orientation, socioeconomic class, etc.). • Review policies, procedures and training/communication materials to ensure they reflect that implementation of family-driven/youth-guided care will vary across cultural groups. (Note that “family-driven/youth guided” may not be a culturally acceptable framework for all. Culturally, the framework may be for the “professionals” to “drive” the care. In addition, the role and voice of youth may be limited in some cultures. These situations require careful management of the differences between SOC values and the cultural values of the group.) • Design messaging campaigns that match cultural communities’ preferred language, preferred medium, messenger, and style – for example, radio (aural communication) or TV (visual communication).

Culturally and Linguistically Appropriate Services and Supports

Vision Statement: In a culturally and linguistically appropriate System of Care the following are available: 1) Culturally and linguistically competent organizations and systems that support a workforce that embodies the cultural and linguistic values of the families being served and have the knowledge and skills to be effective; and 2) A statewide tool that assesses cultural, linguistic socioeconomic information that can be written, telecommunicated or collected appropriately that assists in developing service plans for youth and their families.

Strengths & Resources ➡	Context, Needs, Challenges ➡	Goals ➡	Strategies and Sub-Strategies ➡
			<ul style="list-style-type: none"> • Develop strategies to understand existing protective factors in cultural communities (particularly first generation immigrant communities) and to support/promote them. • Identify and engage culturally affirmed messengers in prevention and early intervention activities – faith leaders, tribal leaders, media personalities, etc.

Prevention and Early Intervention

Vision Statement: In three years, all children and families are supported by a coordinated continuum of prevention and intervention services. The public is educated and invested in community ownership of the success and well-being of children and their families. Entry at any point of the service gives you access to all appropriate services of the system; no wrong door.

Strengths & Resources ➔	Context, Needs, Challenges ➔	Goals ➔	Strategies and Sub-Strategies ➔
<p>Home visitation programs</p> <ul style="list-style-type: none"> • Birth to 3 • Increasing statewide <p>Community/local interest</p> <p>Increased awareness</p> <p>Alternative Response</p> <p>Resources</p> <ul style="list-style-type: none"> • Training, education • Skilled providers • Great services in Metro area 	<ul style="list-style-type: none"> • Lack of definition for Community Prevention • Fragmented (“siloed”) systems have limited integration and coordination • Lack of services, programs and personnel for services for all ages <ul style="list-style-type: none"> - Afterschool - 0-8 years - Transitional • Sustainable and limited funding that does not support prevention, collaboration and is competitive 	<ul style="list-style-type: none"> • Develop an integrated community prevention system where agencies/systems collaborate on a shared definition, support, training and implementation of services for families. • Establish and maintain connectedness for families through community-based informal and formal supports. • Identify and increase prevention services and supports for all youth across the state. • Realign funding and support to promote sustainable community-owned prevention systems. • Empower families by prioritizing family-centered policies and practices within all systems. 	<ul style="list-style-type: none"> • Include Alternative Response and develop a service array according to and aligned with identified protective factors. • Make technical assistance, facilitation, and support available for communities to build a collaborative prevention system (tool kits, definition, processes, functions). • Effectively involve community assets (volunteers, churches) in community prevention systems and in messaging about activities. • Continue to promote trauma-informed practices and training as central to delivery of prevention services. • Provide equitable access to supportive services for all families. • Encourage community ownership of outcomes and success of youth. • Create policies to support community and state partnerships to develop an effective community-based prevention system definition and plan. • Increase awareness of existing resources and connections in places where parents are likely to be. • Build on informal family supports prior to formal services ending/transition by creating a more strategic method. (Family Navigator). • Increase statewide capacity for home-based crisis response. • Increase funding for evidence-based youth development programs. • Utilize new and existing data through a multi-sector approach; identify common goals; and select measures we can influence. • Facilitate the development of an inventory of prevention services that exist and where the gaps are located.

Prevention and Early Intervention			
<p>Vision Statement: In three years, all children and families are supported by a coordinated continuum of prevention and intervention services. The public is educated and invested in community ownership of the success and well-being of children and their families. Entry at any point of the service gives you access to all appropriate services of the system; no wrong door.</p>			
Strengths & Resources ➡	Context, Needs, Challenges ➡	Goals ➡	Strategies and Sub-Strategies ➡
			<ul style="list-style-type: none"> • Integrate behavioral health identification and resources into primary care settings. • Integrate diverse prevention services in many community-level and family-serving settings such as Early Childhood and evidence-based home visiting programs. • Increase out-of-school programs that are safe for youth. • Include parenting programs that stress good connections and relationships with infants and toddlers so that healthy attachments are developed. (Using parenting curriculums like Circle of Security in Home Visitation programs like Sixpence, Healthy Families, EDN, etc). • Provide child care providers with professional development opportunities surrounding early childhood behavioral health.

Policy, Administrative and Regulatory			
<p>Vision Statement: Nebraska policies support child and family well-being in a System of Care that achieves the Triple Aim: efficiency; overall improved health; improved child and family experience</p>			
Strengths & Resources ➡	Context, Needs, Challenges ➡	Goals ➡	Strategies and Sub-Strategies ➡
<ul style="list-style-type: none"> • Circle of Security pilots • Implementation of LB561 • Behavioral Health focusing on TIC • BH Regions Contracting with DBH • Prevention Coalitions • Focus on Community-level coordination 	<p>Funding</p> <ul style="list-style-type: none"> • Provisionally licensed individuals not eligible for reimbursement with Medicaid/Magellan • Seed/pilot projects not sustainable • Eligibility or access to services not the same between systems • Lack of flexible funding • Lack of transparency in how funds are being spent, why certain people get service and others not 	<ul style="list-style-type: none"> • Develop policies that promote flexible funding to maximize all available funding sources and meet accessibility and scheduling needs of youth and families. 	<ul style="list-style-type: none"> • Develop policy for best practices for youth involvement, leadership, and youth-driven services. • Develop performance indicators and oversight for family engagement, culturally responsive services and supports, and youth engagement.

Policy, Administrative and Regulatory

Vision Statement: Nebraska policies support child and family well-being in a System of Care that achieves the Triple Aim: efficiency; overall improved health; improved child and family experience

Strengths & Resources ➔	Context, Needs, Challenges ➔	Goals ➔	Strategies and Sub-Strategies ➔
<ul style="list-style-type: none"> • Efforts to include family organizations • LB216 - Bridges to Independence - Senator McGill's Bill • NE Family Help Line • Project Everlast • Caseworkers within the system are very helpful • LB566 - Telehealth in schools • LB1078 – Provider-patient relation; remote health monitoring; insurance health reimbursement 	<ul style="list-style-type: none"> • Maximize Medicaid, federal funding, state, county • Lack of funding for former wards <p>Conflicting Policies</p> <ul style="list-style-type: none"> • Multiple services cannot be provided on the same day • Incentivize high quality services • Transparency re: rules and regulations are done • Communication between systems (HIPAA/FRPA) • Cross training across systems • Do the different systems' mandates conflict with each <p>Lack of true family involvement</p> <ul style="list-style-type: none"> • "Expert" mentality; not listening to youth and family input • Meetings are held at times not conducive to families • No clear guidelines on what family involvement should look like • Families may lack skills/support to participate at the "systems level" • Family and youth not paid to participate in meetings • Language and culture barriers • Professional lingo/acronyms • Families fear of being judged 	<ul style="list-style-type: none"> • Develop policies that maximize funds through multiple strategies (such as: leveraging, grant development, and blending) to enhance or create programs that will grow and maximize services for youth and families. • Develop policies, procedures and practices that ensure transparency and accountability of all funding streams. • Policy development by cross-system teams that include youth and family that promote parallel eligibility and accessibility standards. Policies will utilize a common language and address risk benefit. 	<ul style="list-style-type: none"> • Identify ways to enforce accountability – rules, regulations, contracts, policy, results-based accountability, joint multi-system agreements on policy on system of care. • Develop policy around how trauma-informed care is implemented across systems. • Integrate SOC principles with state and local policy decisions. • Develop policies to support "no wrong door" for accessing service. • Develop policies, rules, procedures that support CLC, implement CLAS standards, and address disparities. Include requirements for Disparities Impact analysis and requires corrective actions. • Develop policies that place prevention/early intervention as part of a continuum within the System of Care

Outcomes

Functional Outcomes and Indicators

- Children and youth will experience improved wellness and mental health.
- Children and youth will live at home.
 - Decrease utilization of long-term, out-of-home placements.
 - Increase use of residential alternatives such as High Fidelity Wraparound, short-term crisis, respite, and related supports.
 - Children and youth will experience improved stability in living situation.
- Children, youth and families exhibit well-being.
 - Improved coping skills.
 - Improved social connectedness.
 - Increased ability to overcome behavioral health needs.
- Children and youth will function successfully in the community.
 - Attend school and graduate.
 - Succeed in employment.
 - Engage in pro-social activities.
 - Experience more positive relationships with family, friends and others.
 - Effective support networks.
 - Experience decreased substance use.
- Costs for out-of-home care will decrease.

Process Outcomes

- Nebraska child and family serving agencies/systems partner and collaborate.
 - Engage in the implementation of coordinated and integrated system of care.
 - Efficiently and effectively deploy services and supports as determined by wraparound teams.
 - Implement culturally and linguistically appropriate and trauma-informed practice in all phases of interacting with children, youth and families.
 - Create an integrated system with “no wrong door” access.
 - Engage in equal partnership with families and youth in developing improved system of care.
 - Agree to, and implement, a common set of functional outcomes and work toward them together.
 - Have access to flexible funding to ensure individualized service delivery.
 - Be evaluated on implementation of family-centered practice within the agency/system.
- Nebraska children, youth and families
 - Have access to services in 75%-90% of home communities.
 - Understand the systems and services they are involved in and know how to access information and get questions answered.
- Policies and funding for behavioral health in Nebraska will place a greater emphasis on prevention and early identification/intervention.

Appendix B: Definitions and Acronyms

The Definitions document, presented below, is a working document created to help those involved with the Nebraska SOC understand the terms and acronyms used throughout the planning documents.

Nebraska Children and Youth System of Care: Working Definitions

Adverse Childhood Experiences (ACEs): ACEs include verbal, physical, or sexual abuse as well as family dysfunction (an incarcerated, mentally ill, or substance-abusing family member, domestic violence, and absence of a parent due to divorce or separation).

Alternative Response (AR): An approach that allows a response to low-risk reports of child abuse and neglect in a way that is different than a traditional investigation. Family assessments are conducted to determine the family's strengths and needs as well as to assess for child safety and risk. Families will be connected to the supports and services they need in order to enhance the parent's ability to keep their children safe and healthy. Low-risk reports of child abuse and neglect will be assigned to a Children and Family Services Specialist (CFSS) who will begin the assessment process. Research shows that families who receive an assessment rather than an investigation are more likely to be receptive to and engage in services when they are approached in a non-adversarial, non-accusatory manner. Law enforcement agencies will receive all reports assigned for an Alternative Response as they do with traditional responses.

Braided Funding: Braided funding involves multiple funding streams utilized to pay for all of the services needed by a given population, with careful accounting of how every dollar from each stream is spent. The term braiding is used because multiple funding streams are initially separate, brought together to pay for more than any one stream can support, and then carefully pulled back apart to report to funders on how the money was spent.

Child/Youth: For purposes of this document children and youth are collectively defined as the stage from birth to age 24.

Community: In this plan "*community*" is in reference to "*location*" and indicates a large group living in close proximity. Examples range from the local neighborhood, town, city, region, or state. Occasionally it may be in reference to a group of people with a common identity other than location. Examples include a shared identity such as professional, cultural, religious, ethnicity, etc.

Culturally and Linguistically Appropriate Services (CLAS) Standards: The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards) are intended to advance health equity, improve quality, and help eliminate health care

disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services.⁵

Cultural and Linguistic Competence (CLC): Cultural competence is the integration and transformation of knowledge, behaviors, attitudes and policies that enable policy makers, professionals, caregivers, communities, consumers and families to work effectively in cross-cultural situations. Cultural competence is a developmental process that evolves over an extended period of time. Individuals, organizations and systems are at various levels of awareness, knowledge and skills along the cultural competence continuum.⁶

Early Childhood Intervention: Integrating behavioral health services within primary care and early childhood service settings for children from birth to age seven.

Family-driven Care: Family-driven means families have a primary decision-making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory and nation. This includes: choosing supports, services, and providers; setting goals; designing and implementing programs; monitoring outcomes; and determining the effectiveness of all efforts to promote the mental health of children and youth.⁷

Family Organizations: A family-run organization is a private, nonprofit entity that meets the following criteria: Its explicit purpose is to serve families who have a child, youth, or adolescent with a serious emotional disorder (children, youth, and adolescents who have an emotional, behavioral, or mental disorder, age 0-18; or age 21), if served by an Individual Education Plan (IEP). It is governed by a board of directors comprised of a majority (at least 51%) of individuals who are family members. It gives preference to family members in hiring practices. It is incorporated as a private, nonprofit entity (i.e. 501C3).

Flexible Service Funds: Flexible service funds are a crucial resource in supporting a child/youth and their family. The funds are used to help support individualized wraparound plans that are identified by the family, allowing purchase of services that typically cannot be accessed in any other way. All possible funding options are explored before making available flexible service dollars, including traditional funding streams, entitlements, agency funds and parent/community contributions. Common examples of how flexible service funds are used include: community programs that support a child/youth's interests and strengths (art, sports, music); camp or after-school programs for working families; time-limited job stipend for a youth; respite opportunities for family members to spend

⁵ Accessed from the US Health and Human Services-The Office of Minority Health website on 6/3/14.

<http://guchdtacenter.georgetown.edu/publications/SOC%20ExpansionStrategies%20Issue%20Brief%20%20FINAL.pdf>

⁶ Accessed from the SAMHSA website on 6/4/14: <http://www.samhsa.gov/children/core-values.asp>

⁷ Accessed from the SAMHSA website on 6/4/14: <http://www.samhsa.gov/children/core-values.asp>

quality time together; bus tickets to support a family's participation in support groups or other activities; and emergency funds to provide help with basic needs, such as food, furniture or clothing.

High Fidelity Wraparound (HFW): High Fidelity Wraparound (HFW) is a youth-guided and family-driven planning process that follows a series of steps to help youth and their families realize their hopes and dreams. It is a process that allows more youth to grow up in their homes and communities. It is a planning process that brings people together (natural supports and providers) from various parts of the youth and family's life. The HFW workforce (HFW Facilitator, and if desired, a HFW Family Support Partner and HFW Youth Support Partner), helps the youth and family achieve the goals that they have identified and prioritized, with assistance from their natural supports and system providers. This is the HFW team. High Fidelity Wraparound is driven by the same HFW Principles, and follows the same HFW Phases and basic HFW activities.⁸

Locus of Accountability: Locus of accountability refers to the continual assessment of practice, organizational, and financial outcomes to determine the effectiveness of system of care in meeting the needs of children and families. Two essential components of an effective accountability strategy in a system of care are:

- The development of an interagency management information system that tracks important indicators of service and system performance, and
- A strong evaluation strategy.

Mental Health Promotion: Mental health promotion is any action taken to maximize mental health and well-being among populations and individuals to enhance the capacity of individuals, families, groups, or communities to strengthen or support positive emotional, cognitive, and related experiences across the lifespan.

No Wrong Door Access: Families and youth will be directed to the appropriate service from whichever provider (healthcare, behavioral health, social service) they initially access.

Prevention: The active process of creating conditions or attributes that promote the wellbeing of people. Prevention activities avert the onset and reduce the progression of disease (public health) or alcohol, tobacco, and other drug abuse and/or symptoms of mental illness (behavioral health), and other problems related to these concerns.

For behavioral health:

- A universal prevention intervention targets all people within the general population or a certain subgroup not selected based on individual risk.
- A selective prevention intervention targets individuals or a subgroup whose risk of developing a condition is higher than average.

⁸ Accessed from the Youth and Family Training website on 6/4/14: <http://antrios.wpic.pitt.edu/pages/definition>

- An indicated prevention intervention targets individuals who are high risk and present minimal, but detectable, symptoms of a mental, emotional, or behavioral disorder, but they do not yet have a diagnosis.

For public health:

- Primary prevention refers to methods used before a person gets a disease. Primary prevention aims to prevent the disease from occurring.
- Secondary prevention is used after the disease has occurred but before the person notices that anything is wrong.
- Tertiary prevention targets the person who already has symptoms of the disease.

Regional Behavioral Health Authorities (Regions): *Regional Behavioral Health Authorities (Regions) are responsible for the development and coordination of publicly funded behavioral health services within their respective geographic region and manage a network of providers for an array of behavioral health services.* The Regions contract with the Department of Health and Human Services, Division of Behavioral Health for federal and state mental health and substance abuse funds. Counties provide local matching funds for the operation of the Regions and for the provision of behavioral health services within their region. The following are the official titles of the six Regions.

- Region 1 Behavioral Health Authority
- Region II Human Services
- Region 3 Behavioral Health Services
- Region 4 Behavioral Health System
- Region V Systems
- Region 6 Behavioral Healthcare

Single Service Plan: The practice by which a service plan is developed through a multi-partner process of all participating agencies providing behavioral services to the child or youth.

SOC Leadership Team: A leadership team with equal representation of youth, family, and system partners charged with pursuing dissemination and implementation of the Nebraska SOC strategic plan.

System of Care (SOC): System of care includes the following characteristics:

1. Family-driven and youth-guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided.
2. Community-based, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level.
3. Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate

access to and utilization of appropriate services and supports and to eliminate disparities in care.⁹

Systems: State agencies included in the SOC are:

- Department of Health and Human Services Divisions: Children and Family Services, Medicaid and Long-Term Care, Behavioral Health, Developmental Disabilities, Public Health;
- Judicial Branch: Juvenile Services Division;
- Department of Education.

Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being. The long-lasting adverse effects on an individual are the result of the individual's experience of the event or circumstance. Trauma is not the event itself, but rather a response to a highly stressful experience in which a person's ability to cope is compromised. It can include:

- The personal experience of interpersonal violence including sexual abuse, physical abuse, severe neglect, loss, and/or the witnessing of violence, terrorism, urban violence, war/combat, motor vehicles accidents and disasters;
- Events that are shocking, terrifying and/or overwhelming to the individual;
- Feelings of horror, fear, helplessness;
- Occurs when an external threat overwhelms a person's internal and external positive coping resources.

Trauma-informed: A trauma-informed approach to the delivery of behavioral health services includes an understanding of trauma and an awareness of the impact it can have across settings, services, and populations. It involves viewing trauma through an ecological and cultural lens and recognizing that context plays a significant role in how individuals perceive and process traumatic events, whether acute or chronic. It involves four key elements of a trauma-informed approach: (1) realizing the prevalence of trauma; (2) recognizing how trauma affects all individuals involved with the program, organization, or system, including its own workforce; (3) responding by putting this knowledge into practice; and (4) resisting re-traumatization.

- *Trauma-informed care (TIC):* TIC is a strengths-based service delivery approach that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment. It is an approach to engage people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges that trauma has played a part in their lives. Being trauma-

⁹ Accessed from the SAMHSA website on 6/4/14: <http://www.samhsa.gov/children/core-values.asp>

informed and trauma-capable includes avoiding re-traumatization and understanding and recognizing the triggers of trauma survivors.

- *Trauma-specific treatment services:* These services are evidence-based and promising practices that facilitate recovery from trauma. The term “trauma-specific services” refers to prevention, intervention, or treatment services that address traumatic stress as well as any co-occurring disorders (including substance use and mental disorders) that developed during or after trauma.¹⁰

Tribes:

- Omaha Tribe of Nebraska
- Ponca Tribe of Nebraska
- Santee Sioux Nation
- Winnebago Tribe of Nebraska

Wraparound Principles: Wraparound is an intensive, holistic method of engaging with children and youth with complex needs so that they can live in their homes and communities and realize their hopes and dreams. Wraparound has been most commonly conceived of as an *intensive, individualized care planning and management process*. Wraparound is not a treatment *per se*. The wraparound *process* aims to achieve positive outcomes by providing a structured, creative and individualized team planning process that, compared to traditional treatment planning, results in plans that are more effective and more relevant to the child/youth and family. The ten Wraparound Principles include: Family Voice & Choice; Team Based; Natural Supports; Collaboration; Community Based; Culturally Competent; Individualized; Strengths Based; Persistence; and Outcome Based.¹¹

Youth-Guided: Youth guided means that youth are engaged as equal partners in creating systems change in policies and procedures at the individual, community, state and national levels. Applicants are required to develop plans for infusing a youth-guided approach throughout the system of care, including plans for training and supporting youth in positions of leadership and system transformation.¹²

Youth Organization: Any structured group of children or youth who gather on a regular basis to develop skills, grow peer-to-peer informal support, and complete other service, awareness or voice activities unique to their group. Groups are typically located within communities and/or youth-

¹⁰ Accessed from the SAMHSA website on 6/4/14:

http://beta.samhsa.gov/samhsaNewsletter/trauma_tip/key_terms.html#.U4-f7Y0U9D8

¹¹ 10 Principles of the Wraparound Process. National Wraparound Initiatives. Accessed from the National Wraparound Initiatives website on 6/4/14. <http://www.nwi.pdx.edu/pdf/TenPrincWAProcess.pdf>

¹² Accessed from the SAMHSA website on 6/4/14: <http://www.samhsa.gov/children/core-values.asp>

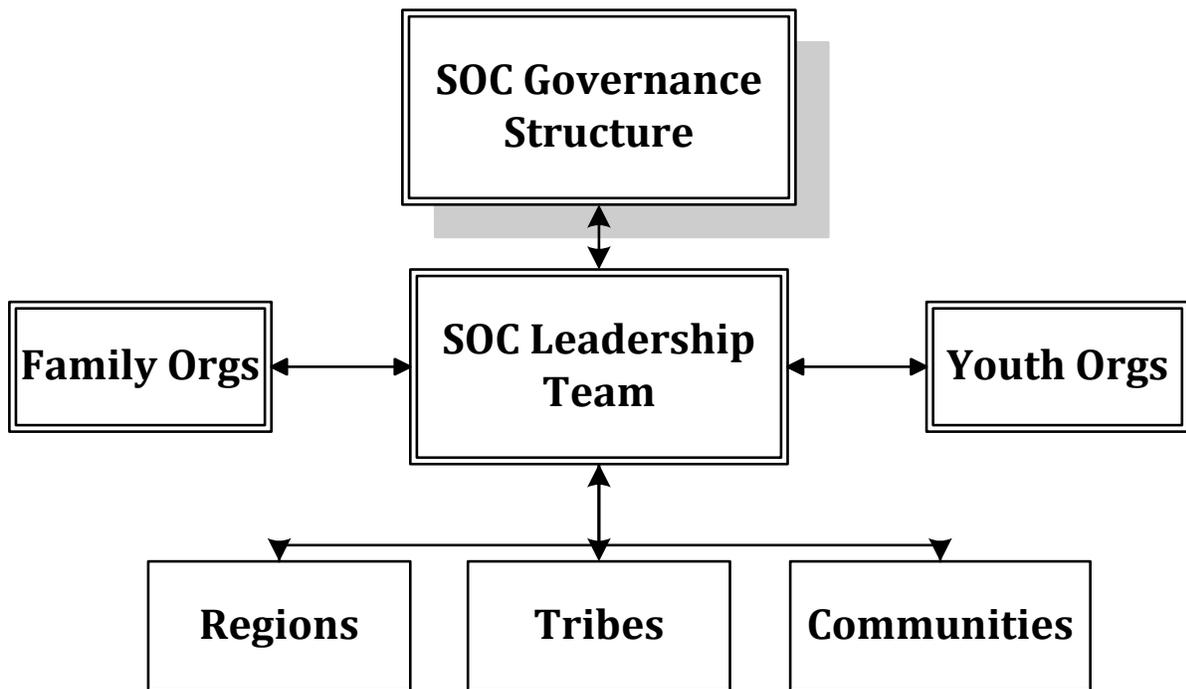
serving entities and supported by agency staff. For the purpose of this plan, they operate as a loose network by which youth voice is gathered.

Strategic Plan Acronyms

AR: Alternative Response Model
BHEC: Behavioral Health Education Center of Nebraska
CFS: Children and Family Services
CLAS: Culturally and Linguistically Appropriate Services
CLC: Cultural and Linguistic Competence
CQI: Continuous Quality Improvement
CST: Core Strategy Team
DD: Developmental Disabilities
DHHS: Nebraska Department of Health and Human Services
DBH: Division of Behavioral Health
ED: Department of Education
HFW: High Fidelity Wraparound
HIE: Health Information Exchange
JJ: Juvenile Justice
LB: Legislative Bill
MHPAEA: Mental Health Parity and Addiction Equity Act
MLTC: Medicaid and Long-Term Care
NCFF: Nebraska Children and Families Foundation
NFF: Nebraska Federation of Families
PMT: Project Management Team
PPP: Professional Partner Program
RBA: Results-Based Accountability
SA: Service Areas - Children and Family Services
SED: Serious and Emotional Disturbance
SOC: System of Care
TIC: Trauma-Informed Care
UNL PPC: University of Nebraska Public Policy Center
UNMC: University of Nebraska Medical Center
YSC: Youth System of Care

Appendix C: Governance Diagram

The following diagram illustrates the proposed governance structure that will oversee implementation of the strategic plan. The SOC Leadership team will have equal representation of youth, family, and system partners. As suggested by family and youth partners, family organizations and youth organizations will also meet separately from the SOC Leadership Team. Regions, tribes and communities will have local SOC implementation teams with representation on the SOC Leadership Team.



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