

Nebraska

**UNIFORM APPLICATION
FY2011**

**SUBSTANCE ABUSE PREVENTION AND TREATMENT
BLOCK GRANT**

42 U.S.C.300x-21 through 300x-66

OMB - Approved 07/20/2010 - Expires 07/31/2013

(generated on 10/4/2010 9:41:01 AM)

Substance Abuse and Mental Health Services Administration

Center for Substance Abuse Treatment

Center for Substance Abuse Prevention

Introduction:

The Substance Abuse Prevention and Treatment Block Grant represents a significant Federal contribution to the States' substance abuse prevention and treatment service budgets. The Public Health Service Act [42 USC 300x-21 through 300x-66] authorizes the Substance Abuse Prevention and Treatment Block Grant and specifies requirements attached to the use of these funds. The SAPT Block Grant funds are annually authorized under separate appropriation by Congress. The Public Health Service Act designates the Center for Substance Abuse Treatment and the Center for Substance Abuse Prevention as the entities responsible for administering the SAPT Block Grant program.

The SAPT Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-66), as implemented by the Interim Final Rule (45 CFR Part 96, part XI). With regard to the requirements for Goal 8, the Annual Synar Report format provides the means for States to comply with the reporting provisions of the Synar Amendment (Section 1926 of the Public Health Service Act), as implemented by the Tobacco Regulation for the SAPT Block Grant (45 CFR Part 96, part IV).

Public reporting burden for this collection of information is estimated to average 454 hours per respondent for Sections I-III, 40 hours per respondent for Section IV-A and 42.75 hours per respondent for Section IV-B, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (OMB No. 0930-0080), 1 Choke Cherry Road, Room 7-1042, Rockville, Maryland 20857. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is OMB No. 0930-0080.

The Web Block Grant Application System (Web BGAS) has been developed to facilitate States' completion, submission and revision of their Block Grant application. The Web BGAS can be accessed via the World Wide Web at <http://bgas.samhsa.gov>.

DUNS Number: 808819957-

Uniform Application for FY 2011-13 Substance Abuse Prevention and Treatment Block Grant

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

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

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

Name: Scot L Adams, Ph. D
Agency Name: Division of Behavioral Health
Mailing Address: PO Box 95026
City: Lincoln Code: 68509
Telephone: (402) 471-8553 FAX: (402) 471-9449
Email Address: scot.adams@nebraska.gov

III. State Expenditure Period:

From: 7/1/2008 To: 6/30/2009

IV. Date Submitted:

Date: 10/1/2009 5:34:19 PM Original: Revision:

V. Contact Person Responsible for Application Submission:

Name: Jim Harvey Telephone: (402) 471-7824
Email Address: Jim.Harvey@Nebraska.Gov FAX: (402) 471-7859

Form 2 (Table of Contents)

Form 1	pg.3	Charitable Choice (formerly Attachment I)	pg.357
Form 2	pg.4	Waivers (formerly Attachment J)	pg.359
Form 3	pg.5	Waivers	pg.360
1. Planning	pg.15	Form 8 (formerly Form 4)	pg.362
Planning Checklist	pg.21	Form 8ab (formerly Form 4ab)	pg.364
Form 4 (formerly Form 8)	pg.22	Form 8c (formerly Form 4c)	pg.366
Form 5 (formerly Form 9)	pg.25	Form 9 (formerly Form 6)	pg.367
How your State determined the estimates for Form 4 and Form 5 (formerly Forms 8 and 9)	pg.27	Provider Address Table	pg.371
Form 6 (formerly Form 11)	pg.33	Form 9a (formerly Form 6a)	pg.372
Form 6ab (formerly Form 11ab)	pg.34	Form 10a (formerly Form 7a)	pg.388
Form 6c (formerly Form 11c)	pg.35	Form 10b (formerly Form 7b)	pg.390
Purchasing Services	pg.36	Description of Calculations	pg.392
PPM Checklist	pg.37	SSA (MOE Table I)	pg.395
Form 7	pg.38	TB (MOE Table II)	pg.396
Goal #1: Improving access to prevention and treatment services	pg.48	HIV (MOE Table III)	pg.397
Goal #2: Providing Primary Prevention services	pg.58	Womens (MOE TABLE IV)	pg.398
Goal #3: Providing specialized services for pregnant women and women with dependent children	pg.112	Form T1	pg.399
Programs for Pregnant Women and Women with Dependent Children (formerly Attachment B)	pg.124	Form T2	pg.401
Goal #4: Services to intravenous drug abusers	pg.131	Form T3	pg.403
Programs for Intravenous Drug Users (IVDUs) (formerly Attachment C)	pg.142	Form T4	pg.405
Program Compliance Monitoring (formerly Attachment D)	pg.147	Form T5	pg.410
Goal #5: TB Services	pg.153	Form T6	pg.415
Goal #6: HIV Services	pg.168	Form T7	pg.417
Tuberculosis (TB) and Early Intervention Services for HIV (formerly Attachment E)	pg.172	Treatment Performance Measures (Overall Narrative)	pg.419
Goal #7: Development of Group Homes	pg.177	Corrective Action Plan for Treatment NOMS	pg.429
Group Home Entities and Programs (formerly Attachment F)	pg.185	Form P1	pg.431
Goal #8: Tobacco Products	pg.189	Form P2	pg.432
Goal #9: Pregnant Women Preferences	pg.191	Form P3	pg.433
Capacity Management and Waiting List Systems (formerly Attachment G)	pg.200	Form P4	pg.434
Goal #10: Process for Referring	pg.205	Form P5	pg.435
Goal #11: Continuing Education	pg.208	Form P6	pg.436
Goal #12: Coordinate Services	pg.222	Form P7	pg.437
Goal #13: Assessment of Need	pg.238	Form P8	pg.438
Goal #14: Hypodermic Needle Program	pg.308	Form P9	pg.439
		Form P10	pg.440
		Form P11	pg.441
		P-Forms 12a- P-15 – Reporting Period	pg.442
		Form P12a	pg.444
		Form P12b	pg.446
		Form P13 (Optional)	pg.448
		Form P14	pg.449
		Form P15	pg.451
		Corrective Action Plan for Prevention NOMS	pg.453
		Prevention Attachments A, B, and C (optional)	pg.455
		Prevention Attachment D (optional)	pg.456

Goal #15: Independent Peer Review	pg.315
Independent Peer Review (formerly Attachment H)	pg.324
Goal #16: Disclosure of Patient Records	pg.327
Goal #17: Charitable Choice	pg.349

Prevention Attachment D (optional)	pg.456
Description of Supplemental Data	pg.458
Attachment A, Goal 2	pg.460
Addendum - Additional Supporting Documents (Optional)	pg.462

FORM 3: UNIFORM APPLICATION FOR FY 2011 SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

Funding Agreements/Certifications

as required by Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act

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

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

I. Formula Grants to States, Section 1921

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

II. Certain Allocations, Section 1922

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

III. Intravenous Drug Abuse, Section 1923

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

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

V. Group Homes for Recovering Substance Abusers, Section 1925

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

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

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

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

VII. Treatment Services for Pregnant Women, Section 1927

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

VIII. Additional Agreements, Section 1928

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

FORM 3: UNIFORM APPLICATION FOR FY 2011 SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

Funding Agreements/Certifications

As required by Title XIX , Part B, Subpart II and Subpart III of the PHS Act (continued)

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

X. Maintenance of Effort Regarding State Expenditures, Section 1930

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

XI. Restrictions on Expenditure of Grant, Section 1931

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

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

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

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

XV. Additional Requirements, Section 1943

XVI. Prohibitions Regarding Receipt of Funds, Section 1946

XVII. Nondiscrimination, Section 1947

XVIII. Services Provided By Nongovernmental Organizations, Section 1955

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

State: Nebraska

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

Signature of CEO or Designee:

Title: Director Division of Behavioral Health

Date Signed:

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

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

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

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

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

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

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

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

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

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

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

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

3. CERTIFICATION REGARDING LOBBYING

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

The undersigned (authorized official signing for the

applicant organization) certifies, to the best of his or her knowledge and belief, that:

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

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

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

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of

his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

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

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

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

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

DISCLOSURE OF LOBBYING ACTIVITIES

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

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

**DISCLOSURE OF LOBBYING ACTIVITIES
CONTINUATION SHEET**

Reporting Entity:

Page

of

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

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

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

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

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

ASSURANCES – NON-CONSTRUCTION PROGRAMS

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

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

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

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

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

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

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

1. Planning

THREE YEAR PLAN, ANNUAL REPORT, and PROGRESS REPORT: PLAN FOR FY 2011-FY 2013 PROGRAM ACTIVITIES

This section documents the States plan to use the FY 2011 through FY 2013 Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant. For each SAPT Block Grant award, the funds are available for obligation and expenditure for a 2-year period beginning on October 1 of the Federal Fiscal Year (FY) for which an award is made. States are encouraged to incorporate information on needs assessment, resource availability and States priorities in their plan to use these funds over the next three fiscal years. In the interim years (FY 2012 and FY 2013), updates to this 3-year plan are required; however, if the plan remains unchanged, additional narrative is not necessary. This section requires completion of needs assessment forms, services utilization forms and a narrative description of the States planning processes.

1. Planning

This section provides an opportunity to describe the State's planning processes and requires completion of needs assessment data forms, utilization information and a description of the State's priorities. In addition, this section provides the State the opportunity to complete a three year intended use plan for the periods of FY 2011-FY 2013. Finally this section requires completion of planning narratives and a checklist. These items address compliance with the following statutory requirements:

- 42 U.S.C. §300x-29, 45 C.F. R. §96.133 and 45 C.F.R. §96.122(g)(13) require the State to submit a Statewide assessment of need for both treatment and prevention.

The State is to develop a 3-year plan which covers the three (3) fiscal years from FFY 2011-FY 2013. In a narrative of **up to five pages**, describe:

- How your State carries out sub-State area planning and determines which areas have the highest incidence, prevalence, and greatest need.
- Include a definition of your State's sub-State planning areas (SPA).
- Identify what data is collected, how it is collected and how it is used in making these decisions.
- If there is a State, regional or local advisory council, describe their composition and their role in the planning process.
- Describe the monitoring process the State will use to assure that funded programs serve communities with the highest prevalence and need.
- Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the planning process for primary prevention and treatment planning. States are encouraged to utilize the epidemiological analyses and profiles to establish substance abuse prevention and treatment goals at the State level.

Describe how your State evaluates activities related to ongoing substance abuse prevention and treatment efforts, such as performance data, programs, policies and practices, and how this data is produced, synthesized and used for planning. A general narrative describing the States planned approach to using State and Federal resources should be included. For the prevention assessment, States should focus on the SEOW process. Describe State priorities and activities as they relate to addressing State and Federal priorities and requirements.

- 42 U.S.C. §300x-51 and 45 C.F. R. §96.123(a)(13) require the State to make the State plan public in

such a manner as to facilitate public comment from any person during the development of the plan.

In a narrative of **up to two pages**, describe the process your State used to facilitate public comment in developing the State's plan and its FY 2011-FY 2013 application for SAPT Block Grant funds.

For FY 2012 and FY 2013, only updates to the 3-year plan will be required. In the Section addressing the Federal Goals, the States will still need to provide Annual and Progress reports. Fiscal reporting requirements and performance data reporting will also be required annually.

The Prevention component of your Three Year Plan Should Include the Following:

Problem Assessment (Epidemiological Profile)

Using an array of appropriate data and information, describe the substance abuse-related problems in your State that you intend to address under Goal 2. **Describe the criteria and rationale for establishing primary prevention priorities.**

(See 45 C.F.R §96.133(a) (1))

Prevention System Assessment (Capacity and Infrastructure)

Describe the substance abuse prevention infrastructure in place at the State, sub-State, and local levels. Include in this description current capacity to collect, analyze, report, and use data to inform decision making; the number and nature of multi-sector partnerships at all levels, including broad-based community coalitions. In addition, describe the mechanisms the SSA has in place to support sub-recipients and community coalitions in implementing data-driven and evidence-based preventive interventions. If the State sets benchmarks, performance targets, or quantified objectives, describe the methods used by the State to establish these.

Prevention System Capacity Development

Describe planned changes to enhance the SSA's ability to develop, implement, and support—at all levels—processes for performance management to include: assessment, mobilization, and partnership development; implementation of evidence-based strategies; and evaluation. Describe the challenges associated with these changes, and the key resources the State will use to address these challenges. Provide an overview of key contextual and cultural conditions that impact the State's prevention capacity and functioning.

Implementation of a Data-Driven Prevention System

Describe the mechanism by which funding decisions are made and funds will be allocated. Explain how these mechanisms link funds to intended State outcomes. Provide an overview of any strategic prevention plans that exist at the State level, or which will be required at the sub-State or sub-recipient level, including goals, objectives, and/or outcomes. Indicate whether sub-recipients will be required to use evidence based programs and strategies. Describe the data collection and reporting requirements the State will use to monitor sub-recipient activities.

Evaluation of Primary Prevention Outcomes

Discuss the surveillance, monitoring, and evaluation activities the State will use to assess progress toward achieving its capacity development and substance abuse prevention performance targets. Describe the way in which evaluation results will be used to inform decision making processes and to modify implementation plans, including allocation decisions and performance targets.

1. Planning

• 42 U.S.C. 300x-29, 45 C.F. R. 96.133 and 45 C.F.R. 96.122(g)(13) require the State to submit a Statewide assessment of need for both treatment and prevention (**up to three pages**) describe:

§ How your State carries out sub-State area planning and determines which areas have the highest incidence, prevalence, and greatest need.

Nebraska carries out sub-State area planning and determines which areas have the highest incidence, prevalence, and greatest need via the six Regional Behavioral Health Authorities. The Nebraska Behavioral Health Services Act (§ 71-801 to 71-830) sets up the structure used for this sub-State area planning.

- 71-808 (1) A regional behavioral health authority shall be established in each behavioral health region by counties acting under provisions of the Interlocal Cooperation Act. Each regional behavioral health authority shall be governed by a regional governing board consisting of one county board member from each county in the region. (2) The Regional Governing Board appoints a regional administrator who is responsible for the management of the regional behavioral health authority. Each regional behavioral health authority facilitates the involvement of consumers in all aspects of service planning and delivery within the region and coordinates such activities with the Office Of Consumer Affairs within the division.
- 71-809 (1) Each regional behavioral health authority shall be responsible for the development and coordination of publicly funded behavioral health services within the behavioral health region including, but not limited to, (c) comprehensive planning for the provision of an appropriate array of community-based behavioral health services and continuum of care for the region.

§ Include a definition of your State's sub-State planning areas.

The Nebraska Behavioral Health Services Act (§ 71-801 to 71-830) defines the sub-State planning areas. Specifically, §71-807 establishes the six behavioral health regions, consisting of the following counties: Region 1 consists of Sioux, Dawes, Box Butte, Sheridan, Scotts Bluff, Morrill, Garden, Banner, Kimball, Cheyenne, and Deuel counties; Region 2 consists of Grant, Hooker, Thomas, Arthur, McPherson, Logan, Keith, Lincoln, Perkins, Chase, Hayes, Frontier, Dawson, Gosper, Dundy, Hitchcock, and Red Willow counties; Region 3 consists of Blaine, Loup, Garfield, Wheeler, Custer, Valley, Greeley, Sherman, Howard, Buffalo, Hall, Phelps, Kearney, Adams, Clay, Furnas, Harlan, Hamilton, Merrick, Franklin, Webster, and Nuckolls counties; Region 4 consists of Cherry, Keya Paha, Boyd, Brown, Rock, Holt, Knox, Cedar, Dixon, Dakota, Thurston, Wayne, Pierce, Antelope, Boone, Nance, Madison, Stanton, Cuming, Burt, Colfax, and Platte counties; Region 5 consists of Polk, Butler, Saunders, Seward, Lancaster, Otoe, Fillmore, Saline, Thayer, Jefferson, Gage, Johnson, Nemaha, Pawnee, York, and Richardson counties; and Region 6 consists of Dodge, Washington, Douglas, Sarpy, and Cass counties.

§ Identify what data is collected, how it is collected and how it is used in making these decisions.

- The data collected is consistent with the requirements under State Outcomes Measurement and Management System (SOMMS) requirements and the National Outcome Measures (NOMS). Those requirements are part of the contract with Magellan Behavioral Health. Included in this contract are requirements for revisions to improve the State of Nebraska's capacity to report data to meet Federal requirements.
- The data are collected using an Administrative Services Organization (ASO) under contract with the Nebraska Department of Health and Human Services. The ASO manages, maintains, and coordinates the Mental Health, Substance Abuse treatment, and Gambling Addictions for

the Division of Behavioral Health. Magellan Behavioral Health was selected as the Administrative Service Organization contractor.

- Magellan produces reports for the Division of Behavioral Health and the six Regions to use in making decision. In addition, the Division of Behavioral Health receives a complete copy of the data base once per month. Via this data base, additional reports can be prepared consistent with the work to be done. The Division has also reorganized the data analysis and reporting functions to better use these data for quality improvement, management, and related areas.

§ If there is a State, regional or local advisory council, describe their composition and their role in the planning process.

- § 71-808 (2) establishes each Regional Behavioral Health Authority have a regional advisory committee consisting of consumers, providers, and other interested.
- § 71-815 (1) establishes the State Advisory Committee on Substance Abuse Services. The committee consists of twelve members appointed by the Governor. (2) The committee is responsible to the division and has a number of duties including providing advice and assistance to the division relating to the provision of substance abuse services in the State of Nebraska.

§ Describe the monitoring process the State will use to assure that funded programs serve communities with the highest prevalence and need.

- The state monitors the adequacy of efforts by the Regions and providers through a number of checks and balances. These methods include monthly financial reports, registration, authorizations and continued care reviews through Magellan Health data system and on-site technical assistance by Division staff, in addition to the waiting list monitoring system.
- As a contractual requirement, each Region monitors the provision of services through audits of program fidelity. A Program Fidelity Audit is conducted by the Region for their contracted network providers, and by the Division for Regions who provide these services directly. An internal tracking system was designed to ensure that program fidelity audits were completed correctly and in a timely manner. If a corrective action plan was indicated in the program fidelity audit, the Division worked with the Region and the provider to ensure that technical assistance was provided in any area where problems were identified.

§ Describe the State's Epidemiological Outcomes Workgroup's (SEOW) composition and contribution to the planning process for primary prevention and treatment planning. States are encouraged to utilize the epidemiological analyses and profiles to establish substance abuse prevention and treatment goals at the State level.

- The Nebraska Substance Abuse Epidemiology Workgroup (NSAEW), formed in March 2007, is a workgroup of administrators, epidemiologists, and key decision makers who collaborate to make decisions regarding the collection and reporting of data related to substance use and abuse, the consequences of substance abuse, and the factors that contribute to substance abuse in the State of Nebraska. Work completed by the NSAEW has and will continue to guide decision making around substance abuse prevention in the state, including decisions made by the Nebraska Partners in Prevention (NePiP), the Governor's Advisory Council for substance abuse prevention.
- The initial tasks of the NSAEW included (1) creating an epidemiological profile report on substance abuse in Nebraska, the first such report in the state, which was released in December 2007 and (2) establishing a set of criteria that helped to facilitate the selection of the Nebraska's SPF SIG substance abuse prevention priorities. This information served as the foundation for the development of the Nebraska Substance Abuse Prevention Strategic Plan, released in March 2008. Since then, the NSAEW has worked to identify substance abuse data gaps in Nebraska as

well as formed two sub-committees to (1) further explore health disparities related to substance abuse and (2) further explore the patterns of alcohol use and binge drinking among young adults in the state. In addition, the NSAEW continues to serve as a platform for discussing substance abuse issues and stimulating relationship building and collaboration among those in the field.

- The NSAEW currently has 38 members representing the following organizations or areas in Nebraska: Native American Tribal Representatives; Nebraska Crime Commission; Nebraska Department of Correctional Services; Nebraska Department of Education; Nebraska Local Public Health Departments; Nebraska Office of Highway Safety; Nebraska Substance Abuse Regional Prevention Center; University of Nebraska-Lincoln; University of Nebraska Medical Center; Divisions/programs within the Nebraska Department of Health and Human Services including: maternal and child health, behavioral health, tobacco prevention, epidemiology, and minority health. The Participant List (as of September 27, 2010) for the State Epidemiological Outcomes Workgroup (SEOW), which is called the Nebraska Substance Abuse Epidemiology Workgroup (NSAEW) is in Appendix / Addendum - Additional Supporting Documents (Optional).

§ Describe how your State evaluates activities related to ongoing substance abuse prevention efforts, such as programs, policies and practices, and how this data is used for planning.

State level: As part of the SPF SIG efforts, Nebraska's external evaluator, Research Triangle Institute (RTI) is conducting annual data collection at the state level using the SAMHSA developed Grantee Level Instrument (GLI) as well as the Systems Integration Interview (SII) tool that was developed by RTI. The SII is designed to measure how well the NDHHS Divisions of Public Health and Behavioral Health collaborate on SA prevention as well as how both divisions interact with the Behavioral Health Regional Prevention staff.

Community level: Under the SPF SIG, each community has hired an external evaluator to assist them with data collection and reporting. Coalition staff and local evaluators work together to develop evaluation plans for the community as well as collect and report evaluation related data to the coalition and to the state and RTI. As part of the broader evaluation, the SPF SIG and Block Grant programs have been collaborating to assess the policies, programs, and practices currently being used within Nebraska in an effort to ensure that prevention and evaluation are coordinated to the best extent possible across the state. To help accomplish this, both divisions are currently working on improving the www.npirs.org website, the online reporting site for block grant and eventually SPF SIG recipients.

§ For the prevention assessment, States should focus on the SEOW process. Provide a summary of how data/data indicators were chosen, as well as, key data construct and indicators for understanding State-level substance use patterns and related consequences and mechanisms for tracking data and reporting significant changes should be outlined.

First, substance abuse data sources within Nebraska were identified by completing an inventory of available data. Second, data constructs were identified and used to organize data sources and data reporting. The constructs were separated by consequences (e.g., mortality, medical care, motor vehicle crashes, legal consequences, etc.) and consumption (e.g., lifetime use, current use, excessive use, etc.). Lastly, data indicators were selected through group discussion and NSAEW member supplemental online indicator scoring. The following items were considered as part of the indicator selection process: data quality, state level data availability, national comparison, trend availability, future collection plans, and sample size or number of cases.

The NSAEW continues to discuss data sources and gaps and their relation to ongoing data planning and reporting. As part of this process, the NSAEW will be updating the content of the epidemiology profile report within the next year and will continue to pursue opportunities to collect and report both state and community level data.

- 42 U.S.C. 300x-51 and 45 C.F. R. 96.123(a)(13) require the State to make the State plan public in such a manner as to facilitate public comment from any person during the development of the plan.

- § In a narrative of **up to two pages**, describe the process your State used to facilitate public comment in developing the State's plan and its FY 2010 application for SAPT Block Grant funds.

A draft of the application for the FY 2011 Substance Abuse Prevention and Treatment Block Grant was prepared for review and comment by the State Advisory Committee on Substance Abuse Services. The formal review was completed on September 21, 2010 from 9:00 a.m. to 3:00 p.m. at the Country Inn and Suites, 5353 No 27th Street, Lincoln, NE. The comments received during this public meeting will be used for the FY 2011 Substance Abuse Prevention and Treatment Block Grant Application (due October 1, 2010).

In addition, the public can review the previous applications are posted on the Division of Behavioral Health Web site. They provide examples of the types of issues addressed within the Application To see these documents, go to: <http://www.dhhs.ne.gov/sua/suaindex.htm>

Federal Block Grant Information

-  [Substance Abuse Block Grant Application Federal Fiscal Year 2010, SYNAR Results](#) - November 2009
-  [Substance Abuse Block Grant Application Federal Fiscal Year 2010](#) - September 2009
-  [Substance Abuse Block Grant Application Federal Fiscal Year 2009, SYNAR Results](#) - October 2008
-  [Substance Abuse Block Grant Application Federal Fiscal Year 2009](#) - September, 2008
-  [Final Results SYNAR Retail List Verification Study April-August 2007](#) - November 2007
-  [Substance Abuse Block Grant Application Federal Fiscal Year 2008, SYNAR Results](#) - November 2007
-  [Substance Abuse Block Grant Application Federal Fiscal Year 2008](#) - Sept 29, 2007
-  [Substance Abuse Block Grant Application Federal Fiscal Year 2007](#) - September 30, 2006
-  [Substance Abuse Block Grant Application Federal Fiscal Year 2006](#) - September 30, 2005
-  [Nebraska SYNAR Report FFY 2007 \(Calendar Year 2006 Activities\)](#) - October 2006
-  [Nebraska SYNAR Report FFY 2006 \(Calendar Year 2005 Activities\)](#) - November 2005

See Goal #2: Providing Primary Prevention services for the Prevention component of the Nebraska Three Year Plan which addresses the following:

- Problem Assessment (Epidemiological Profile)
- Prevention System Assessment (Capacity and Infrastructure)
- Prevention System Capacity Development
- Implementation of a Data-Driven Prevention System
- Evaluation of Primary Prevention Outcomes

Planning Checklist

Criteria for Allocating Funds

Use the following checklist to indicate the criteria your State will use how to allocate FY 2011-2013 Block Grant funds. Mark all criteria that apply. Indicate the priority of the criteria by placing numbers in the boxes. For example, if the most important criterion is 'incidence and prevalence levels', put a '1' in the box beside that option. If two or more criteria are equal, assign them the same number.

1 Population levels, Specify formula:

Region percent of population

Incidence and prevalence levels

Problem levels as estimated by alcohol/drug-related crime statistics

Problem levels as estimated by alcohol/drug-related health statistics

Problem levels as estimated by social indicator data

Problem levels as estimated by expert opinion

2 Resource levels as determined by (specify method)

Region percent of total state income

Size of gaps between resources (as measured by)

and needs (as estimated by)

Other (specify method)

Form 4 (formerly Form 8)

Treatment Needs Assessment Summary Matrix

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2009			7. Incidence of communicable diseases		
								6. Prevalence of substance-related criminal activity					
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: Liquor laws	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Panhandle	85,468	7,607	487	51	3	2,799	179	649	482	556	1.17		0

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2009			7. Incidence of communicable diseases		
								6. Prevalence of substance-related criminal activity					
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: liquor laws	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Southwest	99,040	8,815	564	59	4	3,177	203	752	558	644	0	0	0

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2009			7. Incidence of communicable diseases		
								6. Prevalence of substance-related criminal activity					
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: liquor laws	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
South Central	223,970	19,933	1,276	134	9	7,243	464	1,700	1,263	1,456	0.45	0	0.45

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2009			7. Incidence of communicable diseases		
								6. Prevalence of substance-related criminal activity					
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: liquor laws	A. Hepatitis B /100,000	B. AIDS/ 100,000	C. Tuberculosis /100,000
Northeast	205,596	18,298	1,171	123	8	6,593	422	1,560	1,159	1,337	0.49	0	3.40

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		Calendar Year: 2009			7. Incidence of communicable diseases		
								6. Prevalence of substance-					

		related criminal activity											
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: liquor laws	A. Hepatitis B /100,000	B. AIDS/100,000	C. Tuberculosis /100,000
Southeast	437,999	38,982	2,495	263	17	14,019	897	3,324	2,469	2,848	2.05	0	1.60

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: liquor laws	A. Hepatitis B /100,000	B. AIDS/100,000	C. Tuberculosis /100,000
Omaha Metro	744,546	66,265	4,241	447	29	24,087	1,542	5,651	4,198	4,841	2.15	0	2.28

1. Substate Planning Area	2. Total Population	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
		A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: liquor laws	A. Hepatitis B /100,000	B. AIDS/100,000	C. Tuberculosis /100,000
State Total	1,796,619	159,899	10,234	1,078	69	57,918	3,707	13,635	10,129	11,681	1.56	3.49	1.78

Footnote: AIDS/ 100,000 was not available for CY2009. Rate for CY2008 was reported. CY08's rate (6.4%) was used to calculate total population, number of IVDUs, and number of women in need that would seek treatment in CY09.

Form 5 (formerly Form 9)

Treatment Needs by Age, Sex, and Race/ Ethnicity

AGE GROUP	A. Total	B. White		C. Black or African American		D. Native Hawaiian / Other Pacific Islander		E. Asian		F. American Indian / Alaska Native		G. More than one race reported		H. Unknown		I. Not Hispanic Or Latino		J. Hispanic Or Latino	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
17 Years Old and Under	37,377	20,743	11,780	1,489	846	32	18	349	198	481	273	745	423			20,282	11,519	3,480	1,977
18 - 24 Years Old	29,267	16,790	9,536	1,002	569	30	17	281	160	260	147	303	172			16,977	9,642	1,636	929
25 - 44 Years Old	35,936	20,802	11,814	1,182	671	27	15	386	219	290	165	233	132			20,454	11,616	2,405	1,366
45 - 64 Years Old	36,377	21,890	12,432	785	446	13	7	195	111	193	109	125	71			21,997	12,493	1,016	577
65 and Over	19,220	11,825	6,716	265	151	3	2	62	35	59	33	44	25			11,888	6,751	247	140
Total	158,177	92,050	52,278	4,723	2,683	105	59	1,273	723	1,283	727	1,450	823	0	0	91,598	52,021	8,784	4,989

NOTE: Form 5 was completed using (1) Nebraska census data estimated for 2009 and (2) data from SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2007 and 2008 [Table G.29 – Substance Dependence or Abuse in the Past Year among Persons Aged 12 or Older, by Demographic Characteristics: Percentages, 2007 and 2008]

NOTE: The estimates for each age category in this table are based on the age categories in the SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2007 and 2008 [Table G.29 – Substance Dependence or Abuse in the Past Year among Persons Aged 12 or Older, by Demographic Characteristics: Percentages, 2007 and 2008] and are as follows: Age Category 1 in this table includes ages 12 through 17 years; Age Category 2 in this table includes ages 18 through 25 years; Age Categories 3, 4, and 5 in this table includes ages 26 years and older.

NOTE: The National Survey on Drug Use and Health, 2007 and 2008 estimates are only provided by race, age, and gender independent of one another. Form 5 requires a more detailed breakout of this data. Some basic calculations were used to provide this level of detail. To calculate the estimate of need for each age group within each race, the national estimate by race and the national estimate by age was averaged and applied to the state population per 2009 U.S. Census estimates within each category. To calculate the estimate of need for each age group within each Hispanic origin category, the national estimate by Hispanic origin and the national estimate by age was averaged and applied to the state population per 2009 U.S. Census estimates within each category. To further break these race, origin, and age estimates down by gender, the percent of the total population in need from form 4 that is female (31.93091%) was applied to the population in need within each age and race group and within each age and origin group in Form 5. To determine the number of males in need in Form 9, the number of females in need were subtracted from the total number in need within each age and race group and within each age and origin group.

How your State determined the estimates for Form 4 and Form 5 (formerly Form 8 and Form 9)

How your State determined the estimates for Form 4 and Form 5 (formerly Form 8 and Form 9)

Under 42 U.S.C. §300x-29 and 45 C.F.R. §96.133, States are required to submit annually a needs assessment. This requirement is not contingent on the receipt of Federal needs assessment resources. States are required to use the best available data. Using **up to three pages**, explain what methods your State used to estimate the numbers of people in need of substance abuse treatment services, the biases of the data, and how the State intends to improve the reliability and validity of the data. Also indicate the sources and dates or timeframes for the data used in making these estimates reported in both Forms 4 and 5. This discussion should briefly describe how needs assessment data and performance data is used in prioritization of State service needs and informs the planning process to address such needs. The specific priorities that the State has established should be reported in Form 7. State priorities should include, but are not limited to the set of Federal program goals specified in the Public Health Service Act. In addition, provide any necessary explanation of the way your State records data or interprets the indices in columns 6 and 7, Form 4.

How your State determined the estimates for Form 4 and Form 5 (formerly Form 8 and Form 9)

Form 4 was completed

1. SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health

90416 (5.4B)

<http://www.oas.samhsa.gov/NSDUH/2k8NSDUH/AppG.htm#TabG-29>

Table G.29 – Substance Dependence or Abuse in the Past Year among Persons Aged 12 or Older, by Demographic Characteristics: Percentages, 2007 and 2008

Demographic Characteristic	Illicit Drugs or Alcohol ¹ -2007	Illicit Drugs or Alcohol ¹ -2008
TOTAL	9	8.9
AGE		
17-Dec	7.7	7.6
18-25	20.7	20.8
26 or Older	7.2	7
GENDER		
Male	12.5 ^a	11.5
Female	5.7 ^b	6.4
HISPANIC ORIGIN AND RACE		
Not Hispanic or Latino	9.1	8.8
White	9.4	9
Black or African American	8.5	8.8
American Indian or Alaska Native	13.4	11.1
Native Hawaiian or Other Pacific Islander	9.9	*
Asian	4.7	4.2
Two or More Races	10.8	9.8
Hispanic or Latino	8.3	9.5

2. Total population in need / A. Needing treatment services

<http://www.oas.samhsa.gov/NSDUH/2k8NSDUH/AppG.htm#TabG-29>

- In 2007, an estimated 22.3 million persons (**9.0 percent of the population aged 12 or older**) were classified with substance dependence or abuse in the past year based on criteria specified in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV). Of these, 3.2 million were classified with dependence on or abuse of both alcohol and illicit drugs, 3.7 million were dependent on or abused illicit drugs but not alcohol, and 15.5 million were dependent on or abused alcohol but not illicit drugs.
- Treatment need is defined as having a substance use disorder or receiving treatment at a specialty facility (hospital inpatient, drug or alcohol rehabilitation, or mental health centers) within the past 12 months.

3. Total population in need / B. That would seek treatment

- Of these, 2.4 million (**1.0 percent of persons aged 12 or older** and 10.4 percent of those who needed treatment) received treatment at a specialty facility. Thus, 20.8 million persons (**8.4 percent of the population aged 12 or older**) needed treatment for an illicit drug or alcohol use problem but did not receive treatment at a specialty substance abuse facility in the past year.

- Of the 20.8 million people in 2007 who were classified as needing substance use treatment but did not receive treatment at a specialty facility in the past year, 1.3 million persons (6.4 percent) reported that they felt they needed treatment for their illicit drug or alcohol use problem.
- Of these 1.3 million persons who felt they needed treatment, 380,000 (28.5 percent) reported that they made an effort to get treatment, and 955,000 (71.5 percent) reported making no effort to get treatment.
- Figure 7.7 Past Year Perceived Need for and Effort Made to Receive Specialty Treatment among Persons Aged 12 or Older Needing But Not Receiving Treatment for Illicit Drug or Alcohol Use: 2007. Thus, the 6.4% of those in need is based on 93.60% did not feel they needed treatment

<http://www.oas.samhsa.gov/NSDUH/2k7NSDUH/2k7Results.cfm#7.3.1>

2007

20.8 million needing but not receiving treatment for illicit drug or alcohol use	
93.60%	Did not feel they needed treatment
4.60%	Felt they needed treatment and did not make an effort
1.80%	Felt they needed treatment and did make an effort

2008

<http://www.oas.samhsa.gov/NSDUH/2k8NSDUH/2k8Results.cfm#7.3.1>

Illicit Drug or Alcohol Use Treatment and Treatment Need

- In 2008, 23.1 million persons aged 12 or older needed treatment for an illicit drug or alcohol use problem (9.2 percent of the persons aged 12 or older). Of these, 2.3 million (0.9 percent of persons aged 12 or older and 9.9 percent of those who needed treatment) received treatment at a specialty facility. Thus, 20.8 million persons (8.3 percent of the population aged 12 or older) needed treatment for an illicit drug or alcohol use problem but did not receive treatment at a specialty substance abuse facility in the past year. **These estimates are similar to the estimates for 2007.**
- Of **the 20.8 million persons in 2008** who were classified as needing substance use treatment but not receiving treatment at a specialty facility in the past year, 1.0 million persons (**4.8 percent**) reported that they perceived a need for treatment for their illicit drug or alcohol use problem (Figure 7.10). Of these 1.0 million persons who felt they needed treatment but did not receive treatment in 2008, 233,000 (23.3 percent) reported that they made an effort to get treatment, and 766,000 (76.7 percent) reported making no effort to get treatment. These estimates remained stable between 2007 and 2008, except that the **number of persons who felt they needed treatment, made an effort to get treatment, but did not receive treatment in 2008** decreased from 380,000 persons in 2007 to 233,000 persons in 2008, and the percentage of persons who felt they needed treatment among those who were classified as needing substance use treatment declined from 6.4 percent in 2007 to **4.8 percent in 2008.**

20.8 million needing but not receiving treatment for illicit drug or alcohol use	
4.8%	number of persons who felt they needed treatment, made an effort to get treatment, but did not receive treatment

4. a. Average of past year injection drug use rate (among heroin, cocaine, stimulants, and methamphetamine) for persons aged 12 and older in the Midwest region of the country (SAMHSA, National Survey on Drug Use and Health, 2002-2005).

5. Number of women in need - 5.7% of women from Table G.29 – Substance Dependence or Abuse in the Past Year among Persons Aged 12 or Older / Illicit Drugs or Alcohol. Figure 7.7

Past Year Perceived Need for and Effort Made to Receive Specialty Treatment among Persons Aged 12 or Older Needing But Not Receiving Treatment for Illicit Drug or Alcohol Use: 2007. Thus, the 6.4% of those in need is based on 93.60% did not feel they needed treatment
<http://www.oas.samhsa.gov/NSDUH/2k7NSDUH/2k7Results.cfm#7.3.1>

6. Prevalence of substance-related criminal activity - Calendar Year 2006, 2007, 2008, 2009

Query Results / Year VS Offense						
YEAR(s): 2006, 2007, 2008, 2009						
AGE: ADULT & JUVENILE / Result Set: 366,892 records found (Aug 13, 2010)						
Offense	2006	2007	2008	2009	Total	% of total
Driving Under the Influence	13,528	13,532	13,989	13,635	54,684	14.905%
Liquor Laws	12,831	12,472	12,986	11,681	49,970	13.620%
Drug Abuse Violations	10,588	10,508	10,588	10,129	41,813	11.397%

* Liquor laws could be anything other than DUI so it could range from manufacturing to procuring for a minor. It is a general category but the Nebraska Crime Commission does not have any other breakdowns.

Source: Michael Overton, Chief, Information Services Division, Nebraska Crime Commission Michael.Overton@nebraska.gov 402-471-3992 September, 2010

7.a. Alison Keyser-Metobo, Epidemiology Surveillance Coordinator
 Nebraska Department of Health and Human Services
 Phone: 402-471-0457 e-mail: Alison.KeyserMetobo@nebraska.gov

hepatitis B cases in Nebraska August 16, 2010

Year	Acute Number	Rate (per 100,000 pop)	Chronic Number	Rate (per 100,000 pop)
2006	26	1.47	250	14.14
2007	20	1.13	242	13.64
2008	9	0.5	210	11.69
2009	22	1.22	197	10.97

Source: Alison Keyser-Metobo, MPH
 Epidemiology Surveillance Coordinator
 Nebraska Department of Health and Human Services
 Work: 402-471-0457
 Cell: 402-450-3383
 e-mail: Alison.KeyserMetobo@nebraska.gov

7.b. The number of cases diagnosed in 2007 was 62. The AIDS rate for 2007 was 3.49 per 100,000. [Tina Brubaker, Health Program Manager | DHHS - Public Health - Infectious Diseases
 Phone: (402)471-0360 tina.brubaker@nebraska.gov

7.c. The Nebraska Tuberculosis (TB) rate
 Pat Infield, TB Program Manager, DHHS Office of Public Health, Lincoln, NE 68509
 402-471-6441 pat.infield@nebraska.gov

TUBERCULOSIS IN NEBRASKA – 2009

Tuberculosis (TB) is a disease caused by bacteria called Mycobacterium tuberculosis. The bacteria can attack any part of the body, but it usually attacks the lungs. Below are the Nebraska Division of Public Health web sites on TB.

<http://www.dhhs.ne.gov/cod/Tuberculosis/tbindex.htm>

<http://www.dhhs.ne.gov/cod/Tuberculosis/tbindex.htm#Statistics>

http://www.dhhs.ne.gov/puh/cod/Tuberculosis/docs/TB_AnnualReport2009.pdf

Nebraska has ninety-three (93) counties, seven (7) of which reported cases of Tuberculosis in 2009. For the period of 2005-2009, twenty-two (22) counties reported at least one (1) case of Tuberculosis and are reported on the list that follows.

Region	COUNTY	2005	2006	2007	2008	2009	TOTAL
2	Dawson		1				1
2	Lincoln	1	2	1			4
3	Adams			1	1		2
3	Buffalo	1				1	2
3	Franklin	1		1			2
3	Hall			1	4		5
3	Howard		1				1
4	Burt		1				1
4	Colfax					1	1
4	Dakota	1	2	1		5	9
4	Madison	1				1	2
4	Platte	2	1	1			4
4	Rock			1			1
4	Thurston	1	1		1		3
5	Johnson	1					1
5	Lancaster	7	3	6	2	7	25
5	Nemaha		1				1
5	Saline				2		2
6	Cass			1			1
6	Dodge	1					1
6	Douglas	16	10	10	19	16	71
6	Sarpy	2	2	1	4	1	10
	TOTAL	35	25	25	33	32	150

Form 5 was completed using

- (1) Nebraska census data estimated for 2008 and
- (2) data from SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2006 and 2007 [Table G.29 – Substance Dependence or Abuse in the Past Year among Persons Aged 12 or Older, by Demographic Characteristics: Percentages, 2006 and 2007]
- (3) The estimates for each age category in this table are based on the age categories in the SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2006 and 2007 [Table G.29 – Substance Dependence or Abuse in the Past Year among Persons Aged

12 or Older, by Demographic Characteristics: Percentages, 2006 and 2007] and are as follows: Age Category 1 in this table includes ages 12 through 17 years; Age Category 2 in this table includes ages 18 through 25 years; Age Categories 3, 4, and 5 in this table includes ages 26 years and older.

- (4) The National Survey on Drug Use and Health, 2006 and 2007 estimates are only provided by race, age, and gender independent of one another. Form 9 requires a more detailed breakout of this data. Some basic calculations were used to provide this level of detail. To calculate the estimate of need for each age group within each race, the national estimate by race and the national estimate by age was averaged and applied to the state population per 2008 U.S. Census estimates within each category. To calculate the estimate of need for each age group within each Hispanic origin category, the national estimate by Hispanic origin and the national estimate by age was averaged and applied to the state population per 2008 U.S. Census estimates within each category. To further break these race, origin, and age estimates down by gender, the percent of the total population in need from form 8 that is female (31.93091%) was applied to the population in need within each age and race group and within each age and origin group in Form 9. To determine the number of males in need in Form 9, the number of females in need were subtracted from the total number in need within each age and race group and within each age and origin group.

Nebraska Substance Abuse Epidemiology Workgroup

The Nebraska Substance Abuse Epidemiology Workgroup (NSAEW), formed in March 2007, is a workgroup of administrators, epidemiologists, and key decision makers who collaborate to make decisions regarding the collection and reporting of data related to substance use and abuse, the consequences of substance abuse, and the factors that contribute to substance abuse in the State of Nebraska. Work completed by the NSAEW has and will continue to guide decision making around substance abuse prevention in the state, including decisions made by the Nebraska Partners in Prevention (NePIP), the Governor's Advisory Council for substance abuse prevention.

The initial tasks of the NSAEW included (1) creating an epidemiological profile report on substance abuse in Nebraska, the first such report in the state, which was released in December 2007 and (2) establishing a set of criteria that helped to facilitate the selection of the Nebraska's SPF SIG substance abuse prevention priorities. This information served as the foundation for the development of the Nebraska Substance Abuse Prevention Strategic Plan, released in March 2008. Since then, the NSAEW has worked to identify substance abuse data gaps in Nebraska as well as formed two sub-committees to (1) further explore health disparities related to substance abuse and (2) further explore the patterns of alcohol use and binge drinking among young adults in the state. In addition, the NSAEW continues to serve as a platform for discussing substance abuse issues and stimulating relationship building and collaboration among those working in the field.

The NSAEW has 30 members representing the organizations or areas in Nebraska.

- The work of the EPI workgroup serves as a foundation for establishing SA prevention and treatment goals for the state. However, the actual goals are established in collaboration between the Nebraska Divisions of Behavioral Health and Public Health.
- NSAEW has not done much regarding treatment planning. However, the Division of Behavioral Health is increasing participation is a step. It can serve as a platform for compiling/collecting data that could guide SA treatment planning, whether that be through larger workgroup discussion of the eventual formation of a SA treatment subcommittee.

Form 6 (formerly Form 11)

INTENDED USE PLAN

(Include ONLY Funds to be spent by the agency administering the block grant. Estimated data are acceptable on this form)

SOURCE OF FUNDS

Activity	(24 Month Projections)					
	A.SAPT Block Grant FY 2011 Award	B.Medicaid (Federal, State and Local)	C.Other Federal Funds (e.g., Medicare, other public welfare)	D.State Funds	E.Local Funds (excluding local Medicaid)	F.Other
Substance Abuse Prevention* and Treatment	\$ 5,824,315	\$	\$	\$ 24,481,464	\$	\$
Primary Prevention	\$ 1,673,967		\$	\$ 173,291	\$	\$
Tuberculosis Services	\$	\$	\$	\$	\$	\$
HIV Early Intervention Services	\$	\$	\$	\$	\$	\$
Administration: (Excluding Program/Provider Lvl)	\$ 394,646		\$	\$	\$	\$
Column Total	\$7,892,928	\$0	\$0	\$24,654,755	\$0	\$0

*Prevention other than Primary Prevention

Form 6ab (formerly Form 11ab)

Form 6a. Primary Prevention Planned Expenditures Checklist

Activity	Block Grant FY 2011	Other Federal	State Funds	Local Funds	Other
Information Dissemination	\$ 83,023	\$	\$ 5,702	\$	\$
Education	\$ 219,704	\$	\$ 4,068	\$	\$
Alternatives	\$ 82,710	\$	\$ 1,082	\$	\$
Problem Identification & Referral	\$ 98,856	\$	\$ 85,037	\$	\$
Community Based Process	\$ 520,199	\$	\$ 51,682	\$	\$
Environmental	\$ 583,025	\$	\$ 25,719	\$	\$
Other	\$	\$	\$	\$	\$
Section 1926 - Tobacco	\$ 86,450	\$	\$	\$	\$
Column Total	\$1,673,967	\$0	\$173,290	\$0	\$0

Form 6b. Primary Prevention Planned Expenditures Checklist

Activity	Block Grant FY 2011	Other Federal	State Funds	Local Funds	Other
Universal Direct	\$	\$	\$	\$	\$
Universal Indirect	\$	\$	\$	\$	\$
Selective	\$	\$	\$	\$	\$
Indicated	\$	\$	\$	\$	\$
Column Total	\$0	\$0	\$0	\$0	\$0

Form 6c (formerly Form 11c)

Resource Development Planned Expenditure Checklist

Did your State plan to fund resource development activities with FY 2011 funds?

Yes No

Activity	Treatment	Prevention	Additional Combined	Total
Planning, Coordination and Needs Assessment	\$	\$ 15,000	\$	\$ 15,000
Quality Assurance	\$ 20,940	\$ 16,440	\$	\$ 37,380
Training (post-employment)	\$ 120,426	\$ 3,000	\$	\$ 123,426
Education (pre-employment)	\$ 50,000	\$	\$	\$ 50,000
Program Development	\$ 54,801	\$ 54,801	\$	\$ 109,602
Research and Evaluation	\$	\$	\$	\$ 0
Information Systems	\$	\$ 48,500	\$	\$ 48,500
Column Total	\$246,167	\$137,741	\$0	\$383,908

Purchasing Services

This item requires completing two checklists.

Methods for Purchasing

There are many methods the State can use to purchase substance abuse services. Use the following checklist to describe how your State will purchase services with the FY 2011 block grant award. Indicate the proportion of funding that is expended through the applicable procurement mechanism.

- | | |
|---|--------------------------|
| <input type="checkbox"/> Competitive grants | Percent of Expense: % |
| <input checked="" type="checkbox"/> Competitive contracts | Percent of Expense: 5 % |
| <input type="checkbox"/> Non-competitive grants | Percent of Expense: % |
| <input checked="" type="checkbox"/> Non-competitive contracts | Percent of Expense: 1 % |
| <input checked="" type="checkbox"/> Statutory or regulatory allocation to governmental agencies serving as umbrella agencies that purchase or directly operate services | Percent of Expense: 94 % |
| <input type="checkbox"/> Other | Percent of Expense: % |
| (The total for the above categories should equal 100 percent.) | |
| <input type="checkbox"/> According to county or regional priorities | Percent of Expense: % |
-

Methods for Determining Prices

There are also alternative ways a State can decide how much it will pay for services. Use the following checklist to describe how your State pays for services. Complete any that apply. In addressing a State's allocation of resources through various payment methods, a State may choose to report either the proportion of expenditures or proportion of clients served through these payment methods. Estimated proportions are acceptable.

- | | |
|--|--|
| <input type="checkbox"/> Line item program budget | Percent of Clients Served: %
Percent of Expenditures: % |
| <input type="checkbox"/> Price per slot | Percent of Clients Served: %
Percent of Expenditures: % |
| Rate: \$ | Type of slot: |
| Rate: \$ | Type of slot: |
| Rate: \$ | Type of slot: |
| <input type="checkbox"/> Price per unit of service | Percent of Clients Served: %
Percent of Expenditures: % |
| Unit: | Rate: \$ |
| Unit: | Rate: \$ |
| Unit: | Rate: \$ |
| <input type="checkbox"/> Per capita allocation (Formula:) | Percent of Clients Served: %
Percent of Expenditures: % |
| <input type="checkbox"/> Price per episode of care | Percent of Clients Served: %
Percent of Expenditures: % |
| Rate: \$ | Diagnostic Group: |
| Rate: \$ | Diagnostic Group: |
| Rate: \$ | Diagnostic Group: |

Program Performance Monitoring

On-site inspections

Frequency for treatment: EVERY TWO YEARS

Frequency for prevention: ANNUALLY

Activity Reports

Frequency for treatment: QUARTERLY

Frequency for prevention: QUARTERLY

Management Information System

Patient/participant data reporting system

Frequency for treatment: MONTHLY

Frequency for prevention: MONTHLY

Performance Contracts

Cost reports

Independent Peer Review

Licensure standards - programs and facilities

Frequency for treatment: EVERY TWO YEARS

Frequency for prevention: NONE SELECTED

Licensure standards - personnel

Frequency for treatment: EVERY TWO YEARS

Frequency for prevention: NONE SELECTED

Other:

Specify:

State Priorities

	State Priorities
1	<p>1. Access/ Block Grant Requirement – Priority Populations – Ensure immediate access to substance abuse treatment for individuals from the four priority populations. The SAPTBG Priority Populations are Pregnant Injecting Drug Users, Pregnant Substance Abusers, Injecting Drug Users, Women with Dependent Children. From the priority populations, there are people in need for substance abuse services as well as people waiting for services. According to Form 4 (formerly Form 8), the number of Intravenous Drug Users (IVDUs) in need of substance abuse services in Nebraska is 1,078. According to data from the Division of Behavioral Health, there were 603 number of persons served for FY2010 who report IV injection as the route (Primary, secondary, tertiary). IVDU in need of treatment services are individuals who use hypodermic needles or syringes to take illegal drugs such as heroin, cocaine, or other substances. A person is defined as being in need of services if the individual has a diagnosable substance use disorder with the usual route of admission through needles intravenously and leading to significant functional impairment. According to the Treatment Needs Assessment Summary [Form 4 /formerly Form 8], the number of women needing treatment services in Nebraska (State Total) is 57,918. On Form 10b (formerly Form 7b), for FY2009, Nebraska reported 5,322 (32%) women of the 16,747 persons served (unduplicated count) for alcohol and other drug use in state funded services. Of that group, there were 162 Pregnant Women. The Capacity Management and Waiting List System tracks and monitors individuals waiting for treatment. The enhanced Capacity Management/Waiting List System was implemented on October 5, 2009. As reported in the Annual Summary for the Substance Abuse Capacity and Waiting List Report, after the first nine months of implementation, there were individuals identified as priority populations waiting for substance abuse services in each of the quarters ... the 2nd quarter (October to December 2009 – n=182) ... the 3rd quarter (January to March 2010 – n=325) ... the 4th quarter (April to June 2010 – n=275). This is consistent with Federal SAPTBG Goal 1: Maintain a continuum of SA treatment services. On September 21, 2010, the State</p>

Advisory Committee on Substance Abuse Services reviewed this priority. After discussion the Committee approved a motion in support of this priority.

2. Access/ Block Grant Requirement – Interim Services Within 48 Hours – The Division of Behavioral Health continues to work on improving the access to treatment services and monitors individuals waiting for treatment services via placement on the Waiting List and providing interim services. Client specific monitoring is completed by the Regional Behavioral Health Authorities. The revised Statewide Waiting List system was implemented on October 5, 2009. However, statewide data are not available to clearly show that individuals from the four priority populations receive Interim Services within 48 hours. What is reported is the Statewide Substance Abuse average wait days by Priority Population and Service Type for State Fiscal Year 2010. It is important to note that people on the waiting list can fall into more than one priority population category and/or be waiting for more than one type of service on more than one provider waiting list. As a result, the sum of population category numbers is larger than the total number of people waiting for service. What is available in the statewide data are the average waiting times by Priority Populations. For Pregnant/IV Users, the average wait for Short-Term Residential was 8 days; for Therapeutic Community, the average wait days was 36.5. For Pregnant Women, the average wait to get into a Dual Disorder Residential program was 7 days; for Intensive Outpatient (IOP) the average was 12.8 wait days; for Outpatient the average was 54.67 wait days; for Short-Term Residential there was an average of 16.5 wait days; and for Therapeutic Community it was an average of 30.14 wait days. For IV Users, the average wait for Community Support was one day, for Dual Disorder Residential average wait days were 17.53; for Halfway House the average wait days were 26.43; Intensive Outpatient (IOP) the average wait days were 29.57; for Intermediate Residential the average wait days were 14.25; for Outpatient the average waiting days were 15.95; for Outpatient Dual the average waiting days were 36.2; in Short-Term Residential the average wait was 18.6 days and Therapeutic Com was an average of 37.97 wait days. All individuals on the Waiting List must receive interim services. All of these individuals need access to interim services. This is consistent with Federal SAPTBG Goal 9: Each pregnant woman be given preference in admission to treatment facilities ...

2

	<p>Capacity Management and Waiting List Systems. On September 21, 2010, the State Advisory Committee on Substance Abuse Services reviewed this priority. After discussion the Committee approved a motion in support of this priority.</p>
3	<p>3. Access /System Coordination – Ensure that individuals from the four priority populations have access to a Substance Abuse Evaluation. This means the individual will receive an appointment within 48 hours of making their request. The evaluations must be completed within 7 business days of appointment. Via the audit process, the Regional Behavioral Health Authorities monitor for the provision of substance abuse evaluations. The Regional Audit Reports are received by the Division of Behavioral Health, who will be developing a method to better monitor and review the trends. This priority is based on reviewing the Capacity Management and Waiting List System. This priority is based on data from the Capacity Management/Waiting List System and Division Quality Improvement Team discussions. The revised Waiting List system was implemented on October 5, 2009. As reported in the Annual Summary for the Substance Abuse Capacity and Waiting List Report, in the 2nd quarter, most people were waiting for substance abuse services were intravenous drug users (40.7%, n=74). In the 3rd (44.9%, n=146) and 4th (40.7%, n=112) quarters, the majority of the identified priority populations waiting for substance abuse services were women with dependent children. This is consistent with Federal SAPTBG Goal 9: Each pregnant woman be given preference in admission to treatment facilities ...</p> <p>Capacity Management and Waiting List Systems. On September 21, 2010, the State Advisory Committee on Substance Abuse Services reviewed this priority. After discussion the Committee approved a motion in support of this priority.</p>
4	<p>4. Enhance Continuing Education / Capacity & Partnerships - Improve statewide access to Continuing Education for substance abuse providers. Division of Behavioral Health and the Office of Probation Administration will continue to partner by exploring web-based training platform opportunities. This will involve producing web-based training for the workforce development in substance use, co-occurring disorders and the criminal justice system. DBH will also explore online training provided by Mid-America ATTC. There are a number of reasons this important. It creates a foundation training available for providers to access in all</p>

	<p>areas of the state. It allows contracted dollars to be utilized for more skill-based training. It strengthens partnerships between multi-systems. Trainings could be used by: providers, judges, attorneys, law enforcement, local jails, DHHS workforce and other related stakeholders. This is consistent with Federal SAPTBG Goal 11: Provide continuing education ... prevention activities or treatment services. On September 21, 2010, the State Advisory Committee on Substance Abuse Services reviewed this priority. After discussion the Committee approved a motion in support of this priority.</p>
5	<p>5. Data Utilization / Partnership / ASI-CASI & Other Instruments – A mandatory requirement of completing a substance abuse evaluation involves utilizing the Addiction Severity Index (ASI) as the statewide structured interview process and the Comprehensive Adolescent Severity Inventory (CASI). The ASI and CASI have been adopted by the Criminal Justice System in Nebraska. The Division of Behavioral Health will continue to partner with the criminal justice system to implement a process for aggregating ASI/CASI data to be utilized by substance abuse providers and Division of Behavioral Health (DBH) and the criminal justice system, for the purposes of improving our knowledge of those we serve. Other related strategies will be discussed at the State Advisory Committee on Substance Abuse Services. Discussions with stakeholders need to occur as to the utility of the ASI/CASI. On September 21, 2010, the State Advisory Committee on Substance Abuse Services reviewed this priority. After discussion the Committee approved a motion in support of this priority.</p>
6	<p>6. Focus on Prevention – Enhance state leadership with Substance Abuse Prevention by development of a Prevention Strategic Plan. DBH contracts with Regional Behavioral Health Authorities for prevention system coordination, training and technical assistance. SAPTBG prevention priorities are blended with those of other funding streams to maximize limited resources. Resources are prioritized utilizing both local assessment and information gathered by the State. At the Regional level, community coalitions are charged with assessing local needs and presenting a plan to the region to address identified gaps. The proposals then go through an internal review. Technical assistance and/or training is provided to the coalitions on how best to implement and assess their programs and/or strategies. The coalitions then either provide the services directly to the community or contract with providers to complete specific tasks.</p>

	<p>Meanwhile, DBH, as the Single State Agency, in partnership with Division of Public Health, will work to improve prevention statewide leadership. The Nebraska Information Reporting System (NPIRS) will be improved. DBH may request Technical Assistance on this from the Center for the Application of Prevention Technologies (CAPT). This is consistent with Federal SAPTBG Goal 2: Twenty percent on primary prevention programs. On September 21, 2010, the State Advisory Committee on Substance Abuse Services reviewed this priority. After discussion the Committee approved a motion in support of this priority.</p>
7	<p>7. Access and Retention / Technical Assistance – Continue to implement the strategies identified in the In Depth Technical Assistance (IDTA) that are designed to improve access to and retention while in treatment. The partners on this include the Division of Behavioral Health (DBH), Division of Medicaid and Long-Term Care (DMLTC), Division of Children and Family Services (DCFS), Office of Probation Administration (Probation), Juvenile Courts, and Division of Public Health (DPH). The ultimate goal is to improve the system’s response when serving substance abusing parents who have children in the Child Welfare System. This is consistent with Federal SAPTBG Goal 12: Coordinate prevention activities and treatment services with other ... services. On September 21, 2010, the State Advisory Committee on Substance Abuse Services reviewed this priority. After discussion the Committee approved a motion in support of this priority.</p>
8	<p>8. Waiting List / Data Management – Improve the Capacity Management Information System (CMIS) process of tracking Substance Abuse Waiting List/Interim Services by exploring the feasibility of “real time” data software. Nebraska made substantial changes to the Waiting List with implementation starting on October 5, 2009. The Regional Behavioral Health Authorities find the improved Waiting List system very beneficial. However, additional enhancements to data collection need to be explored. This is consistent with Federal SAPTBG Goal 9: Each pregnant woman be given preference in admission to treatment facilities ... Capacity Management and Waiting List Systems. On September 21, 2010, the State Advisory Committee on Substance Abuse Services reviewed this priority. After discussion the Committee approved a motion in support of this priority.</p>
	<p>9. Co-Occurring System of Care - Continue to promote a</p>

9

statewide Recovery Oriented System of Care that is capable of serving individuals with co-occurring disorders. Recovery Oriented Systems of Care (ROSC) is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resilience of individuals, families, as well as communities to achieve abstinence and more. For the Individual in a ROSC, outcomes may involve things like abstinence, education, employment, reduced criminal justice involvement, stability in housing, improved health, wellness, social connectedness and quality of life. On May 6, 2010 the Division of Behavioral Health held the first Joint Meeting of the State Advisory Committee on Mental Health Services and the State Advisory Committee on Substance Abuse Services. Representatives from the State Committee on Problem Gambling also attended. This meeting helped to further document the unmet needs of people who have a co-occurring mental health, substance abuse, and gambling problems. The Division of Behavioral Health has chartered a Co-Occurring Disorders Quality Initiative. This initiative will promote recovery of individuals and families by creating a road map to a statewide, integrated co-occurring service delivery system. This is consistent with Federal SAPTBG Goal 10: Information, Education / Access – An agreement to improve the process in the State for referring individuals to the treatment modality that is most appropriate for the individual. On September 21, 2010, the State Advisory Committee on Substance Abuse Services reviewed this priority. After discussion the Committee approved a motion in support of this priority.

10. Justice Behavioral Health – Continue to partner with the Department of Corrections to ensure that individuals with substance abuse disorders receive information and referrals to community-based substance abuse treatment services. According to the Nebraska Crime Commission, for the four year time period of 2006 to 2009, about 40% of the reported offenses involve substance abuse: Driving Under the Influence (14.9%), Liquor Laws (13.6%) and Drug Abuse Violations (11.4%) [Source: Michael Overton, Chief, Information Services Division, Nebraska Crime Commission; September, 2010]. Liquor laws could be anything other than Driving Under the Influence (DUI) so it could range from manufacturing to procuring for a minor. It is a general category but the Nebraska Crime Commission does not have any other breakdowns. However, there are many

10

other reported offenses which do not show up in the crime statistics as substance abuse, but are influenced by these problems such as disorderly conduct, vandalism, offense against family and children, stolen property, robbery, prostitution and forcible rape. According to the Nebraska Department of Correctional Services, the rate of individuals diagnosed with substance-related disorders at intake in the state prison system is significant. In FY2009 there were 1,496 (79%) of the Inmate population with a substance abuse or dependence diagnosis out of the total number of inmates screened (1,903). In FY2010, it was 76% (1,477 of the 1,955). The substance related diagnosis is made by Nebraska Department of Correctional Services Substance Abuse Staff at intake. NE Division of Behavioral Health is implementing a U.S. Department of Justice – Bureau of Justice Assistance (BJA) Grant - Justice and Mental Health Collaboration Program (CDFA #16.745) Category II: Planning and Implementation grant. The Justice and Mental Health Collaboration Program will increase public safety by facilitating collaboration among the criminal justice, juvenile justice, and mental health and substance abuse treatment systems to increase access to services for offenders with mental illness and substance abuse. The three year grant ends on August 31, 2011. Through grant implementation, it is clear more efforts need to be made to address jail diversion as well as jail discharge planning efforts. The Division of Behavioral Health does note the Restrictions on Expenditure of Grant, Section 1931 [§ 96.135(b) (2)] which restricts expenditure of SAPTBG for the purpose of providing treatment services in penal or correctional institutions of the State. This is consistent with Federal SAPTBG Goal 10: An agreement to improve the process in the State for referring individuals to the treatment modality that is most appropriate for the individual. On September 21, 2010, the State Advisory Committee on Substance Abuse Services reviewed this priority. After discussion the Committee approved a motion in support of this priority.

11. Data Management – Continue to ensure the accurate and timely submission (admission and discharge) of data required for SAPTBG reporting. The ultimate goal is to ensure for the most accurate data which will drive decision making. However, accountability for the substance abuse system needs to be improved by continuing to develop the performance measurement capacity. Substance Abuse and Mental Health Services

11

Administration (SAMHSA) expects data reporting under the Substance Abuse Prevention and Treatment Block Grant (SAPTBG). SAMHSA has the National Outcome Measures (NOMS). The data reporting is completed under the Drug and Alcohol Services Information System (DASIS), an integrated data system maintained by SAMHSA's Office of Applied Studies. The data are used for the Federal reporting under the National Outcome Measures (NOMS), performance measures within the SAPTBG and much more. The Treatment Episode Data Set (TEDS) is one of the data reporting mechanisms. TEDS is a compilation of data on the demographic characteristics and substance abuse problems of those admitted to substance abuse treatment at programs receiving SAPTBG funding. Information on treatment admissions is routinely collected by State administrative systems and then submitted to SAMHSA in a standard format. TEDS records represent admissions rather than individuals, as a person may be admitted to treatment more than once. State admission data are reported to TEDS by the Single State Agency (SSAs) for substance abuse treatment. The Division of Behavioral Health is the SSA in Nebraska. Nebraska currently participates in the TEDS Substance Abuse transfer. The State Outcomes Measurement and Management System (SOMMS) subcontract program had been providing useful feedback via the quarterly data quality assessment reports. The SOMMS subcontract officially ended in June 2010. These SOMMS data quality assessment reports provided useful feedback on areas such as the timeliness and completeness of data, discharge record match rate (discharge records matched to an admission record), the number and percent of admission records (excluding detox) with unknown values, the number and percent of those discharge records with unknown values, and more. The Division of Behavioral Health's quality improvement efforts will continue to work on improving the accurate and timely submission (admission and discharge) of data required for SAPTBG data reporting. On September 21, 2010, the State Advisory Committee on Substance Abuse Services reviewed this priority. After discussion the Committee approved a motion in support of this priority.

12. Healthcare Reform – Ensure the Division of Behavioral Health, through strategic planning and related efforts, is focused on positioning Nebraska to successfully implement mandatory elements of National Healthcare Reform by January 1, 2014. Federal

12

legislation regarding the combination of Parity (2008) plus Healthcare Reform (2010) means the systems for delivering community based substance abuse services will be changing. It is essential for Nebraska to continue to focus on how those individuals in the priority populations will receive substance abuse treatment services. Aligning with healthcare organizations will remain a priority. On September 21, 2010, the State Advisory Committee on Substance Abuse Services reviewed this priority. After discussion the Committee approved a motion in support of this priority.

1. The Form 7 SAPTBG Priorities for Nebraska are not listed in any order of priority.
2. The list was developed for the purposes of prioritizing system initiatives in the SA System. However, the Division of Behavioral Health is currently engaged in a major strategic planning effort. The preliminary draft is due in November 2010.
3. As of October 1, 2010, this is a list of Nebraska's top substance abuse services priorities. The form was completed based on the Nebraska's informed planning process.
4. Under Nebraska Statute [§71-815], the State Advisory Committee on Substance Abuse Services is responsible for providing input to the Division of Behavioral Health relating to the provision of substance abuse services in the State of Nebraska, as well as to promote the interests of consumers and their families. On September 21, 2010, the State Advisory Committee on Substance Abuse Services reviewed the Form 7 priorities. After discussion the Committee approved a motion in support of all twelve listed priorities.

Goal #1: Improving access to Prevention and Treatment Services

The State shall expend block grant funds to maintain a continuum of substance abuse prevention and treatment services that meet these needs for the services identified by the State. Describe the continuum of block grant-funded prevention (with the exception of primary prevention; see Goal # 2 below) and treatment services available in the State (See 42 U.S.C. §300x-21(b) and 45 C.F.R. §96.122(f)(g)).

Note: In addressing this narrative the State may want to discuss activities or initiatives related to: *Providing comprehensive services; Using funds to purchase specialty program(s); Developing/maintaining contracts with providers; Providing local appropriations; Conducting training and/or technical assistance; Developing needs assessment information; Convening advisory groups, work groups, councils, or boards; Providing informational forum(s); and/or Conducting provider audits.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

Goal #1: Intended Use – Improving Access to Prevention and Treatment Services /
September 10, 2010 / Page 1

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

FY2011 – FY2013 (Intended Use/Plan)

Prevention Services

The Division of Behavioral Health utilizes a multi-pronged approach with managing and implementing the Prevention System. The Prevention System includes community level prevention coordination as well as state activities to support coalitions, communities, stakeholders and partners in a variety of ways. The Nebraska Department of Health and Human Services (DHHS), Division of Behavioral Health (hereafter referred to as the Division) supports the Nebraska Behavioral Health Prevention System through interagency coordination as well as funding prevention activities directly and through a Regional Prevention Coordination System. The funding of prevention includes contracts for Technical Assistance, Training, and Database development to support the various regions, coalitions and community entities. Coordination activities include Children's Behavioral Health planning and implementation for the state of which substance abuse prevention is a foundation, SYNAR committee, Tobacco Free Nebraska coordination, improving workforce development opportunities for preventionists, participating with on the State Epidemiological workgroup, collaborating with the Department of Health and Human Service Division of Public Health Strategic Prevention Framework-State Incentive Grant (SPF-SIG) program, interagency coordination, and understanding the overall direction of the Drug Free Communities grantees that are funded. The Division also sponsors the NebraskaPrevention@yahoo.com list serve which functions as a discussion board for community coalitions and Prevention Specialists, as well as the online resource NebraskaPrevention.gov web site (www.nebraskaprevention.gov).

Funding for each of the Regional Behavioral Health Authorities (Regions) Substance Abuse Prevention System comes primarily from the Division. Each of the six (6) Regions maintains staff purposed for the coordination and oversight of the regional/local prevention community in support of the statewide system. Regional prevention systems are defined as purposeful, effective, and sustained partnerships of agencies, organizations, and individuals committed to preventing substance abuse, addictive disorders, and related societal problems through the life span. They operate at the community level embracing community culture while leading the development of strong, sustainable, community-based prevention activities focused on producing pro-social changes. Prevention system activities prevent the onset and reduce the progression of substance abuse, reduce the related problems, and build prevention capacity and infrastructure at the State/Tribal and community level. Regions, community coalitions, prevention providers, schools, law enforcement and other key stakeholders help make up this system. Regional Prevention System Coordination (RPSC) is funded by the Division and is specifically designed to support the statewide prevention system in partnership with coexisting prevention efforts such as SPF-SIG. In addition to this role, the Regions utilize Division funding to purchase prevention activities to expand the delivery of prevention strategies and support local community efforts. Each of the six Behavioral Health Regions has a designated Regional Prevention Coordinator (RPC) that is the contact for prevention system information.

Coordination of State Activities

Under the direction of the Division the RPSC is responsible for the coordination of activities in support of a unified prevention system across Nebraska. Consistent and frequent communication occurs among all Regions and with the Divisions of Behavioral Health and the Division of Public Health SPF-SIG. This direct relationship encourages systemic growth, professional support, increases outcome focused initiatives and utilizes data driven decisions for comprehensive state and regional planning.

Coordination of Regional Coalitions

RPSC is knowledgeable about prevention strategies that occur among existing and newly developing community coalitions and works to bridge together the diverse substance abuse prevention funding streams from (but not limited to) federal block grant, SPF-SIG, and Drug Free Communities. The coordination of these multiple efforts is imperative for the success at a community, regional and statewide level. The RPSC utilizes the community partnerships to establish common directives, geographic and target population strategic planning and to better utilize training and technical assistance initiatives.

Training

RPSC develops and implements training opportunities to all substance abuse prevention coalitions. Trainings focus around specific state, regional, and community developed priorities. Training also is provided for the professional development of prevention providers including formal staff, volunteers and community partners.

Technical Assistance

RPSC provides technical assistance to substance abuse prevention coalitions and other providers in implementing data-driven evidence-based policies, programs, and practices. Assistance is available on the Strategic Prevention Framework planning process. This portion of the RPSC responsibilities is critical to the development of community based prevention coalitions. Although there is tremendous support provided directly to the SPF-SIG funded coalitions via the Division of Public Health, local relationships and assistance via the RPSC has proven to be an invaluable asset. The collaboration of these efforts has greatly strengthened the progress of local coalitions and provided consistent, reliable and sustainable system management.

Reporting

RPSC collects and reports on all substance abuse prevention activities among community coalitions and other prevention providers/programs, particularly those that are funded in whole or part by the federal substance abuse block grant. They also collect on the National Outcome Measures (NOMS) outlined by SAMHSA. Collecting the broad variety of activities performed by the RPSC, coalitions and providers can be an arduous task. To this end, supporting the local and often times volunteer run coalitions with immediate access to technical assistance has greatly improved the quantity and quality of prevention data.

Treatment Services

The Nebraska Behavioral Health Services Act established the Regional Behavioral Health Authority (RBHA). This Act assigns all 93 Nebraska counties to one of six RBHA's who are also known as Behavioral Health Regions. Each RBHA is governed by a Regional Governing Board consisting of one county board member (locally elected official) from each county in the region. The Regional Administrator of the RBHA is appointed by the Regional Governing Board.

Goal #1: Intended Use – Improving Access to Prevention and Treatment Services /
September 10, 2010 / Page 3

Region	Substate Planning Area (SPA)	Regional Office	Counties	Total population Census data (estimated)	% of population
1	Panhandle	Scottsbluff	11	85,813	4.80%
2	West Central	North Platte	17	99,148	5.60%
3	South Central	Kearney	22	223,379	12.50%
4	Northeast & North Central	Norfolk	22	204,799	11.50%
5	Southeast	Lincoln	16	436,512	24.50%
6	Eastern	Omaha	5	733,781	41.10%
Totals			93	1,783,432	100%

The Division of Behavioral Health (DBH) and the Division of Medicaid and Long Term Care have recently completed a collaborative review of each of the Substance Abuse Service Definitions as part of process to update DBH Regulations Title 203 (Substance Abuse Services) and Title 204 (Community Mental Health Programs). The Title 203 -- Substance Abuse Services Regulations govern the organization and implementation of substance abuse services. They address Department responsibilities, regional governing boards, finance and administration, certification of substance abuse programs, and specific programmatic requirements. While there is no expansion of services, the new draft Service Definitions are more inclusive of “trauma informed care” and “recovery” language. Due to delays in coordinating the Service Definitions with Medicaid, they were not implemented in 2010 as planned. The Service Definitions were included in a public hearing of the Regulations on August 19, 2010, and the new plan is to have them finalized by January, 2011.

The DBH, within the Department of Health and Human Services (DHHS), expends Substance Abuse Prevention and Treatment Block Grant (SAPTBG) funds to provide a statewide continuum of substance abuse assessment, prevention, and treatment services. The DBH utilizes a combination of funding which includes block grant funds, state general funds, healthcare cash funds, and Medicaid funds to provide this statewide continuum of substance abuse services.

Target Population--

The DBH provides treatment services through contracts with each of the six Regional Behavioral Health Authorities (RBHA) who contract with community providers (subcontractors) to serve individuals 19 years of age and older who meet the clinical criteria for substance abuse and dependence (DSM). Access to treatment is prioritized giving preference to the following priority populations:

1. Pregnant Injecting Drug Users
2. Pregnant Substance Abusers
3. Injecting Drug Users
4. Women with Dependent Children

Substance Abuse services may be provided to 17 and 18 year olds through the DBH Age Waiver, when there is documentation supporting the clinical rationale for serving transition age youth in the adult service system. Requests for Age Waivers come from the Substance Abuse provider to the RBHA who, upon approval, request permission from the DBH to serve. During FY2010, there were 9 age waivers, and all of those individuals received Substance Abuse treatment services.

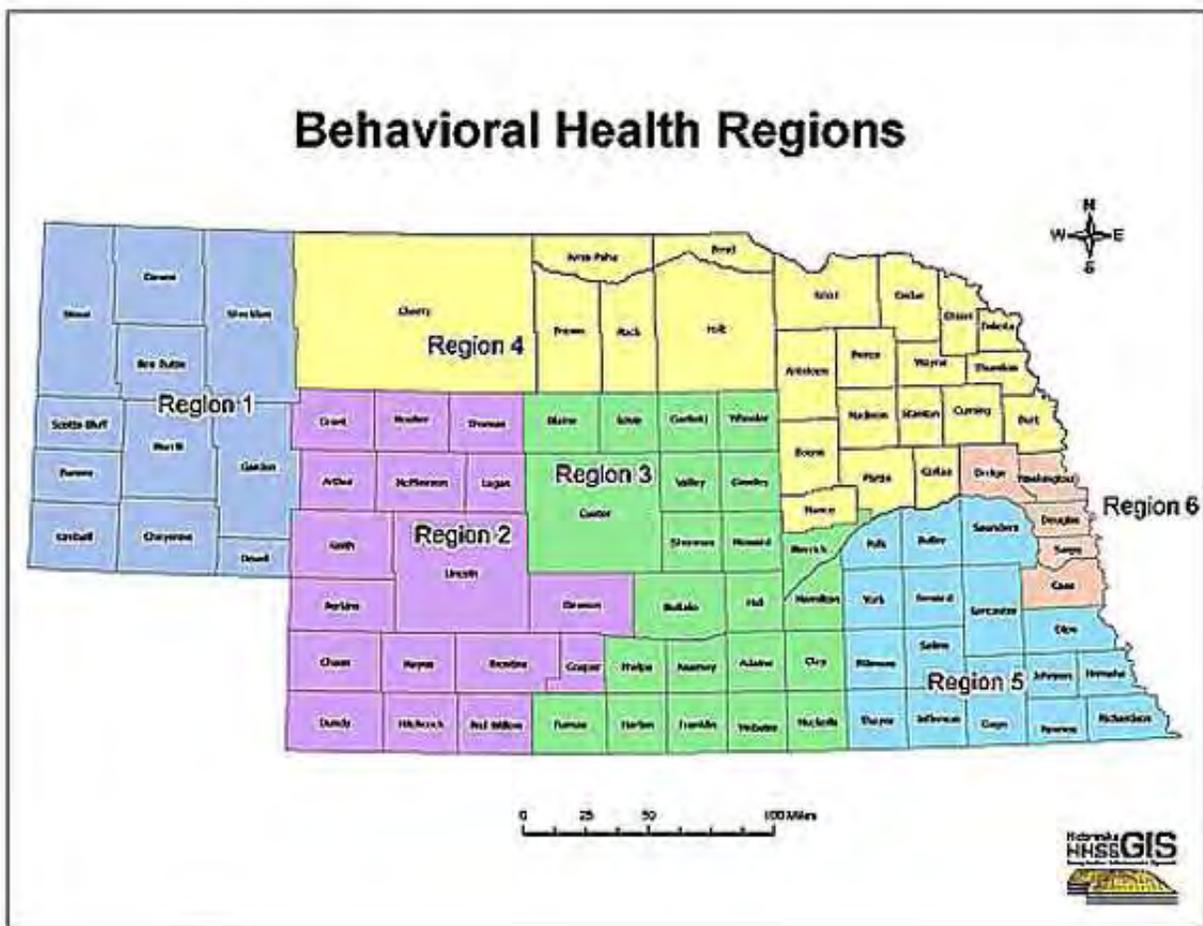
Goal #1: Intended Use – Improving Access to Prevention and Treatment Services /
September 10, 2010 / Page 4

The Nebraska Behavioral Health Services Act [Neb. Rev. Stat. §§ 71-801 to 71-830] establishes the framework for the provision of behavioral health services in Nebraska. Under the Act, Rev. Stat. §§ 71-807 to 71-809 authorizes the regional administration of the Nebraska Behavioral Health System. Under §71-807, the Act assigns all 93 counties to one of six Behavioral Health Regions.

The Region's statutory and regulatory responsibilities include:

- Organize and supervise comprehensive behavioral health services,
- Ensure access to needed behavioral health services,
- Report annually to the Department of Health and Human Services regarding the expenditure of funds and the evaluation of services,
- Develop an annual regional plan based upon need and availability of resources,
- Appoint an advisory committee, and
- Consult with advisory committees on planning, organizing, contracting, program evaluation, and fiscal analysis of services in the Region.

The map below shows Nebraska Behavioral Health Regions.



The Division of Behavioral Health contracts with the six Regional Behavioral Health Authorities for substance abuse services. Each county in a Behavioral Health Region provides “match” funding against state general funds for the operation of the Behavioral Health Authority and the provision of behavioral health services within their regional area. The Act prohibits the RBHA

from directly providing services except under very limited circumstances. State Statute §71-809 (2) does provide exceptions, the most prominent allows Regional Behavioral Health Authority's to be a direct provider of any services that it operated on July 1, 2004.

The RBHA is responsible for the development and coordination of publicly funded behavioral health services in the region pursuant to rules and regulations of the Department of Health and Human Services. The Division of Behavioral Health contracts with the RBHA to purchase services using the funds received from the Substance Abuse Prevention and Treatment Block Grant (SAPTBG).

Initial Adult Substance Abuse Assessment, Patient Placement Criteria and Treatment Services

Substance Abuse Assessments

The Division of Behavioral Health implemented a strategy to improve access to treatment services for individuals identified as a Priority Population. Individuals who request treatment are briefly screened by the treatment provider (over the phone, or in person for drop in's) to determine if they are (1) Considered a Priority Population for treatment and (2) To determine if they have received a Substance Abuse Assessment within the previous 6 months. If an individual is determined to be a Priority and has not received a Substance Abuse Assessment, the treatment provider must schedule an appointment for the Substance Abuse Assessment, which must occur within 48 hours from the time of the request for treatment. The Substance Abuse Assessment must also be completed within 7 business days of the appointment. These timeframes were developed to improve access to treatment and are included in the contracts with each of the RBHA's.

Each of the six RBHA's, through collaboration with their contracted substance abuse providers, have developed a Regional Plan which outlines how they will operationalize and implement the new timeframes. Each RBHA has developed a unique plan, specific to their communities, which ensures Substance Abuse Assessment capacity. These Regional Plans are submitted annually to the DBH for review and approval.

Initial Adult Substance Abuse Assessments completed in Nebraska (Medicaid and DBH funded) must be inclusive of at least one of the following nationally accepted screening instruments:

- SASSI (Substance Abuse Subtle Screening Inventory)
- TII (Treatment Intervention Inventory)
- SUDDS (Substance Use Disorder Diagnostic Schedule)
- MADIS (Michigan Alcohol Drug Inventory Screen)
- MAST (Michigan Alcoholism Screening Test)
- MINI (Mini International Neuropsychiatric Interview)
- WPI (Western Personality Interview)
- PBI (Problem Behavior Inventory)
- RAATE (Recovery Attitude and Treatment Evaluator)
- CIWA (Clinical Institute Withdrawal Assessment)

The Addiction Severity Index (ASI) is also required for all Nebraska Substance Abuse Assessments (Behavioral Health, Medicaid and Criminal Justice providers). This tool is designed to be used as a face-to-face structured interview guide for the evaluation of substance abuse treatment.

Patient Placement Criteria

Adult Substance Abuse providers utilize the Patient Placement Criteria for the Treatment of Substance-Related Disorders of the American Society of Addiction Medicine, Second Edition Revised (ASAM PPC-2R) to determine the most appropriate level of care based on the six dimensions.

Treatment Services

The Divisions of Medicaid and Long Term Care and Behavioral Health have recently completed a collaborative review of each of the Service Definitions which outline each of the Substance Abuse services funded by the Divisions. The final draft version of the Service Definitions has incorporated feedback from consumers, behavioral health associations and providers and will be referenced in the newly revised DHHS Regulations. The Regulations were reviewed in a public hearing on August 19, 2010, and final approval is expected by January 2011.

The following information outlines the Comprehensive Biopsychosocial Assessment/Substance Abuse Assessment.**DEMOGRAPHICS**

1. Identify provider name, address, phone, fax, and e-mail contact information.
2. Identify client name, identifier, and other demographic information of the client that is relevant.

PRESENTING PROBLEM / CHIEF COMPLAINT

1. External leverage to seek evaluation
2. When was client first recommended to obtain an assessment
3. Synopsis of what led client to schedule this evaluation

MEDICAL HISTORY**WORK / SCHOOL / MILITARY HISTORY****ALCOHOL & DRUG HISTORY SUMMARY**

1. Frequency and amount
2. Drug & alcohol of choice
3. History of all substance use/misuse/abuse
4. Use patterns
5. Consequences of use (physiological, legal, interpersonal, familial, vocational, etc.)
6. Periods of abstinence - when and why
7. Tolerance level
8. Withdrawal history and potential
9. Influence of living situation on use
10. Other addictive behaviors (e.g. problem gambling)
11. IV drug use
12. Prior SA evaluations and findings
13. Prior SA treatment
14. Client's family chemical use history

LEGAL HISTORY (*Information from Criminal Justice System*)

1. Criminal history & other information
 2. Drug testing results
 3. Simple Screening Instrument Results
 4. Risk Assessment Reporting Format for Substance Abusing Offenders Results
- Behavioral Health (MH/SA) – ASAM Levels of Care and Patient Placement Criteria
Approved by the Policy Cabinet 12/17/2005 FOR DIVISIONS: BEHAVIORAL HEALTH,
MEDICAID 34

**FAMILY / SOCIAL / PEER HISTORY
PSYCHIATRIC / BEHAVIORAL HISTORY**

1. Previous mental health diagnoses
2. Prior mental health treatment

COLLATERAL INFORMATION (*Family / Friends / Criminal Justice*)

1. Report any information about the client's use history, pattern, and/or consequences learned from other sources.

OTHER DIAGNOSTIC / SCREENING TOOLS—SCORE & RESULTS

CLINICAL IMPRESSIONS

1. Summary of evaluation
 - a. Behavior during evaluation (agitated, mood, cooperation)
 - b. Motivation to change
 - c. Level of denial or defensiveness
 - d. Personal agenda
 - e. Discrepancies of information provided
2. Diagnostic impression (including justification) (may include DSM-IV-TR Axis IV)
3. Strengths Identified (client and family)
4. Problems Identified

RECOMMENDATIONS

1. Complete III. Multidimensional Risk Profile
2. Complete the ASAM Clinical Assessment and Placement Summary
 - A comprehensive biopsychosocial assessment can only be obtained through collateral contacts with significant others or family members to gather relevant information about individual and family functioning and through collateral contacts with former and current healthcare providers, friends, and court contacts to verify medical history, substance usage, and legal history.
 - When dually credentialed clinicians are completing the evaluation, the recommendations must include co-occurring issues based on the DSM-IV-TR diagnosis.
 - When Licensed Alcohol/Drug Counselors are completing the evaluation, they must include a screening for possible co-occurrence of mental health problems and include referral for mental health evaluation, if appropriate, in their recommendations.

The following service categories are based on the Adult Criteria of the Patient Placement Criteria for the Treatment of Substance-Related Disorders, American Society of Addiction Medicine, Second Edition Revised (ASAM PPC-2R).

Level I: Outpatient (Individual, Family, Group and Community Support)

Outpatient Treatment services are services which may be delivered in any appropriate community setting that is licensed in Nebraska as a Substance Abuse Treatment Center. While the services follow a defined set of policies and procedures or clinical protocols, they must be tailored to each patient's individual level of clinical severity and must be designed to help the patient achieve changes in his or her alcohol or other drug using behaviors. Individual Therapy, Group Therapy, Family Therapy and Community Support all meet the criteria defined for Level I Outpatient.

Level II.1: Intensive Outpatient

Intensive Outpatient services may be delivered in any appropriate community setting that meets state licensure requirements in Nebraska as a Substance Abuse Treatment Center. Such treatment may be offered during the day, before or after work or school, in the evening or on a weekend. The services follow a defined set of policies and procedures or clinical protocols. The service also provides a coordinated set of individualized treatment services to persons who are able to function

in a school, work, and home environment but are in need of treatment services beyond traditional outpatient programs.

Level II.5: Partial Hospitalization (Partial Care)

The Division of Behavioral Health identifies Partial Care as the treatment modality meeting the requirements of Level II.5 Partial Hospitalization services may be delivered in an appropriately licensed Nebraska Substance Abuse Treatment Center in a community setting such as a mental health center, substance abuse center or hospital setting. Such treatment may be offered during the day, before or after work or school, in the evening or on a weekend. Partial Hospitalization provides a coordinated set of individualized treatment services to persons who are able to function in a school, work, and home environment but are in need of treatment services beyond traditional outpatient programs. Treatment may appropriately be used to transition persons from higher levels of care or may be provided for persons at risk of being admitted to higher levels of care, and can provide essential education and treatment services while allowing patients to apply their newly acquired skills in “real world” environments.

Level III.1: Clinically Managed Low Intensity Residential (Halfway House)

The current treatment modality within Level III.1 is Halfway House. The Halfway House programs for adult substance abuse provide transitional residential services for adults seeking to re-integrate into the community. These programs must provide a structured set of activities designed to develop the living skills necessary for an independent life free from substance abuse ousted of a primary residential treatment program. The program must also focus on assisting clients to maintain or access employment as needed.

Level III.3: Clinically Managed Medium Intensity Residential (Intermediate Residential, Therapeutic Community)

There are currently two service definitions that meet the definition of Level III.3 Intermediate Residential and Therapeutic Community both provide long term comprehensive residential treatment for substance abusing adults for whom shorter term treatment is inappropriate, either because of the pervasiveness of the impact of the substance abuse on the individual’s life or because of a history of repeated treatment failures. These programs must provide psychosocial skill building through a longer-term set of treatment activities with the expectation of a slower progress toward individual change and rehabilitation than is achieved with short-term treatment modalities. Intermediate Residential programs are typically more supportive than therapeutic communities, and rely less on peer dynamics in their treatment approach. Such services are provided through a longer term set of treatment activities with the expectation of a slower progress toward individual change. Therapeutic Community programs provide psychosocial skill building through a long term, highly structured set of peer oriented treatment activities which define progress toward individual change and rehabilitation. Client progress is marked by advancement toward accepting personal responsibility.

Level III.5: Clinically Managed High Intensity Residential (Short Term Residential, Dual Disorder Residential – III.5 Enhanced)

Services currently available within Level III.5 are Short Term Residential Treatment and Dual Disorder Treatment. The Dual Disorder Treatment is a Dual Diagnosis Enhanced Program. Short Term Residential Treatment provides highly structured 24-hour comprehensive services for substance abusing individuals who require a more restrictive treatment environment to prevent the use of abused substances. Activities of this program must provide a daily structure to prevent access to abused substances must focus on developing knowledge and skills for making lifestyle changes

necessary to achieve a life free from substance abuse. Dual Disorder Treatment is designed to serve persons with co-occurring diagnosis of serious mental illness and substance abuse. The desired outcomes of the Dual Disorder Treatment Program are to stabilize the acute symptoms and to engage the individual to participate in a longer-term program of maintenance, treatment, rehabilitation, and recovery. The individuals served in this program generally present more pervasive with inadequate support systems and have difficulty sustaining involvement with treatment. The dual disorder treatment program provides simultaneous and integrated treatment of co-occurring psychiatric and substance use disorders. This requires a staff composition of dually credentialed staff. Clinical directors must be dually credentialed (LMHP/LADC). Counselors must be dually credentialed LMHP/LADC, however, provisional credentialed in one of the two areas is acceptable.

Level III.7: Medically Monitored Intensive Inpatient Services

This level of care is not included in the SA continuum of services funded by the DBH.

Level II.D: Ambulatory Detoxification

This level of care is not included in the SA continuum of services funded by the DBH.

Level III.2D: Clinically Monitored Residential Detoxification (Social Detox)

Social setting emergency detoxification programs provide intervention in substance abuse emergencies on a 24 hour per day basis to individuals experiencing acute intoxication. Such programs must have the capacity to provide a safe residential setting with staff present for observation and delivery of services designed to physiologically restore the individual from an acute state of intoxication.

Level III.7D: Medically Monitored Inpatient Detoxification

This level of care is not included in the SA continuum of services funded by the DBH.

Opioid Replacement Therapy (ORT) involves the use of methadone or buprenorphine as part of the client's treatment plan for opioid addiction. Therapies offered in ORT programs include: Individualized assessment and treatment, Medication: Assessing, prescribing, administering, reassessing and regulating dose levels appropriate to the individual; Supervising detoxification from opiates, or methadone; overseeing and facilitating access to appropriate treatment, including medication for other physical and mental health disorders, provided as needed; Monitored urine testing; Counseling: A range of cognitive, behavioral and other addiction-focused therapies, reflecting a variety of treatment approaches, provided to the patient on an individual, group or family basis; Case management, including medical monitoring and coordination of on- and off-site treatment services, provided as needed. Case managers also assure the provision of, or referral to, educational and vocational counseling, treatment of psychiatric illness, child care, parenting skills development, primary health care and other adjunct services, as needed; Psycho education, including HIV/AIDS and other health education services.

The DBH has changed the terminology "Opioid Replacement Therapy" to "Medication Assisted Treatment" at the recommendation of the Division's Chief Clinical Officer. The SAPT Block Grant, under the Treatment Episode Data Set (TEDS), uses the term "Opioid Replacement Therapy" (ORT). Under TEDS, ORT "Identifies whether or not the use of methadone or buprenorphine is part of the client's treatment plan for opioid addiction."

Goal #2: Providing Primary Prevention services

An agreement to spend not less than 20 percent of the SAPT Block Grant on a broad array of primary prevention strategies directed **at individuals not identified to be in need of treatment**. Comprehensive primary prevention programs should include activities and services provided in a variety of settings for both the general population, and targeted sub-groups who are at high risk for substance abuse.

Specify the activities proposed for each of the six strategies or by the Institute of Medicine Model of Universal, Selective, or Indicated as defined below: (See 42 U.S.C. §300x-22(a)(1) and 45 C.F.R. §96.124(b)(1)).

Primary Prevention: Six (6) Strategies

- **Information Dissemination** – This strategy provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the source to the audience, with limited contact between the two.
- **Education** – This strategy builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental abilities. There is more interaction between facilitators and participants than in the information strategy.
- **Alternatives** – This strategy provides participation in activities that exclude alcohol and other drugs. The purpose is to meet the needs filled by alcohol and other drugs with healthy activities, and to discourage the use of alcohol and drugs through these activities.
- **Problem Identification and Referral** – This strategy aims at identification of those who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs in order to assess if their behavior can be reversed through education. It should be noted however, that this strategy does not include any activity designed to determine if a person is in need of treatment.
- **Community-based Process** – This strategy provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning.
- **Environmental** – This strategy establishes or changes written and unwritten community standards, codes, and attitudes, thereby influencing alcohol and other drug use by the general population.

Institute of Medicine Classification: Universal, Selective and Indicated:

- o **Universal:** Activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk.
- o **Universal Direct. Row 1** — Interventions directly serve an identifiable group of participants but who have not been identified on the basis of individual risk (e.g., school curriculum, after school program, parenting class). This also could include interventions involving interpersonal and ongoing/repeated contact (e.g., coalitions)

- o **Universal Indirect. Row 2**—Interventions support population-based programs and environmental strategies (e.g., establishing ATOD policies, modifying ATOD advertising practices). This also could include interventions involving programs and policies implemented by coalitions.
- o **Selective:** Activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- o **Indicated:** Activities targeted to individuals in high-risk environments, identified as having minimal but detectable signs or symptoms foreshadowing disorder or having biological markers indicating predisposition for disorder but not yet meeting diagnostic levels. (*Adapted from The Institute of Medicine Model of Prevention*)

• *Note:* In addressing this narrative the State may want to discuss activities or initiatives related to: *Disseminating information to stakeholders; Providing education; Providing training/TA Discussing environmental strategies; Identifying problems and/or making referrals; Providing alternative activities; Developing and/or maintaining sub-state contracts; Developing and/or disseminating promotional materials; Holding community forums/coalitions; Using or maintaining a management information system (MIS); Activities with advisory council, collaboration with State Incentive Grant (SIG) project; Delivering presentations; Data collection and/or analysis; Toll-free help/phone line provision; Procuring prevention services through competitive Request for Proposals (RFPs); Site monitoring visits*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

The Prevention component of your Three Year Plan Should Include the Following:**Problem Assessment (Epidemiological Profile)**

Using an array of appropriate data and information, describe the substance abuse-related problems in your State that you intend to address under Goal 2. Describe the criteria and rationale for establishing primary prevention priorities.

Substance abuse is a growing problem in Nebraska, which places an enormous strain on the healthcare system, the criminal justice system, and the substance abuse treatment system. The Nebraska Substance Abuse Epidemiology Workgroup (NSAEW), formed in March 2007, is a workgroup of administrators, epidemiologists, and key decision makers who collaborate to make decisions regarding the collection and reporting of data related to substance use, consequences of substance abuse, and factors that contribute to substance abuse in the state of Nebraska. One of the main functions of the NSAEW is to identify and prioritize substance abuse data gaps, including missing or incomplete data, availability of data, and utilization of data. In December of 2007, the NSAEW published the *Substance Abuse and Associated Consequences in Nebraska –An Epidemiological Profile*. The following information highlights some of the most recent findings that drive our decision making and focus on underage drinking:

Substance use is common in Nebraska with alcohol being the substance of choice

- In 2005, more than 2 in every 5 Nebraska high school students (42.9%) drank alcohol during the past month, about 1 in every 5 smoked cigarettes (21.8%), and approximately 1 in every 6 used marijuana (17.5%).
- During the combined years of 2007 and 2008, more than half of all persons ages 12 years and older in Nebraska drank alcohol in the past month (55.8%) while one-quarter of all persons binge drank (25.3%). In addition, one-quarter (24.7%) smoked cigarettes and approximately 1 in every 15 used illicit drugs (6.4%). (Source: 2007/2008 National Survey on Drug Use and Health)

Compared to the United States, alcohol use in Nebraska is high while smoking and most drug use is similar

- Nebraska has traditionally had higher level of underage drinking and binge drinking compared to the rest of the nation.
 - Binge drinking among Nebraska adults 18 and older has remained relatively stable over the past 20 years and consistently higher than national estimates, with 17.9 percent of Nebraska residents reporting past month binge drinking in 2009 compared to 15.2 percent of persons nationally. (Source: Behavioral Risk Factor Surveillance System, BRFSS)
 - In 2005, high school students in Nebraska (29.8%) had a higher percentage than high school students nationally (25.5%) for binge drinking. (Source: Youth Risk Behavior Survey)
 - Though the gap has closed considerably over the past couple of years, persons under 21 years of age in Nebraska continue to report a higher percentage for alcohol use than their national counterparts. During the combined years of 2007 and 2008, persons 12 to 20 years of age in Nebraska had a higher percentage, though not significantly higher, than persons 12 to 20 nationally to consume

Goal #2: Intended Use 20% - Primary Prevention / Page 2

- alcohol (28.3% and 27.2%, respectively) and to binge drink (18.6% and 18.0%, respectively). (Source: 2007/2008 National Survey on Drug Use and Health)
- Among persons 12 and older during the combined years of 2007 and 2008, cigarette smoking among Nebraska residents was nearly identical to residents nationally while marijuana and non-marijuana illicit drug use was lower (although the differences were not significantly lower). (Source: 2007/2008 National Survey on Drug Use and Health)

Alcohol impaired driving is particularly high and is common in fatal motor vehicle crashes

- High school students in Nebraska were 1.7 times more likely than students nationally to report driving after drinking in the past month (17.3% and 9.9%, 2005) while adults were 1.6 times more likely than adults nationally to report past month alcohol impaired driving (3.9% and 2.5%, 2008).
- In 2009, more than one-third of all fatal motor vehicle crashes in Nebraska involved alcohol (35.6%), killing 79 individuals in 73 alcohol-involved fatal crashes.

Alcohol is the primary drug of choice in substance abuse treatment admissions

- In 2006, alcohol was listed as the primary drug of choice during 7 in every 10 substance abuse treatment admissions (70.9%) in Nebraska, followed by methamphetamine (12.5%), marijuana (9.1%), and cocaine (4.7%).

Work completed by the NSAEW has and will continue to guide decision making around substance abuse prevention in the state, including decisions made by the Nebraska Partners in Prevention (NePiP), the Governor's Advisory Council for substance abuse prevention. At a meeting on October 31, 2007, NePiP considered the recommendations from the NSAEW. After considerable discussion and recommendation from the NePiP it was decided that Nebraska's SPF SIG should focus exclusively on the three alcohol-related priorities identified by the NSAEW, chosen were:

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

In essence, the findings and priorities described above are being used as a guide for distributing funds for substance abuse prevention initiatives regardless of whether they are funded under the Substance Abuse Prevention and Treatment Block Grant (SAPTBG), the Strategic Prevention Framework-State Incentive Grant (SPF-SIG), or other grant programs.

Prevention System Assessment (Capacity and Infrastructure)

Describe the substance abuse prevention infrastructure in place at the State, sub-State, and local levels. Include in this description current capacity to collect, analyze, report, and use data to inform decision making; the number and nature of multi-sector partnerships at all levels, including broad-based community coalitions. In addition, describe the mechanisms the SSA has in place to support sub-recipients and community coalitions in implementing data-driven and evidence-based preventive interventions. If the State sets benchmarks, performance targets, or quantified objectives, describe the methods used by the State to establish these.

Goal #2: Intended Use 20% - Primary Prevention / Page 3

The Division of Behavioral Health's Prevention System uses a multi pronged approach. The System includes community level prevention coordination as well as state activities to support coalitions, communities, stakeholders and partners in a variety of ways. The State of Nebraska's Department of Health and Human Service (DHHS), Division of Behavioral Health (hereafter referred to as the Division) supports the Nebraska Behavioral Health Prevention System through interagency coordination, as well as funding prevention activities, directly and through a Regional Prevention Coordination System. The funding of prevention includes contracts for technical assistance, training, and database development to support the various regions, coalitions and community entities. [Interagency coordination activities include: Children's Behavioral Health planning and implementation for the state of which substance abuse prevention is a foundation, SYNAR committee, partnering with Tobacco Free Nebraska, improving workforce development opportunities for preventionists, participating with the Nebraska Substance Abuse Epidemiological Workgroup, collaborating with the DHHS Division of Public Health SPF-SIG program, and understanding the overall direction of the Drug Free Communities grantees that are funded]. The Division also sponsors the NebraskaPrevention@yahoogroups.com list serve, which functions as a discussion board for community coalitions and Prevention Specialists, as well as the online resource NebraskaPrevention.gov web site (www.nebraskaprevention.gov).

2.1 -- The Division of Behavioral Health will contract with the Regional Behavioral Health Authorities for Prevention System Coordination, training and technical assistance via a Regional Prevention Coordinator in each of the six regions.

Funding for each of the Regional Behavioral Health Authorities (Regions) Substance Abuse Prevention System comes primarily from the Division. Each of the six (6) Regions maintains staff purposed to the coordination and oversight of the regional/local prevention community in support of the statewide system. Regional prevention systems are defined as purposeful, effective, and sustained partnerships of agencies, organizations, and individuals committed to preventing substance abuse, addictive disorders, and related societal problems through the life span. They operate at the community level embracing community culture while leading the development of strong, sustainable, community-based prevention activities focused on producing pro-social changes. Prevention system activities prevent the onset and reduce the progression of substance abuse, reduce the related problems, and build prevention capacity and infrastructure at the State/Tribal and community level. Regions, community coalitions, prevention providers, schools, law enforcement and other key stakeholders help make up this system. The Regional Prevention Coordination System is funded by the Division of Behavioral Health and is specifically designed to support the statewide prevention system in partnership with coexisting prevention efforts such as SPF-SIG, which is managed by the Division of Public Health (DPH).

In addition to this role, the Regions utilize Division of Behavioral Health (DBH) funding to purchase prevention activities to expand the delivery of prevention strategies and support local community efforts which are described later under Regional Focus Plans. Each of the six Behavioral Health Regions has a designated Regional Prevention Coordinator (RPC) that is the contact for prevention system information. Under the direction of the DBH the RPC is responsible for the coordination of activities in support

Goal #2: Intended Use 20% - Primary Prevention / Page 4

of a unified prevention system across Nebraska. Consistent and frequent communication occurs among all Regions and with the Divisions of Behavioral Health and the Division of Public Health, (SPF-SIG). This direct relationship encourages systemic growth, professional support, increases outcome focused initiatives and utilizes data driven decisions for comprehensive state and regional planning.

The RPC is knowledgeable about prevention strategies that occur among existing and newly developing community coalitions and works to bridge together the diverse substance abuse prevention funding streams from (but not limited to) federal block grant, SPF-SIG, and Drug Free Communities. The coordination of these multiple efforts is imperative for the success at a community, regional and statewide level. The RPC utilizes the community partnerships to establish common directives, geographic and target population strategic planning and to better utilize training and technical assistance initiatives. Training opportunities are developed and implemented to all substance abuse prevention coalitions that focus around specific state, regional, and community developed priorities. Training also is provided for the professional development of prevention providers including formal staff, volunteers and community partners.

Technical assistance to substance abuse prevention coalitions and other providers in implementing data-driven evidence-based policies, programs, and practices is primarily provided by the RPC. Assistance is available on the Strategic Prevention Framework planning process. This portion of the RPC responsibilities is critical to the development of community based prevention coalitions. Although there is tremendous support provided directly to the SPF-SIG funded coalitions via the Division of Public Health, local relationships and assistance via the RPC has proven to be an invaluable asset. Partnership with the Regional Prevention Coordinators remains essential as they are instrumental in providing training and technical assistance to community coalitions. Most often they have the best understanding of their communities' local issues and problems because they live near them and regularly work with them. The collaboration of these efforts has greatly strengthened the progress of local coalitions and provided consistent, reliable and sustainable system management.

While all Regions are expected to provide the Division with their annual focus plan and individual goals, one specific and statewide system goal continues to be carried forward, this goal is determined in collaboration with the Regions. Our Statewide Prevention System goal aims to coordinate a unified prevention system with diverse funding streams that produce outcomes in reducing substance abuse and related problems. The primary objective is to increase the capacity (development) level of SAPTBG funded community coalitions. Other statewide objectives are addressed throughout this document.

Prevention System Capacity Development

Describe planned changes to enhance the SSA's ability to develop, implement, and support—at all levels—processes for performance management to include: assessment, mobilization, and partnership development; implementation of evidence-based strategies; and evaluation. Describe the challenges associated with these changes, and the key resources the State will use to address these challenges. Provide an overview of key contextual and cultural conditions that impact the State's prevention capacity and functioning.

Goal #2: Intended Use 20% - Primary Prevention / Page 5

Although Nebraska has made considerable progress in developing substance abuse prevention capacity and infrastructure, some areas must be strengthened. Common challenges experienced when cultivating coalition membership and collaborative relationships include: inadequate coalition representation from all sectors; the amount of phone and travel time required to maintain contact and connections with other community agencies in the target area. The need for creativity and flexibility with days/times of meeting; and the struggles in determining the best arrangement for setting up the tables in the meeting room so as to encourage productivity and participation.

Nebraska is also working towards improving the coordination of substance abuse prevention funding, planning, and strategy implementation at the state level. In the past, the lack of coordination could be attributed to “silo” funding streams and different prevention approaches among state agencies. However, Nebraska has begun to breakdown this barrier by (1) using the SPF-SIG five-step model to set state priorities across the diverse array of agencies funding substance abuse prevention activities, (2) distributing funds to communities based on the NSAEW’s epidemiological profile, (3) using a common evaluation approach regardless of the funding source, (4) increasing our use of the Tele-Health network (5) collaborating on the development of training curriculums, and (6) exploring possibilities for a Prevention Specialist credentialing program.

In a coordinated approach, the Division of Public Health and the Division of Behavioral Health are working toward training all communities receiving substance abuse prevention funding to apply the SPF process, whether funded by the block grant (which are funneled through the Regions) or the SPF-SIG. The Divisions of Behavioral Health and Public Health in cooperation with Regional Prevention Coordinators, continue to fund training events throughout the state to introduce, enhance and improve the use of evidence-based, promising and local prevention strategies in particular to support their local community goals. These local goals can include the reduction of underage drinking, reduction of driving under the influence and reduction of binge drinking. Ultimately, by requiring all communities to use the SPF model, and by providing effective statewide training and technical assistance in the use of the model, greater progress is being achieved in reducing substance abuse and related health consequences across the state. Our efforts towards statewide training are described in further detail below.

In addition, for communities within Nebraska, the State SPF SIG Program, Division of Behavioral Health, and Regional Prevention Coordinators from the six Behavioral Health Regions collaborated to prepare a community assessment toolkit. This toolkit allows communities to conduct a thorough assessment of substance abuse in their communities through examining the structure and functioning of their community, assessing their coalition capacity, measuring community readiness, conducting a detailed needs assessment, and examining the programs, policies, and practices available within their community. This document remains available for all communities within Nebraska.

2.2 -- The Division of Behavioral Health, Division of Public Health and Regional Prevention System Coordination will provide opportunities for training and technical assistance to local community coalitions and prevention professionals to strengthen their capacity to deliver effective prevention programs, policies, and practices.

Goal #2: Intended Use 20% - Primary Prevention / Page 6

Based on the experience under State Incentive Cooperative Agreement (SICA), it's been our experience that community coalitions benefit enormously from hands-on, face-to-face training and technical assistance that takes them through every step of the prevention planning process. Nebraska has taken significant steps towards growing our field of preventionists through the revision and development of an entry-level substance abuse prevention curriculum. In May 2007, staff from the Divisions of Behavioral Health and Public Health and the Regional Prevention Coordinators began meeting to determine the skills and competencies that are needed to educate communities in assessment, capacity building, planning, implementation, evaluation, cultural competency, and sustainability. A consultant (previously employed as the Southwest Center for the Application of Prevention Technologies - Nebraska Liaison from May 2002 to May 2006, and who developed training materials for the SICA sub recipients) was hired to facilitate the meetings and begin working with the group to develop the tools and materials that are needed.

The Nebraska Substance Abuse Prevention Training (NETSAP) is organized into nine modules that may be facilitated in singular events, may build upon each other, or may be offered in "101" and "201" versions to accommodate the growing needs of prevention specialist professionals and local volunteer based prevention coalition members. The content has been finalized, an initial training of trainers occurred in August 2010 and we are now in the planning stages of an annual statewide training. Regions have begun to schedule trainings for local coalitions and field staff. The provision of this training is intended to build upon the knowledge, skills, and abilities of Nebraska's Prevention workforce to reach all segments of the population, hopefully influencing our ultimate goal of reducing substance abuse in our state.

2.3 -- In support of Workforce Development, the Division of Behavioral Health will research the credentialing processes for Prevention Specialists and identify a potential program for Nebraska.

In 2003, the NePiP formed a workgroup – the Workforce Development Leadership Team (WFDLT) and charged it with developing a strategic plan for Substance Abuse Prevention Workforce development. In the spring of 2005, WFDLT drafted and implemented a statewide, comprehensive on-line assessment survey of the prevention workforce, to which roughly 320 individuals responded. Over a period of several months, the WFDLT conducted a detailed analysis of the on-line survey results across five sectors: (1) community, (2) behavioral health, (3) public health, (4) education, and (5) law enforcement/public safety. The WFDLT also analyzed the answers of urban versus rural respondents.

Based on the survey results, the WFDLT has developed a prevention workforce vision, mission, and goals designed to inspire strategic planning processes across state agencies that will invigorate the prevention workforce and mobilize public support for prevention. In addition, the WFDLT identified 22 areas that are top priorities for improving the knowledge, skills, and abilities of Nebraska's prevention workforce. These top priorities fall into four over-arching categories that were developed into goal statements. In addition, the WFDLT has brainstormed several possible strategies that could be implemented in order to achieve desired goals.

Goal #2: Intended Use 20% - Primary Prevention / Page 7

Taking into consideration these findings and recommendations from the WFDLT, the Division is currently exploring all of our options for creating progress for prevention. Having a Prevention Specialist Credentialing Program would acknowledge and further establish the field of Prevention as a key component of the Continuum of Care for Behavioral Health. Therefore, we have begun to review 29 other states that have implemented Prevention Specialist Credentialing and examine the feasibility of implementing this type of program in 2013.

Implementation of a Data-Driven Prevention System

Describe the mechanism by which funding decisions are made and funds will be allocated. Explain how these mechanisms link funds to intended State outcomes. Provide an overview of any strategic prevention plans that exist at the State level, or which will be required at the sub-State or sub-recipient level, including goals, objectives, and/or outcomes. Indicate whether subrecipients will be required to use evidence based programs and strategies. Describe the data collection and reporting requirements the State will use to monitor sub-recipient activities.

RPCs collect and report on all substance abuse prevention activities among community coalitions and other prevention providers/programs, particularly those that are funded in whole or part by the federal substance abuse block grant. Our primary mechanism to support implementation of data-driven and evidence-based preventive interventions is utilization of one web-based centralized data collection and reporting system. This reporting system, the Nebraska Prevention Information Reporting System (NPIRS), is utilized for both block grant and SPF-SIG funded grantees and allows communities and Regions to report on their goals and objectives, evidence-based strategies, National Outcome Measures (NOMs), and other data that are needed to evaluate the effectiveness of substance abuse prevention strategies. The Nebraska Substance Abuse Epidemiology Workgroup (NSAEW) also has an active health disparities sub-committee that focuses on improvement of the collection and reporting of health disparities data, including racial and ethnic minority, urban/rural, and socio-economic status data.

Additionally, the Division of Public Health has been collaborating with the Nebraska Department of Education to conduct school survey advisory committee meetings and finalize plans for the Student Health and Risk Prevention (SHARP) Survey. SHARP consists of three public health school-based student health surveys in Nebraska including the Nebraska Risk and Protective factor Student Survey (NRPFSS), the Youth Risk Behavior Survey (YRBS), and the Youth Tobacco Survey (YTS). This year a series of workshops were delivered in each of the six Behavioral Health Regions to educate and garner further support for SHARP administration in [urban and other] school-based settings. Preparation of the second edition of the SPF SIG Community Data Documents (CDDs) is complete. The information can be used by communities for on-going planning and evaluation of outcomes. In support of assessment of the magnitude of substance abuse related problems, the Young Adult Alcohol Opinion Survey (also referred to as the binge-drinking survey) has been administered across the state to measure attitudes and behaviors of 19-25 year olds.

2.4 -- The Division of Behavioral Health and the Division of Public Health will work to improve the Nebraska Prevention Information Reporting System (for SAPTBG and SPF-

Goal #2: Intended Use 20% - Primary Prevention / Page 8

SIG funding recipients) and prepare it for use as a statewide prevention reporting system available for use by other funded prevention agencies/coalitions.

The NSAEW's work on our state's epidemiological profile has helped identify some of the most serious data gaps and develop strategies to alleviate them. Therefore, the development of an interactive substance abuse data web site for the State of Nebraska that serving as a substance abuse data repository became a priority and ongoing project for our Prevention system. This resulted in the development of current NPIRS system in 2008, an internet based prevention reporting system, based on the concept of communities, regions and the state all requiring similar information for prevention data collection and reporting. Community coalitions are able to review progress in the development of planning and implementation activities. Regions can also review all of their communities together or separately in their region and the state has the ability to review regional and statewide activities.

Negotiation with a new vendor, Orion Healthcare Technology, took place throughout the spring, and this contract took effect July of 2010 to assume the help desk function, day-to-day site maintenance, and hosting of the NPIRS on their server. In addition, as the Division of Public Health progresses into the Implementation Phase of the SPF-SIG, they are working collaboratively with their contracted evaluative technical assistance provider, the Research Triangle Institute, to determine appropriate data elements, reporting requirements and best collection mechanisms. The two Divisions are collectively reviewing the current NPIRS system and reassessing the framework, utilization ease and potential use to better serve the community as well as the meet the state and federal requirements. Throughout the course of the FY2011, Orion will be assisting the Division of Behavioral Health explore and analyze our projected needs for this system to be fully functional for statewide use. It is anticipated that enhancements and recommendations made by Orion will help us improve availability of data for community planning and ability for informed decision making that ultimately leads us closer to a more unified and integrated approach the prevention of substance abuse problems.

2.5 -- In effort to provide statewide coordinated Prevention Leadership, the Division of Behavioral Health will collaborate with Regional and State prevention staff to develop an updated statewide strategic prevention plan.

SAPTBG prevention priorities in Nebraska are often blended with those of other funding streams, such as the SPF-SIG, to maximize limited resources. Resources are then prioritized utilizing both local assessment and information gathered by the State. At the Regional level, community coalitions are charged with assessing local needs and presenting a plan to the region to address identified gaps. The most recent strategic plan for substance abuse prevention was completed by the Nebraska Department of Health and Human Services in March of 2008 as a requirement of the SPF-SIG. As we begin to phase out of the SPF-SIG, another round of strategic planning for prevention is being considered. Currently, DBH is engaged in its own strategic planning process addressing mental health, substance abuse/addictions and gambling addictions. Building upon this strategic plan and in partnership with the Division of Public Health, DBH is working to enhance prevention coordination and statewide leadership utilizing a planning process similar to the SPF.

Goal #2: Intended Use 20% - Primary Prevention / Page 9

Future efforts are anticipated to take on a broader focus of prevention in effort to increase public awareness of the relationships between substance and mental health and prevention of suicide, the need for more early intervention programs, prescription drug abuse, bullying, and ATOD for all ages. The Center for the Application of Prevention Technologies (CAPT) - Southwest Region Expert Team (SWRET) will be consulted and providing technical assistance in this strategic planning process led by the Division. The first opportunity for this consultation is scheduled during the SWRET's second site visit September 23-24, 2010.

With the recent passage of the Patient Protection and Affordable Care, we must also explore what new resources, capabilities and partnerships are possible. On May 6, 2010 the Division of Behavioral Health held the first Joint Meeting of the State Advisory Committee on Mental Health Services and the State Advisory Committee on Substance Abuse Services. Representatives from the State Committee on Problem Gambling also attended. This meeting helped to further document the unmet needs of people who have a co-occurring mental health and substance abuse problem. Additionally, work with Tobacco Free Nebraska (TFN) and other State Prevention System partners continues in effort to develop additional strategies that promote regional and local participation in SYNAR compliance, including environmental and merchant education strategies.

Evaluation of Primary Prevention Outcomes

Discuss the surveillance, monitoring, and evaluation activities the State will use to assess progress toward achieving its capacity development and substance abuse prevention performance targets. Describe the way in which evaluation results will be used to inform decision making processes and to modify implementation plans, including allocation decisions and performance targets.

The Department of Health and Human Services (DHHS) has implemented several measures to enhance the state, regional and local level capacity to engage in effective evaluation of substance abuse prevention initiatives.

In conjunction with local evaluators, as a statewide evaluator, the Research Triangle Institute (RTI) conducts the monitoring and evaluation of coalition activities using a variety of information sources. These sources include collecting information from the state advisory committees, local coalition members, state and national survey data, key informant interviews, and site visits. The evaluation will include both process and outcome measures.

2.6 -- In support of increasing capacity level and evaluating progress, each SPF-SIG and SAPTBG funded community coalition, in cooperation with the Regional Prevention Coordinator, will conduct a self assessment using the online Coalition Capacity Survey.

As we have begun the implementation of the SPF-SIG, RTI is working more closely with local evaluators to ensure both a standardization of evaluation processes and greater synergy between local evaluation efforts and the statewide evaluation. Coalitions have also participated in key informant interviews/site visits conducted by the RTI. By the end of the SPF-SIG program, the desired goal is to have developed a team of local evaluators that have expertise in evaluating the outcomes of evidence-based substance abuse prevention strategies and policies implemented by community coalitions, and whose experience can be leveraged by both SPF-SIG and other coalitions working on substance

Goal #2: Intended Use 20% - Primary Prevention / Page 10

abuse prevention throughout the state. This team will be responsible for providing training and technical assistance to the regions and coalitions in order to build their capacity around evaluation, with the ultimate intention of ensuring that all communities are capable of engaging in effective evaluation of substance abuse prevention initiatives.

Monitoring the implementation of community-level strategic plans and activities involves a standard quarterly progress reporting form which is utilized by coalitions. The progress report template asks them to report relevant to each step of the SPF model, and to provide information in appropriate detail as they begin applying their work plans. The quarterly reporting design and methods are intended to avoid duplication with other reporting requirements and to facilitate the local evaluation of community strategic plans. Not only will this reporting system aid in the evaluation of individual coalitions, it allows state staff and researchers an opportunity to plan for future projects by allowing them to identify areas of the state that are receiving funding and/or lacking funding, areas that have been particularly successful or unsuccessful, and the types of strategies that are being implemented in different regions of the state.

In collaboration with the Statewide Audit Workgroup and Regional Prevention Coordinators, the Division of Behavioral Health is near completion of a standardized audit form that will be used to monitor and assess the Region's prevention providers/coalition's performance activities outlined in the coalitions work plan on at least an annual basis. In addition, the Division has implemented the requirement of assessing the performance of the prevention provider/coalitions fiscal agent through annual expense verification process.

2.7 -- The Division of Behavioral Health will research Fee for Service (FFS) Prevention Systems and make recommendations for Nebraska's Prevention System.

Nebraska's prevention reporting system is not conducive for reporting cost data associated with substance abuse prevention activities. Due to this restriction, the Division has been limited in our ability to examine the cost effectiveness of prevention programs funded through our Division. To address this gap, the Division has begun to review information from various states utilizing standardized rate systems for reimbursement of prevention services and a rate methodology study is targeted for FY2012. As part of this, the Division will examine the feasibility of implementing a standardized rate system for prevention in FY2013.

FY2011-2013 (Intended Use)

GOAL # 2. Providing Primary Prevention services: An agreement to spend not less than 20 percent of the SAPT Block Grant on a broad array of primary prevention strategies directed at individuals not identified to be in need of treatment. Comprehensive primary prevention programs should include activities and services provided in a variety of settings for both the general population, and targeted sub-groups who are at high risk for substance abuse.

Specify the activities proposed for each of the six strategies or by the Institute of Medicine Model of Universal, Selective, or Indicated as defined below: (See 42 U.S.C. §300x-22(a)(1) and 45 C.F.R. §96.124(b)(1)).

- 1.) How will the activities/services be operationalized – this may be through direct procurement, subcontractors or grantees, or intra-governmental agreements?

The following language is instructed in the FY2011 Division to Region contract to specifically address the expectations of the RPC:

Attachment D**Prevention System Coordination, Planning and Service Requirements****I. REGIONAL ADMINISTRATION OF PREVENTION SERVICE SYSTEM**

Contractor shall be responsible for Regional Prevention System Coordination in order to ensure a continuum of substance abuse prevention services.

- A.** Regional Prevention System Coordinator is defined as the administrative responsibility to ensure effective use of prevention funds through regional needs assessment, policy development, coordination, maintenance and monitoring of a Regional Prevention System. This includes the coordination of local coalitions and other community activities to ensure that prevention services are available, accessible and duplication of efforts are minimized. Regional Coordinators will work cooperatively with the Division of Public Health.
- B.** The Regional Prevention System Coordinator shall be designated by the contractor. Travel to attend and participate in system meetings as scheduled by the team to be held throughout the state shall be budgeted. Travel within the contractor's jurisdiction shall be budgeted to support development, coordination, maintenance and monitoring of Community Coalitions and other Prevention activities.
- C.** Contractor will develop and maintain a comprehensive plan of prevention services which utilizes Strategic Prevention Framework strategies to prevent the abuse of substances.
- D.** Contractor will ensure that all prevention efforts including specific strategies implemented are documented. Contractor will ensure that all Prevention Capacity Data is collected and recorded as directed by DHHS.

Goal #2: Intended Use 20% - Primary Prevention / Page 12

- E. Contractor will ensure that SAPTBG funded prevention coalitions and their workforce are offered training specific to Federal Confidentiality and Charitable Choice (42CFR part 2 and 54) including the penalties for noncompliance.

II. COMMUNITY COALITIONS

Contractor shall subcontract with Community Coalitions to implement the Region's prevention plan. Community Coalitions may subcontract with providers in order to ensure service delivery.

- A. The Contractor must ensure that not less than 50 percent of the SAPTBG funds designated for prevention services are made available to Community Coalitions through a regionally developed grant process. Such funds shall support the communities' implementation of identified prevention strategies through evidence, scientific or promising program based activities identified by the Community Coalitions through the use of the Strategic Prevention Framework planning process.
- B. A Community Coalition is defined as a community-based organization of individuals representing diverse organizations, factions or constituencies who agree to work together in order to achieve a common goal. The coalition's work includes identification of prevention services and/or strategies designed to specifically reduce or delay the onset of substance abuse.
- C. Regional Prevention Coordinators shall provide for training, technical assistance and resource development activities in support of the Community Coalitions and the network of prevention providers. Regional Prevention Coordinators may act as fiscal agents to Community Coalitions at the request of the Community Coalition. The Regional Prevention Coordinator shall ensure that Community Coalitions have knowledge of and continually work towards completing the five step Strategic Prevention Framework planning process. This plan must be documented and made available at the request of the Department.
- D. The contractor will ensure that all prevention activities funded by this Contract fall within the Institute of Medicine Prevention Classification categories:
 1. Universal Prevention - activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk.
 2. Selective Prevention - activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
 3. Indicated Prevention - activities targeted to individuals in high-risk environments, identified as having minimal but detectable signs or symptoms foreshadowing disorder or having biological markers indicating predisposition for disorder but not yet meeting diagnostic levels.
- E. The Contractor will ensure that the 6 Primary Prevention strategies designated below are used to implement prevention activities. At least 50% of the funding received by Community Coalitions must be used to fund Community Based (Strategy #5) and Environmental (Strategy #6).

Goal #2: Intended Use 20% - Primary Prevention / Page 13

As mentioned in the Division's three year plan for prevention goals and activities, several contract deliverables are new the State to Region contract this year:

Attachment H
Deliverables to the Contract
Prevention System

Deliverable #1:

- Region will perform a Prevention Readiness/Capacity Assessment on all SAPTBG funded coalitions using the SPF-SIG tool.
 - Region will submit assessment, including a summary report of baseline for each coalition and Region total to Division
 - § Timeframe: Annually, due January 15, 2011
- Division Prevention Coordinator will review Region reports internally and present for discussion at Regional Prevention Coordination meeting
 - Division Prevention Coordinator will capture discussion in meeting minutes
 - § Timeframe: Meeting minutes distributed to Regional Coordinators within 30 days of the meeting
 - Division Prevention Coordinator will compile Regional information to develop a statewide baseline reflecting assessment results and send to Regions.
 - § Timeframe: June 30, 2011

Deliverable #2:

- Region will coordinate Prevention System efforts within the Regional catchment area.
 - Region will submit a report outlining the course of action for the Region's prevention system. The report will reflect training and technical assistance, system coordination, and description of funded service array.
 - § Timeframe: Due with FY12 Regional Budget Plan as specified by the Division
 - Division Prevention Coordinator will confirm receipt of plan
 - § Timeframe: Within two weeks of receipt
 - Division Prevention Coordinator will provide technical assistance to Regions reflecting state needs in the development of their prevention system
 - § Timeframe: As requested

Deliverable #3:

- Region will serve as a resource to the Division for the Regional and State Prevention System.
 - Region will maintain and submit a spreadsheet of all Regionally funded Prevention providers and coalitions and additional partnering prevention serving groups within the Region
 - § Timeframe: Biennially, in even-numbered calendar years, due August 15th, 2011 for FY11 and FY12.
 - Division Prevention Coordinator will develop a statewide rollup to share with Regions and providers
 - § Timeframe: November 1, 2011

Deliverable #4:

- Region will ensure participation in the Nebraska Prevention Information Reporting System by all SAPTBG funded prevention providers.
 - Regions will submit coalition/provider meeting minutes reflecting discussion and compliance expectations for data entry.
 - § Timeframe: meetings minutes due to the Division

Goal #2: Intended Use 20% - Primary Prevention / Page 14

- Division Prevention Coordinator will monitor utilization of NPIRS data system and provide quarterly feedback to Regions, reflected in Prevention System meeting minutes
 - § Timeframe: Meeting minutes due to Regions 30 days following meeting

As part of the annual budget proposal process, Regions were given the requirement of submitting a focus plan for FY2011, describing how their Prevention System will address the reduction of substance abuse through the provision of effective primary prevention services, strategies and activities that support the NOMs. This was to address any training and technical assistance planned for local community coalitions, local prevention providers and partners. Also to be included was a description of the Region's prevention service array funded by the SAPTBG and Strategic Prevention Framework-State Infrastructure Grant. Please note for reference the submitted focus plans by each Region for FY11 are included below and address each of the following questions:

- 2.) What activities/services will be provided, expanded, or enhanced – this may include activities/services by treatment modality or prevention strategy?
- 3.) When will the activities/services be implemented (date) – for ongoing activities/services, include information on the progress toward meeting the goals including dates on which integral activities/services began or will begin?
- 4.) Where in the state (geographic area) will the activities/services be undertaken – this may include counties, districts, regions, or cities?

Region 1 Prevention Focus Plan FY11

Assess/Plan

The Region 1 Prevention System is an integrated collaborative of partners including local (county) coalitions, a Panhandle wide regional coalition, and other agencies and organizations working together to positively impact substance abuse and its related consequences in the 11 counties of the Panhandle. Systemic funding originates from various public and private sources including but not limited to the SAPTBG, Drug Free Communities (DFC), the SPF-SIG, Juvenile Justice, and County Aid. Operating under a comprehensive strategic plan and braiding resources has dramatically increased coalitions' capacity to affect change.

SAPTBG funding is utilized for training, technical assistance, regional coordination and to directly support the strategies and programs of nine local level community coalitions:

- Banner County Prevention Coalition
- Box Butte County Family Focus Coalition
- Kids Plus, Inc (Cheyenne County)
- Dawes/Sioux Family Preservation Team
- Deuel County Prevention Team
- Garden County Coalition
- Morrill County Prevention Coalition
- Scotts Bluff County Prevention Coalition
- Human Needs Network of Sheridan County

Together with the Panhandle-wide, regional coalition, they comprise the Panhandle Prevention Coalition (PPC). The regional coalition meets every other month with broad

Goal #2: Intended Use 20% - Primary Prevention / Page 15

participation from local community coalitions, and Panhandle agencies, organizations and individuals. Most local coalitions meet monthly and have good participation and support from the 12 community sectors. Among the local coalitions, development and mobilization varies based on community readiness, investment and inclusivity among stakeholders. Through regional prevention system coordination, we strive to increase the capacity of all local and regional coalitions.

Capacity

Collaborative planning efforts ensure a comprehensive array of substance abuse prevention services within the Region. Technical assistance and consultation is provided to build coalition infrastructure, diversity and sustainability using the Strategic Prevention Framework (SPF) model to equip coalitions successfully develop comprehensive strategic plans and implement evidence-based prevention strategies. The SFP model has become fully integrated into our substance abuse prevention work and is now being used for child abuse prevention, juvenile justice and suicide prevention.

Over the past couple of years, the Region and coalitions have been undergoing a paradigm shift. In the past, the Region's contracted prevention provider was relied upon for decision making and, informally, coalition leadership. Much of the work recently has been to shift our role away from decision making and coalition leadership and toward technical assistance and training. For example, rather than drafting strategic plans, we are facilitating the development of strategic plans by coalition membership. At times, it has been a difficult shift and we continue to define the lines between providing leadership in the prevention field and being leadership at the coalition table. Despite the difficulty, coalitions are relying much more on us more for guidance and less for daily operations.

In large part due to our frontier demographics, the Region is the fiscal agent for the PPC's SPF SIG and holds the coordination contract for the DFC. In an effort to decrease confusion, one Region staff person is primarily assigned to the SPF-SIG and DFC and is paid for almost entirely by grant funding.

Evaluation

Region 1 conducts an annual review of all SAPTBG funded coalitions. The review follows the SPF model and is invaluable in assessing the infrastructure and progress of the coalition. The Region collects quarterly reports, receives updates via attendance at coalition meetings, and provides follow-up after technical assistance is provided.

In addition, the Region engages in biennial analysis of the Nebraska Risk and Protective Factor Student Survey data. Regular review of the data takes place at local and regional meetings and data is an integral part of much of our training and technical assistance.

Training

Training continues to be addressed on both an as needed (short term) basis and through long term strategically planned trainings. As needed training and technical assistance is often difficult to anticipate, but can be mitigated by closely monitoring coalition activities. The Region continues to diligently work at recognizing need and implementing larger scale regional trainings to address the needs of the prevention system. Long term planning for FY11 training includes:

Goal #2: Intended Use 20% - Primary Prevention / Page 16

- Training Events
 - Northwest Alcohol Conference
 - National Prevention Network
 - CADCA Coalition Institute
 - CADCA Leadership Forum
 - CADCA Midyear
 - CADCA Coalition Specific Training
- Specific Trainings/Trainers
 - John Underwood, American Athletic Institute
 - Communities Mobilizing for Change on Alcohol (CMCA)
 - 40 Developmental Assets
 - NETSAP
- Training Topics
 - Cultural Competency
 - Youth Leadership
 - Sustainability

Region 1 Prevention activities in FY2011 include, but are not limited to:

Information Dissemination (5%) – Red Ribbon Week, county fairs and health fairs, community festivals, parent teacher conferences.

Alternate Activities (4%) – Drug-free youth events held simultaneous to community events, family camp-out, youth camps, pre-teen and teen dances, post prom parties.

Education – Parent/Family night at school, guest speakers, coalition training, presentations to schools and community groups, SHARP (Student Health and Risk Prevention) survey presentations to principals and superintendents, drug and alcohol presentation by the Nebraska State Patrol.

Problem ID and referral – Assisting with the SHARP survey, American College Health Survey (ACHS) and Community Health Assessments.

Environmental – Communities Mobilizing for Change on Alcohol, responsible beverage server training, responsible alcohol merchant award, random student drug testing, "Community Hero" media campaign, and local law enforcement assist Nebraska State Patrol with compliance checks and sobriety checks.

Community Based – All-Stars, TeamMates, Hemingford Youth Center, Too Good for Drugs, Circle of Courage, and 40 Developmental Assets training.

Region 2 Prevention Focus Plan FY11

Asses/Plan

The substance abuse prevention program, Region II Prevention Services, in Region 2, (referred to Region II Human Services) was created to meet the prevention needs of the 17 county area served by the Region. At its core this program works with communities, community organizations, schools, and parents to develop and provide evidence based

Goal #2: Intended Use 20% - Primary Prevention / Page 17

programs and norm changing practices. The needs of the communities are data-driven and are identified through statistics and from student health and risk prevention survey results. This work is built to delay the onset of first use, to reduce the progression of substance abuse including underage drinking, to reduce substance related problems in communities and to build coalition capacity to continue addressing these problems.

Prevention Specialists are employees of Region II Human Services. They are supervised by the Regional Administration. Coordination of the prevention program is the responsibility of the lead prevention coordinator appointed by Regional Administration. Regional prevention meetings are held at least bi-monthly and include the lead prevention specialist, all prevention specialists and the Regional administrator.

Region II participates in and assists numerous community coalitions throughout its 17 counties. Prevention staff from Lexington, North Platte, and Ogallala are active on a monthly basis with Community Connections, Citizen's Drug & Alcohol Forum, Coalition For Children, Substance Abuse Leadership Council, Lincoln County Tobacco Coalition, Region II Prevention Coalition, Central Nebraska Coalition Against Substance Abuse, and Ogallala Youth Committee. All of the coalitions receive an invitation from Region II for technical assistance or support with any needs they might have. Each coalition has a prevention specialist assigned to them to ensure consistency region wide.

Region II Prevention Services is funded through the Substance Abuse Prevention & Treatment Block Grant (SAPTBG). Additional funding for community Coalitions in the Region II area include the Strategic Prevention Framework-State Incentive Grant (SPF-SIG), Tobacco Free Nebraska (TFN), Nebraska Department of Highways Safety Grant, City of Ogallala, Community Foundation Grants, Drug Free Communities, and the Crime Commission.

Capacity

The FY11 prevention system plan for Region II is to continue to strengthen existing coalitions and to promote and empower coalition building in new communities. Prevention staff will evaluate the different levels of readiness with each coalition. Coalitions will participate in strategic planning and complete training at the state level. Coalitions will be provided training opportunities to address capacity building in their communities. Coalitions will receive mailings that provide resources for sustaining the activities in place.

A Region II Prevention Coalition is being developed. Through out the course of the year it will assess the environmental and community based needs of the region. Region II Prevention Coalition will develop strategies to meet the identified needs.

Region II will maintain information on all Coalitions throughout its 17 counties. Region II will keep record of and maintain a data base on all Coalition activities funded by the Substance Abuse Grant, State Incentive Grant, and Region II; activities will be recorded on the state NPIRS system. Region II Prevention program is committed to using evidence based prevention programs. Prevention programs fall under one of four categories: Universal Direct, Universal Indirect, Selected, and Indicated. These categories are accomplished by using one or more of six strategies. Each of the six

Goal #2: Intended Use 20% - Primary Prevention / Page 18

strategies Information Dissemination, Education, Alternative Activities, Problem Identification and Referral, Building Community Based Process, and Environmental Development are developed each year with goals, objectives and timelines. 50% of the funding received by Community Coalitions will be used to fund Community Based and Environmental strategies. The Region will ensure that all prevention activities fall within the Institute of Medicine Prevention Classification categories.

Training

Prevention staff will attend state trainings, regional meetings, and other trainings. Resources and information will be shared with community coalitions. Region II prevention professionals will meet as a regional group to create additional support and information for local coalitions. Volunteers from coalitions will attend state trainings at the expense of the Region if need be.

Coalition building and strengthening is a training area which will be addressed in the first half of FY11. CADCA, Community Anti-Drug Coalitions of America, training will be offered in Region II to address these needs of coalitions. Providing the training in the region will increase attendance and promote the “grass roots” effort. Creative training opportunities will be researched and made available to coalitions in the region.

Evaluation

As a result of regional participation in coordination of State Prevention Systems and State-Sponsored prevention activities and trainings, working with community coalitions to understand and implement grant priorities, and participating in ongoing communication with prevention coordinators throughout the state:

1. Prevention staff will be trained and will have the opportunity to attend state training. Staff will share information region wide
2. Prevention staff will meet bi-monthly.
3. Coalitions will know the grant priorities and how to access funds to help promote the National Outcome Measures (NOMs). Data collected will be used to evaluate and determine strategies.

As a result of Region II coordinating Regional Community Coalitions, facilitating community coalition development, and maintaining information on all coalitions throughout Region II:

1. Coalitions will participate in strategic planning.
2. Coalitions will have the opportunity to complete training at the state level.
3. Coalitions will have the opportunity to attend quarterly training.
4. Region II will be informed on all coalitions in the area.
5. Region II will be aware of all activities funded throughout the area.
6. Ongoing sustainability training will be available to coalitions.
7. Grants will be used by coalitions to fund evidence based programs supported by readiness/capacity assessments.

Programs offered by Region II administer a pre and a post survey. These surveys are compiled to illustrate a change/difference in attitude, and an increase in knowledge.

Goal #2: Intended Use 20% - Primary Prevention / Page 19

School surveys such as the Risk and Protective Factors Survey are administered in many communities in Region II. Activities and Practices will be based on survey results and evaluation of the programs will be based on future survey results. All SAPTBG funded coalitions submit monthly reports include budget, outcomes and barriers.

Region 2 Prevention activities in FY2011 include, but are not limited to:

Information Dissemination (1%) – Project Extra Mile Sticker Shock & “No Free Ride” campaigns, legislative advocacy, and liquor control commission license monitoring. Central Nebraska Coalition Against Substance Abuse campaign against procuring alcohol to minors. Distribute Prevention educational materials at Dundy County Fair, Lincoln Co & Keith Co National Night Out, Town Halls, & community events. Public Service announcements: “Celebrating Sober”, “Rethink Your Reaction”, and various prevention slogan promotions.

Alternate Activities (12%) – After school programs: Anger Education and Choosing the Best Youth & Family Appreciation Month (April annual event), Post Prom, Rec Center Without Wall activities. TeamMates and Across Ages Mentoring, substance free activities and Teen Court.

Education (21%) – HALO (Healthy Alternative for Little Ones), ALL STARS, Common Sense Parenting, Family Education Group, Love & Logic, Active Parenting of Teens, W.A.I.T. Training, Unmasking Sexual Con Games, High Expectations, 40 Developmental Asset Education, Class Action, Parenting & Family Skills Education.

Problem ID and Referral (7%) – Participation in the SHARP Survey, Prime For Life, Alcohol Education, Living Sober, Celebrate Recovery and Films & educational materials shared with schools, Keith Co jail & Dawson Co jail.

Environmental (25%) – Substance Abuse Prevention Leadership Council, Citizens Alcohol and RBST, Class Action, addressed county liquor licensing issue and community event beer garden procedures, compliance checks & CMCA (Communities Mobilizing for Change on Alcohol). Project Extra Mile legislative advocacy, and liquor control commission license monitoring.

Community Based (13%) – Project Extra Mile: Youth group projects/programs and Youth Legislative Day, YMCA Kids Day, Project Alert, Prime for Life, Citizen’s Drug & Alcohol Forum, Coalition for Children, Substance Abuse Leadership Council, Lincoln County Tobacco Coalition, High Expectations, Parent & Community Workshops, Community Action Teams, Southwest Nebraska Child Advocacy Team and Family Night Connections.

Region 3 Prevention Focus Plan FY11

Assess/Plan

The Region 3 Prevention system is a multifaceted partnership encompassing community coalitions, agencies, providers and other system partners collaborating to impact substance abuse and its related consequences in a 22 county service area. The sources of systemic funding are diverse and include public and private funds. Many Region 3 communities demonstrate expanding capacity to successfully address identified prevention needs. Several SAPTBG funded coalitions have developed into experienced grant writers skilled at braiding multiple funding streams. See Table 1. SAPTBG funded

Goal #2: Intended Use 20% - Primary Prevention / Page 20

coalitions implement evidence-based prevention programming, practice, policies and strategies to prevent and reduce substance abuse and its negative consequences for youth, adults, families, and communities.

Non SAPTBG funded coalitions are integral partners within the regional prevention system. Non SAPTBG coalitions include Tobacco-Free Hall County, Buffalo County Tobacco-Free Coalition, Central Nebraska Coalition Against Substance Abuse (Harlan, Franklin, Phelps, Kearney, Dawson, Gosper Co.), Superior SCARED, Responsible Beverage Service Coalition, UNK Taskforce, Project Extra Mile (Hall Co.) and the Ron Gardner Meth Coalition Project (Hastings area). Using funding from Tobacco Free Nebraska, Office of Highway Safety, health departments and other local sources of funding, these coalitions provide evidence-based prevention programming to create positive community change. Both SAPTBG funded and non funded coalitions typically have separate youth advisory boards associated with the larger coalition and/or work with their local drug-free youth group. Throughout the current fiscal year, Region 3 has collaborated with the NEDHHS Office of Community Health Development to provide technical assistance and training to SPF-SIG funded coalitions.

Table 1	SAPTBG	DFC	SPF-SIG	Juv. Justice	County Aid	Other
SAPTBG Funded Coalitions						
Area Substance & Alcohol Abuse Prevention (ASAAP)	X	X	X			X
o Adams, Webster, Clay, Nuckolls Co.						
GLW Children's Council	X	X		X	X	
o Garfield, Loup, Wheeler Co.						
Grand Island Substance Abuse Prevention Coalition	X	X	X			
o SAPTBG & SPF SIG funding includes Merrick & Hamilton County Coalitions						
Buffalo Co. Positive Pressure Coalition	X	X	X			X
*In last year of DFC funding						
Sherman Co. Prevention Coalition	X		X	X		X

Region 3 staff have participated in committees, helped to develop training materials, hosted meetings and provided technical assistance and training to the five SPF-SIG communities in Region 3: Sherman County Prevention Coalition, Positive Pressure Coalition, Grand Island Substance Abuse Prevention Coalition, Area Substance & Alcohol Abuse Prevention Coalition and Central Nebraska Coalition Against Substance Abuse. This partnership will continue in fiscal year 2011 as prevention staff will facilitate both SAPTBG funded and non funded community coalition's development through the provision of training and technical assistance. Additionally, all SAPTBG funded coalitions have completed or will complete a prevention readiness/capacity assessment using the SPF-SIG tool.

Capacity/Training Needs

Collaborative planning efforts with substance abuse service providers as well as multiple community, regional and state coalitions ensures a comprehensive array of substance abuse prevention services within the Region. Technical assistance and consultation is provided to community coalitions, prevention providers and other key stakeholders to

Goal #2: Intended Use 20% - Primary Prevention / Page 21

build coalition infrastructure, diversity and sustainability using the Strategic Prevention Framework (SPF) model to equip them to successfully implement evidence-based prevention strategies. In FY2011, Prevention System Coordination efforts will continue to focus on providing support, training and technical assistance to coalitions being developed and those implementing and/or sustaining strategic plans, providing contract management to coalitions on a quarterly basis, coordinating regional efforts in NPIRS data collection for achievement of the National Outcome Measures (NOMS), monitoring the implementation of evidence-based strategies for effectiveness, and identifying and coordinating training for community coalitions. Prevention staff will continue to attend scheduled community coalition meetings, including non SAPTBG funded coalition meetings, to provide on-going technical assistance and contract monitoring.

Region 3 intends to develop a strong prevention workforce by supporting access to professional development. In February 2010, a "Coalition Training Needs Survey" was conducted by Region 3 with both SAPTBG funded and non SAPTBG funded coalitions. Results obtained from the survey were used to develop a training strategy to support prevention workforce development. See Table 2.

Survey results indicated that coalitions prefer that training occurs in the middle of the week (Tuesday--Thursday) and employs a face to face format. Preferred location included the tri-city area of Kearney, Grand Island and Hastings (regionally vs. statewide). To address the topics identified in Table 2, we are planning to schedule training on a quarterly basis. The first training for FY11 is scheduled on July 15, 2010. The topic will be on creating connections with youth (youth development). In addition to addressing the identified topics, coalitions would like training to remain flexible enough that emerging topics and trends can be addressed on an as needed basis. Regional prevention coordination staffs also plan to resume training responsibilities for the Nebraska Training for Substance Abuse (NETSAP) prevention trainings through statewide coordination efforts. NETSAP was identified by coalitions as a priority training need.

Table 2		
Identified Training Topic	Target Population	Projected Timeline
Youth Development -Youth to Youth International	All coalitions, schools, youth, other stakeholders, community members	July 15, 2010
-John Underwood		October 2010
Facilitating Diverse Groups -cultural competency piece	Coalition coordinators, prevention providers, other stakeholders	Late Fall/Early Winter 2010
Sustainability	All coalitions, community members, prevention providers, other stakeholders	TBD
Advocacy	All coalitions, community members, prevention providers, other stakeholders	TBD
NETSAP/SAPST 101	Coalitions, community members, schools, prevention providers, other stakeholders	On-going; after DHHS curriculum approval
Scholarships for CADCA, UDETC, other identified trainings/conferences	Coalition members	TBD

Goal #2: Intended Use 20% - Primary Prevention / Page 22**Evaluation**

Current evaluation elements of the Region 3 prevention system include the following; NPIRS data collection, regional prevention system coordination meetings every other month where community up-dates and successes is a standing agenda item, utilization of data from the NRPFS for 2003, 2005, 2007 and again in 2010, and coalition follow-up after technical assistance is provided. Additionally, site visits are completed each quarter with SAPTBG funded coalitions during which programmatic audits are completed at mid-year and end of fiscal year points. Programmatic audits include the review of any program evaluation data such as pre/post tests, coalition work plans and any other program documentation. During the 1st and 3rd quarter visits, the SPF process is the focus of the review. Annual assessments of individual strategies include cost effectiveness, collection of data if available, and achieving outcome measures. Prevention staff continues to attend scheduled community coalition meetings which provide an additional avenue for the monitoring and evaluation of coalition strategies and activities.

Region 3 Prevention activities in FY2011 include, but are not limited to:

Information Dissemination (9%) – Info dissemination for all evidence based programming, media campaigns, coalition marketing and recruitment, prevention events notification and training.

Alternate Activities (5%) – Youth Leadership Teams/Advisory Boards, Youth Congress events, youth/adult mentoring activities/

Education (33%) – *Multiple evidence based programs.

Environmental (29%) – Communities Mobilizing for Change on Alcohol training, Community Trials, Responsible Beverage Service and Compliance checks

Community Based (24%) – Community group initiatives, development and recruitment, Communities Mobilizing for Change on Alcohol, Community Trials and mentoring programs.

Region 4 Prevention Focus Plan FY11

Assess/Plan

The Region 4 Prevention System is comprised of agencies, coalitions, organizations, and individuals whose main goal is to reduce alcohol, tobacco and other drug abuse and misuse in a 22 county area. A main source of funding for the local coalitions is the Substance Abuse Prevention and Treatment Block Grant (SAPTBG). Other sources of funding include the Strategic Prevention Framework-State Incentive Grant (SPF-SIG), Safe and Drug Free Schools, Drug Free Communities Grant (DFC) and Tobacco Free Nebraska (TFN).

Coalitions in this Region are learning the importance of braiding multiple funding streams as most of the SAPTBG funded coalitions also are receiving SPF SIG dollars and have applied for DFC as shown in Table 1.

Goal #2: Intended Use 20% - Primary Prevention / Page 23

Table 1 SAPTBG Funded Coalitions	SAPTBG	SPF SIG	DFC	Other
North Central Community Care Partnership (NCCCP)	X	X	Applied for FY11	
Healthy Communities Initiative (HCI)	X	X	Applied for FY11	
Rain Maker Coalition	X	X	X	
Back-to-BASICs Coalition	X	X		

Non SAPTBG funded coalitions that are part of the prevention system include Project Extra Mile, TRUST-WSC Coalition, ACDC (Antelope County Does Care), BKR Alcohol Awareness Coalition, BC4BC (Better Choices for Boyd County), Knox County Alcohol Awareness Coalition, Winnebago Meth Taskforce, Tribal Advisory Council and Pierce County Coalition.

Capacity

The FY11 Prevention System plan is a new direction for this Region set forth to empower local community coalitions and further role adjustments. In the past, the prevention system coordinator was only a part-time position so it was decided to partner with the local health departments to assist in providing technical assistance and training to the emerging local coalitions. The health departments were contracted providers and received SAPTBG funding to serve as an extension of the prevention coordinator. The health departments were a vital resource in assisting emerging coalitions and three of the four area health departments have received SPF-SIG funding.

In December 2008, a full-time Prevention Coordinator was hired. Because of this, roles across the Region were re-assessed. Public health departments were still given provider contracts but were to be implementing strategies rather than providing technical assistance to local coalitions. The role of technical assistance and training became that of the Region’s Prevention Coordinator again.

FY10 was considered a transition year for Region 4. Coalitions and health department providers were informed that in FY11, SAPTBG dollars would be going directly to local coalitions to keep with the federal expectation of growing coalitions and drive initiatives at the local level. Technical assistance and trainings were offered to SAPTBG funded and non SAPTBG funded coalitions to help build capacity and empower coalitions for the upcoming funding opportunity in FY11.

Over the past year, there has been coalition growth across Region 4 and new coalitions have been documented. Another area of growth/improvement has been with the tribal community. Region 4 houses three reservations and four state-recognized tribes. In the past year, much effort has been put forth to build strong partnerships with the tribes and though the work continues, it has been viewed as a success so far.

The Region Prevention System continues to provide technical assistance, training, and system coordination. This role includes assisting with community assessments, resource development and strategic planning as well as building capacity within community coalitions and increasing the effectiveness of prevention strategies and funding.

Goal #2: Intended Use 20% - Primary Prevention / Page 24

Bi-monthly Regional Coalition meetings are held where coalition coordinators from around the Region come together to share resources, ideas and struggles. Needs for the regional prevention system are also assessed through this format. These meetings have served as a huge resource for the local coalitions and have helped build partnerships across the 22 county area. In FY11, these meetings will also include a training component for the coordinators that focuses on utilizing the Strategic Prevention Framework model as well as other ATOD topics that arise.

Evaluation

All SAPTBG funded coalitions submit quarterly reports to the Prevention Coordinator showing completion of objectives and outcomes for the fiscal year. Data is typically reported on and submitted to the Region. Evaluation also occurs at regular coalition meetings that the Prevention Coordinator attends.

A Regional Prevention System Coordination Satisfaction Survey was distributed through Survey Monkey in December 2009 to SAPTBG funded and non SAPTBG funded coalitions and health departments in the Region 4 area. Some of the topics covered were if training and technical assistance needs were being met, if participants had a good understanding of services offered by the Region as well as other community coalitions, and areas of support or concern that needed to be addressed. The results and feedback were used by the Prevention Coordinator to assess how to better serve the coalitions in Region 4 and was shared with the Regional Administrator. It is planned to conduct this satisfaction survey again in the fall of 2010.

For FY11, a Coalition Capacity Survey will be administered to all coalitions regardless of their funding stream. This survey will help assess where the coalitions are at and help identify strengths as well as areas of improvements. A long term goal for Region 4 is to assist all local coalitions in achieving a level of capacity where they are able to apply for SAPTBG funding. These surveys will also help determine the training needs for the next year.

Training

Training needs were assessed in December 2009 through the satisfaction survey and again in March 2010 at the Regional Coalition meeting for SAPTBG and non-SAPTBG funded coalitions. A common theme was “coalition building”. Other training topics included social norming, media literacy, sustainability and youth leadership. Another important training topic that will be addressed in FY11 is the Nebraska Training for Substance Abuse Prevention (NETSAP). The goal is to train coalition coordinators in this Region that will then in turn take it back to the coalition. The coalitions preferred that this training was a 2 day training or closer together than originally planned of being 6 months apart. They also felt that a certification of some sort would also be beneficial.

To address the identified needs, trainings will occur on a quarterly basis. The target date for the first training will be September 2010. It is also hoped to use the \$20,000 available to send coalition members to other trainings and conferences across the country to build capacity.

Goal #2: Intended Use 20% - Primary Prevention / Page 25

Region 4 Prevention activities in FY2011 include, but are not limited to:

Information Dissemination (6%) – School speakers, provide materials at P.T conferences

Alternate Activities (3%) – Drug-free teen dances, Club NECC, Coffee Nights, and the Junction Youth Center

Education (2%) – Keep a Clear Mind and T.R.A.I.L.S.

Problem Solving/Referral (1%) -

Environmental (64%) – Compliance Checks, Communities Mobilizing for Change on Alcohol, Community Trials, Responsible Beverage Service Training

Community Based (25%) – Increase participation in SHARP surveys, increase partnerships in local community, develop consistent compliance check system with law enforcement

Region 5 Prevention Focus Plan FY11

Assess/Plan

Within Region 5, coalition development and mobilization varies from county to county, based on community investment and inclusivity among various stakeholders. It is evident through our Regional Coalition that Lancaster, Otoe, Gage, Nemaha, Thayer, Jefferson, Mead (Saunders), Polk, Johnson, and Seward counties model leadership in strategic planning and implementation for less experienced coalitions within York, Fillmore, Richardson, Butler, Saline, and Pawnee counties. At regional quarterly coalition meetings the community updates take about 2-3 hours and play a significantly vital role in coalitions trying new strategies or learning various prevention tools that have been effective for the coalitions succeeding. Those coalitions that are successful have the following commonalities; community investment, community leaders at the prevention table, and various funding sources including, SAPTBG, DFC, SPF-SIG, Crime Commission, Highway Safety, and local health district funding as well as local funding sources available to assist with specific partnerships and collaborations on prevention projects.

Within Region 5, Lancaster, Otoe, Gage, and Nemaha all receive DFC funding, modeling for Thayer County, who recently submitted a DFC application for 2010-2011. In Region 5 there are three SPF-SIG coalitions, Lancaster, Otoe and an eight county, Southeast NE Coalition. Every year the coalitions are asked to base their SAPTBG application on their strategic plan, prioritizing needs and consistently funding has followed for all urban/rural coalitions. They can assist coalition volunteers or staff with stipends, but only 20% of requested budget can go for direct personnel. This strategy has been very effective in Region 5, as it has allowed us to be able to spread more funding across the Region. The strategy has also required coalitions to find various resources to maintain prevention workforces. Subsequently, coalitions sub-contract for evaluation, and programming offered through prevention agencies, health districts, schools, and ESU's. Law enforcement, RC&D's, health districts, schools, parents and youth have been consistent stakeholders at the table, as well as evaluation and businesses as requested. Braided

Goal #2: Intended Use 20% - Primary Prevention / Page 26

funding streams has advanced coalitions needs to have strong media campaigns in conjunction with their annual strategic plans.

Within Region 5, most of tobacco prevention funding is funneled through health departments/districts and prevention agencies. However, many youth involved in prevention efforts in their communities are involved with statewide tobacco prevention. Trainings have allowed coalition leads to network and form alliances with federal/state/local government officials, law enforcement entities, diversion, national speakers and organizations, and youth development pieces. Our youth component is strong and continues to grow, including three youth leadership development events a year. Youth are involved in their local coalitions in all counties with exception to York, Butler, Fillmore, and Saline (we hope to see an increase in youth leadership during 2010-2011). The Regional Prevention Coordination System will continue to provide technical assistance including; mobilization of coalitions as they individually and collectively evolve, bi-annual assessments, and trainings specific to the needs of coalitions.

Planning for 2010-2011 includes development of a Native American Coalition in southeast Nebraska to address prevention/behavioral health needs, sustainability trainings, cultural challenges in communities, inclusivity among various youth populations to continue to build leadership and self-efficacy among all youth in our communities (including youth receiving services through family organizations and Family Youth Investment, and quality assurance data collection management. Statewide, regions, coalitions, law enforcement, and treatment providers are working closely through our NE Drug Advisory Board addressing methamphetamine concerns, prescription drug abuse, and a growing trend of marijuana use among youth/adults. For 2010-2011 we are committed to having a statewide initiative on November 13, 2010 to disseminate and educate all sectors of the community on healthy disposal of prescription drugs, as well as decreasing theft and selling of prescription drugs.

Capacity

Building a regional prevention system takes considerable time and commitment from various entities. Within Region 5, coordination would not exist without coalitions being the “hub of the system” throughout communities/counties. The first ten years of development have really been an exercise in risk taking, learning about strategic planning, learning to use data to drive prevention efforts, trusting and collaborating with local, regional, statewide and national partners. Region 5 has found that patience definitely is a virtue in coalition sustainability. Prevention education is relentless at times; often individuals in other professional capacities or community members do not understand the foundation building required for social change to occur. During 2010-2011 regional focus will be on those coalitions that have struggled with development/sustainability Butler, Saline, Fillmore, Richardson, and Pawnee. In January 2010 the Regional Coalition prioritized training needs for 2010-2011. Trainings for all the coalitions will include: data management, cultural challenges and barriers in Region 5, sustainability efforts, inclusivity among diverse youth populations, long-term planning, and identification of cost-effective regional goals for all counties.

Trainings Plan 2010-2011

Goal #2: Intended Use 20% - Primary Prevention / Page 27

<u>Training</u>	<u>Population served</u>	<u>Date</u>
John Underwood	Coaches, athletes, schools, coalitions, concerned community	October 5, 2010
Native American regional coalition development	Native Americans and those that work with Native Americans	TBD by group members of the coalition.
Bridges of Poverty or variation of to address socio-economic impact of ATOD abuse in rural and urban communities.	All coalitions, prevention providers, interested stakeholders	TBD – Region 1 will provide effectiveness of the training in their area as well as the SPF/SIG
Day camp modeled after annual “June Jam” for youth receiving assistance in behavioral health services.	FYI partners, Family organizations, providers	TBD – possibly in Aug 2010
Long term sustainability planning	Prevention Coalition Leads, community members, invested stakeholders	TBD - possibly a training component at each of the quarterly Regional Coalition meetings
Data analysis and management	Regional Coalition and community coalition members	TBD
Marijuana	Regional Coalition	TBD
Prescription Drugs Abuse Toolkits for youth and senior citizens	Regional Coalition	TBD
Scholarships for CADCA Midyear and Annual CADCA, DC	Coalition Members	TBD

Evaluation

At this time evaluation components in Region 5 include the following, NPIRS data collection, bi-annual coalition assessments, quarterly reports, updates/successes during regional coalition meetings, coalition follow-up after technical assistance is provided, utilizing comparison data from NRPFs, 2003, 2005, 2007 and again in 2010. Annual assessment of individual strategies including cost effectiveness, collection of data if available, and achieving outcome measures. During first quarter of 2010-2011, Region 5 will produce an audit form that would capture each strategy and measurable progress. In previous years we have been doing the majority of evaluation on process outcomes. Coalitions would benefit from an audit that would effectively measure successes and progress made. Coalitions are learning more from evaluation requirements of DFC and SPF-SIG – specific to priorities. Technical assistance will be provided to assist coalitions with doing in the same for SAPTBG.

Mini-grants allocations for 2010-2011 will be determined following the fall and spring cycle application process. Region 5 has set aside \$30,000 for adult and youth mini-grant applications. The intent of mini-grants is seed funding, allowing community stakeholders some funding that may not have previously been planned for in their initial 2010-2011 SAPTBG.

Region 5 Prevention activities in FY2011 include, but are not limited to:

Information Dissemination(26%) – Information disseminated for all evidence-based programming, Diversion, School Community Intervention Program (SCIP), media campaigns, prom and graduation letters from law enforcement, Red Ribbon week, coalition marketing, prevention events notification, trainings, and coalition recruitment.

Goal #2: Intended Use 20% - Primary Prevention / Page 28

Alternate Activities (2%) – Youth/adult mentoring activities, prevention poster contests with youth, community drug free walk, coalition celebrations, youth dances, June Jam.

Education(16%) – Several evidence-based programs including; Health Rocks, 40 Developmental Assets, PSC curriculum, Northland Project, DARE, Diversion education, Community Trials, SCIP trainings, Safe Homes Program. Other educational strategies include trainings, booths, June Jam, Town Hall meetings, Coalition recruitment, prevention events and celebrations, Prevention Awareness Campaigns, Prom/Graduation letters from law enforcement, presentations from law enforcement, Red Ribbon week, community festivals, drug free walk, and media campaigns. State/Regional curriculum development for prevention.

Problem ID and Referral (4%) – Diversion, evidence-based programming including Celebrating Families, and the School Community Intervention Program (SCIP).

Environmental(29%) – PSC Curriculum (Peru State College), Community Trials, Safe Homes Programs, media campaigns, Prevention Awareness Campaigns, Red Ribbon Week, Drug Free Walk, Environmental Scans, June Jam and various youth activities.

Community Based (23%) – Community trials, Celebrating Families, Safe Homes Program, mentoring programs, community celebrations of achievements, community group initiatives, Prevention Leadership Team, community development and recruitment, Town Hall meetings.

Region 6 Prevention Focus Plan FY11

Assess/Plan

The Region 6 Prevention System is a collection of interrelated and often overlapping coalitions, agencies, and providers focused on the task of reducing alcohol, tobacco, and other drug use and abuse. Systemic funding originates from various public and private sources including, but not limited to, the Substance Abuse Prevention and Treatment Block Grant (SAPTBG). Additional funding sources include the Drug Free Communities Grant (DFC), the Strategic Prevention Framework- State Incentive Grant (SPF-SIG), Tobacco Free Nebraska (TFN), Safe and Drug Free Schools (through FY10), Nebraska Department of Highway Safety Grants, and private sources.

Region 6 Prevention System Services primarily receives funding from two sources to help coordinate the area prevention system. The first source is the Nebraska Department of Health and Human Services (DHHS) Division of Behavioral Health and the second is the DHHS Tobacco Free Nebraska program. Currently monies issued through the SAPTBG from the Division of Behavioral Health are utilized to directly support the strategies and programs of two area multi-county prevention coalitions; pay for regional coordination, support, and technical assistance; and provides training funding for the area prevention system. Supportive services are provided communities, coalitions, and agencies within the five counties of the region regardless of whether or not they are funded provided their focus is on ATOD prevention. Dollars received through TFN are utilized to support one area tobacco coalition, coalition coordination, and fiscal agent duties.

Capacity

The FY11 Region 6 Prevention System plan is an outgrowth of practices set in place approximately four years ago. During the last years of the State Incentive Cooperative Agreement (SICA), the Region began to reassess its role within the prevention system. Prior to SICA, the regional prevention system was provider driven with the Region taking a directive role in the creation/implementation of prevention strategies and programs. This type of system management was effective for managing providers, but not community coalitions. The system was, however, extremely well suited for capacity building and allowed the Region to help establish area community coalitions in a relatively short period of time.

Once the Region was able to help create stable coalitions, the relationships with the area coalitions changed. Following the philosophy of both the SICA and later the SPF framework, communities were empowered to create and implement effective strategies and programs to address ATOD problems within their communities. The Region recused itself from coalition leadership and voting status. Instead it accepted the role of providing technical assistance, training, and system coordination. This role has includes everything from facilitating the development of annual strategic plans, hosting large seminars, providing regular system coordination meetings, to answering simple phone calls.

In furtherance of the SPF-SIG grant, the Region has cooperated on multiple levels with the DHHS Office of Community Health Development (OCHD). We have provided personnel and services to sit on committees, help develop training materials, host meetings for OCHD, and provide technical assistance to applicants including LiveWise and the Ponca Tribe of Nebraska. Additionally, we have encouraged the utilization of the Strategic Prevention Framework model (and/or modifications thereof) within our funded and non funded coalitions. This continual reassessment process has become an integral theme in our coordination strategy.

Evaluation

Each year the Region 6 Prevention Staff conduct an annual review of the previous year's implementation plans. During this time, we review the past year's activities, relevant data, and surveys (etc.) to determine the effectiveness of our system and to make needed adjustments. In FY10, SABPTBG dollars funded the LiveWise Coalition and the Greater Omaha Healthy Communities/Healthy Youth Coalition. A year to date review of the programs and strategies under this funding source has indicated a need for possible re-evaluation of several areas within each coalition. A complete overview of the system's service array for both block grant and non- block grant funded coalitions can be found in the attached chart.

The LiveWise Coalition has continued to grow, diversify, and take on a number of different challenges. The rapid growth has caused the coalition to rely heavily on established providers to engage in primary prevention activities and strategies. Programmatic site reviews by the Region have noted that there has been a loss of fidelity to some of the strategies/programs currently in use by sub grantees and lack of focused engagement strategies/programs for priority populations.

The regional response was providing LiveWise with documented information about areas

Goal #2: Intended Use 20% - Primary Prevention / Page 30

that are in need of improvement and to offer assistance in addressing the issues through technical assistance and training. One such example was the formation of the Cultural Competency Advisory Group. The group consists of members of different area coalitions whose primary focus is to act as a support resource for the area prevention system. The group has created several mini-trainings which have been made available to the regional prevention system at coordination meetings. It has, also, taken on the challenge to help design another day long cultural competency training designed at helping coalitions to become more inclusive.

The year to date review of the Greater Omaha Healthy Community Healthy Youth (GOHCHY) coalition presented slightly more challenges. GOHCHY is a relatively new coalition. Since the region began funding the group about a year and a half ago the focus has been to increase capacity and awareness on the 40 Developmental Asset framework. The group has become fairly successful at capacity building and has hosted two major training workshops that have had over 500 attendees from business, government, and youth. It has, also, been responsible for a significant number of smaller trainings that have addressed a wide variety of groups within the region.

During a recent planning session with the group, it was highlighted again that the coalition needs to move into concrete, evidence prevention work. In an effort to assist the coalition in the transition from a capacity building phase to strategy development and implementation, the Region has worked with Vision Training Associates (a division of the Search Institute) to create an "Assets into Action" workshop. This training is designed to identify those assets closely associated with risk taking and ATOD abuse behaviors and look at evidence based strategies that have shown promise in increasing these in children. Although this training was designed with GOHCHY in mind, it has been made available to the prevention system at large.

Moving forward through the remainder of FY10 and into FY11, the Region 6 Prevention System will continue to monitor, evaluate, and offer assistance to both funded and non funded area prevention coalitions. Simple logic model charts (such as the attached addendum) will continue to be utilized to both identify areas of strengths and service gaps. Where possible, the Region will offer support by bringing resources and assistance to coalitions in filling those gaps. Our evaluation plan, also, includes the utilization and creation of instruments designed to examine the needs and wants of the area coalitions and their leadership.

Training

We have again budgeted \$20,000 in support of regional training of the prevention workforce. Training issues continue to be addressed on both an as needed (short term) basis and through long term strategically planned trainings. As-needed technical assistance is difficult to anticipate but can be mitigated by closely monitoring coalition activities. It will continue to be handled as problems and questions arise within the prevention system that can be addressed through the region.

The Region continues to diligently work at recognizing need and implementing larger scale regional trainings to address the needs of the prevention system. Throughout FY10 the Region hosted or is scheduled to several large trainings. These *free to participants*

Goal #2: Intended Use 20% - Primary Prevention / Page 31

trainings have included or will include: “Youth Prevention Training” (resulted in the development of a Youth Advisory Group for the Region), “Assets into Action” (40 Developmental Assets for Prevention), and “A Difficult Conversation: Community Support for the Human Experience” (Cultural Competency). We have, also, collaborated on a number of different conferences including the GOHCHY annual workshop, the PMP “Celebrating Collaboration Workshop”, and various other collaborations.

A recent survey conducted by the Region of area coalition leaders has identified a number of areas for larger trainings in FY11. Possible trainings on the agenda for the next fiscal year include: Leadership Development and Grant’s Management. There is, also, an interest and a need to continue more training on Cultural Competency and Youth Development. We anticipate three to four large scale trainings in FY11. Although no dates have been set, one will take place every 3 to 4 months of the year.

Region 6 Prevention activities in FY2011 include, but are not limited to:

Information Dissemination (1%) – Press releases regarding Compliance Check results. Using media outlets to inform the community about the 40 Developmental Assets and disseminating culturally appropriate materials on the benefits of smoke-free housing.

Alternate Activities (5%) – Brief Alcohol Screening and Intervention of College Students (BASICS) and Non-Alcohol sponsored events for college students.

Education (2%) – Building Assets-Reducing Risks (BARR) Evidence-Based Program, Peer Lead Education Course, Awareness Campaign of alcohol laws and associated consequences, education of social and health consequences of binge drinking via media campaign and peer leaders, Peer to Peer Programming for Middle and High School Students, annual Asset Building conference, Resource Library Kits in all 5 counties, Youth Advocacy Training, Media Campaign Targeting 18-24 Year-olds, Youth Minority Congress events, Publish Compliance Check Results in Newsletter, Speakers Bureau, business recognitions for 100% Tobacco-Free Policies, Law Enforcement trainings, Meth 360 Trainings, ‘360’ Community Trainings on gateway drugs, Business Recognitions for 100% tobacco-free policies, and educating businesses/individuals on the benefits of smoke-free housing.

Problem ID and Referral (17%) – Needs Assessment, conduct/participate in American College Health Survey, Collect data from the participants of the BASICS Program, Environmental Scan of the Community for Marijuana Paraphernalia. Survey law enforcement and prosecutors to gain insight regarding marijuana and prescription drugs issues. Assess the human impact of prescription drug abuse in the community. Implement the Developmental Asset Profile (DAP) in Participating Schools. Assess DAP Results to obtain target assets for intervention. Assess NSCS/ATS to determine baseline data for smoke-free homes, survey local tenants living in multi-housing complexes, internal coalition assessment tool administered to several coalitions, and strategic plans updated.

Environmental (73%) – Project Prom/Graduation and MIP Party Patrols. Several Media Campaigns including ‘Be the Difference’. Responsible Beverage Server Training.

Goal #2: Intended Use 20% - Primary Prevention / Page 32

Coordinate Drug Disposal Sites in the community for Prescription Drugs. Assisting businesses, multi-family housing, faith-based organizations, and educational facilities to adopt policies for indoor and outdoor tobacco-free policies. Inspect and follow-up with retailers to ensure compliance with State Clean Air Law. Quarterly Compliance Checks and follow-up visits to retailers.

Community Based (1%) – TRACE Program, 40 Developmental Asset Seal of Approval Stipend Program, Youth Group Development in Cass County, improving communication among medical providers in the community and implementing activities pertaining to DAP Asset results. Tobacco Media Campaign to promote the benefits of smoke-free housing, educational presentations in the community to promote 100% smoke-free environments, and newsletters and other on-going provider communications to educate advocates and policy-makers about local tobacco control activities.

Goal #2: Compliance – Primary Prevention / Page 1**FY2008 (Compliance)**

GOAL # 2. Providing Primary Prevention services: An agreement to spend not less than 20 percent of the SAPT Block Grant on a broad array of primary prevention strategies directed at individuals not identified to be in need of treatment. Comprehensive primary prevention programs should include activities and services provided in a variety of settings for both the general population, and targeted sub-groups who are at high risk for substance abuse.

Specify the activities proposed for each of the six strategies or by the Institute of Medicine Model of Universal, Selective, or Indicated as defined below: (See 42 U.S.C. §300x-22(a)(1) and 45 C.F.R. §96.124(b)(1)).

In recognizing the need for a prevention system and a particular focus on primary prevention programming, Nebraska has been working to acknowledge the potential for problematic substance abuse later in the lives of youth, adolescents and adults. To this end, the Nebraska Department of Health and Human Services (DHHS) has been focused on providing opportunities to grow, strengthen and support systems of care values across the state. As DHHS also continues to move forward with a new direction for children's behavioral health, the prevention system is becoming interwoven as an integral component of this vision. To this end, the current activities of recent years have and will continue, but with a particular emphasis on strategic planning as the SPF-SIG coalitions move into implementation, as Regional Prevention System Coordination further develops their role and as the Division of Behavioral Health utilizes planning with multiple system partners to identify the strengths and opportunities across the state.

In FY2008 a variety of prevention activities and programs were utilized across the state to ensure utilization of all six prevention strategies targeting a broad population. The Division of Behavioral Health (DBH) contracted directly with entities such as the Nebraska Prevention Information Reporting System database developer, a technical assistance provider for the development of a prevention training curriculum, statewide programming for school prevention programming, a prevention conference, and for SYNAR related activities. DBH utilized the majority of the 20% Primary Prevention funding towards contract with the six Regional Behavioral Health Authorities for the purchase of Regional Prevention System Coordination. This is for the provision of technical assistance and training to community coalitions and prevention providers as well as the purchase of prevention activities from local programs/coalitions.

Within this contract, DBH requires the Regions to utilize 50% of funding to support community based and environmental strategies. This effort was specifically designed to support the capacity development of local prevention coalitions and particularly the current phase of SPF-SIG implementation. The Regions were also expected to utilize the SPF-SIG process in the identification of appropriate activities and measurable outcomes. In FY2008, the total amount of SAPTBG funds expended for Primary Prevention activities for was \$2,077,471. From the Regional Budget Plan Guidelines, the following are the Prevention Objectives for Region Prevention System Coordination:

Please describe how the Regional Behavioral Authority has focused efforts on completion of the CSAP goals (see below), including but not limited to activities associated with Prevention System

Goal #2: Compliance – Primary Prevention / Page 2

Coordination.

Center for Substance Abuse Prevention (CSAP) Priorities are outlined below:

- Prevent the onset and reduce the progression of substance abuse, including underage drinking;
- Reduce substance abuse related problems in communities; and
- Build prevention capacities and infrastructure at the state/tribal and community levels.

1.) How will the activities/services be operationalized – this may be through direct procurement, subcontractors or grantees, or intra-governmental agreements?

Following is the contract expectations for each Region for FY2008-2009:

I. REGIONAL ADMINISTRATION OF PREVENTION SERVICE SYSTEM

Contractor shall be responsible for Regional Prevention System Coordination in order to ensure a continuum of substance abuse prevention services, in relation to identified prevention needs specific to each its geographic area.

- A. Prevention System Coordinator.** Regional Prevention System Coordinator is defined as the region's administrative responsibility to ensure effective use of prevention funds through a regional needs assessment, policy development, the maintenance and monitoring of a Regional Prevention System, and the coordination of local coalitions and other community activities to ensure that prevention services are available, accessible and duplication of efforts are minimized. Regional Coordinators will work cooperatively with the Division of Public Health.
- B.** A Regional prevention system coordinator shall be designated by the contractor. Travel to quarterly prevention coordinators meetings held throughout the state shall be budgeted. Travel within the contractor's jurisdiction shall be budgeted to support development, mentoring and maintenance of community coalitions.

II. COMMUNITY COALITIONS. Contractor shall subcontract with community coalitions to implement the Region's prevention plan. Community Coalitions may subcontract with providers per the identified need of the community coalition.

- A.** A Community Coalition is defined as a community based organization of individuals representing diverse organizations, factions or constituencies who agree to work together in order to achieve a common goal. The coalition's work includes identification of prevention services and/or strategies designed to specifically reduce or delay the onset of substance abuse.
- B.** Regional Prevention Coordinator shall provide for Training, Technical Assistance and resource development activities in support of community coalitions. Regional Prevention Coordinators may act as fiscal agents to community coalitions at the request of the coalition. The Regional Prevention Coordinator shall ensure that community coalitions know and work on completing the five step strategic prevention framework planning process and that a written plan is available.
- C.** The contractor shall ensure that not less than 50 percent of the Federal Block Grant Funds designated for prevention services are made available to community coalitions through technical assistance, training and a regionally developed grant process in fiscal year 2008. Such funds shall support the communities' implementation of identified prevention

Goal #2: Compliance – Primary Prevention / Page 3

strategies through evidence, scientific or promising program based activities identified by the community coalitions through the use of the strategic prevention framework planning process.

- D. Federal funds cannot be used to contract with a for-profit entity.
 - E. Contract with Providers- the Contractor shall be permitted to continue contracts with prevention service providers through fiscal year 2008. Such direct contracts shall have a date certain of termination. Regions may contract with prevention service providers on behalf of community coalitions where such coalitions have made specific plans for such contracts.
- 2.) What activities/services will be provided, expanded, or enhanced – this may include activities/services by treatment modality or prevention strategy?
 - 3.) When will the activities/services be implemented (date) – for ongoing activities/services, include information on the progress toward meeting the goals including dates on which integral activities/services began or will begin?
 - 4.) Where in the state (geographic area) will the activities/services be undertaken – this may include counties, districts, regions, or cities?

Highlights of primary prevention related activities from each of the six Regional Prevention Coordination Systems include, but is not limited the following:

Region 1: The Region 1 Prevention System has a strong commitment to the Strategic Prevention Framework and has continued to work towards increased capacity for evidence based, data driven prevention services within the panhandle. In partnership with the Panhandle Drug Task Force, this group has had significant success in bringing training to Western Nebraska and working with legislators to initiate change. In support of changing community policies and practices of youth access to alcohol, the Region hosted a Communities Mobilizing for Change on Alcohol (CMCA) overview training. In addition, Community Organizer training for local coalition organizers was provided and five (5) coalition members attended the CADCA Leadership Institute.

Region 2: The Region 2 Prevention Center provided parent education regarding current alcohol and drug use trends. These classes are intended to increase skills to help reduce the risk of use and teach parents appropriate skills to deal with difficult behaviors. The Lincoln County Coalition circulated a “Celebrating Sober” public service announcement via the North Platte Telegraph which is delivered to North Platte, Sutherland, Hershey, Brady, and Maxwell communities. Sutherland Community Action Team promoted prevention slogans via water bottles purchased at school sponsored events. The Lincoln County Child Abuse Prevention Council sponsored the “Rethink Your Reaction” campaign which promoted positive reaction to stress and the reduction of substance abuse.

Region 3: The Region offered many training opportunities throughout the year in support of increasing the capacity, diversity and sustainability of their community substance abuse prevention coalitions. Region 3 Prevention Coordination coordinated a Meth 360 Training of Trainers in August 2008. Prevention staff provided monthly training/technical assistance sessions with coalitions applying for the Strategic Prevention

Goal #2: Compliance – Primary Prevention / Page 4

Framework-State Incentive Grant. SPF-SIG funds were awarded to five of the six coalitions in Region 3 who applied. An Environmental Prevention Strategies training facilitated by the Youth Leadership Institute (YLI) was held in Grand Island during January 2009. The Region also hosted an Evidence-Based Practices session facilitated by DHHS in February 2009.

Region 4: The Region continued to work closely with their local Public Health Departments and the Public Health Association of Nebraska group to incorporate prevention into local plans. On September 20, 2008, the Region hosted an All-Nation Pow-Wow to address substance abuse issues in a culturally and ethnically-appropriate manner and 112 people attended. The Lt. Governor presented as well as a representative from the Ponca tribe Substance Abuse Program. In December 2008, a full-time Prevention Coordinator was hired. Public Health departments were still sub-contracted with, but focus began to shift away from providing technical assistance to local coalitions and move towards implementing strategies. With this change, the role of technical assistance and training became that of the Region's Prevention Coordinator again.

Region 5: The Region 5 Prevention team served 16 community/county prevention coalitions in southeast Nebraska. The Region utilized various funding streams in their work towards sustaining prevention efforts in Nebraska, with this, partnerships throughout communities continue to grow. The use of training funds made has enhanced capacity building and assistance in sustaining long term prevention planning. Local coalitions and their communities continue working on underage drinking issues as well as alcohol and drug issues throughout the lifespan and in addition are beginning to address local and state policy/legislation. Region 5 worked closely with law enforcement regarding methamphetamine concerns specific to southeast Nebraska. In January 2008, a statewide group of prevention, treatment, law enforcement, and legislative entities formed the Nebraska Drug Advisory Board.

Region 6: The Region has been working to assess community needs and perceptions by encouraging local participation in state surveys, providing representation on the state epidemiological workgroup, and through the creation of local survey instruments. In addition, technical assistance to 25 coalitions and organizations was provided throughout the year. Training dollars were given to the Healthy Communities/Healthy Youth Coalition to put on an all-day training regarding the introduction to Developmental Assets and also the Utilization of the Developmental Asset Profile, an assessment tool to identify assets in youth. The training was open to the community and was attended by 230 people over the four sessions. A Meth 360 Training was coordinated and several Town Hall meetings focusing on youth ATOD se and quality of life also took place.

Following is a summary of the Division of Behavioral Health's compliance with Prevention goals:

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

The Division of Behavioral Health (DBH) continues to work with the Division of Public

Goal #2: Compliance – Primary Prevention / Page 5

Health Tobacco Free Nebraska, Division of Public Health Community Affairs Office, State Treasurer Office, Nebraska State Patrol and Nebraska Attorney General's Office. The workgroup met electronically over the year to exchange information from compliance checks. A request for violator information was received from the Lorillard and Phillip Morris tobacco (Altria agency) and DBH submitted information regarding the state's retailer compliance checks. State Treasurer Field staff is using the tobacco licensee list developed for the Division of Behavioral Health to review licensee information and to send correct information back to DBH staff. The tobacco licensee list was developed with the assistance of all the municipal and county clerks of the state. Information is continually updated through clerk and treasure staff reports on new tobacco outlets determined through field observation.

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

Tobacco enforcement efforts have been centered on the SYNAR compliance checks and additional checks made in the line of duty of local and state patrol officers. The Nebraska Liquor Control Commission has developed a protocol for responsible beverage server training and merchant education. Because of the number of establishments that sell both liquor and tobacco products are similar (convenience stores, groceries, gas stations etc.) trainers have been working to incorporate both age restricted venues in the training sessions. North Platte, Omaha, Lincoln cities, Otoe County and several other entities require training of local merchants and staff at intervals throughout the year. An effort to provide for a statewide "training certificate" was made based on these local efforts and continues to develop across the state. Additional meetings and legislative action were identified as potential requirement in order to allow for the age restricted seller certification.

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

Contracts with the Nebraska State Patrol and City of Omaha police were developed and a list of retailers was provided to ensure SYNAR checks were conducted throughout the state. A total of 950 compliance checks were conducted.

2.4 -- The Division of Behavioral Health will contract with the Regional Behavioral Health Authorities for Prevention Coordinators in each of the six Regions. Each of the six Regional Behavioral Health Authorities has a designated prevention coordinator, and prevention staff. Regions 3, 5, and 6 have more than one full-time staff member devoted to the prevention effort. Regional staff worked with state staff to develop a core training curriculum for prevention specialists and staff/volunteers as well as community leaders working in prevention. In addition, all regional staff provided ongoing technical assistance and training to local community coalitions on the Strategic Prevention Framework, and worked with local officials to foster environmental and community based prevention efforts based on the sound planning principles of the

Goal #2: Compliance – Primary Prevention / Page 6

strategic prevention framework. Regions have worked closely together to develop, solicit and administer training for their respective regions and consumers.

In partnership with the Regional Prevention Coordinators, the statewide prevention coordination goal as it pertains to the state to region contract was revised by DBH. This statement now represents one unified goal, objective and measure for the state to track in order to 1) utilize a single common reporting measure for performance based contracting, 2) utilize a single common goal and objective to unify the state's prevention coordination efforts. This goal has allowed for more flexibility in each region for local circumstances and growth as well as frame direction annually.

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

This effort was delayed due to the development of 16 specific community profiles to answer the data needs of the 16 SPF-SIG sub-grantees of Nebraska. Each of the 16 sub-grantees was provided a data compendium to support their strategic prevention framework in the planning stage of their grants. The Division of Behavioral Health and the Division of Public Health are collaboratively planning for the opportunities for shared data collection, measureable elements and system utilization and reporting.

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

NPIRS.org was fully operational for the last six months of the FY2008 fiscal year. The system is an internet based prevention reporting system that was developed with the concept of communities, regions and the state all requiring similar information for prevention data collection and reporting. Community coalitions are able to review progress in the development of planning and implementation activities. Regions can review all the communities together or separately in their region and the state has the ability to review regional and statewide activities. As the Division of Public Health progresses into the Implementation Phase of the SPF-SIG, they are working collaboratively with their contracted evaluative technical assistance provider RTI to determine appropriate data elements, reporting requirements and best collection mechanisms. The two Divisions are collectively reviewing the current NPIRS system and reassessing the framework, utilization ease and potential use to better serve the community as well as the meet the state and federal requirements.

2.7 -- The Division of Behavioral Health will continue to participate in the development of the epidemiological study for the state and regions to identify areas of greatest need and further assess the statewide patterns of use and system function.

The DHHS Division of Public Health was given the responsibility for the epidemiological study of Nebraska's substance abuse prevention and treatment needs.

Goal #2: Compliance – Primary Prevention / Page 7

Through the year, several Division of Behavioral Health staff actively participated with the epidemiological work group, and in meetings with the Division of Public Health to define data elements, measures and resource needs as well as review study and interpret report for best next steps in statewide system planning.

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

Multiple events have increased the collaboration of Divisions serving youth and adults experiencing behavioral health challenges. In FY2005, the Division received a SAMHSA State Infrastructure Grant focused on improving systems of care for children's behavioral health. In 2007 Legislative Bill 542 was passed, re-energizing a new focus on children's behavioral health. With the reorganization of DHHS and increasing collaborations, multi-Division systemic planning and cross system efforts were significantly multiplied. Some examples of this include attention on the shared roles of addressing substance abusing parents of youth entering into the child welfare system, identifying appropriate best practices for the prevention and treatment of both individuals and environmental communities, braided funding opportunities in programming and utilizing access to high risk populations to increase messaging and supports.

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

The Nebraska Partners in Prevention worked with the Regional Behavioral Health Authorities to foster a system of regional expertise. Training to Regional Prevention staff has specifically included Strategic Prevention Framework. The Regions have worked with the Division of Behavioral Health and the Division of Public Health to coordinate local planning efforts among the 16 SPF-SIG sub-grantees and with local coalitions who did not receive SPF-SIG funds and who may be receiving block grant funds. These training efforts also included topics such as cultural competency and the importance of identifying measures within prevention that include all populations.

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

In October 2008, a statewide prevention conference was held that included Drug Free Communities, Safe and Drug Free Community, Strategic Prevention Framework sub-grantees, and Substance Abuse Prevention and Treatment Block Grant Prevention recipient. This two day conference hosted more than 150 attendees who actively participated in a wide variety of workshops, learning and networking opportunities. Additionally, in December of 2008, Governor Heineman and First Lady Sally Ganem kicked-off the Nebraska Chapter of Mother's Against Drunk Driving *Annual Tie One On For Safety* campaign with a primary message of urging everyone to "drive safe, sober and buckle up" during the holidays and throughout the new year.

FY2010 (Progress)

GOAL # 2. Providing Primary Prevention services: An agreement to spend not less than 20 percent of the SAPT Block Grant on a broad array of primary prevention strategies directed at individuals not identified to be in need of treatment. Comprehensive primary prevention programs should include activities and services provided in a variety of settings for both the general population, and targeted sub-groups who are at high risk for substance abuse.

Specify the activities proposed for each of the six strategies or by the Institute of Medicine Model of Universal, Selective, or Indicated as defined below: (See 42 U.S.C. §300x-22(a)(1) and 45 C.F.R. §96.124(b)(1)).

- 1.) How will the activities/services be operationalized – this may be through direct procurement, subcontractors or grantees, or intra-governmental agreements?

The State of Nebraska's Department of Health and Human Service (DHHS), Division of Behavioral Health (hereafter referred to as the Division) supports the Nebraska Behavioral Health Prevention system through interagency coordination as well as funding prevention activities directly and through a Regional Prevention Coordination System. The following are the Prevention Objectives for the Regions and the State in FY2010 as provided in the FY2009-2010 Regional Budget Plan Guidelines:

A. FY10 BEHAVIORAL HEALTH PRIORITIES These priorities will continue for FY10:

I. Governor's Priorities:

- Complete Behavioral Health Reform, and
- Integrate Children's Behavioral Health Services into the Division of Behavioral Health.

II. Center for Substance Abuse Prevention (CSAP) Priorities:

- Prevent the onset and reduce the progression of substance abuse, including underage drinking;
- Reduce substance abuse related problems in communities; and
- Build prevention capacities and infrastructure at the state/tribal and community levels;

III. Compliance with the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) Priorities:

- The array of substance abuse services will be based on a documented Needs Assessment and corresponding strategic planning.
- The Nebraska Behavioral Health System (NBHS) will collect and utilize data in the planning and monitoring of substance abuse services.
- Regional staff and providers will demonstrate knowledge of SAPTBG requirements.

The expectation of the Regional **Prevention System Coordination** continues to be:

- Regional Coordination of Prevention Services in the Region,
- Quality Assurance/Quality Improvement,
- Integration of Services and Resources with other Systems, and
- Participation in the Statewide Prevention System.

Following is the contractual requirements for Regional Prevention System Coordination for FY2010:

- I. REGIONAL ADMINISTRATION OF PREVENTION SERVICE SYSTEM.** Contractor shall be responsible for Regional Prevention System Coordination in order to ensure a continuum of substance abuse prevention services, in relation to identified prevention needs specific to each its geographic area.

Goal #2: Progress - 20% for Primary Prevention / Page 2

- A. Prevention System Coordinator. Regional Prevention System Coordinator is defined as the region's administrative responsibility to ensure effective use of prevention funds through a regional needs assessment, policy development, the maintenance and monitoring of a Regional Prevention System, and the coordination of local coalitions and other community activities to ensure that prevention services are available, accessible and duplication of efforts are minimized. Regional Coordinators will work cooperatively with the Division of Public Health.
- B. A Regional prevention system coordinator shall be designated by the contractor. Travel to quarterly prevention coordinators meetings held throughout the state shall be budgeted. Travel within the contractor's jurisdiction shall be budgeted to support development, mentoring and maintenance of community coalitions.

II. COMMUNITY COALITIONS. Contractor shall subcontract with community coalitions to implement the Region's prevention plan. Community Coalitions may subcontract with providers per the identified need of the community coalition.

- A. A Community Coalition is defined as a community based organization of individuals representing diverse organizations, factions or constituencies who agree to work together in order to achieve a common goal. The coalition's work includes identification of prevention services and/or strategies designed to specifically reduce or delay the onset of substance abuse.
 - B. Regional Prevention Coordinator shall provide for Training, Technical Assistance and resource development activities in support of community coalitions. Regional Prevention Coordinators may act as fiscal agents to community coalitions at the request of the coalition. The Regional Prevention Coordinator shall ensure that community coalitions know and work on completing the five step strategic prevention framework planning process and that a written plan is available.
 - C. The contractor shall ensure that not less than 50 percent of the Federal Block Grant Funds designated for prevention services are made available to community coalitions through technical assistance, training and a regionally developed grant process in fiscal year 2008. Such funds shall support the communities' implementation of identified prevention strategies through evidence, scientific or promising program based activities identified by the community coalitions through the use of the strategic prevention framework planning process.
 - D. Federal funds cannot be used to contract with a for-profit entity.
- 2.) What activities/services will be provided, expanded, or enhanced – this may include activities/services by treatment modality or prevention strategy?
 - 3.) When will the activities/services be implemented (date) – for ongoing activities/services, include information on the progress toward meeting the goals including dates on which integral activities/services began or will begin?
 - 4.) Where in the state (geographic area) will the activities/services be undertaken – this may include counties, districts, regions, or cities?

The Division allocated the majority of the 20% Primary Prevention funding to the Regions for the purchase of Regional Prevention System Coordination, the provision of technical assistance and training to community coalitions and providers as well as the purchase of prevention activities from local programs/coalitions. As stated above, the Division requires the Regions to utilize 50% of funding to support community based and environmental strategies. This effort was specifically designed to support the capacity development of local prevention coalitions and particularly the current phase of SPF-SIG implementation. The Regions are also expected to utilize the SPF-SIG process in the identification of appropriate activities and measurable outcomes.

The following is summary of Regional Prevention activities in FY2010:

Region 1: The Region 1 Prevention System is an integrated collaboration of partners including local (county) coalitions, a Panhandle wide regional coalition, and other agencies and organizations working together to positively impact substance abuse and its related consequences in the 11 counties of the Panhandle. Among the local coalitions, development and mobilization has varied based on community readiness, investment and inclusivity among stakeholders.

SAPTBG funding is utilized for training, technical assistance, regional coordination and to directly support the strategies and programs of nine local level community coalitions and a regional coalition that comprise the Panhandle Prevention Coalition (PPC). The regional coalition met every month with broad participation from local community coalitions, Panhandle agencies, organizations and individuals. Most local coalitions met monthly and had good participation and support from the 12 community sectors. In FY09 and FY10, the Region placed a great deal of emphasis on training and supporting growth of coalition members, leadership and staff. This includes facilitating the development of strategic plans by coalition membership. Region 1 also conducts an annual review of all SAPTBG funded coalitions. Region 1 Prevention activities in FY2010 included, but were not limited to:

Information Dissemination – Red Ribbon Week, county fairs and health fairs, community festivals, parent teacher conferences.

Alternate Activities – Drug-free youth events held simultaneous to community events, family camp-out, youth camps, pre-teen and teen dances, post prom parties.

Education – Parent/Family night at school, guest speakers, coalition training, presentations to schools and community groups, SHARP (Student Health And Risk Prevention) survey presentations to principals and superintendents, drug and alcohol presentation by the Nebraska State Patrol.

Problem ID and referral – Assisting with the SHARP survey, American College Health Survey (ACHS) and Community Health Assessments.

Environmental – Communities Mobilizing for Change on Alcohol, responsible beverage server training, responsible alcohol merchant award, random student drug testing, "Community Hero" media campaign, local law enforcement assist Nebraska State Patrol with compliance checks and sobriety checks.

Community Based – All-Stars, TeamMates, Hemingford Youth Center, Too Good for Drugs, Circle of Courage, and 40 Developmental Assets training.

Region 2: In Region 2, the development of community teams remains an ongoing priority. Community teams assisted with local assessments and identified priority substance abuse issues, related mental health disorders, and other substance-related problems in their area. Teams currently in place include: North Platte, Ogallala, Dawson County Project Extra Mile and Sutherland.

Region 2 promoted and attended county wide meetings throughout the region on the issues of youth and substance abuse and provided education and information. Region Prevention staff helped establish protocols for communities so that consistent no use messages and policies are developed. In April of 2010, Region 2 sponsored a Chuck Matson speaking tour across the 17 counties. The tour included 19 school presentations to approximately 3,600 students in both middle schools and high schools and two community Town Hall's. Region 2 Prevention activities in FY2010 included, but were not limited to:

Goal #2: Progress - 20% for Primary Prevention / Page 4

Information Dissemination – Project Extra Mile Sticker Shock & “No Free Ride” campaigns, legislative advocacy, and liquor control commission license monitoring. Central Nebraska Coalition Against Substance Abuse campaign against procuring alcohol to minors. Prevention educational materials were distributed at Dundy County Fair, Lincoln Co & Keith Co National Night Out, Town Halls, & community events. Public Service announcements: “Celebrating Sober”, “Rethink Your Reaction”, and various prevention slogan promotions. Project Extra Mile updated prevention brochures and suicide prevention materials available in all Region 2 offices and for Community Connections. Ogallala Youth Committee hosted several community and parent educational workshops.

Alternate Activities – After school programs: Anger Education and Choosing the Best Youth & Family Appreciation Month (April annual event), Post Prom, Rec Center Without Wall activities. TeamMates and Across Ages Mentoring, substance free activities and Teen Court.

Education – HALO (Healthy Alternative for Little Ones), ALL STARS, Common Sense Parenting, Family Education Group, Love & Logic, Active Parenting of Teens, W.A.I.T. Training, Unmasking Sexual Con Games, High Expectations, 40 Developmental Asset Education, Class Action, Parenting & Family Skills Education.

Problem ID and Referral – Participation in the SHARP Survey, Prime For Life, Alcohol Education, Living Sober, Celebrate Recovery and Films & educational materials shared with schools, Keith Co jail & Dawson Co jail.

Environmental – Substance Abuse Prevention Leadership Council, Citizens Alcohol and RBST, Class Action, addressed county liquor licensing issue and community event beer garden procedures, compliance checks & CMCA (Communities Mobilizing for Change on Alcohol). Project Extra Mile legislative advocacy, and liquor control commission license monitoring.

Community Based – Project Extra Mile: Youth group projects/programs and Youth Legislative Day, YMCA Kids Day, Project Alert, Prime for Life, Citizen’s Drug & Alcohol Forum, Coalition for Children, Substance Abuse Leadership Council, Lincoln County Tobacco Coalition, High Expectations, Parent & Community Workshops, Community Action Teams, Southwest Nebraska Child Advocacy Team and Family Night Connections.

Region 3: The Region 3 Prevention system is a multifaceted partnership encompassing community coalitions, agencies, providers and other system partners collaborating to impact substance abuse and its related consequences in a 22 county service area. Region 3 has been focusing on increasing service capacity of community coalitions through the provision of training opportunities regarding evidence-based programs, practices, and policies. The Prevention System Coordinator is a member of a statewide steering committee that met on a weekly basis for the purpose of developing the training materials to be utilized in the training of communities to apply for funding. Contract management is provided to coalitions who receive block grant funds through the on-site audit and programmatic review of coalition activities. Both SAPTBG funded and non funded coalitions typically have separate youth advisory boards associated with the larger coalition and/or work with their local drug-free youth group.

Throughout the FY2010, Region 3 staff participated in committees, helped to develop training materials, hosted meetings and provided technical assistance and training to their five SPF-SIG communities. Based on Training Needs Assessment Survey completed by community coalitions, the following trainings were coordinated by Region 3: Communities Mobilizing for Change on Alcohol training on Oct. 27 & 28, 2009, Protecting You/Protecting Me curriculum training on Feb. 1, 2010, and a 40 Developmental

Goal #2: Progress - 20% for Primary Prevention / Page 5

Assets workshop on May 26, 2010. In addition, coalition members accessed training dollars to attend CADCA's National Leadership Forum and UDETC's Annual National Leadership Conference. Region 3 Prevention activities in FY2010 included, but were not limited to:

Information Dissemination – Info dissemination for all evidence based programming, media campaigns, coalition marketing and recruitment, prevention events notification and training.

Alternate Activities – Youth Leadership Teams/Advisory Boards, Youth Congress events, youth/adult mentoring activities/

Education – *Multiple evidence based programs.

Environmental – Communities Mobilizing for Change on Alcohol training, Community Trials, Responsible Beverage Service and Compliance checks

Community Based – Community group initiatives, development and recruitment, Communities Mobilizing for Change on Alcohol, Community Trials and mentoring programs.

*Funded prevention services including the following evidence-based strategies: All-Stars, Parenting Wisely, Tobacco Compliance Checks, Alcohol Compliance Checks, Responsible Beverage Server Training, Big Brothers/Big Sisters, Strengthening Families, Communities Mobilizing for Change on Alcohol, Project Northland, Class Action, Atlas, Athena, CASA Start, East Texas Experiential Learning Experience, Norms for Rule Setting in School, Project Alert and Family Matters.

Region 4: The Region 4 Prevention System is comprised of agencies, coalitions, organizations, and individuals whose main goal is to reduce alcohol, tobacco and other drug abuse and misuse in a 22 county area. In the past, the Regional Prevention Coordinator was only a part-time position who partnered with many of the local health departments to assist in providing technical assistance and training to the emerging local coalitions. FY10 was considered a transition for Region 4 to begin directly funding local coalitions to build capacity and drive initiatives at the local level. Region 4 offered technical assistance, trainings, assistance with community assessments and resource development to both SAPTBG funded and non SAPTBG funded coalitions. The Regional Prevention Coordinator worked on strategic planning as well as increasing the effectiveness of prevention strategies and funding. On March 2-4, 2010 the Region hosted two CADCA trainings – topics included coalition building, SPF 101, leadership and sustainability. Local coalitions have increased prevention activities across Region 4 and new coalitions have been documented. Another area of growth has been with the tribal community. This Region houses three reservations and four state-recognized tribes. In the past year, much effort has been put forth to build strong partnerships with the tribes and though the work continues, it has been viewed as a success so far.

All SAPTBG funded coalitions submit quarterly reports to the Prevention Coordinator showing completion of objectives and outcomes for the fiscal year. A Regional Prevention System Coordination Satisfaction Survey was distributed through Survey Monkey in December 2009 to SAPTBG funded and non SAPTBG funded coalitions and health departments in the Region 4 area. The results and feedback were used by the Regional Prevention Coordinator to assess how to better serve their local coalitions. Region 4 Prevention activities in FY2010 included, but were not limited to:

Information Dissemination – School speakers, materials given out at P.T conferences

Alternate Activities – Drug-free teen dances, Club NECC, Coffee Nights, and the Junction Youth Center

Education – Keep a Clear Mind and T.R.A.I.L.S.

Environmental – Compliance Checks, Communities Mobilizing for Change on Alcohol, Community Trials, Responsible Beverage Service Training

Community Based – Increasing participation in SHARP surveys, increasing partnerships in local community, developing consistent compliance check system with law enforcement

Region 5: Coalition development and mobilization varies from county to county, based on community investment and inclusivity among various stakeholders within the Region 5 Prevention System. Regional Prevention Coordination provided technical assistance including; mobilization of coalitions as they individually and collectively evolve, bi-annual assessments, and trainings specific to the needs of coalitions. Braided funding streams has advanced coalitions needs to have strong media campaigns in conjunction with their annual strategic plans. Additionally, the Region 5 Prevention Director is active on the State Epidemiological Workgroup.

The Region's youth component is strong and continues to grow, including three youth leadership development events a year. As youth leadership builds capacity, the Region will be working closely with youth struggling with substance abuse and mental health concerns. Youth involvement within their local coalitions takes place in all but three counties. Many of these youth are involved with statewide tobacco prevention. Statewide, regions, coalitions, law enforcement, and treatment providers are working closely through our NE Drug Advisory Board addressing methamphetamine concerns, prescription drug abuse, and a growing trend of marijuana use among youth/adults. Funding that has been provided for development of a strong prevention system in Region 5 has allowed communities to continue working on underage drinking issues as well as alcohol and drug issues throughout the lifespan. Coalitions are also beginning to address local and state policy/legislation. Trainings have allowed coalition leads to network and form alliances with federal/state/local government officials, law enforcement entities, diversion, national speakers and organizations, and youth development pieces.

Evaluation components in Region 5 include the following, NPIRS data collection, bi-annual coalition assessments, quarterly reports, updates/successes during regional coalition meetings, coalition follow-up after technical assistance is provided, utilizing comparison data from the Nebraska Risk and Protective Factors Survey. Region 5 Prevention activities in FY2010 included, but were not limited to:

Information Dissemination – Information disseminated for all evidence-based programming, Diversion, School Community Intervention Program (SCIP), media campaigns, prom and graduation letters from law enforcement, Red Ribbon week, coalition marketing, prevention events notification, trainings, and coalition recruitment.

Alternate Activities – Youth/adult mentoring activities, prevention poster contests with youth, community drug free walk, coalition celebrations, youth dances, June Jam.

Education – Several evidence-based programs including; Health Rocks, 40 Developmental Assets, PSC curriculum, Northland Project, DARE, Diversion education, Community Trials, SCIP trainings, Safe Homes Program. Other educational strategies include trainings, booths, June Jam, Town Hall meetings, Coalition recruitment, prevention events and celebrations, Prevention Awareness Campaigns, Prom/Graduation letters from law enforcement, presentations from law enforcement, Red Ribbon week, community festivals, drug free walk, and media campaigns. State/Regional curriculum development for prevention.

Problem ID and Referral – Diversion, evidence-based programming including Celebrating Families, and the School Community Intervention Program (SCIP).

Environmental – PSC Curriculum (Peru State College), Community Trials, Safe Homes Programs, media campaigns, Prevention Awareness Campaigns, Red Ribbon Week, Drug Free Walk, Environmental Scans, June Jam and various youth activities.

Community Based – Community trials, Celebrating Families, Safe Homes Program, mentoring programs, community celebrations of achievements, community group initiatives, Prevention Leadership Team, community development and recruitment, Town Hall meetings.

Region 6: The Region 6 Prevention System has been working to assess community needs and perceptions by encouraging local participation in state surveys, providing representation on the state epidemiological workgroup, and through the creation of our own local survey instruments. The Region has focused much of its efforts supporting those activities addressing the problems caused through alcohol abuse. In addition, the Region partnered with the State on the creation of a replacement for the Minimum Data Set system to better assess trends, changes, and strategy effectiveness. Region 6 has worked diligently to reduce the barriers that have traditionally separated coalitions by funding stream and focus. Each quarter Region 6 has hosted a regional system coordination meeting and all active prevention coalitions and providers were invited to attend. As a result, many of the area coalitions have cross representation in their membership and this has enhanced their ability to coordinate activities, minimize over lap of services, and to maximize limited resources.

The region plays significant and diverse roles throughout the prevention system. Funded and un-funded coalitions and prevention providers utilize the region for technical assistance and training. Additionally, Omaha has been the focus point for several other developing coalitions/community groups including the Empowerment Network, and Building Bright Futures. The Empowerment Network's focus is primarily on issues affecting the African-American community including violence and drug use. The Building Bright Futures Coalition is involved in children's health reform on all levels, including prevention. This group has garnered attention from community leaders and has been making recommendations to the state legislature on these issues. Region 6 Prevention activities in FY2010 included, but were not limited to:

Information Dissemination – Press releases regarding Compliance Check results. Using media outlets to inform the community about the 40 Developmental Assets and disseminating culturally appropriate materials on the benefits of smoke-free housing.

Alternate Activities – Brief Alcohol Screening and Intervention of College Students (BASICS) and Non-Alcohol sponsored events for college students.

Education – Building Assets-Reducing Risks (BARR) Evidence-Based Program, Peer Lead Education Course, Awareness Campaign of alcohol laws and associated consequences, education of social and health consequences of binge drinking via media campaign and peer leaders, Peer to Peer Programming for Middle and High School Students, annual Asset Building conference, Resource Library Kits in all 5 counties, Youth Advocacy Training, Media Campaign Targeting 18-24 Year-olds, Youth Minority Congress events, Publish Compliance Check Results in Newsletter, Speakers Bureau, business recognitions for 100% Tobacco-Free Policies, Law Enforcement trainings, Meth 360 Trainings, '360' Community Trainings on gateway drugs, Business Recognitions for 100% tobacco-free policies, and educating businesses/individuals on the benefits of smoke-free housing.

Goal #2: Progress - 20% for Primary Prevention / Page 8

Problem ID and Referral – Needs Assessment, conduct/participate in American College Health Survey, Collect data from the participants of the BASICS Program, Environmental Scan of the Community for Marijuana Paraphernalia. Survey law enforcement and prosecutors to gain insight regarding marijuana and prescription drugs issues. Assess the human impact of prescription drug abuse in the community. Implement the Developmental Asset Profile (DAP) in Participating Schools. Assess DAP Results to obtain target assets for intervention. Assess NSCS/ATS to determine baseline data for smoke-free homes, survey local tenants living in multi-housing complexes, internal coalition assessment tool administered to several coalitions, and strategic plans updated.

Environmental – Project Prom/Graduation and MIP Party Patrols. Several Media Campaigns including ‘Be The Difference’. Responsible Beverage Server Training. Coordinate Drug Disposal Sites in the community for Prescription Drugs. Assisting businesses, multi-family housing, faith-based organizations, and educational facilities to adopt policies for indoor and outdoor tobacco-free policies. Inspect and follow-up with retailers to ensure compliance with State Clean Air Law. Quarterly Compliance Checks and follow-up visits to retailers.

Community Based – TRACE Program, 40 Developmental Asset Seal of Approval Stipend Program, Youth Group Development in Cass County, improving communication among medical providers in the community and implementing activities pertaining to DAP Asset results. Tobacco Media Campaign to promote the benefits of smoke-free housing, educational presentations in the community to promote 100% smoke-free environments, and newsletters and other on-going provider communications to educate advocates and policy-makers about local tobacco control activities.

In conjunction with each of the Region’s individual goals, the continued utilization of one specific and statewide goal led our efforts for this year.

Statewide Prevention System Goal: To coordinate a unified prevention system with diverse funding streams that produce outcomes in reducing substance abuse and related problems.

Objective: Increase the capacity (development) level of SAPTBG funded community coalitions.

Activity: Each Region will conduct an assessment on each of their SAPTBG funded coalitions using the online Coalition Capacity Survey. This has been into the 2011 contract as a deliverable. Initially, we will be measuring/establishing our baseline. The results of the assessment will be compiled into a report after January of 2010.

Measure: With the results of the completed assessment, the Regions will be able to identify their own baselines and then agree upon a target performance indicator such as x% of increase growth or readiness to perform prevention activities.

The following is an update on the progress of Nebraska’s Prevention goals for FY2010:

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

The Division of Behavioral Health continues to work with the Division of Public Health Tobacco Free Nebraska, Division of Public Health Community Affairs Office, State Treasurer Office, Nebraska State Patrol and Nebraska Attorney General’s Office. The Work Group met in person several times throughout the year to exchange information from compliance checks and also discuss state’s potential for participation in FDA compliance checks to conduct merchant training and under aged compliance

Goal #2: Progress - 20% for Primary Prevention / Page 9

checks. Field staff from the State Treasurer's office is using the tobacco licensee list developed for the Division of Behavioral Health to review licensee information and to send correct information back to the Division staff.

The tobacco licensee list was developed with the assistance of all the municipal and county clerks of the state. Information is continually updated through clerk and treasure staff reports on new tobacco outlets determined through field observation. During FY 2010 the Division made contact with the Nebraska Supreme Court data system administrators and received a listing of court records that identified violations of tobacco laws and the disposition of those cases from reporting counties. We are currently in the process of analyzing the information for use by the SYNAR committee.

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

Legislation was not introduced at the state level to require tobacco merchant educations. Local communities continue to work with merchants to educate them on the requirements. Under the Family Smoking Prevention and Tobacco Control Act'' the FDA is reported to increasing efforts to educate merchants on the requirements of the law regarding sales to minors and sales of flavored cigarettes. The state of Nebraska does not have any staff charged with the responsibility to conduct and/or develop merchant education. However, the Tobacco Free Nebraska has made materials available to local coalitions to work with merchants. At this time, there is no state sanctioned standard merchant education is in place.

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

Due to time and financial constraints the FY2010 compliance checks were reduced to 481 checks. The contracted and budget amount of \$50,000 was insufficient to continue the previous number of checks. It was the State Patrol administration position that the SYNAR checks must fund the entire cost. Therefore, the current negotiated rate of \$128 per survey resulted in only 390 Patrol surveys being conducted. PRIDE Omaha conducts surveys using the Omaha Police Department and charges a lower fee per survey.

The Division's SYNAR workgroup met to discuss making initial application to FDA Tobacco Enforcement checks under the "Family Smoking Prevention and Tobacco Control Act". The group reviewed application materials and determined that Nebraska would not be able to meet the stringent requirement for staffing, training of cooperating individuals, officers' certifications, and evidence handling at this time.

2.4 -- The Division of Behavioral Health will contract with Regional Behavioral Health Authorities for prevention system coordination, training and technical assistance via a Prevention Coordinator in each of the six regions.

Each of the six Regional Behavioral Health Authorities has a designated prevention coordinator, and prevention staff. Regions 1, 3, 5, and 6 have more than one full-time staff member devoted to the prevention effort. Region 2 has one full time coordinator and two part time staff. Region 4 welcomed a new coordinator in June of 2010. Regional staff continued meeting throughout the year to finalize content and identify appropriate training of trainer activities for the Nebraska Training for Substance Abuse

Goal #2: Progress - 20% for Primary Prevention / Page 10

Prevention (NETSAP 101) training curriculum for prevention specialists and staff/volunteers as well as community leaders working in prevention. The training workgroup also received significant technical assistance regarding content and piloting modules at a time for content, style, format and venue success.

Regional staff provided ongoing technical assistance and training to local community coalitions on the Strategic Prevention Framework, and working with local officials to foster environmental and community based prevention efforts based on the sound planning principles of the strategic prevention framework.

The Division worked in partnership with the Regional Prevention Coordinators towards a revision of their statewide prevention coordination goal as it pertains to the state to region contract. Consensus was reached to identify one unified goal, objective and measure for the state to track in order to 1) utilize a single common reporting measure for performance based contracting, 2) utilize a single common goal and objective to unify the state's prevention coordination efforts. This goal will allow for flexibility in each region for local circumstances and growth as well as frame direction annually.

2.5 -- Under the Department of Health and Human Services, the Division of Behavioral Health and Division of Public Health will make available data for community planning designed to provide decision making support to community coalitions.

This effort has been delayed due to the development of 16 specific community profiles to answer the data needs of the 16 SPF-SIG sub-grantees of Nebraska. Each of the 16 sub-grantees were provided a data compendium to support their strategic prevention framework in the planning stage of their grants. Currently, the Division of Behavioral Health and the Division of Public Health are collaboratively planning for the opportunities for shared data collection, measureable elements and system utilization and reporting. This goal will continue to be a focused effort for FY2011. Opportunities for community coalitions to communicate the progress and specifics of their work were made available at various forums so that preventionists across the state might understand the scope of work being accomplished within the larger context (statewide), and potentially benefit by lessons learned via others' experiences within their local communities.

2.6 -- The Division of Behavioral Health and the Division of Public Health will support the Nebraska Prevention Information Reporting System (<http://www.NPIRS.org>) for Block Grant and SPF-SIG funded entities. With the assistance of Region 6 Behavioral Health Authority and our internal quality assurance team, we will work to improve this system and ideally prepare it for use as a statewide prevention reporting system available for use by other prevention agencies/coalitions that may have other funding such as Drug Free Communities.

The current NPIRS system is an internet based prevention reporting system that was developed with the concept of communities, regions and the state all requiring similar information for prevention data collection and reporting. Community coalitions are able to review progress in the development of planning and implementation activities. Regions can also review all of their communities together or separately in their region and the state has the ability to review regional and statewide activities.

The contract with Region 6 Behavioral Health was extended for an additional three months to transfer the management and hosting of this program to a new vendor. Negotiation with Orion Healthcare Technology took place throughout the spring and entered into contract in July of 2010. In consultation with Orion, the Division has begun to explore and analyze our projected needs for this system to be fully functional for statewide use. In addition, as the Division of Public Health progresses into the

Goal #2: Progress - 20% for Primary Prevention / Page 11

Implementation Phase of the SPF-SIG, they are working collaboratively with their contracted evaluative technical assistance provider, the Research Triangle Institute (RTI), to determine appropriate data elements, reporting requirements and best collection mechanisms. The two Divisions are collectively reviewing the current NPIRS system and reassessing the framework, utilization ease and potential use to better serve the community as well as the meet the state and federal requirements.

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

The Nebraska Department of Health and Human Services, Division of Public Health has been given the responsibility for the epidemiological study of Nebraska substance abuse prevention and treatment needs. Several Division of Behavioral Health staff actively participates in the epidemiological work group, and in meetings with Public Health to define data elements, measures and resource needs as well as review study and interpret report for best next steps in statewide system planning. This group continues to work toward the goal of increasing awareness of substance abuse and sustaining support for substance abuse prevention beyond the SPF SIG.

2.8 -- The Division of Behavioral Health will work with the Division of Public Health and the Division of Children and Family Services to promote a system of care that includes prevention activities. This goal will support the 'flip of the pyramid' with a purposeful intention of providing a more integrated and comprehensive behavioral health system of care for children, youth and adolescents.

Of late, multiple events have increased the collaboration of Divisions serving youth and adults experiencing behavioral health challenges. In 2007 Legislative Bill 542 was passed, re-energizing a new focus on children's behavioral health. And with the merger of the three agencies of the Health and Human Services System into one Department of Health and Human Services (DHHS) in 2007, the ability to coordinate, communicate and manage the Children's Behavioral Health System has become increasingly less challenging.

The following are some examples of our progress this year. Each of the six Behavioral Health Regions now have multidisciplinary teams designed to assist youth with transitioning their services from child-serving agencies to the adult behavioral health system. The Statewide Helpline, Family Navigator's and Right Turn are new services added to our continuum. The Help Line now provides a single point of contact that's available 24 hours a day, seven days a week, operated by trained personnel and supervised by licensed behavioral health professionals for families experiencing a youth-related crisis. Family Navigators assists families with navigating the behavioral health system and are provided by individuals who have lived-experience with youth with behavioral health problems. Assistance for post-adoption/post guardianship families will be provided through the Right Turn program in effort to prevent adoption and guardianship disruptions and promote permanency.

Partnerships with the Department of Education and Vocational Rehabilitation, the Nebraska Federation of Families for Children's Mental Health and the Juvenile Court System have also improved. Lastly, Nebraska's In-Depth Technical Assistance (IDTA) project involving six systems partners is working together to achieve systems integration and coordination for the benefit of children and families.

2.9 -- The Division of Behavioral Health in cooperation with regional Prevention Coordinators will fund training events throughout the state to introduce, enhance and improve the use of evidence based, promising and local prevention strategies; in particular to support their local community goals for the reduction of underage drinking, reduction of driving under the influence and reduction of binge drinking.

Goal #2: Progress - 20% for Primary Prevention / Page 12

The Regions are working with the Division of Behavioral Health and the Division of Public Health to coordinate local planning efforts among the 16 SPF-SIG sub-grantees and with local coalitions who did not receive SPF-SIG funds and who may be receiving block grant funds. These training efforts have also included topics such as cultural competency and the importance of identifying measures within prevention that include all populations. Together, we are continuing to build on and expand the scope of collaborative relationships with additional stakeholders as an on-going process.

2.10 -- The Division of Behavioral Health and the Division of Public Health will partner to provide guidance and funding in support of a statewide prevention conference that invites all prevention entities to foster networking among community coalitions, prevention professionals and agencies.

The theme for this year's prevention conference was "The Power of Prevention." Held in November of 2009, this one day conference included Drug Free Communities, Safe and Drug Free Community, Strategic Prevention Framework sub-grantees, and Substance Abuse Prevention and Treatment Block Grant Prevention recipients. Over 125 people attended from throughout the state. Several key speakers presented including Dennis Embry, Sally Zellers and Clay Roberts. Local panels were provided on topics ranging from cultural competency, youth gambling prevention, and the role of faith based organizations in addressing substance abuse prevention. In the spring of 2010, the University of Nebraska/Lincoln Collegiate Consortium sponsored the 2nd in the series of alcohol prevention workshops attended by State Prevention staff and coalitions. The event broadened assessment and prevention to discussion of specific college prevention planning.

2.11 -- The Division of Behavioral Health will work with the Division of Public Health to facilitate the implementation of the Nebraska Risk and Protective Factor Survey in FY2010.

The Division of Public Health has been collaborating with the Nebraska Department of Education to conduct school survey advisory committee meetings and finalize plans for the Student Health and Risk Prevention (SHARP) Survey. SHARP consists of three public health school-based student health surveys in Nebraska including the Nebraska Risk and Protective factor Student Survey (NRPFSS), the Youth Risk Behavior Survey (YRBS), and the Youth Tobacco Survey (YTS). A series of workshops were delivered in each of the six behavioral health regions to educate and garner further support for SHARP administration in [urban and other] school-based settings. The Young Adult Alcohol Opinion Survey (also referred to as the binge-drinking survey) is being administered across the state to measure attitudes and behaviors of individuals aged 19-25 years. The results will be available in the fall of 2010.

2.12 -- The distribution and marketing of the Nebraska produced video: Your Kids are Drinking via media outlets, prevention coalitions, behavioral health providers and community partners.

Nebraska was one of eleven states given the opportunity to develop an hour long video to support local community coalitions. Narrated by Candy Kennedy of the Federation of Families for Children's Mental Health, the video highlights the hard work of several community coalitions in planning for and implementing substance abuse prevention activities. The video is comprised of scenes, discussion, narrative and facts including a visit to a small town celebration where heavy drinking is a tradition and families protect their teenage drinkers. In a larger community, cameras capture under-age decoys purchasing liquor from stores and restaurants; and a family discusses their tragic story of consequences and a panel discussion. This product was produced in partnership with NET Television and funded in part by the Nebraska Office of Highway Safety, DHHS, Mutual of Omaha, Methodist Health System and State Farm Insurance. The documentary was featured on public access television and cable channels across the state and has been distributed to prevention coalitions, stakeholders and community level partners.

Goal #2: Progress - 20% for Primary Prevention / Page 13

The video's final scene is a card with The Nebraska Department of Health and Human Services has encouraged coalitions to utilize the video at civic events, schools, local media, and Cable TV outlets, to expand understanding of coalition's efforts, recruit new members, and to encourage the development of additional coalitions in other communities. Macro International produced this video through a contract with the United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, under the auspices of the STOP Act (Sober Truth on Preventing Underage Drinking Act (P. L. 102-422)).

Goal #3: Providing specialized services for pregnant women and women with dependent children

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

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Prenatal care; Residential treatment services; Case management; Mental health services; Outpatient services; Education Referrals; Training/TA; Primary medical care; Day care/child care services; Assessment; Transportation; Outreach services; Employment services; Post-partum services; Relapse prevention; and Vocational services.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

GOAL #3: Intended Use – Providing Specialized Services for Pregnant Women and Women with Dependent Children / September 3, 2010 / Page 1

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

FY2011 – FY2013 Intended Use/Plan

(1) Who will be served? Describe the target population and provide an estimate of the number of persons to be served in the target population.

- Treatment services are made available to pregnant women and women with dependent children who have a Substance Use Disorder as documented in their Substance Abuse Assessment.
- Following is a list of providers, by region, that provide treatment services for pregnant women and for women with dependent children.

Region	Provider
1	Panhandle Mental Health Center
1	Human Services, Inc.
2	Region II Human Services
3	St. Francis Alcohol and Drug Treatment Center
3	South Central Behavioral Services
3	The Bridge, Inc.
4	Well Link, Inc.
5	St. Monica's Home
5	Lincoln Medical Education Foundation
6	Heartland Family Services/ Family Works

(2) What activities/services will be provided, expanded, or enhanced? This may include activities/services by treatment modality or prevention strategy.

The following activities/services will be provided to pregnant women and women with dependent children:

- Gender specific substance abuse treatment
- Pre-natal care
- Primary medical care for women
- Primary pediatric care
- Therapeutic interventions for children
- Transportation to ensure access to services
- Child care while mother is receiving services, and
- Case management to assist the mother with her recovery and promote the child's safety, permanency, and well-being.

GOAL #3: Intended Use – Providing Specialized Services for Pregnant Women and Women with Dependent Children / September 3, 2010 / Page 2

These activities/services are delivered either by the agency providing the primary treatment (subcontractor) to women or by a different agency who has been identified by the treatment agency as having greater expertise, experience, or capacity to provide the service/activity while the mother is receiving primary treatment.

Treatment agencies (subcontractors) who utilize a different organization to provide a specific service/activity enter into a documented working agreement which outlines the nature of the activity to be provided. The documents are maintained by both the Regional Behavioral Health Authority (RBHA) and the Division of Behavioral Health (DBH) and are updated annually.

An example of the monitoring form (WSA-1) used by the six RBHA's to monitor these activities/services can be found in the Attachment at the end of this document. These monitoring forms are submitted by the Regional Behavioral Health Authorities to the Division of Behavioral Health for annual review and approval.

- (3) When will the activities/services be implemented (date)? For ongoing activities/services, include information on the progress toward meeting the goals including dates on which integral activities/services began or will begin.

The actual activity/services are implemented during the time the mother is receiving treatment. The DBH requires, through our contracts with the six RBHA's, that each of the previously listed services/activities be required in their contracts with treatment providers. These required activities/services were included in the last contract with the RBHA's on July 1, 2010. Goals are reviewed and reassessed during the regional budget planning process. The RBHA's ensure compliance via the Site/Audit visits they conduct with contracted providers. The WSA-1 monitoring tool used by the RBHA's can be found in the Attachment at the end of this document.

- (4) Where in the State (geographic area) will the activities/services be undertaken? This may include counties, districts, regions, or cities.

The activities/services identified above are provided to pregnant women and women with dependent children throughout the State of Nebraska. Each of the six RBHA's has contracts with providers who are responsible for ensuring that activities/services are available to women regardless of her county of residence.

- (5) How will the activities/services be operationalized? This may be through direct procurement, subcontractors or grantees, or intra governmental agreements.

Activities/services for pregnant women and women with dependent children are operationalized on two levels. First, they are required via the Division's contracts with the six RBHA's. Secondly, they are required through contracts between the Regional Behavioral Health Authorities and qualified substance abuse providers (subcontractors) serving their geographic area.

In 2009, the DBH provided training to over 100 individuals (RBHA's and Substance Abuse providers) regarding these specific contractual requirements for activities/services related to pregnant women and women with dependent children. During this statewide training, the Division of Behavioral Health stressed the importance of provider collaboration with the Division of Children and Family Services to ensure coordination with case planning and treatment, preventing duplicated efforts, sharing of information for integrated case management/planning and to ensure

GOAL #3: Intended Use – Providing Specialized Services for Pregnant Women and Women with Dependent Children / September 3, 2010 / Page 3

that both Divisions within the Department of Health and Human Services are sharing resources that will ultimately benefit a mother and her children. While this training was an important first step, the Division of Behavioral Health, in collaboration with the Division of Children and Family Services, continues to plan for the expansion of these training opportunities to the Division of Children and Family Services' workforce. This training is one of the goals of the In-Depth Technical Assistance (IDTA) Project, which involves six systems working together to achieve systems integration and coordination for the benefit of children and families. These systems include the Legal System, Child Protective Services, Substance Abuse (Behavioral Health), Medicaid and Long-Term Care, Supreme Court Probation, and the Nebraska Federation of Families.

Nebraska's leaders identified the priority population for this IDTA as all families entering the child welfare/juvenile services system due to problems related to parental substance use, with particular emphasis on substance exposed infants, methamphetamine dependent parents, and children in out-of-home care. To address the needs of this population, Nebraska's partnership has identified the following major products for completion during the IDTA:

Product 1: A cross-system data sharing plan.

Product 2: A coherent funding plan that maximizes the effectiveness of state funds, minimizes confusion about payment source, and expedites parental access to treatment.

Product 3: A protocol that specifies an improved process and cross-systems communication plan aligned with each step of a family's progress through the Child Welfare/Substance Abuse/Court systems.

Product 4: A substance abuse screening tool and associated communication protocol.

Product 5: A cross-system training calendar that includes new training opportunities for all IDTA stakeholders.

Anticipated long-term outcomes (one to two years) for Nebraska's Division of Children and Family Services (DCFS) – involved parents with substance use disorders are:

- Increased reunifications
- Fewer children in foster care
- Shorter child stays in foster care
- Increased family well-being
- Improved Child Family Services Review (CSFR) scores for multiple well-being items
- Greater cost savings to the systems involved
- Reduction in Substance Exposed Newborns (SEN)
- Increased safety, permanency, and well-being of children

Anticipated outcomes for the Division of Behavioral Health are:

- Improved access to treatment services
- Improved retention while in treatment
- Data-sharing capacity
- Integrated care coordination

GOAL #3: Intended Use – Providing Specialized Services for Pregnant Women and Women with Dependent Children / September 3, 2010 / Page 4

• Attachment – WSA – 1

Women's Set Aside Services/Required Service Components Checklist

Department of Health and Human Services
Division of Behavioral Health

Name of Agency: _____
Region: _____
Date: _____

METHOD OF SERVICE PROVISION COLUMNS: Place an "X" in the column box corresponding to services that are presently being provided (e.g. Directly, Affiliation Agreement, Contract). Complete a grid for each service purchased with Women's Set Aside Funds (state, cash and federal). In the Notes Section, please indicate who will provide the services if not offered directly.

Service Purchased: _____

Required Activities/Services	Directly	Affiliation Agreement	MOU	Contract	Notes
1. Gender Specific substance abuse treatment and other therapeutic interventions for women that may address issues of relationships, sexual and physical abuse and parenting					
2. Pre-natal care					
3. Primary medical care for women who are receiving substance abuse services					
4. Primary pediatric care including immunizations for children of women receiving substance abuse services					
5. Therapeutic interventions for children in custody of women in treatment which may, among other things, address their developmental needs, and their issues of sexual and physical abuse and neglect.					
6. Transportation services to ensure that women and children have access to services					
7. Child care while receiving services					
8. Sufficient case management to ensure access to services.					

GOAL #3: Compliance – Providing Specialized Services for Pregnant Women and Women with Dependent Children / September 24, 2010 / Page 1

An agreement to expend not less than an amount equal to the amount expended by the State for FY1994 to establish and/or maintain new programs or expand and/or maintain the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children; and, directly or through arrangements with other public or nonprofit entities, to make available prenatal care to women receiving such treatment services, and, to make available child care while the women are receiving services. [See 42 U.S.C. §300x-22(b)(1)(C) and 45 C.F.R. §96.124(c)(e)].

FY2009 (Compliance):

- (1) **Who** will be served – describe the target population and provide an estimate of the number of persons to be served in the target population;
- Treatment services are made available to pregnant women and women with dependent children who have a Substance Use Disorder as documented in their Substance Abuse Assessment.
 - The table below provides historical data on the number of pregnant women and women with dependent children the Division of Behavioral Health (DBH) served in FY2008 and FY2009.

Unduplicated Count of Persons Served With Women's Set Aside Dollars				
Provider	SFY2008		SFY2009	
	Number	Percent	Number	Percent
Panhandle Mental Health Center	26	3.7	15	2.6
Human Services, Inc.	16	2.3	20	3.4
Region II Arm in Arm	59	8.5	67	11.5
St. Francis Alcohol and Drug Treatment Center	276	39.8	196	33.6
South Central Counseling	192	27.7	167	28.6
The Bridge, Inc.	47	6.8	53	9.1
Well Link, Inc.	18	2.6	13	2.2
St. Monica's Home	32	4.6	27	4.6
Lincoln Medical Education Foundation	0	0.0	0	0.0
Santa Monica, Inc.	28	4.0	25	4.3
Total	694	100	583	100

Source: Magellan data reports, FY2008 and FY2009.

NOTE: To obtain unduplicated count of persons served, the Division used social security numbers and dates of birth to identify unique clients in the data system.

- (2) **What** activities/services will be provided, expanded, or enhanced – this may include activities/services by treatment modality or prevention strategy;

The following services were directly provided or arranged via a written working agreement that is maintained on file at the DBH:

- Gender specific substance abuse treatment
- Pre-natal care
- Primary medical care for women
- Primary pediatric care
- Therapeutic interventions for children

GOAL #3: Compliance – Providing Specialized Services for Pregnant Women and Women with Dependent Children / September 24, 2010 / Page 2

- Transportation to ensure access to services
- Child care while receiving services
- Sufficient case management

An example of the form (WSA-1) used by the six Regional Behavioral Health Authorities (RBHA's) to monitor these activities/services can be found in the Attachment at the end of this document.

- (3) **When** will the activities/services be implemented (date) – for ongoing activities/services, include information on the progress toward meeting the goals including dates on which integral activities/services began or will begin;

Activities/services for pregnant women and women with dependent children are implemented each year upon award of a contract. Progress towards program goals was reassessed at the time Regional Budget Plans were proposed. Continuous implementation occurred throughout the contract year based on the needs of the consumer as identified in their individual treatment plan. Technical assistance regarding clarification of the requirements for Women's Set Aside funded programs was provided in each Region on a one to one basis and during several Statewide Audit Workgroup meetings.

- (4) **Where** in the State (geographic area) will the activities/services be undertaken – this may include counties, districts, regions, or cities;

Activities/services for pregnant women and women with dependent children are undertaken in each of the six behavioral health regions in Nebraska. These are described in GOAL #1, FY 2010 (Intended Use) - Continuum of Services in Nebraska under the section on Regional Behavioral Health Authorities.

- (5) **How** will the activities/services be operationalized – this may be through direct procurement, subcontractors or grantees, or intra-governmental agreements.

Activities/services for pregnant women and women with dependent children are operationalized on two levels. They are first outlined in contracts between the State and the Regional Behavioral Health Authority. Secondly, they are described through contracts between the Regional Behavioral Health Authorities and qualified substance abuse network providers serving their geographic area. From the Division of Behavioral Health point of view, these providers are considered subcontractors. All qualifying program services are offered directly through each of these Women's Set Aside funded programs or through affiliation agreements with agencies in the area upon the consumer's request.

GOAL #3: Compliance – Providing Specialized Services for Pregnant Women and Women with Dependent Children / September 24, 2010 / Page 3

Attachment – WSA – 1

Women's Set Aside Services Qualifying Service Components Checklist

*Department of Health and Human Services
Division of Behavioral Health*

Name of Agency: _____
Region: _____
Date: _____

METHOD OF SERVICE PROVISION COLUMNS: Place an "X" in the column box corresponding to services that are presently being provided (e.g. Directly, Affiliation Agreement, Contract). Complete a grid for each service purchased with Women's Set Aside Funds (state, cash and federal). In the Notes Section, please indicate who will provide the services if not offered directly.

Service Purchased: _____

Qualifying Services	Directly	Affiliation Agreement	MOU	Contract	Notes
1. Gender Specific substance abuse treatment and other therapeutic interventions for women that may address issues of relationships, sexual and physical abuse and parenting					
2. Pre-natal care					
3. Primary medical care for women who are receiving substance abuse services					
4. Primary pediatric care including immunizations for children of women receiving substance abuse services					
5. Therapeutic interventions for children in custody of women in treatment which may, among other things, address their developmental needs, and their issues of sexual and physical abuse and neglect.					
6. Transportation services to ensure that women and children have access to services					
7. Child care while receiving services					
8. Sufficient case management to ensure access to services.					

GOAL #3: Progress – Providing Specialized Services for Pregnant Women and Women with Dependent Children / September 24, 2010 / Page 1

An agreement to expend not less than an amount equal to the amount expended by the State for FY1994 to establish and/or maintain new programs or expand and/or maintain the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children; and, directly or through arrangements with other public or nonprofit entities, to make available prenatal care to women receiving such treatment services, and, to make available child care while the women are receiving services, child care [See 42 U.S.C. §300x-22(b)(1)(C) and 45 C.F.R. §96.124(c)(e)].

FY2010 (Progress)

- (1) **Who** will be served – describe the target population and provide an estimate of the number of persons to be served in the target population;
- Treatment services are made available to pregnant women and women with dependent children who have a Substance Use Disorder as documented in their Substance Abuse Assessment.
 - The table below provides historical data on the number of pregnant women and women with dependent children the Division of Behavioral Health (DBH) served in FY2009 and FY2010.

Unduplicated Count of Persons Served With Women's Set Aside Dollars				
Provider	SFY2009		SFY2010	
	Number	Percent	Number	Percent
Panhandle Mental Health Center	33	3.3%	27	2.7%
Human Services, Inc.	34	3.4%	45	4.5%
Region II Human Services	38	0.2%	46	0.1%
St. Francis Alcohol and Drug Treatment Center	262	26.0%	236	23.4%
South Central Behavioral Services	246	24.4%	259	25.7%
The Bridge, Inc.	92	9.1%	98	9.7%
Well Link, Inc.	34	3.4%	18	1.8%
St. Monica's Home	269	26.7%	268	26.6%
Lincoln Medical Education Foundation	1	0.1%	10	1.0%
Santa Monica, Inc.	36	3.6%	45	4.5%
Total	1009	100.0%	1007	100.0%

NOTE: (a) For FY2010, with the community based services (Magellan Health) data, only the persons admitted to a substance abuse service or a dual service (consumers who received a specialized program including both mental health and substance abuse services) were counted.
 (b) To obtain unduplicated count of persons served, the Division used social security numbers and dates of birth to identify unique clients in the data system.
 (c) Funding for Santa Monica, Inc. was discontinued at the end of FY2010, and was transferred to another provider beginning FY2011

- (2) **What** activities/services will be provided, expanded, or enhanced – this may include activities/services by treatment modality or prevention strategy;

The following activities/services were provided to pregnant women and women with dependent children:

GOAL #3: Progress – Providing Specialized Services for Pregnant Women and Women with Dependent Children / September 24, 2010 / Page 2

- Gender specific substance abuse treatment
- Pre-natal care
- Primary medical care for women
- Primary pediatric care
- Therapeutic interventions for children
- Transportation to ensure access to services
- Child care while mother is receiving services, and
- Case management to assist the mother with her recovery and promote the child's safety, permanency, and well-being.

These activities/services are delivered either by the agency providing the primary treatment (subcontractor) to women or by a different agency who has been identified by the treatment agency as having greater expertise, experience, or capacity to provide the service/activity while the mother is receiving primary treatment.

Treatment agencies (subcontractors) who utilize a different organization to provide a specific service/activity enter into a documented working agreement which outlines the nature of the activity to be provided. The documents are maintained by both the Regional Behavioral Health Authority (RBHA) and the Division of Behavioral Health (DBH) and are updated annually.

An example of the monitoring form (WSA-1) used by the six RBHA's to monitor these activities/services can be found in the Attachment at the end of this document. These monitoring forms are submitted by the RBHA's to the DBH for review and approval.

- (3) **When** will the activities/services be implemented (date) – for ongoing activities/services, include information on the progress toward meeting the goals including dates on which integral activities/services began or will begin;

The activities/services are implemented during the time the mother is receiving treatment. The DBH requires, through our contracts with the six RBHA's, that each of the previously listed activities/services be required in their contracts with treatment providers. These required activities/services were included in the FY2010 contract with the RBHA's. Goals are reviewed and reassessed during the regional budget planning process. The RBHA's ensure compliance via the Site/Audit visits they conduct with contracted providers. The WSA-1 monitoring form used by the RBHA's can be found in the Attachment at the end of this document.

- (4) **Where** in the State (geographic area) will the activities/services be undertaken – this may include counties, districts, regions, or cities;

The activities/services identified above were provided to pregnant women and women with dependent children throughout the State of Nebraska. Each of the six RBHA's has contracts with providers who are responsible for ensuring that activities/services are available to women regardless of her county of residence.

- (5) **How** will the activities/services be operationalized – this may be through direct procurement, subcontractors or grantees, or intra-governmental agreements.

Activities/services for pregnant women and women with dependent children are operationalized on two levels. First, they are required according to the Division's contracts with the six RBHA's.

GOAL #3: Progress – Providing Specialized Services for Pregnant Women and Women with
Dependent Children / September 24, 2010 / Page 3

Secondly, they are required through contracts between the RBHA's and qualified substance abuse providers (subcontractors) serving their geographic area.

In 2009, the DBH provided training to over 100 individuals (RBHA's and Substance Abuse providers) regarding these specific contractual requirements for activities/services related to pregnant women and women with dependent children. During this statewide training, the Division of Behavioral Health stressed the importance of provider collaboration with the Division of Children and Family Services to ensure coordination with case planning and treatment, preventing duplicated efforts, sharing of information for integrated case management/planning and to ensure that both Divisions within the Department of Health and Human Services are sharing resources that will ultimately benefit a mother and her children. While this training was an important first step, the Division of Behavioral Health, in collaboration with the Division of Children and Family Services, intended to expand these training opportunities in 2010 to the Division of Children and Family Services' workforce. This training was included as one of the goals of the In-Depth Technical Assistance (IDTA) Project, which involves six systems working together to achieve systems integration and coordination for the benefit of children and families. These systems include the Legal System, Child Protective Services, Substance Abuse (Behavioral Health), Medicaid, Supreme Court Probation, and the Nebraska Federation of Families.

Nebraska's leaders identified the priority population for this IDTA as all families entering the child welfare/juvenile services system due to problems related to parental substance use, with particular emphasis on substance exposed infants, methamphetamine dependent parents, and children in out-of-home care. To address the needs of this population, Nebraska's partnership has identified the following major products for completion during the IDTA:

Product 1: A cross-system data sharing plan.

Product 2: A coherent funding plan that maximizes the effectiveness of state funds, minimizes confusion about payment source, and expedites parental access to treatment.

Product 3: A protocol that specifies an improved process and cross-systems communication plan aligned with each step of a family's progress through the Child Welfare/Substance Abuse/Court systems.

Product 4: A substance abuse screening tool and associated communication protocol.

Product 5: A cross-system training calendar that includes new training opportunities for all IDTA stakeholders.

GOAL #3: Progress – Providing Specialized Services for Pregnant Women and Women with
Dependent Children / September 24, 2010 / Page 4

Attachment – WSA – 1

Women's Set Aside Services/Required Service Components Checklist

*Department of Health and Human Services
Division of Behavioral Health*

Name of Agency: _____
Region: _____
Date: _____

METHOD OF SERVICE PROVISION COLUMNS: Place an "X" in the column box corresponding to services that are presently being provided (e.g. Directly, Affiliation Agreement, Contract). Complete a grid for each service purchased with Women's Set Aside Funds (state, cash and federal). In the Notes Section, please indicate who will provide the services if not offered directly.

Service Purchased: _____

Required Activities/Services	Directly	Affiliation Agreement	MOU	Contract	Notes
1. Gender Specific substance abuse treatment and other therapeutic interventions for women that may address issues of relationships, sexual and physical abuse and parenting					
2. Pre-natal care					
3. Primary medical care for women who are receiving substance abuse services					
4. Primary pediatric care including immunizations for children of women receiving substance abuse services					
5. Therapeutic interventions for children in custody of women in treatment which may, among other things, address their developmental needs, and their issues of sexual and physical abuse and neglect.					
6. Transportation services to ensure that women and children have access to services					
7. Child care while receiving services					
8. Sufficient case management to ensure access to services.					

Programs for Pregnant Women and Women with Dependent Children (formerly Attachment B)

(See 42 U.S.C. §300x-22(b); 45 C.F.R. §96.124(c)(3); and 45 C.F.R. §96.122(f)(1)(viii))

For the fiscal year three years prior (FY 2008; Annual Report/Compliance) to the fiscal year for which the State is applying for funds:

Refer back to your Substance Abuse Entity Inventory (Form 9 formerly Form 6). Identify those projects serving **pregnant women and women with dependent children** and the types of services provided in FY 2008. In a narrative of **up to two pages**, describe these funded projects.

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

In up to four pages, answer the following questions:

1. Identify the name, location (include sub-State planning area), Inventory of Substance Abuse Treatment Services (I-SATS) ID number (formerly the National Facility Register (NFR) number), level of care (refer to definitions in Section III.4), capacity, and amount of funds made available to each program designed to meet the needs of pregnant women and women with dependent children.
2. What did the State do to ensure compliance with 42 U.S.C. §300x-22(b)(1)(C) in spending FY 2008 Block Grant and/or State funds?
3. What special methods did the State use to **monitor** the adequacy of efforts to meet the special needs of pregnant women and women with dependent children?
4. What sources of data did the State use in estimating treatment capacity and utilization by pregnant women and women with dependent children?
5. What did the State do with FY 2008 Block Grant and/or State funds to establish new programs or expand the capacity of existing programs for pregnant women and women with dependent children?

(See 42 U.S.C. §300x-22(b); 45 C.F.R. §96.124(c)(3); and 45 C.F.R. §96.122(f)(1)(viii))

For the fiscal year three years prior (FY2008; Annual Report/Compliance) to the fiscal year for which the State is applying for funds:

Refer back to your Substance Abuse Entity Inventory (Form 9 formerly Form 6). Identify those projects serving **pregnant women and women with dependent children** and the types of services provided in FY2008. In a narrative of **up to two pages**, describe these funded projects.

Provider		Services
ID	Provider	
100415	Lincoln Medical Education Partnership	Assessments
100418	St. Francis	Outpatient - SA
100622	Women's Empowering Life Line	Halfway House - SA Dual Residential
300205	Panhandle Mental Health Center	Intensive Outpatient - SA
301708	South Central Behavioral Health Services	Outpatient - SA
750540	Santa Monica	Halfway House - SA Intermediate Residential - SA
900038	St. Monica's Behavioral Health	Outpatient - SA Short Term Residential - SA Therapeutic Community - SA
900335	The Bridge	Therapeutic Community - SA
900566	Region 2 Human Services/Heartland Counseling	Community Support - SA
900699	Human Services	Short Term Residential - SA

In FY2008, Nebraska funded the following qualifying programs to serve pregnant women and women with dependent children:

- Panhandle Mental Health Center (PMHC) – 300205: Offers a program specifically for women and women with children who may be at an increased economic, social and/or health risk. Non-residential substance abuse and mental health services and referral to women’s medical services are provided through their Intensive Outpatient program. In an effort to maximize programs services and enhance client services through more efficient means, PMHC is working towards identifying resources through their in-house programs such as respite providers, foster care parents, and mentors who would be willing to provide short-term day care for clients. Additionally, through their Bridges group, increased on-going efforts are in place to identify women in recovery to provide peer support.
- Human Services – 900699: Is a short term residential treatment service providing intensive substance abuse services combined with safe housing and assistance with daily living to women. Length of stay is typically 30 days. This program offers gender specific counseling, appropriate referrals relating to women’s health and is an individualized treatment program designed to provide a continuum of care which enhances recovery. A classic abstinence based program utilizing a 12-Step philosophy is used.

- Region II ARM in ARM Program – 100985: Is a Community Support program coordinated by Region II Human Services to provide support, treatment, information, education and access to primary medical and child care services for pregnant and/or parenting women who are abusing alcohol or other drugs. Additionally, access to primary pediatric care, gender specific substance abuse and mental health treatment, other therapeutic interventions for women, therapeutic interventions for children, case management and transportation is provided for women and their children. This program is focused assessing individual need and building treatment and support services around those needs. A wrap-a-round model is used combining non-residential and community support services for serving pregnant women and women with children in a rural setting.
- The Bridge – 900335: This unique 9 bed long-term residential treatment program offers a therapeutic community for women who are recovering from alcohol and drug addiction and has implemented an educational model for living skills appropriate to recovering women. In addition to the residential Therapeutic Transitional Community for adult women, the Mom & Me program accommodates dependent children, age eight (8) and under, who are in their mother's care while living in the therapeutic community. Programming for mothers with their children carries a heavy emphasis on pertinent parenting issues. Women in recovery are provided with a secure setting, gender specific counseling and referral to women's health care facilities. Treatment is directed toward overcoming the lack of awareness of the effects of substance-related problems on an individual's life, as well as enhancing an individual's readiness to change.
- Saint Francis Alcohol and Drug Treatment Center – 900731: Is a hospital sponsored primary treatment setting for people age 14 and over who are suffering from alcohol/drug dependency and/or related problems. Outpatient counseling services are provided to pregnant women and a woman with children. Intensive Outpatient involves women and their families in counseling, education, and supportive services. All counseling staff are licensed as alcohol & drug abuse counselors. A variety of services are offered in order to help families learn about the disease of alcoholism and understand the level of treatment their loved ones are receiving through family education groups.
- South Central Behavioral Services (SCBS) – 301708: Offers confidential outpatient substance treatment services that give emphasis to individual strengths and a treatment team approach. These program services are designed to assist individuals coping with substance abuse to lead the most productive and satisfying lives possible. A comprehensive substance abuse assessment is completed and used to develop an individualized service plan, integrating the strengths and abilities of the individual with the needs and preferences identified.
- Women's Empowering Life Line – 100622: Is a nine bed Halfway House offering gender specific counseling and access to women's health services. This program provides transitional 24-hour structured supportive living for adult women seeking to reintegrate into the community after primary treatment. Services include safe housing, structure, and support providing consumers an opportunity to develop and practice their interpersonal and group living skills, strengthen recovery skills and reintegrate into their community, and find or return to employment or school. It is their mission to promote the overall health, well-being, independence, and capabilities of adult women by providing behavioral health treatment and transitional services.

- St Monica's Behavioral Health – 900038: Is a behavioral health treatment organization dedicated to serving women. The Project Mother and Child (PMC) offers residential substance abuse treatment services program for pregnant women and women with children. This project is the only residential substance abuse treatment program in Nebraska for pregnant women and women with young children. Women and their children live together at St. Monica's for up to 18 months and receive treatment services simultaneously. Therapeutic Community is a comprehensive recovery program for women that utilizes a Trauma informed therapeutic community model of four phases: Orientation/Evaluation/Assessment, Employment/Recovery, Community Re-integration, and Relapse Prevention/Aftercare. This program includes Individualized treatment planning, individual and group counseling, psycho-educational groups, psychological assessments and evaluations, parenting education for women with children, and 24-hour staff coverage.
- Lincoln Medical Education Partnership – 100415: The Young Family's Program (YFP) strives to improve the health and well-being of infants, mothers-to-be, and already parenting mothers who are economically disadvantaged and at risk due to medical, psychosocial, educational or financial factors. All pregnant women are screened for alcohol, tobacco and other drug use. Services include outpatient substance abuse counseling, family advocacy, childbirth and infant education and WIC services. The YFP program assesses the needs of pregnant and parenting women and their families. Program services are closely coordinated between prenatal care and substance abuse counseling and referrals are made to community agencies for supplementary help.
- Santa Monica – 750540: Offers a residential treatment program which includes individual and group counseling, 12-step meetings and relapse prevention that emphasizes life skills training to handle stresses without dependence on drugs or alcohol. The Halfway House Program, a six to twelve month program, and the Intermediate Residential Program, a twelve to twenty-four month program, offers care to women age 19 and over for up to two years. Program services are designed to stabilize the lives of chemically dependent women and to confront the unique needs of women, which often include issues of depression, economic difficulty, and family responsibilities.

All qualifying program services are available directly through each of these Women's Set Aside funded programs or through affiliation agreements with agencies in the area upon the consumer's request.

Title XIX, Part B, Subpart II, of the PHS Act required the State to expend at least 5 percent of the FY1993 and FY1994 block grants to increase (relative to FY1992 and FY1993, respectively) the availability of treatment services designed for pregnant women and women with dependent children. In the case of a grant for any subsequent fiscal year, the State will expend for such services for such women not less than an amount equal to the amount expended by the State for FY1994.

1. Identify the name, location (include sub-State planning area), Inventory of Substance Abuse Treatment Services (I-SATS) ID number (formerly the National Facility Register (NFR) number), level of care (refer to definitions in Section III.4), capacity, and amount of funds made available to each program designed to meet the needs of pregnant women and women with dependent children.

Nebraska Pregnant Women and Women with Children Program Services Summary

Provider	Location – City (Region)	I-SATS ID#	Services	*Capacity
Panhandle Mental Health Center	Scottsbluff (1)	300205	Intensive Outpatient	10
Human Services	Alliance (1)	900699	Short Term Residential	1-2 beds
Region II Arm in Arm	North Platte (2)	100985	Community Support	30-40
Saint Francis Alcohol Drug Counseling	Grand Island (3)	900731	Outpatient	100
South Central Behavioral Services	Kearney (3) Hastings (3)	301708	Outpatient	120
The Bridge	Hastings (3)	900335	Therapeutic Community	9 beds
Women’s Empowering Life Line	Norfolk (4)	100622	Halfway House	9 beds
St. Monica’s	Lincoln (5)	900038	PMC/ Therapeutic Community	8 women 15 children/ 8 women
Lincoln Medical Education Partnership	Lincoln (5)	100415	Outpatient	220
Santa Monica	Omaha (6)	750540	Halfway House Intermediate Residential	14 beds 4 beds

*The agency wide capacity is reflected for most agencies.

As reported on Form 6 (Substance Abuse Entity Inventory) the actual expenditures for the State Expenditure Period (July 1, 2007 to June 30, 2008) for the SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children is reported below.

Form 6

Substance Abuse Entity Inventory

	1. Entity Number	2. I-SATS ID	3. Area Served	5a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children
Lincoln Medical Education Partnership	100415	100415	South East	\$72,839
Women's Emp. Life Line	100622	100622	North East	\$18,312

South Central Behavioral Health Services	301708	301708	South Central	\$34,035
Santa Monica	750540	750540	South East	\$94,938
St. Monica's Behavioral Health	900038	900038	South East	\$27,869
The Bridge	900335	900335	South Central	\$32,833
Region 2 Human Services/Heartland Counseling	900566	900566	Southwest	\$83,973
St Francis Alcohol-Drug Treatment Center	900731	900731	South Central	\$34,523
			Totals:	\$399,322

2. *What did the State do to ensure compliance with 42 U.S.C. §300x-22(b)(1)(C) in spending FY 2008 Block Grant and/or State funds?*

Each year the state establishes minimum regional allocations of federal, state, and local service funding. The specific set asides for federal funding of women’s services must be met by the respective regions with special emphasis being directed toward building capacity for these services before a contract and funding is awarded. Therefore, as a contractual requirement, the state ensures that, at a minimum, treatment programs receiving funding for such services will provide or arrange for the provision of the following services to pregnant women and women with dependent children, including women who are attempting to regain custody of their children:

- (1) Primary medical care for women, including referral for prenatal care and, while the women are receiving such services, child care;
- (2) Primary pediatric care, including immunization, for their children;
- (3) Gender specific substance abuse treatment and other therapeutic interventions for women which may address issues of relationships, sexual and physical abuse and parenting, and child care while the women are receiving these services;
- (4) Therapeutic interventions for children in custody of women in treatment which may, among other things, address their developmental needs, their issues of sexual and physical abuse, and neglect; and
- (5) Sufficient case management and transportation to ensure that women and their children have access to services provided in (1) through (4) of this section.

The total Women’s Maintenance of Effort is \$753,713.

As part of the Regional Budget Plan proposal process, each Regional Behavioral Health Authority submits a proposed budget plan for all Women’s Set Aside treatment and recovery services to include all revenues supporting the Women’s Set Aside services and all expenses whether paid by state funds from the Division or from other sources.

3. *What special methods did the State use to **monitor** the adequacy of efforts to meet the special needs of pregnant women and women with dependent children?*

The state monitors the adequacy of efforts by programs funded to serve pregnant women and women with dependent children through a number of checks and balances. These methods include monthly financial reports, registration, authorizations and continued care reviews through Magellan Health data system and on-site technical assistance by Division staff, in addition to the waiting list monitoring system.

As a contractual requirement, each Region monitors the provision of services to pregnant women and women with dependent children through audits of program fidelity. *A Program Fidelity Audit is conducted by the Region for their contracted network providers, and by the Division for

Regions who provide these services directly. An internal tracking system ensures that program fidelity audits are completed correctly and in a timely manner. If a corrective action plan is indicated in the program fidelity audit, the Division works with the Region and the provider to ensure that technical assistance is provided in any area where problems are identified.

If any qualifying services are not offered as a direct service provision, the Division mandates that an affiliation agreement be in place with a local entity to ensure that access to such services are made available on request of the consumer. All programs providing such services are encouraged to treat the family as a unit and work toward building capacity that allows admission of both women and their children into treatment services, if appropriate.

4. What sources of data did the State use in estimating treatment capacity and utilization by pregnant women and women with dependent children?

Nebraska utilizes the following data sources for estimating treatment capacity and tracking utilization of services designed to serve pregnant women and women with dependent children:

- Report of Actuals by agencies in the Regional Budget Plans (indicates the previous year's number of clients served);
- Magellan Behavioral Health Services, Management Information System (enumerating the number of clients reported by agencies and the number of units of service authorized for residential and certain high cost outpatient services). The data field which identifies pregnant women in the Magellan data system asks if a woman is pregnant as a yes or no question;
- Nebraska Capacity and Waiting List System reporting on a weekly basis the number of beds/slots available for pregnant women and women with dependent children by the number of beds/slots utilized against capacity by agency at the program level.

5. What did the State do with FY 2008 Block Grant and/or State funds to establish new programs or expand the capacity of existing programs for pregnant women and women with dependent children?

In FY2008, Nebraska maintained funding in all Federal Set Aside programs. Special services for pregnant women and women with children were addressed in contract requirements. Each region was provided allocations of FY2008 block grant funds to establish and maintain programs according to the requirements. As an expectation of the annual Regional Budget Plan proposal process, each Regional Behavioral Health Authority assesses the needs of any priority population in consultation with the waiting list, and in accordance with plans for funding the expansion or creation of a new program as presented. Throughout the entire proposal and review process of each Regional Budget Plan, Division staff work closely with Regional staff to offer technical assistance with behavioral health service planning including, evaluating local, regional and state service needs, goals, and programs, as well as delivery systems for the target population.

Goal #4: Services to intravenous drug abusers

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

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Interim services; Outreach Waiting list(s); Referrals; Methadone maintenance; Compliance reviews; HIV/AIDS testing/education; Outpatient services; Education; Risk reduction; Residential services; Detoxification; and Assessments.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

Goal #4: Services To Intravenous Drug Abusers / Intended Use/Plan / page 1

Goal #4: Services To Intravenous Drug Abusers

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

FY 2011- FY 2013 (Intended Use/Plan): (updated September 30, 2010)

Who – Intravenous Drug Users (IVDU) in need of treatment services are individuals who use hypodermic needles or syringes to take illegal drugs such as heroin, cocaine, or other substances. A person is defined as being in need of services if the individual has a diagnosable substance use disorder with the usual route of admission through needles intravenously and leading to significant functional impairment. The intravenous drug abusers who are in the Substance Abuse Priority Population:

1. Pregnant Injecting Drug Users
2. Injecting Drug Users

When – This is continuously being implemented during the intended use time period.

How – The Division of Behavioral Health (DBH) contracts with each of the six Regional Behavioral Health Authorities (RBHA) to ensure priority access to intravenous drug abusers. The RBHA's contract with treatment providers (subcontractors) within each of their regional areas to provide treatment services for this priority population.

Where – The Division of Behavioral Health (DBH) defines Intravenous Drug Users (IVDU) programs as all funded Substance Abuse Providers. Thus the six Regional Behavioral Health Authorities (RBHA), and providers receiving SAPTBG funds are where IVDU programs are located. There is only one Division of Behavioral Health funded Opioid Replacement Therapy program in Nebraska, BAART Community Healthcare in Omaha. BAART means Bay Area Addiction Research & Treatment Programs.

What – Nebraska has a number of services for Intravenous Drug Users (IVDU). As noted above, the State defines IVDU programs as all funded Substance Abuse Providers and BAART is only funded Opioid Replacement Therapy program in Nebraska. BAART provides Methadone Maintenance. There are Non-Residential Services such as Assessment, Community Support, Intensive Outpatient, Outpatient - SA Assess only, Outpatient Dual, Outpatient, Recovery Support, Community Support (Youth), Intensive Outpatient (Youth) and Outpatient (Youth). There are Residential services such as Dual Disorder Residential, Halfway House, Intermediate Residential, Short-Term Residential, and Therapeutic Community. Detoxification services are considered as part of Emergency substance abuse services which include Social Detox with a Medical Component and Social Setting Detox.

The contract between the Nebraska Department of Health and Human Services – Division of Behavioral Health – Community-Based Services Section and the six Regional Behavioral Health Authorities includes ATTACHMENT F – Federal Block Grant Requirements. This attachment includes a section covering intravenous drug user requirements for programs funded by the Substance Abuse Prevention And Treatment Block Grant.

G. INTRAVENOUS SUBSTANCE USERS/SPECIAL CONSIDERATIONS

1. Individuals requesting treatment for intravenous drug use shall be admitted to a treatment program no later than 14 days after making the request for admission to such a

Goal #4: Services To Intravenous Drug Abusers / Intended Use/Plan / page 2

- program; or 120 days after the date of such request, if no such program has the capacity to admit the individual on the date of the request.
2. Interim Services must be provided within 48 hours of the request for treatment. If the individual has not received a substance abuse evaluation and is requesting treatment, the individual shall be given an appointment for the evaluation within 48 hours, and complete the evaluation within 7 business days.
 3. Upon completion of the substance abuse evaluation (written report), the individual should receive treatment within 14 days or be provided Interim Services until they are able to enter a treatment program.

To see the complete FY2011 Regional Behavioral Health contract ATTACHMENT F - Federal Block Grant Requirements, go to [https://bgas.samhsa.gov/2011/Appendix / Addendum - Additional Supporting Documents \(Optional\)](https://bgas.samhsa.gov/2011/Appendix/Addendum-AdditionalSupportingDocuments(Optional)).

Waiting List/Capacity Management System

In 2009, the Division of Behavioral Health (DBH) completed the planning needed to implement a revised capacity management and waiting list systems for intravenous drug users and pregnant women. The new design has the Behavioral Health Network Providers reporting to Regional Behavioral Health Authority (RBHA) who are the intermediaries – regional entity, who then reports to DBH as the Single State Agency. The weekly reports on capacity include priority persons on waiting lists. In August 2009, Waiting List/Capacity Management procedures and forms were approved. Training was completed for RBHA's and Providers on September 25, 2009. Implementation of the revised Waiting List/Capacity Management system was on October 5, 2009.

As originally designed, each program reports via excel spreadsheets the number of persons and percent of total and regional capacity to the RBHA on Monday of each week. Capacity and waiting list forms are forwarded to the Statistical Analyst at the Division of Behavioral Health on Tuesday afternoons. Division Data Team members are assigned primary responsibility to review and aggregate reports and identify opportunities to improve waiting list management and address capacity issues. The information is also reviewed by the Division's Network Management team and with the RBHA's.

The Weekly Substance Abuse Capacity and Waiting List spreadsheets from each region include the total capacity of the agencies, regional purchased capacity at the time of the submission and percent of both total and regional capacity that is occupied. Each agency lists the number of persons on the total and regional waiting lists followed by the number within each priority populations for the regional capacity. The data also contains weekly substance abuse priority waiting list break outs by region by service, interim service provision and reason for removal from the waiting list.

The annual contract between the Division of Behavioral Health and the Regional Behavioral Health Authority establish the reporting requirements. These contracts also contain additional interim service language. Outreach activities continued to be spelled out in the contract. The contracts stated that IV-drug abusing clients shall be admitted within 14 days of request for treatment, or if no services are available, must be provided with interim services within 48 hours and admitted to treatment with 120 days. Interim services were now defined in the contract.

Contractors and subcontractors were required to report to DBH whenever full (90%) capacity is reached and/or if an IV-drug abusing client is unable to be admitted to service.

Goal #4: Services To Intravenous Drug Abusers / Intended Use/Plan / page 3

For more details, see Capacity Management and Waiting List Systems (formerly Attachment G).

To see the complete Substance Abuse Capacity and Waiting List Report ANNUAL SUMMARY as of September 2010, go to [https://bgas.samhsa.gov/2011/Appendix / Addendum - Additional Supporting Documents \(Optional\)](https://bgas.samhsa.gov/2011/Appendix/Addendum-AdditionalSupportingDocuments(Optional).).

GOAL # 4: Compliance - Intravenous Drug Abusers / September 24, 2010 / Page 1

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

FY 2008 (Annual Report/Compliance)

In FY2008, a Nebraska Core Technical Review was conducted by the Federal Center for Substance Abuse Treatment (CSAT) during April 16-20, 2007. The report, dated September 28, 2007, was valuable feedback to the Nebraska Division of Behavioral Health (DBH). The Division developed a plan of correction which identified a number of strategies to ensure compliance.

On October 28, 2008, Substance Abuse Prevention and Treatment Block Grant 101 training was provided by Federal consultants to Nebraska Division of Behavioral Health staff. This training was provided to DBH staff to ensure an understanding of all block grant requirements.

In the spring of 2009, the Division of Behavioral Health-Community-Based Services (DBH-CBS) Administrator provided training for the Regional Behavioral Health Authorities (RBHA's) and providers in each region. An overview of the grant was provided but the primary focus of the training was on interim services. Here is a summary chart showing the Region, date of the training event, and the number of people attending.

Region	Date	Number Attending
1	March 19, 2009	15
2	March 20, 2009	22
3	May 6, 2009	21
4	April 8, 2009	15
5	June 2, 2009	12
6	May 2, 2009	16
total		101

During the training, the Community Services Administrator emphasized the Substance Abuse Priority Population are:

1. Pregnant Injecting Drug Users
2. Pregnant Substance Abusers
3. Injecting Drug Users
4. Women with dependent Children

During FY2009, the DBH re-organized staff to be more efficient and effective. Data and utilization management was primarily assigned to one manager. The DBH hired a Statistical Analyst in February, 2009. The individual's skill set has been an asset to DBH. Contracted student externs assigned to the data team are now under the direction of the Statistical Analyst. The waiting list and capacity management project was assigned to the data team.

GOAL # 4: Compliance - Intravenous Drug Abusers / September 24, 2010 / Page 2

As part of the plan of correction, in April 2009 the Division of Behavioral Health to Regional Behavioral Health Authority annual contract was amended as were the RBHA to provider subcontracts. Contracts contained additional interim service language. Outreach activities continued to be described in the contract. The contracts stated that IV drug abusing clients shall be admitted within 14 days of request for treatment, or if no services are available, must be provided with interim services within 48 hours and admitted to treatment within 120 days. Interim services were now defined in the contract.

Contractors and subcontractors were required to report to DBH whenever full (90%) capacity is reached and/or an IV drug abusing client is unable to be admitted to service.

On July 1, 2008, DBH entered into a two year contract with an Administrative Service Organization (ASO) vendor along with DHHS Divisions of Children and Family Services and Medicaid and Long Term Care. All three divisions purchased ASO services. One contract liaison was assigned to work with Magellan from each division. The DBH contract liaison is also the Data Team Leader and QI Manager.

DBH relies on the ASO vendor to provide its utilization data management system. DBH was cognizant that it needed an automated waiting list and capacity management to be effective. The new ASO contract included a provision for the development and implementation of such an automated waiting list and capacity management system. With the new contract, there are a variety of ASO time and resource commitments and projects amongst the three divisions. The waiting list and capacity management system is on the list of deliverables, however, it will take collaboration, programming and time to fully implement the system.

Policy and procedure updates were needed and the DBH-CBS Administrator assigned one primary staff member to tackle an entire review and update of existing policies and development of new policies. A block grant policy manual is being developed and will include policy and procedures for the waiting list/capacity management system, priority populations and interim service provision.

DBH recognized that each region had its own variation on the waiting list/capacity management tool and only 3 of 6 regions provided specific data on the provision of interim services. Waiting list and capacity management information continued to be provided on a weekly basis to DBH and all waiting lists were reviewed by the DBH – CBS Administrator.

DBH data team staff continued to explore how such varied data could be aggregated to identify compliance concerns and address opportunities for improvement. The concept of developing one statewide electronic spreadsheet was adopted. The DBH Statistical Analyst researched a variety of waiting list capacity management systems.

Following a series of internal data team meetings in the spring of 2009, collaboration with representatives of the Statewide Audit Workgroup and State Operations Team began

GOAL # 4: Compliance - Intravenous Drug Abusers / September 24, 2010 / Page 3

in June 2009, for the purpose of finalizing operational procedures for a statewide waiting list/capacity management tool. The procedures were to include documentation of treatment capacity, identification of priority populations, requirements for interim services, documentation of interim service provision, time frames for admission to services, reasons for removal from the waiting list, frequency of contact for a person on the waiting list, interim service provision, and an audit/monitoring process.

GOAL # 4: Progress - Intravenous Drug Abusers / September 3, 2010 / Page 1

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

FY 2010 (Progress)

Who – The intravenous drug abusers who are in the Substance Abuse Priority Population:

1. Pregnant Injecting Drug Users
2. Injecting Drug Users

When – This is continuously being implemented.

How – The Division of Behavioral Health (DBH) contracts with each of the six Regional Behavioral Health Authorities (RBHA) to ensure priority access to intravenous drug abusers. The RBHA's contract with treatment providers (subcontractors) within each of their regional areas to provide treatment services for this priority population.

Where – State of Nebraska, Division of Behavioral Health (DBH), the six Regional Behavioral Health Authorities (RBHA), and providers receiving SAPTBG funds.

What –

Following a series of internal data team meetings in the spring of 2009, collaboration with representatives of the Statewide Audit Workgroup and State Operations Team began in June 2009, for the purpose of finalizing operational procedures for a statewide waiting list/capacity management tool. The procedures were to include documentation of treatment capacity, identification of priority populations, requirements for interim services, documentation of interim service provision, time frames for admission to services, reasons for removal from the waiting list, frequency of contact for a person on the waiting list, interim service provision, and an audit/monitoring process.

The waiting list and capacity management project was implemented started October 5, 2009. Regional Behavioral Health Authorities and their and subcontractors were required to report to the Division of Behavioral Health (DBH) whenever full (90%) capacity is reached and/or an IV drug abusing client is unable to be admitted to service.

Substance Abuse Priority Population are:

1. Pregnant Injecting Drug Users
2. Pregnant Substance Abusers
3. Injecting Drug Users
4. Women with dependent Children

Here is a summary of the Substance Abuse Capacity and Waiting List Report

ANNUAL SUMMARY Substance Abuse Capacity (ending June 30, 2010):

- There were only 9 weeks during the reporting period in the 2nd quarter, while there were 13 weeks during the reporting period in the 3rd and 4th quarter.
- There were fewer people identified as priority populations waiting for substance abuse services in the 4th quarter (n=275) than there were in the 3rd quarter (n=325). In the 2nd quarter, 182 persons identified as priority populations were on the waiting list.
- In the 3rd (44.9%, n=146) and 4th (40.7%, n=112) quarters, the majority of the identified priority populations waiting for substance abuse services were women with dependent children. In the 2nd quarter, most people were waiting for substance abuse services were intravenous drug users (40.7%, n=74).
- In all three quarters, most people identified as priority populations waiting for substance abuse service were waiting for admission into short-term residential services (37.9% (n=74) in the 2nd quarter, 50.7% (n=175) in the 3rd quarter, and 48.1% (n=136) in the 4th quarter, respectively).
- The average length of wait for individuals waiting to enter substance abuse treatment decreased from the 2nd quarter (31.7 days) to the 4th quarter (25.5 days) by 6 days.
- Women with dependent children had the longest average wait in all three quarters, 41 days, 35 days and 32 days, respectively.
- The longest waits for substance abuse services were for outpatient services in the 2nd (55 days) and 3rd (63 days) quarters. The longest waits in the 4th quarter were for therapeutic community services (42 days).

Quarter 2 State Fiscal Year 2010 (starting October 5, 2009)

- There were 182 people who were waiting for services during the nine week reporting period, 12 of which were waiting for more than one type of service or service from multiple providers.
- The majority of people waiting for substance abuse service were intravenous drug users (40.7%, n=74), followed by women with dependent children (36.8%, n=67), mental health board commitments (17.6%, n=32), pregnant women (7.7%, n=14), and pregnant intravenous drug users (1.1%, n=4).
- Most people waiting for substance abuse service were waiting for admission into short-term residential services (37.9%, n=74); followed by therapeutic community services (19.5%, n=38), intensive outpatient services (14.4%, n=28), halfway house services (10.8%, n=21), outpatient services (10.3%, n=20), and dual disorder residential services (3.1%, n=6). Less than 5% of people waiting for service were waiting for intermediate residential (2.6%, n=5) or outpatient dual (1.5%, n=3).
- The average wait for individuals waiting to enter substance abuse treatment is 31.72 days. Pregnant women have the longest average wait at 40.79 days, followed by women with dependent children at 40.61 days, pregnant intravenous drug users at 36.50 days, intravenous drugs users at 27.49 days, and mental health board commitments at 22.71 days.
- On average, the longest waits for substance abuse service are for outpatient services (55.45 days), followed by therapeutic community (45.26), outpatient dual (30.67), intensive outpatient (29.57), dual disorder residential (25.17), short-term residential (23.34), halfway house (23.14), and intermediate residential services (12.00).

GOAL # 4: Progress - Intravenous Drug Abusers / September 3, 2010 / Page 3

Quarter 3 State Fiscal Year 2010 (January 1, 2010 to March 31, 2010)

- There were 325 people identified as priority populations who were waiting for services during the thirteen week reporting period, 21 of which were waiting for more than one type of service or service from multiple providers.
- The majority of the identified priority populations waiting for substance abuse service were women with dependent children (44.9%, n=146), followed by intravenous drug users (37.5%, n=122), mental health board commitments (17.2%, n=56), pregnant women (5.8%, n=19), and pregnant intravenous drug users (0.6%, n=2).
- Most people identified as priority populations waiting for substance abuse service were waiting for admission into short-term residential services (50.7%, n=175); followed by therapeutic community services (21.2%, n=73), dual disorder residential services (9.6%, n=33), outpatient services (7%, n=24), and intensive outpatient services (5.2%, n=18). Less than 5% of people waiting for service were waiting for halfway house (3.2%, n=11), intermediate residential (1.4%, n=5), outpatient dual (0.9%, n=3) or therapeutic community for youth (0.9%, n=3).
- The average wait for persons identified as priority populations waiting to enter substance abuse treatment is 29.82 days. Women with dependent children have the longest average wait at 35.3 days, followed by intravenous drugs users at 26.34 days, pregnant women at 25.47 days, mental health board commitments at 24.21 days, and pregnant intravenous drug users at 10.5 days.
- On average, the longest waits for substance abuse services are for outpatient services (62.58 days), followed by outpatient dual (44.33 days), therapeutic community (37.07 days), halfway house (34.36 days), dual disorder residential (29.8 days), short-term residential (23.36 days), intensive outpatient (18.83 days), intermediate residential (15.2 days), and youth therapeutic community services (10.33 days).

Quarter 4 State Fiscal Year 2010 (April 1, 2010 – June 30, 2010)

- There were 275 people identified as priority populations who were waiting for services during the thirteen week reporting period, 11 of which were waiting for more than one type of service or service from multiple providers.
- The majority of identified priority populations waiting for substance abuse service were women with dependent children (40.7%, n=112), followed by intravenous drug users (37.1%, n=103), mental health board commitments (20.7%, n=57), pregnant women (3.3%, n=9), and pregnant intravenous drug users (1.1%, n=3).
- Most people identified as priority populations were waiting for substance abuse service were waiting for admission into short-term residential services (48.1%, n=136); followed by therapeutic community services (20.8%, n=59), dual disorder residential services (12.0%, n=34), intensive outpatient services (9.9%, n=28), and outpatient services (5.7%, n=16). Less than 5% of people waiting for service were waiting for intermediate residential (1.4%, n=4), halfway house (1.1%, n=3), community support (0.4%, n=1), social setting detox (0.4, n=1), or therapeutic community for youth (0.4%, n=1).
- The average wait for persons identified as priority populations waiting to enter substance abuse treatment is 25.54 days. Women with dependent children have the longest average wait at 31.57 days, followed by mental health board commitments at

GOAL # 4: Progress - Intravenous Drug Abusers / September 3, 2010 / Page 4

23.68 days, intravenous drugs users at 20.5 days, pregnant women at 20.11 days, and pregnant intravenous drug users at 8.67 days.

- On average, the longest waits for substance abuse services are for therapeutic community (41.86 days), followed by dual disorder residential (30.74 days), short-term residential (21.05 days), intensive outpatient (20.44 days), halfway house (14.33 days), therapeutic community for youth (12 days), outpatient (10.5 days), intermediate residential (10 days), social detox setting (8 days), and community support services (1 day).

Programs for Intravenous Drug Users (IVDUs) (formerly Attachment C)

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

For the fiscal year three years prior (FY 2008; Annual Report/Compliance) to the fiscal year for which the State is applying for funds:

1. How did the State define IVDUs in need of treatment services?
2. 42 U.S.C. §300x-23(a)(1) requires that any program receiving amounts from the grant to provide treatment for intravenous drug abuse notify the State when the program has reached 90 percent of its capacity. Describe how the State ensured that this was done. Please provide a list of all such programs that notified the State during FY 2008 and include the program's I-SATS ID number (See 45 C.F.R. §96.126(a)).
3. 42 U.S.C. §300x-23(a)(2)(A)(B) requires that an individual who requests and is in need of treatment for intravenous drug abuse is admitted to a program of such treatment within 14-120 days. Describe how the State ensured that such programs were in compliance with the 14-120 day performance requirement (See 45 C.F.R. §96.126(b)).
4. 42 U.S.C. §300x-23(b) requires any program receiving amounts from the grant to provide treatment for intravenous drug abuse to carry out activities to encourage individuals in need of such treatment to undergo treatment. Describe how the State ensured that outreach activities directed toward IVDUs was accomplished (See 45 C.F.R. §96.126(e)).

Programs for Intravenous Drug Users (IVDUs) (formerly Attachment C)

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

For the fiscal year three years prior (FY 2008; Annual Report/Compliance) to the fiscal year for which the State is applying for funds:

1. How did the State define IVDUs in need of treatment services?
2. 42 U.S.C. §300x-23(a)(1) requires that any program receiving amounts from the grant to provide treatment for intravenous drug abuse notify the State when the program has reached 90 percent of its capacity. Describe how the State ensured that this was done. Please provide a list of all such programs that notified the State during FY 2008 and include the program’s I-SATS ID number (See 45 C.F.R. §96.126(a)).
3. 42 U.S.C. §300x-23(a)(2)(A)(B) requires that an individual who requests and is in need of treatment for intravenous drug abuse is admitted to a program of such treatment within 14-120 days. Describe how the State ensured that such programs were in compliance with the 14-120 day performance requirement (See 45 C.F.R. §96.126(b)).
4. 42 U.S.C. §300x-23(b) requires any program receiving amounts from the grant to provide treatment for intravenous drug abuse to carry out activities to encourage individuals in need of such treatment to undergo treatment. Describe how the State ensured that outreach activities directed toward IVDUs was accomplished (See 45 C.F.R. §96.126(e)).

1. How did the State define IVDUs in need of treatment services?

Intravenous Drug Users (IVDU) in need of treatment services are individuals who use hypodermic needles or syringes to take illegal drugs such as heroin, cocaine, or other substances. A person is defined as being in need of services if the individual has a diagnosable substance use disorder with the usual route of admission through needles intravenously and leading to significant functional impairment. [August 20, 2010 from Blaine Shaffer]

Access to treatment is prioritized giving preference to the following priority populations:

1. Pregnant Injecting Drug Users
2. Pregnant Substance Abusers
3. Injecting Drug Users
4. Women with Dependent Children

Based on Magellan Health Services data, the Division of Behavioral Health estimates in FY2010, a total of 603 consumers reported their for their primary, secondary or tertiary route for substance use as IV injection. Here are the numbers of IV drug users in the Magellan database for SFY2010 by region:

Route – IV injection for FY2010

Primary route="IV" or secondary route="IV" or tertiary route="IV" by region

Region	IV Users	
	Number	Percent
Region 1	35	6%
Region 2	27	4%
Region 3	105	17%
Region 4	85	14%
Region 5	198	33%
Region 6	153	25%
total	603	100%

1. Selected only those records that are getting a substance abuse service or the Duals.
2. SSN and Date of birth were used to unduplicate the cases, and last record was selected.
3. Selected those records that have primary route or secondary route or tertiary route="IV".
4. All the records that have primary route of IV injection or second route of IV injection or tertiary route of IV injection by region.

Source: Division of Behavioral Health

The State defined IVDU programs as all funded Substance Abuse Providers. There is only one Division of Behavioral Health funded Opioid Replacement Therapy program in Nebraska, BAART Community Healthcare in Omaha. BAART means Bay Area Addiction Research & Treatment Programs.

Since 2008 Region 6 Behavioral Healthcare in Omaha has contracted with BAART Community HealthCare for the Opioid Replacement Therapy program.

BAART Community HealthCare (NE100781)
 The Center Mall
 1941 S. 42nd Street, Suite 210
 Omaha, NE, 68105
 402/341-6220
 www.baartcdp.com
 Substance Abuse Services – Adults – Methadone Maintenance

2. 42 U.S.C. §300x-23(a)(1) requires that any program receiving amounts from the grant to provide treatment for intravenous drug abuse notify the State when the program has reached 90 percent of its capacity. Describe how the State ensured that this was done. Please provide a list of all such programs that notified the State during FY 2008 and include the program’s I-SATS ID number (See 45 C.F.R. §96.126(a)).

This is addressed by the Division of Behavioral Health having the weekly SA reports submitted to the Division and by reviewing on the weekly call. The following is from the old Waiting List system ended September 2009.

Agencies Reporting Having Reached 90 Percent Capacity at any time during FFY 2008.

NFR Number	Agency	IV Users Exceeded 90%	
750904	Alegent Health, Inc.	YES	YES
750441	ARCH	YES	YES
301302	Behavioral Health Specialists	YES	YES
750953	Blue Valley Mental Health Cen	YES	YES
100126	Catholic Charities - Columbus	YES	YES
100431	Catholic Charities - Omaha	YES	YES
301401	CenterPointe	YES	YES
901051	Chicano Awareness Center	YES	YES
100563	Child Guidance Center	YES	YES
750938	Community Mental Health Center	YES	YES
750250	Cornhusker Place	YES	YES
100613	Faith Regional Health Service	YES	YES

NFR Number	Agency	IV Users Exceeded 90%	
100280	Family Services - Lincoln	YES	YES
750151	Friendship House	YES	YES
100202	Good Samaritan Hospital	YES	YES
100279	Goodwill Industries of Greater NE	YES	YES
101553	Great Plains Medical Center	YES	YES
900491	Heartland Counseling Services	YES	YES
100103	Heartland Family Services	YES	YES
901242	Houses of Hope of Nebraska, I	YES	YES
900699	Human Services	YES	YES
900350	Lincoln Council on Alcoholism	YES	YES
100415	Lincoln Medical Education Par	YES	YES
900962	Lutheran Family Services (LNK)	YES	YES
101793	Lutheran Family Services (OMA)	YES	YES
100278	Lutheran Family Services (SBB)	YES	YES
100100	Mary Lanning Memorial Hospital	YES	YES
301500	Mid Plains Center for Behavio	YES	YES
101258	Milne Detoxification	YES	YES
101296	Nebraska Urban Indian Health	YES	YES
100605	North East Panhandle Substanc	YES	YES
300072	NOVA	YES	YES
100381	Omaha Tribe of Nebraska	YES	YES
300205	Panhandle Mental Health Cente	YES	YES
100779	Ponca Tribe of Nebraska	YES	YES
900566	Region 2 Human Services	YES	YES
101215	Region West Medical Center	YES	YES
100118	Richard Young Hospital	YES	YES
750540	Santa Monica	YES	YES
750607	Santee Sioux Tribe of Nebraska	YES	YES
301708	South Central Behavioral Heal	YES	YES
900731	St Francis Alcohol-Drug Treat	YES	YES
900038	St. Monica's Behavioral Healt	YES	YES
900305	The Bridge	YES	YES
900418	The Link	YES	YES
101413	University of Nebraska Medica	YES	YES
100662	Well Link, Inc.	YES	YES
901374	Winnebago Tribe of Nebraska	YES	YES
000081	Touchstone	YES	YES

3. 42 U.S.C. 300x-23(a)(2)(A)(B) requires that an individual who requests and is in need of treatment for intravenous drug abuse is admitted to a program of such treatment within 14-120 days. Describe how the State ensured that such programs were in compliance with the 14-120 day performance requirement (See 45 C.F.R. 96.126(b)).

The waiting lists were reviewed weekly and monitored by the regions and the state. DBH has tracked the waiting days by service and those are included in the quarterly reports.

The Division of Behavioral Health ensures programs are in compliance with the Federal requirements. One approach involves the Regional Contracts. Details on the content of the Regional Contracts are under **Goal #4: Services To Intravenous Drug Abusers FY2011- FY 2013 Intended Use/Plan (Attachment – Complete Text of the Contract Requirements)**.

There is also a waiting list system. The Division of Behavioral Health has had a waiting list system. This system was revised, and updated to better accomplish the work needed. This new system was implemented on October 5, 2009. Requirements for the waiting list system **Goal #4: Services To Intravenous Drug Abusers FY2011- FY 2013 Intended Use/Plan (Attachment – Complete Text of the Contract Requirements)**. A report on the implementation of the revised system (ending June 30, 2010) is under **GOAL # 4: Progress - Intravenous Drug Abusers ANNUAL SUMMARY Substance Abuse Capacity (ending June 30, 2010)**.

4. 42 U.S.C. 300x-23(b) requires any program receiving amounts from the grant to provide treatment for intravenous drug abuse to carry out activities to encourage individuals in need of such treatment to undergo treatment. Describe how the State ensured that outreach activities directed toward IVDU was accomplished (See 45 C.F.R. 96.126(e)).

The Division of Behavioral Health ensures programs engage in the outreach activities directed toward IVDU in compliance with the Federal requirements with the Regional Contracts. To see the complete FY2011 Regional Behavioral Health contract ATTACHMENT F - Federal Block Grant Requirements, go to <https://bgas.samhsa.gov/2011/>
Appendix / Addendum - Additional Supporting Documents (Optional).

Program Compliance Monitoring (formerly Attachment D)

(See 45 C.F.R. §96.122(f)(3)(vii))

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

For the fiscal year two years prior (FY 2009) to the fiscal year for which the State is applying for funds:

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

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

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

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

For the fiscal year two years prior (FY 2009) to the fiscal year for which the State is applying for funds:

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

For Notification of Reaching Capacity

A description of the strategies developed by the State for monitoring compliance

The Division of Behavioral Health (DBH) contracts with the six Regional Behavioral Health Authorities (RBHA) (Substate Planning Areas): Region 1 (Panhandle), Region 2 (Southwest), Region 3 (South Central), Region 4 (Northeast), Region 5 (Southeast) and Region 6 (Omaha Metro) per the requirements of the Nebraska Behavioral Health Services Act (Neb. Rev. Stat. §§71-801 to 71-830). All of the requirements for the proper monitoring of the Substance Abuse Prevention and Treatment Block Grant are contained within the contract between the Division of Behavioral Health and the Regional Behavioral Health Authority.

Part of the Notification of Reaching Capacity is covered under the Waiting List Management System

On October 5, 2009 the revised Waiting List/Capacity Management system was officially implemented. The revised procedures and corresponding monitoring forms specify that individuals from the priority populations who have requested treatment, but who have not had a substance abuse assessment completed within the last 6 months, must have an appointment for a Substance Abuse (SA) assessment within 48 hours from time of request, and must receive and complete the actual assessment within 7 business days of the appointment. The waiting list clock starts when a client completes the assessment process and a recommendation for treatment is made. This ensures that individuals from the priority populations receive timely access to assessment and treatment services.

When individuals from the priority populations cannot immediately receive treatment as documented in the recommendations of the substance abuse assessment, and in accordance with the levels of care outlined in the American Society of Addiction Medicine (ASAM) Patient Placement

Criteria; the individual must receive interim services within 48 hours and be placed on waiting list for treatment.

The weekly Substance Abuse (SA) Capacity Report and weekly SA Priority Waiting List/Interim Services Report has been completed and updated by the Behavioral Health Network Providers who then submit the Report to the Regional Behavioral Health Authority each week on the date established by the RBHA. The RBHA collect, analyze, and aggregate this data. Every Tuesday, the RBHA will provide the aggregated Report to the Division of Behavioral Health's designated staff via email. The Division analyze and aggregate this data in order to report on the available statewide capacity (purchased and unpurchased) for substance abuse treatment services. The reports serve as notification to the DBH when programs reach 90 percent of capacity and DBH will receive such reports within 7 days of reaching 90 percent capacity.

Since October 5, 2009, the Division has facilitated a weekly, statewide conference call with each of the six RBHA's. The conference call provides structure to system review of statewide capacity which assists to connect the Regional Behavioral Health Authorities to agencies across NE who have available capacity, should a specific level of care not be available in one area of the state.

Data are also monitored via the revised Weekly SA Capacity Report and Weekly SA Priority Waiting List/Interim Services Report that indicate when individuals are placed on the waiting list and when individuals are able to be removed from the waiting list.

Regional Behavioral Health Authorities monitor this information in order to track data regarding "length of time" individuals are waiting to access services. This data will significantly assist our system during the annual budget planning process, where decisions are made regarding funding (adding or decreasing capacity/levels of care). The Capacity Reports also track to ensure all individuals who are on the waiting list are also receiving the required interim services.

Note: All information provided on the Weekly SA Reports will be done so in a manner that does not identify the individual. A unique consumer identifier containing the first four characters of the last name + date of birth (YYYYMMDD) + the last four numbers of the social security number. The unique identifier should help DBH sort out individuals who may be duplicated among waiting lists.

Providers must maintain contact with individuals on the waiting list a minimum of every seven (7) days from the initial screening. Providers must maintain documentation of the following:

1. Client unique identifier, DOB, name, address, phone, and alternate address and phone, if applicable;
2. Date of the initial face to face screening and the recommended treatment service and date placed on the waiting list;
3. Priority category for admission;
4. Whether the client was referred to another agency, if they accepted the outside referral, the date the referral was made and the provider to which the individual was referred;
5. Whether the client was placed in interim services and what type of interim services;
6. Counselor/client follow-up (minimum every 7 days from initial screening) including date and type of contact and name of staff person;
7. Number of days before placed in recommended treatment; and
8. Date and reason for removal from the waiting list if the client was not placed into the appropriate recommended treatment.

The monitoring of interim service provision is accomplished through the Regional Behavioral Health Authority Audit staff. An interim service provision audit tool was developed, summer 2009, which is utilized at the time of the subcontractor's services purchased and/or fidelity audit. RBHA Audit staff provide audit results and technical assistance to the provider and then fax or mail the checklist to the assigned DBH staff. DBH data team members aggregate and analyze the audit data and review the data findings with the Network Manager, who will make recommendations to the Division Administrator's Management Team (DAMT) regarding system improvements for treatment capacity and enhanced waitlist monitoring.

Aggregate data is shared with RBHA staff and providers through the Quality Improvement structure and Tuesday morning calls to ensure ongoing improvement and compliance with federal block grant requirements. Reports may include:

- Average wait time for admission by priority population by service by region by state;
- Total capacity by service by region by state;
- Regional Purchased capacity by service by provider by region by state;
- Number of individual on the waiting list by priority by service by region by state;
- Number of individuals receiving interim services within 48 hours;
- Average length of interim services;
- Number of priority population served with 14 days or by 120 days;
- Number of Magellan authorized or registered interim services for individuals on the waiting list by service by region by state; and
- Reason for removal from waiting list by service by provider by region by state.

As noted above, the revised system was implemented on October 5, 2009. The SUBSTANCE ABUSE ANNUAL WAITING LIST SUMMARY as of June 30, 2010 is reported under **Addendum - Additional Supporting Documents (Optional)**.

The Audit Work Group is part of this monitoring function. This group is composed of staff from the six Regions plus the Division of Behavioral Health. The group meets monthly to establish and maintain the standards used for monitoring substance abuse providers who receive funds under the Division of Behavioral Health. These standards are approved by the Division of Behavioral Health. The expectation is that each provider is monitored once per year by the Region using these standards.

Tuberculosis Services

A description of the strategies developed by the State for monitoring compliance

The Division of Behavioral Health contracts with the six Regional Behavioral Health Authorities (Substate Planning Areas): Region 1 (Panhandle), Region 2 (Southwest), Region 3 (South Central), Region 4 (Northeast), Region 5 (Southeast) and Region 6 (Omaha Metro) per the requirements of the Nebraska Behavioral Health Services Act (Neb. Rev. Stat. §§71-801 to 71-830). All of the requirements for the proper monitoring of the Substance Abuse Prevention and Treatment Block Grant are contained within the contract between the Division of Behavioral Health and the Regional Behavioral Health Authority.

The Division of Behavioral Health contracts with the six Regional Behavioral Health Authorities (Substate Planning Areas): Region 1 (Panhandle), Region 2 (Southwest), Region 3 (South Central), Region 4 (Northeast), Region 5 (Southeast) and Region 6 (Omaha Metro) per the requirements of the Nebraska Behavioral Health Services Act (Neb. Rev. Stat. §§71-801 to 71-830). All of the

requirements for the proper monitoring of the Substance Abuse Prevention and Treatment Block Grant are contained within the contract between the Division of Behavioral Health and the Regional Behavioral Health Authority.

The Audit Work Group is part of this monitoring function. This group is composed of staff from the six Regions plus the Division of Behavioral Health. The group meets monthly to establish and maintain the standards used for monitoring substance abuse providers who receive funds under the Division of Behavioral Health. These standards are approved by the Division of Behavioral Health. The expectation is that each provider is monitored once per year by the Region using these standards.

The following matrix is a portion of the Program Fidelity Audit, and includes the components reviewed by Regional Auditors regarding Tuberculosis:

<p>Review Provider policy and procedures for TB and/or look in individual record.</p>
<p>16. The program reports active cases of TB to the DHHS Division of Public Health Tuberculosis Program Manager and</p> <ul style="list-style-type: none">(a) adheres to all reporting requirements as set forth including NRS Sec.71-502, 71-1626 and 173 NAC Chapters 1-6.(b) adheres to all state and Federal confidentiality requirements when reporting such cases.(c) maintains infection control procedures that are consistent with those established by the DHHS Division of Public Health Infection Control Office.
<p>17. The program routinely makes TB services available to each individual receiving treatment for substance abuse and monitors such service delivery. Review individual record.</p>
<p>18. The program has established procedures that ensures the following TB services are provided, either directly or through arrangement/agreements with other public or non-profit private entities:</p> <ul style="list-style-type: none">(a) Screening of all admissions for TB(b) Positive screenings shall receive test for TB(c) Counseling related to TB(d) Referral for appropriate medical evaluations for TB treatment(e) Case management for obtaining any TB services(f) Reports any active cases of TB to the DHHS Division of Public Health Tuberculosis Program(g) Documents screening, testing and referrals and/or any necessary follow-up information

The Region is responsible for conducting the monitoring review using the standards set by the Audit Work Group and approved by the Division of Behavioral Health. If there are problems identified during the monitoring visit, the Region requires the provider to complete a corrective action plan.

Each Region then submits the results of the Program Fidelity Audit to the Division of Behavioral Health. The Division's designated Network Specialist reviews the Audit results and notes the need for any corrective action with compliance to these regulations. The Network Specialist will complete a cover sheet for the audit, which documents the receipt and review of the audit as well as the need for corrective action when appropriate.

Upon receipt of the corrective action plan, the Region will forward the plan to the Division. The Network Specialist at the Division reviews the plan and works with the Region to make certain the provider implements the plan to ensure compliance with the Standards.

Treatment Services for Pregnant Women

The state monitors the adequacy of efforts by programs funded to serve pregnant women and women with dependent children through a number of checks and balances. These methods include monthly financial reports, registration, authorizations and continued care reviews through Magellan Health data system and on-site technical assistance by Division staff, in addition to the waiting list monitoring system.

As a contractual requirement, each Region monitors the provision of services to pregnant women and women with dependent children through audits of program fidelity. A Program Fidelity Audit is conducted by the Region for their contracted network providers, and by the Division for Regions who provide these services directly. An internal tracking system was designed to ensure that program fidelity audits were completed correctly and in a timely manner. If a corrective action plan was indicated in the program fidelity audit, the Division worked with the Region and the provider to ensure that technical assistance was provided in any area where problems were identified.

If any qualifying services were not offered as a direct service provision, the Division mandated that an affiliation agreement be in place with a local entity to ensure that access to such services were made available upon request of the consumer. All programs providing such services were encouraged to treat the family as a unit and work towards building capacity that would allow admission of both women and their children into treatment services, if appropriate.

Goal #5: TB Services

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

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Compliance monitoring; Referrals; Screening; PPD or Mantoux Skin tests; Provider contracts; Site visits/reviews; Assessments; Counseling; Training/TA; Cooperative agreements; Case management; Wait lists; Promotional materials*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

Goal 5 Intended Use TB Services | October 1, 2010 | page 1

Goal #5: TB Services

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

FY 2011- FY 2013 (Intended Use/Plan):

(1) Who

The people who will be served (target population) persons entering a substance abuse treatment service. Tuberculosis screening is provided to all persons entering a substance abuse treatment service. Additional services and/or referrals for services are made available to those individuals whose screening indicates “high risk” for TB. The Nebraska Tuberculosis Program reported to the Centers for Disease Control and Prevention (CDC) the following data on a calendar year basis.

• **Tuberculosis in Nebraska 2009 by Region by County**

Region	COUNTY	2009
3	Buffalo	1
4	Colfax	1
4	Dakota	5
4	Madison	1
5	Lancaster	7
6	Douglas	16
6	Sarpy	1
	TOTAL	32

The most recent available are for Calendar Years 2009.	Yes:	No
Injected Drug Use Within Past Year	0	32
Non-Injected Drug Use Within Past Year	0	32
Excess Alcohol Use Within Past Year	1	31
% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment	3%	

Source: Pat Infield, Tuberculosis Program Manager
DHHS - Division of Public Health | September 10, 2010

(2) What

Tuberculosis (TB) is a disease caused by bacteria called Mycobacterium tuberculosis. The bacteria can attack any part of the body, but it usually attacks the lungs.

The Tuberculosis Program in the NE Division of Public Health provides the overall coordination for the State of Nebraska in this area. The Tuberculosis Program reports to the Federal Centers for Disease Control (CDC). For more details on the Nebraska DHHS Division of Public Health Tuberculosis (TB) program see:

http://www.dhhs.ne.gov/puh/cod/Tuberculosis/docs/TB_AnnualReport2009.pdf

All Substance Abuse Providers under contract with the six Regional Behavioral Health Authorities and receiving Federal Substance Abuse Prevention and Treatment Block Grant (SAPTBG) funds need to address the contract requirements for tuberculosis services.

Goal 5 Intended Use TB Services | October 1, 2010 | page 2

The FY2011 Regional BH contract ATTACHMENT F - Federal Block Grant Requirements includes these requirements.

F. INTERIM SERVICES for PRIORITY POPULATIONS The purpose of Interim Services is to reduce the adverse effects of substance abuse, promote health, and reduce the risk of transmission of disease. Interim Substance Abuse Services are services that are provided until an individual is admitted to a treatment program. Contractor will ensure compliance of Subcontractors with the delivery of Interim Services in the following manner:

2. Interim Services for injecting drug users must include counseling and education about human immunodeficiency virus (HIV), tuberculosis (TB), the risks of needle-sharing, the risks of transmission to sexual partners and infants, and the steps that can be taken to ensure that HIV and TB transmission does not occur, as well as referral for HIV or TB treatment services if necessary.
4. Case management services must also be made available in order to assist client with obtaining HIV and or TB services.

J. TUBERCULOSIS (TB) SCREENING AND SERVICES

1. Contractor will ensure that all subcontractors receiving SAPTBG funds shall:
 - a. Report active cases of TB to the DHHS Division of Public Health Tuberculosis Program Manager and adhere to all reporting requirements as set forth including NRS Sec.71-502, 71-1626 and 173 NAC Chapters 1-6, which can be found at www.dhhs.ne.gov/reg/t173.htm.
 - b. Maintain infection control procedures that are consistent with those that are established by the State's infection control office.
 - c. Adhere to State and Federal confidentiality requirements when reporting such cases.
2. The Contractor will ensure that subcontractors of SAPTBG funding will routinely make TB services available to each individual receiving treatment for substance abuse and to monitor such service delivery.
3. The Contractor shall establish procedures that ensure that the following (TB) services are provided, either directly or through arrangements/agreements with other public or non-profit private entities:
 - a. Screening of all admissions for TB,
 - b. Positive screenings shall receive test for TB,
 - c. Counseling related to TB,
 - d. Referral for appropriate medical evaluations or TB treatment,
 - e. Case management for obtaining any TB services,
 - f. Report any active cases of TB to state health officials, and
 - g. Document screening, testing, referrals and/or any necessary follow-up information.
4. The Contractor is responsible to provide DHHS with documentation which illustrates facilitation or provision of the above listed services and ensure that any changes are reported and on file with DHHS.

To see the complete FY2011 Regional Behavioral Health contract ATTACHMENT F - Federal Block Grant Requirements, go to <https://bgas.samhsa.gov/2011/> Appendix / Addendum - Additional Supporting Documents (Optional).

(3) When.

Tuberculosis (TB) screening and services are important. TB services are available to individuals on a continuous basis. Substance Abuse Providers under contract with the Regional Behavioral Health Authority screen all persons admitted for services. If the screen is positive, there is a referral to the local health department. Agencies serving people with substance abuse problems have working agreements with local health departments to refer persons who, through a screening instrument developed in conjunction with local health departments, are identified as being at high risk for TB.

The Division of Behavioral Health (DBH) expects the substance abuse provider to report active cases of TB to the local health department. They in turn report the case to the DHHS Division of Public Health Tuberculosis Program. DBH also expects the substance abuse provider to maintain infection control procedures that are consistent with those that are established by the State's infection control office, adhere to State and Federal confidentiality requirements when reporting such cases, and routinely make TB services available to each individual receiving treatment for substance abuse as well as monitor such service delivery. TB services are provided, either directly or through arrangements/agreements with other public or non-profit private entities. This includes:

- a. Screening of all admissions for TB,
- b. Positive screenings shall receive test for TB,
- c. Counseling related to TB,
- d. Referral for appropriate medical evaluations or TB treatment,
- e. Case management for obtaining any TB services,
- f. Report any active cases of TB to state health officials, and
- g. Document screening, testing, referrals and/or any necessary follow-up information.

(4) Where (geographic area).

Each substance abuse treatment provider contracted with the Regional Behavioral Health Authority is required to screen all admissions for TB. These substance abuse treatment providers are located in each of the six Behavioral Health regions across NE. The substance abuse providers receiving SAPTBG fund throughout the State of Nebraska, have working agreements with local health departments in order to ensure service coordination/treatment for TB.

(5) How

- Substance abuse providers receiving SAPTBG funding have a working agreement with their local Health Department. These documented working agreements outline the responsibilities and operationalize the expectations of how the entities will work together to ensure that individuals requiring TB services (as outlined above) receive them. The Regional Behavioral Health Authorities monitor and review these working agreements annually when they complete their provider audits. The Behavioral Health Authorities submit these provider audits to the Department for review and approval on an annual basis. The Department, through the contracts with the Regional Behavioral Health Authorities, mandates the review of the working agreements between providers and the local Health Department.

Goal 5 Intended Use TB Services | October 1, 2010 | page 4

- A description of the strategies developed by the State for monitoring compliance - The Division of Behavioral Health contracts with the six Regional Behavioral Health Authorities (Substate Planning Areas): Region 1 (Panhandle), Region 2 (Southwest), Region 3 (South Central), Region 4 (Northeast), Region 5 (Southeast) and Region 6 (Omaha Metro) per the requirements of the Nebraska Behavioral Health Services Act (Neb. Rev. Stat. §§71-801 to 71-830). All of the requirements for the proper monitoring of the Substance Abuse Prevention and Treatment Block Grant are contained within the contract between the Division of Behavioral Health and the Regional Behavioral Health Authority.

The Audit Work Group is part of this monitoring function. This group is composed of staff from the six Regional Behavioral Health Authorities and representatives from the Division of Behavioral Health. The Audit Work Group meets monthly to establish and maintain the standards/requirements used for monitoring substance abuse providers who receive funds under the Division of Behavioral Health. These standards are approved by the Division of Behavioral Health. The expectation is that each provider is monitored once per year by the Region using these standards.

The following matrix is a component of the Program Fidelity Audit, and includes the components reviewed by Regional Auditors regarding Tuberculosis:

Review Provider policy and procedures for TB and/or look in individual record.	
16.	The program reports active cases of TB to the DHHS Division of Public Health Tuberculosis Program Manager and <ul style="list-style-type: none"> (a) adheres to all reporting requirements as set forth including NRS Sec.71-502, 71-1626 and 173 NAC Chapters 1-6. (b) adheres to all state and Federal confidentiality requirements when reporting such cases. (c) maintains infection control procedures that are consistent with those established by the DHHS Division of Public Health Infection Control Office.
17.	The program routinely makes TB services available to each individual receiving treatment for substance abuse and Monitors such service delivery. Review individual record.
18.	The program has established procedures that ensures the following TB services are provided, either directly or through arrangement/agreements with other public or non-profit private entities: <ul style="list-style-type: none"> (a) Screening of all admissions for TB (b) Positive screenings shall receive test for TB (c) Counseling related to TB (d) Referral for appropriate medical evaluations for TB treatment (e) Case management for obtaining any TB services (f) Reports any active cases of TB to the DHHS Division of Public Health Tuberculosis Program (g) Documents screening, testing and referrals and/or any necessary follow-up information

Each Regional Behavioral Health Authority is responsible for conducting the audit/monitoring review using the standards/requirements established by the Audit Work Group and approved by the Division of Behavioral Health. If there are problems identified during the monitoring visit, the Region requires the provider to complete a corrective action plan designed to alleviate the areas of concern.

Each Region must submit the results of the Program Fidelity Audit to the Division of Behavioral Health. The Division's designated Network Specialist reviews the Audit results and reviews the noted corrective action with plans to address compliance. The Network Specialist will complete a

Goal 5 Intended Use TB Services | October 1, 2010 | page 5

cover sheet for the audit, which documents the receipt and review of the audit, and documents the need for corrective action when appropriate.

Upon receipt of the corrective action plan, the Region will forward the plan to the Division. The Network Specialist at the Division reviews the plan and works with the RBHA to ensure the provider implements the plan and monitors compliance with the standards/requirements.

The above referenced checklist was implemented in summer 2009. Provider audits generally occur in the late spring or early summer of the fiscal year.

GOAL #5: Compliance - Tuberculosis Services / September 24, 2010 / Page 1

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

(1) Who will be served? Describe the target population and provide an estimate of the number of persons to be served in the target population.

- Tuberculosis screening is provided to all persons entering a substance abuse treatment service. Additional services are made available to those individuals whose screening indicates “high risk” for TB.
- For 2007, the Nebraska Tuberculosis (TB) data reported to the Centers for Disease Control was a total of 25 people. The chart below shows the data by Injected Drug Use Within Past Year, Non-Injected Drug Use Within Past Year, and Excess Alcohol Use Within Past Year.

Injected Drug Use Within Past Year	
	2007
Yes:	1
No:	24
Non-Injected Drug Use Within Past Year	
Yes:	0
No:	25
Excess Alcohol Use Within Past Year	
Yes:	1
No:	24

Source: Pat Infield, Tuberculosis Program Manager, DHHS - Public Health (August 12, 2009)

In FY2009, 5% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment was reported. The percentage reported was based on 2 of the 25 reported to the CDC had Injected Drug Use (1), or Excess Alcohol (1). The percentage reported was based on 5 of the 33 reported to the CDC had Non-Injected Drug Use (1) and Excess Alcohol Use (4).

The Tuberculosis Program in the NE Division of Public Health is the best source for these data. At this time, an unduplicated count is not available because they are currently making some changes to their data system. Next year, they should be able to produce an unduplicated count across these three areas (Injected Drug Use, Non-Injected Drug Use, and Excess Alcohol Use).

(2) What activities/services will be provided, expanded, or enhanced? This may include activities/services by treatment modality or prevention strategy.

- A. All Substance Abuse Providers under contract with the six Regional Behavioral Health Authorities and receiving Federal Substance Abuse Prevention and Treatment Block Grant (SAPTBG) funds will:

GOAL #5: Compliance - Tuberculosis Services / September 24, 2010 / Page 2

1. Report active cases of tuberculosis (TB) to the Nebraska Department of Health and Human Services (NDHHS) Division of Public Health, Tuberculosis Program Manager and adhere to all reporting requirements as set forth including NRS Sec.71-502, 71-1626 and 173 NAC Chapters 1-6, which can be found at www.dhhs.ne.gov/reg/t173.htm.
 2. Maintain infection control procedures that are consistent with those that are established by the State's infection control office.
 3. Adhere to State and Federal confidentiality requirements when reporting such cases.
 4. Routinely make TB services available to each individual receiving treatment for substance abuse and to monitor such service delivery.
 5. Establish procedures that ensure that the following tuberculosis (TB) services are provided, either directly or through arrangements/agreements with other public or non-profit private entities:
 - a. Screening of all admissions for TB,
 - b. Positive screenings shall receive test for TB,
 - c. Counseling related to TB,
 - d. Referral for appropriate medical evaluations or TB treatment,
 - e. Case management for obtaining any TB services,
 - f. Report any active cases of TB to state health officials, and
 - g. Document screening, testing, referrals and/or any necessary follow-up information.
 6. Refer individuals who screen as "high risk" for TB for testing and counseling to local health department or primary physicians.
- B. The Regional Behavioral Health Authority is responsible to provide the Department with annual documentation via program audits, which demonstrates compliance with the above listed expectations.
- (3) When will the activities/services be implemented (date)? For ongoing activities/services, include information on the progress toward meeting the goals including dates on which integral activities/services began or will begin.
- Tuberculosis services are available to individuals on a continuous basis. Agencies servicing substance abusers have working agreements with local health departments to refer persons who, through a screening instrument developed in conjunction with local health departments, are identified as being at high risk for TB.
- (4) Where in the State (geographic area) will the activities/services be undertaken? This may include counties, districts, regions, or cities;
- The substance abuse service providers receiving SAPTBG fund throughout the State of Nebraska, have working agreements with local health departments
- (5) How will the activities/services be operationalized? This may be through direct procurement, subcontractors or grantees, or intra governmental agreements.

GOAL #5: Compliance - Tuberculosis Services / September 24, 2010 / Page 3

- Substance abuse providers receiving SAPTBG funding have a working agreement with their local Health Department. These working agreements outline the responsibilities and operationalize the expectations of how the entities will work together to ensure that individuals requiring TB services (as outlined above) receive them. The Regional Behavioral Health Authorities monitor and review these working agreements annually when they complete their provider audits. The Behavioral Health Authorities submit these provider audits to the Department for review and approval on an annual basis. The Department, through the contracts with the Regional Behavioral Health Authorities, mandates the review of these working agreements between providers and the local Health Department.

- A description of the strategies developed by the State for monitoring compliance

The Division of Behavioral Health contracts with the six Regional Behavioral Health Authorities (Substate Planning Areas): Region 1 (Panhandle), Region 2 (Southwest), Region 3 (South Central), Region 4 (Northeast), Region 5 (Southeast) and Region 6 (Omaha Metro) per the requirements of the Nebraska Behavioral Health Services Act (Neb. Rev. Stat. §§71-801 to 71-830). All of the requirements for the proper monitoring of the Substance Abuse Prevention and Treatment Block Grant are contained within the contract between the Division of Behavioral Health and the Regional Behavioral Health Authority.

The Audit Work Group is part of the monitoring function. This group is composed of staff from the six Regions plus the Division of Behavioral Health. The group meets monthly to establish and maintain the standards used for monitoring substance abuse providers who receive funds under the Division of Behavioral Health. These standards are approved by the Division of Behavioral Health. The expectation is that each provider is monitored once per year by the Region using these standards.

The following matrix is a component of the Program Fidelity Audit, and includes the components reviewed by Regional Auditors regarding Tuberculosis:

[Review Provider policy and procedures for TB and/or look in individual record.](#)

- | |
|--|
| <p>16. The program reports active cases of TB to the DHHS Division of Public Health Tuberculosis Program Manager and</p> <ul style="list-style-type: none"> (a) adheres to all reporting requirements as set forth including NRS Sec.71-502, 71-1626 and 173 NAC Chapters 1-6. (b) adheres to all state and Federal confidentiality requirements when reporting such cases. (c) maintains infection control procedures that are consistent with those established by the DHHS Division of Public Health Infection Control Office. |
|--|

17. The program routinely makes TB services available to each individual receiving treatment for substance abuse and monitors such service delivery. [Review individual record.](#)

- | |
|--|
| <p>18. The program has established procedures that ensures the following TB services are provided, either directly or through arrangement/agreements with other public or non-profit private entities:</p> <ul style="list-style-type: none"> (a) Screening of all admissions for TB (b) Positive screenings shall receive test for TB |
|--|

GOAL #5: Compliance - Tuberculosis Services / September 24, 2010 / Page 4

- (c) Counseling related to TB
 - (d) Referral for appropriate medical evaluations for TB treatment
 - (e) Case management for obtaining any TB services
 - (f) Reports any active cases of TB to the DHHS Division of Public Health Tuberculosis Program
 - (g) Documents screening, testing and referrals and/or any necessary follow-up information
-

The Region is responsible for conducting the monitoring review using the standards set by the Audit Work Group and approved by the Division of Behavioral Health. If there are problems identified during the monitoring visit, the Region requires the provider to complete a corrective action plan.

Each Region then submits the results of the Program Fidelity Audit to the Division of Behavioral Health. The Division's designated Network Specialist reviews the Audit results and notes the need for any corrective action with compliance to these regulations. The Network Specialist will complete a cover sheet for the audit, which documents the receipt and review of the audit, and Documents the need for corrective action when appropriate.

Upon receipt of the corrective action plan, the Region will forward the plan to the Division. The Network Specialist at the Division reviews the plan and works with the Region to ensure the provider implements the plan to ensure compliance with the Standards.

A description of the problems identified and corrective actions taken

The checklist above was implemented in 2009 and, to date, no problems have been identified by this checklist and no corrective actions have been taken.

GOAL #5: Progress - Tuberculosis Services / September 16, 2010 / Page 1

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

FY 2010 (Progress):

(1) Who (target population)

Tuberculosis (TB) is a disease caused by bacteria called Mycobacterium tuberculosis. The bacteria can attack any part of the body, but it usually attacks the lungs.

The Tuberculosis Program in the NE Division of Public Health provides the overall coordination for the State of Nebraska in this area. The Tuberculosis Program reports to the Federal Centers for Disease Control (CDC). For more details on the Nebraska DHHS Division of Public Health Tuberculosis (TB) program see:

http://www.dhhs.ne.gov/puh/cod/Tuberculosis/docs/TB_AnnualReport2009.pdf

Tuberculosis screening is provided to all persons entering a substance abuse treatment service. Additional services and/or referrals for services are made available to those individuals whose screening indicates “high risk” for TB. The Nebraska Tuberculosis Program reported data to the CDC. The available data are reported on a calendar year basis. The most recent available are for Calendar Year (January 1 to December 31) 2007, 2008 and 2009.

		2007	2008	2009
Injected Drug Use Within Past Year	Yes:	1	0	0
	No:	24	33	32
Non-Injected Drug Use Within Past Year	Yes:	0	1	0
	No:	25	32	32
Excess Alcohol Use Within Past Year	Yes:	1	4	1
	No:	24	29	31
% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment		4%	12%	3%

Source: Pat Infield, Tuberculosis Program Manager
DHHS - Division of Public Health | September 10, 2010

(2) What activities/services

Statewide Non-federal Expenditures for TB Services to SA in Treatment

Tuberculosis (TB) MOE Table

Total of All State Funds Spent on TB Services

	DAS Acctg Division, Budget Status Report as of June 30 – Division 960, Program 514 (Health Aid), Subprogram 116	Division of Behavioral Health, Disease Prevention Section / Tuberculosis Program
SFY2008	54,871	5%
SFY2009	83,524	3%
SFY 2010	87,772	3%

- A. All Substance Abuse Providers under contract with the six Regional Behavioral Health Authorities and receiving Federal Substance Abuse Prevention and Treatment Block Grant (SAPTBG) funds will:
 - 1. Report active cases of tuberculosis (TB) to the Nebraska Department of Health and Human Services (NDHHS) Division of Public Health, Tuberculosis Program Manager and adhere to all reporting requirements as set forth including NRS Sec.71-502, 71-1626 and 173 NAC Chapters 1-6.
 - 2. Maintain infection control procedures that are consistent with those that are established by the State’s infection control office.
 - 3. Adhere to State and Federal confidentiality requirements when reporting such cases.
 - 4. Routinely make TB services available to each individual receiving treatment for substance abuse and to monitor such service delivery.
 - 5. Establish procedures that ensure that the following tuberculosis (TB) services are provided, either directly or through arrangements/agreements with other public or non-profit private entities:
 - a. Screening of all admissions for TB,
 - b. Positive screenings shall receive test for TB,
 - c. Counseling related to TB,
 - d. Referral for appropriate medical evaluations or TB treatment,
 - e. Case management for obtaining any TB services,
 - f. Report any active cases of TB to state health officials, and
 - g. Document screening, testing, referrals and/or any necessary follow-up information.
 - 6. Refer individuals who screen as “high risk” for TB for testing and counseling to local health department or primary physicians.

- B. The Regional Behavioral Health Authority is responsible to provide the Department with annual documentation via program audits, which demonstrates compliance with

GOAL #5: Progress - Tuberculosis Services / September 16, 2010 / Page 3

the above listed expectations.

(3) When will the activities/services be implemented (date)? For ongoing activities/services, include information on the progress toward meeting the goals including dates on which integral activities/services began or will begin.

- Tuberculosis services are available to individuals on a continuous basis. Agencies servicing substance abusers have working agreements with local health departments to refer persons who, through a screening instrument developed in conjunction with local health departments, are identified as being at high risk for TB.

(4) Where in the State (geographic area) will the activities/services be undertaken? This may include counties, districts, regions, or cities;

The substance abuse service providers receiving SAPTBG fund throughout the State of Nebraska, have working agreements with local health departments

(5) How will the activities/services be operationalized? This may be through direct procurement, subcontractors or grantees, or intra governmental agreements.

- Substance abuse providers receiving SAPTBG funding have a working agreement with their local Health Department. These working agreements outline the responsibilities and operationalize the expectations of how the entities will work together to ensure that individuals requiring TB services (as outlined above) receive them. The Regional Behavioral Health Authorities monitor and review these working agreements annually when they complete their provider audits. The Behavioral Health Authorities submit these provider audits to the Department for review and approval on an annual basis. The Department, through the contracts with the Regional Behavioral Health Authorities, mandates the review of these working agreements between providers and the local Health Department.

- A description of the strategies developed by the State for monitoring compliance

The Division of Behavioral Health contracts with the six Regional Behavioral Health Authorities (Substate Planning Areas): Region 1 (Panhandle), Region 2 (Southwest), Region 3 (South Central), Region 4 (Northeast), Region 5 (Southeast) and Region 6 (Omaha Metro) per the requirements of the Nebraska Behavioral Health Services Act (Neb. Rev. Stat. §§71-801 to 71-830). All of the requirements for the proper monitoring of the Substance Abuse Prevention and Treatment Block Grant are contained within the contract between the Division of Behavioral Health and the Regional Behavioral Health Authority.

The Audit Work Group is part of the monitoring function. This group is composed of staff from the six Regions plus the Division of Behavioral Health. The group meets monthly to establish and maintain the standards used for monitoring substance abuse providers who receive funds under the Division of Behavioral Health. These standards are approved by the Division of Behavioral Health. The expectation is that

GOAL #5: Progress - Tuberculosis Services / September 16, 2010 / Page 4

each provider is monitored once per year by the Region using these standards.

The following matrix is a component of the Program Fidelity Audit, and includes the components reviewed by Regional Auditors regarding Tuberculosis:

Review Provider policy and procedures for TB and/or look in individual record.	
16.	The program reports active cases of TB to the DHHS Division of Public Health Tuberculosis Program Manager and <ul style="list-style-type: none"> (a) adheres to all reporting requirements as set forth including NRS Sec.71-502, 71-1626 and 173 NAC Chapters 1-6. (b) adheres to all state and Federal confidentiality requirements when reporting such cases. (c) maintains infection control procedures that are consistent with those established by the DHHS Division of Public Health Infection Control Office.
17.	The program routinely makes TB services available to each individual receiving treatment for substance abuse and monitors such service delivery. Review individual record.
18.	The program has established procedures that ensures the following TB services are provided, either directly or through arrangement/agreements with other public or non-profit private entities: <ul style="list-style-type: none"> (a) Screening of all admissions for TB (b) Positive screenings shall receive test for TB (c) Counseling related to TB (d) Referral for appropriate medical evaluations for TB treatment (e) Case management for obtaining any TB services (f) Reports any active cases of TB to the DHHS Division of Public Health Tuberculosis Program (g) Documents screening, testing and referrals and/or any necessary follow-up information

The Region is responsible for conducting the monitoring review using the standards set by the Audit Work Group and approved by the Division of Behavioral Health. If there are problems identified during the monitoring visit, the Region requires the provider to complete a corrective action plan.

Each Region then submits the results of the Program Fidelity Audit to the Division of Behavioral Health. The Division’s designated Network Specialist reviews the Audit results and notes the need for any corrective action with compliance to these regulations. The Network Specialist will complete a cover sheet for the audit, which documents the receipt and review of the audit, and Documents the need for corrective action when appropriate.

Upon receipt of the corrective action plan, the Region will forward the plan to the Division. The Network Specialist at the Division reviews the plan and works with the Region to ensure the provider implements the plan to ensure compliance with the Standards.

A description of the problems identified and corrective actions taken

The checklist above was implemented in 2009 and, to date, no problems have been identified by this checklist and no corrective actions have been taken.

GOAL #5: Progress - Tuberculosis Services / September 16, 2010 / Page 5

Goal #6: HIV Services

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

Note: If the State is or was for the reporting periods listed a designated State, in addressing this narrative the State may want to discuss activities or initiatives related to the provision of: HIV testing; Counseling; Provider contracts; Training/TA Education; Screening/assessment; Site visits/reviews; Rapid HIV testing; Referral; Case management; Risk reduction; and HIV-related data collection

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

Nebraska is not a Designated HIV State

Nebraska is not a Designated HIV State

Nebraska is not a Designated HIV State

Tuberculosis (TB) and Early Intervention Services for HIV (formerly Attachment E)

(See 45 C.F.R. §96.122(f)(1)(x))

For the fiscal year three years prior (FY 2008; Annual Report/Compliance) to the fiscal year for which the State is applying for funds:

Provide a description of the State's procedures and activities and the total funds expended for tuberculosis services. If a "designated State," provide funds expended for early intervention services for HIV. Please refer to the FY 2008 Uniform Application, Section III.4, FY 2008 Intended Use Plan (Form 11), and Appendix A, List of HIV Designated States, to confirm applicable percentage and required amount of SAPT Block Grant funds expended for early intervention services for HIV.

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

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

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

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

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

For the fiscal year three years prior (FY 2008; Annual Report/Compliance) to the fiscal year for which the State is applying for funds:

Provide a description of the State's procedures and activities and the total funds expended for tuberculosis services. If a "designated State," provide funds expended for early intervention services for HIV. Please refer to the FY 2008 Uniform Application, Section III.4, FY 2008 Intended Use Plan (Form 11), and Appendix A, List of HIV Designated States, to confirm applicable percentage and required amount of SAPT Block Grant funds expended for early intervention services for HIV.

EARLY INTERVENTION SERVICES FOR HIV

Nebraska is not a Designated HIV State. No Substance Abuse Prevention and Treatment Block Grant funds are used to provide HIV treatment or referral.

TUBERCULOSIS SERVICES

The Division of Behavioral Health has no specific financial set aside for tuberculosis (TB) services. Division contracts with the six Regional Behavioral Health Authorities require programs to have working relationships with local health departments and to screen all persons requesting services for communicable diseases.

The contract between the Division of Behavioral Health and the six Regional Behavioral Health Authorities addresses the TB Screening and Services requirements under ATTACHMENT F - Federal Block Grant Requirements:

J. TUBERCULOSIS (TB) SCREENING AND SERVICES

1. Contractor will ensure that all subcontractors receiving SAPTBG funds shall:
 - a. Report active cases of TB to the DHHS Division of Public Health Tuberculosis Program Manager and adhere to all reporting requirements as set forth including NRS Sec.71-502, 71-1626 and 173 NAC Chapters 1-6, which can be found at www.dhhs.ne.gov/reg/t173.htm.
 - b. Maintain infection control procedures that are consistent with those that are established by the State's infection control office.
 - c. Adhere to State and Federal confidentiality requirements when reporting such cases.
2. The Contractor will ensure that subcontractors of SAPTBG funding will routinely make TB services available to each individual receiving treatment for substance abuse and to monitor such service delivery.
3. The Contractor shall establish procedures that ensure that the following (TB) services are provided, either directly or through arrangements/agreements with other public or non-profit private entities:
 - a. Screening of all admissions for TB,
 - b. Positive screenings shall receive test for TB,
 - c. Counseling related to TB,
 - d. Referral for appropriate medical evaluations or TB treatment,
 - e. Case management for obtaining any TB services,
 - f. Report any active cases of TB to state health officials, and
 - g. Document screening, testing, referrals and/or any necessary follow-up information.

4. The Contractor is responsible to provide DHHS with documentation which illustrates facilitation or provision of the above listed services and ensure that any changes are reported and on file with DHHS.

Source: Nebraska Department of Health and Human Services
 Division of Behavioral Health - Community-Based Services Section
 Contract with each of the six Regional Behavioral Health Authorities
 FY2011 - ATTACHMENT F - **Federal Block Grant Requirements**

NOTE: To see the complete FY2011 Regional Behavioral Health contract ATTACHMENT F - **Federal Block Grant Requirements**, go to <https://bgas.samhsa.gov/2011/> ... Appendix / Addendum - Additional Supporting Documents (Optional)

The Tuberculosis Program in the NE Division of Public Health provides the overall coordination for the State of Nebraska in this area. The Tuberculosis Program reports to the Federal Centers for Disease Control (CDC). The available data are reported on a calendar year basis. The most recent available are for Calendar Year 2007, 2008 and 2009.

		2007	2008	2009
Injected Drug Use Within Past Year	Yes:	1	0	0
	No:	24	33	32
Non-Injected Drug Use Within Past Year	Yes:	0	1	0
	No:	25	32	32
Excess Alcohol Use Within Past Year	Yes:	1	4	1
	No:	24	29	31

Source: Pat Infield, Tuberculosis Program Manager
 DHHS - Division of Public Health | September 10, 2010

Based on these data, the Division of Behavioral Health estimates that 15% of DHHS Tuberculosis (TB) expenditures were for consumers with Injected Drug Use, Non-Injected Drug Use, and Excess Alcohol Use in 2008. In FY2009, 5% was reported. The percentage reported was based on 2 of the 25 reported to the CDC had Injected Drug Use (1), or Excess Alcohol (1). In FY2010, the estimated number was adjusted to 15%. The percentage reported was based on 5 of the 33 reported to the CDC had Non-Injected Drug Use (1) and Excess Alcohol Use (4).

TUBERCULOSIS IN NEBRASKA – 2009

Tuberculosis (TB) is a disease caused by bacteria called Mycobacterium tuberculosis. The bacteria can attack any part of the body, but it usually attacks the lungs. For more details on the Nebraska DHHS Division of Public Health Tuberculosis (TB) program see: http://www.dhhs.ne.gov/puh/cod/Tuberculosis/docs/TB_AnnualReport2009.pdf

Nebraska has ninety-three (93) counties, seven (7) of which reported cases of Tuberculosis in 2009. For the period of 2005-2009, twenty-two (22) counties reported at least one (1) case of Tuberculosis and are reported on the list that follows.

Tuberculosis in Nebraska 2009 by Region by County

Region	COUNTY	2005	2006	2007	2008	2009	TOTAL
2	Dawson		1				1
2	Lincoln	1	2	1			4
3	Adams			1	1		2
3	Buffalo	1				1	2
3	Franklin	1		1			2
3	Hall			1	4		5
3	Howard		1				1
4	Burt		1				1
4	Colfax					1	1
4	Dakota	1	2	1		5	9
4	Madison	1				1	2
4	Platte	2	1	1			4
4	Rock			1			1
4	Thurston	1	1		1		3
5	Johnson	1					1
5	Lancaster	7	3	6	2	7	25
5	Nemaha		1				1
5	Saline				2		2
6	Cass			1			1
6	Dodge	1					1
6	Douglas	16	10	10	19	16	71
6	Sarpy	2	2	1	4	1	10
	TOTAL	35	25	25	33	32	150

Tuberculosis Services (Maintenance of Effort Table II)

Expenditures for TB are of the Nebraska Department of Health and Human Services, Division of Public Health, Disease Prevention Section, state general funds for the State Fiscal Year stated. No Substance Abuse state general funds or Substance Abuse Federal Block Grant funds are used for TB services other than as a part of the disease assessment conducted by agencies as a part of the Health History in the general assessment of clients seeking treatment.

Statewide Non-federal Expenditures for TB Services to SA in Treatment

Tuberculosis (TB) MOE Table

Total of All State Funds Spent on TB Services

	DAS Acctg Division, Budget Status Report as of June 30 – Division 960, Program 514 (Health Aid), Subprogram 116	Division of Behavioral Health, Disease Prevention Section / Tuberculosis Program
SFY2008	54,871	5%
SFY2009	83,524	3%
SFY 2010	87,772	3%

NE Division of Behavioral Health does not set aside funds for TB service from block grant or state funds passing through The Division of Behavioral Health. Each client is screened using a screening instrument developed in consultation with physicians and using the guidance of TIP 11 "Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases" SAMHSA 1994.

Sources: Lori Dawes, DHHS Budget Analyst, DHHS - Operations
(402)471-9464 | Lori.Dawes@nebraska.gov

DAS Acctg Division, Budget Status Report as of June 30, 2009 for
Division 960, Program 514 (Health Aid), Subprogram 016

Pat Infield, Tuberculosis Program Manager
DHHS - Public Health
Lincoln, NE 68509
(402)471-6441 | pat.infield@nebraska.gov

Goal #7: Development of Group Homes

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

Note: If this goal is no longer applicable because the project was discontinued, please indicate.

If the loan fund is continuing to be used, please indicate and discuss distribution of loan applications; training/TA to group homes; loan payment collections; Opening of new properties; Loans paid off in full; and loans identified as in default.

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

GOAL # 7 – Intended Use – Development of Group Homes / September 9, 2010 / Page 1

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

FY 2011- FY 2013 (Intended Use/Plan):

- 1) **Who** will be served – describe the target population and provide an estimate of the number of persons to be served in the target population;

In FY2010, Nebraska had seven (7) outstanding Recovery Home loans. Those 7 loans supported 195 beds (176 filled). The individuals who occupied these beds were, at a minimum, people required to be in recovery from alcoholism and/or drug addiction. The traditional method of arriving at a recovery home is toward the end of an individual’s treatment regimen which might include a 30-day inpatient facility, halfway house stay and, finally, a recovery home. After a stay in the recovery home individuals are ready for independent living. The number of individuals occupying the approximately 100 beds is not known as the State does not request registration of individuals into the house. As part of the model of self-run, self-supporting recovery homes, a recovering individual must complete an application for membership and be interviewed by the residents of the house he or she wants to live in. The decision of the house residents is final.

- (2) **What** activities/services will be provided, expanded, or enhanced – this may include activities/services by treatment modality or prevention strategy;

The Recovery Homes are self-supporting, self-run homes for substance abusers. They are the residential location for individuals in recovery. No treatment or prevention services are offered in the house. Houses are required to hold regularly scheduled meetings. Operational rules of the houses include:

- The use of alcohol or drugs on the premises is prohibited.
- Residents violating use prohibition are expelled.
- Costs of the housing, including fees for rent and utilities, are paid by residents.
- Residents of house, through majority vote, establish house rules.
- Residents of house, through majority vote, approve new residents.

- (3) **When** will the activities/services be implemented (date) – for ongoing activities/services, include information on the progress toward meeting the goals including dates on which integral activities/services began or will begin;

Recovery Homes are currently available in Lincoln, Omaha, Grand Island, and Kearney. Loan Application materials are available at the state web site:

<http://www.dhhs.ne.gov/hew/sua/recvyexp.htm>

- (4) **Where** in the State (geographic area) will the activities/services be undertaken – this may include counties, districts, regions, or cities;

As of July 2010, Nebraska Oxford House International, Inc. operates 23 homes in Omaha (167 beds), 1 home in Lincoln (7 beds) (a new home is scheduled to open on September 15, 2010), two homes in Grand Island (12 beds), and one in Kearney (9 beds). A new home, which is a non-Oxford House model, is scheduled to open on September 15, 2010 in Lincoln.

GOAL # 7 – Intended Use – Development of Group Homes / September 9, 2010 / Page 2

- (5) **How** will the activities/services be operationalized – this may be through direct procurement, subcontractors or grantees, or intra-governmental agreements.

Loans are provided to non-profit entities for the development of self-supporting, self-run group homes for substance abusers in recovery. Loans are provided from the Recovery Home Loan Fund established with the Division of Behavioral Health who also manages/monitors the Recovery Home Loan repayments. The chart below indicates the “loan fund” balances during the progress year.

Date	Loan Fund Balance *
September 30, 2009	\$30,325
December 31, 2009	\$28,515
March 30, 2010	\$26,515
June 30, 2010	\$33,379

* Fund balances are interest and principle derived from the initial deposit to the Oxford House program and do not include State Investment authority interest payments.

Following is a summary of Recovery Home Loan activity to date:

- Active Loans = 6
- Paid Loans = 41
- Homes closed, Loans being re-paid = 1
- Lost Loans = 14

The Division of Behavioral Health has entered into a contract with Nebraska Oxford House International, Inc., through the Good Neighbor Foundation in Omaha to monitor Recovery Homes within Nebraska by:

1. Visiting registered Oxford Houses at least semi-annually,
2. Visiting other Recovery Home loan recipients at least quarterly.
3. Work with Recovery Home Loan recipients to:
 - a. Build a recovery home based on the recovery home loan philosophy.
 - b. Instruct loan recipients on loan repayment parameters.
 - c. Encourage Oxford House designation of homes not so designated.
 - d. Review with delinquent homes/non profit entities loan repayment requirements and, working with the Division, establish repayment options for delinquent loan recipients.
4. Conduct quarterly meetings of recovery home loan recipients
 - a. Build coordination between Oxford Homes and other Recovery Homes.
 - b. Encourage loan repayments.
 - c. Resolve issues of house coordination and peer support.
5. Establish additional Recovery Homes.
 - a. Recruit additional locations within Nebraska.
 - b. Meet with potential residents, explaining requirements of the loan and of the Recovery Home model.
 - c. Assist in completing application materials.
6. The contractor attends Regional Behavioral Health Authority provider meetings at least once in each Region to promote Recovery Homes during the contract period.

GOAL # 7: Compliance – Development of Group Homes / September 24, 2010 / Page 1

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

FY2009 (Compliance)

- (1) **Who** will be served? – describe the target population and provide an estimate of the number of persons to be served in the target population;

In FY2009, Nebraska had 15 outstanding Recovery Home loans. Those 15 loans supported 100 beds. People who occupied these beds were at a minimum people who must be in recovery from alcoholism and/or drug addiction. The traditional method of arriving at a recovery home is toward the end of their treatment regiment which might include a 30 day inpatient facility, halfway house stay and finally recovery home. After a stay in the recovery home individuals are ready for independent living. The number of individuals occupying the 100 or so beds is not known as the State does not request registration of individuals into the house. As part of the model of self-run, self-supporting recovery homes, a recovering individual must complete an application for membership and be interviewed by the residents of the house he or she wants to live in. The decision of the house residents is final.

- (2) **What** activities/services will be provided, expanded, or enhanced? – this may include activities/services by treatment modality or prevention strategy;

The Recovery Homes are self-supporting, self-run houses for substance abusers, and are a residential location for individuals in recovery. No treatment or prevention services are offered in the house. The houses hold regular business meetings. Operational rules of the house include:

- The use of alcohol or drugs on the premises is prohibited.
- Residents violating use prohibition are expelled.
- Costs of the housing, including fees for rent and utilities, are paid by residents.
- Residents of house, through majority vote, establish house rules.
- Residents of house, through majority vote, approve new residents.

- (3) **When** will the activities/services be implemented (date)? – for ongoing activities/services, include information on the progress toward meeting the goals including dates on which integral activities/services began or will begin;

Recovery homes are available in Lincoln, Omaha, and Grand Island.

- (4) **Where** in the State (geographic area) will the activities/services be undertaken? – this may include counties, districts, regions, or cities;

As of June 2009 Nebraska Oxford House International, Inc. operates 23 homes in Omaha, 3 in Lincoln, one Grand Island, and is proposing a home in Kearney, McCook, North Platte and Hastings. Beacon of Light operates two homes in Omaha.

- (5) **How** will the activities/services be operationalized? – this may be through direct procurement, subcontractors or grantees, or intra-governmental agreements.

GOAL # 7: Compliance – Development of Group Homes / September 24, 2010 / Page 2

Loans are provided to non-profit entities for the development of self-supporting, self-run group homes for recovering substance abusers. Loans are provided from the Recovery Home Loan Fund established at the State. One staff member within the Division of Behavioral Health oversees the recovery home loans repayments. The chart below indicates the “loan fund” balances during FFY2009.

Date	Loan Fund Balance *
September 30, 2008	\$79,903
December 31, 2008	\$80,643
March 30, 2009	\$78,366
June 30, 2009	\$72,291
* Fund balances are interest and principle derived from the initial deposit to the Oxford House program and do not include State Investment authority interest payments.	

Three new applications for loan funds were received and approved during the year from Nebraska Oxford House, Inc. In May 2008, the Division entered into a contract with Nebraska Oxford House International, Inc., through the Omaha Good Neighbor Foundation to monitor Recovery Homes within Nebraska by:

1. Visiting registered Oxford Houses at least semi-annually,
2. Visiting other Recovery Home loan recipients at least quarterly.
3. Work with Recovery Home Loan recipients to:
 - a. Build a recovery home based on the recovery home loan philosophy.
 - b. Instruct loan recipients on loan repayment parameters.
 - c. Encourage Oxford House designation of homes not so designated.
 - d. Review with delinquent homes/non profit entities loan repayment requirements and, working with the Department, establish repayment options for delinquent loan recipients.
4. Conduct quarterly meetings of recovery home loan recipients
 - a. Build coordination between Oxford Homes and other Recovery Homes.
 - b. Encourage loan repayments.
 - c. Resolve issues of house coordination and peer support.
5. Establish additional recovery homes.
 - a. Recruit additional locations within Nebraska.
 - b. Meet with potential residents, explaining requirements of the loan and of the recovery home model.
 - c. Assist in completing application materials.
6. The contractor shall attend regional behavioral health authority provider meetings at least twice to promote recovery homes during the contract period.

This contract is for \$24,000 for the year and is intended to promote house development, inter-house assistance and to obtain repayment on delinquent loans. Funds are made available from interest earned by the state deposited into the loan

During this fiscal year, each house was visited at least twice. Two houses were closed because of code violations and mold problems. Two women’s homes were converted to men’s houses, and the women’s houses were consolidated. This move provided consolidation of women’s house efforts, reduced women’s house rent and provided more space for men’s housing. Two loan repayment plans were approved, and Oxford House chapters agreed to pay \$50 per month to pay down a house

GOAL # 7: Compliance – Development of Group Homes / September 24, 2010 / Page 3

that was previously closed because of low occupancy. The Nebraska Oxford House chapters were reorganized and monthly meetings are conducted that are mandatory for all chapter and house presidents.

A new home opened in Kearney, NE housing 8 men. Initial local concerns delayed the opening of the house . Nebraska Oxford House representatives met with local residents, selected a house and began negotiations with the landlord, who then wanted city council approval of the home before opening it.

Homes associated with Beacon of Light are being encouraged to achieve Oxford House status and to begin repayment of the loans for which they are in arrears. According to the Oxford House representative, the homes have only two rules: stay sober and pay rent. Participation in house activities and continued activities to maintain recovery are not required of the residents of these houses.

GOAL # 7: Progress – Development of Group Homes / September 24, 2010 / Page 1

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

FY 2010 (Progress):

- 1) **Who** will be served – describe the target population and provide an estimate of the number of persons to be served in the target population;

At the beginning of FY2010, Nebraska had 15 active Recovery Home Loans, supporting 75 recovery beds. Recovery homes are utilized by individuals who have completed primary treatment and desire assistance with future planning for independent living and self-sufficiency. The number of individuals occupying the 200 plus beds is not known as the State does not request registration of individuals into the house. As part of the model of self-run, self-supporting recovery homes, an individual must complete an application for membership and be interviewed by the residents of the house he or she want to live in.

- (2) **What** activities/services will be provided, expanded, or enhanced – this may include activities/services by treatment modality or prevention strategy;

Self supporting, self run Recovery Homes for individuals recovering from an addiction. The houses are residentially located and designed for individuals in recovery from their addiction. No treatment or prevention services are offered in the house. Houses conduct regular meetings to discuss house business. Operational rules of the houses include:

- § The use of alcohol or drugs on the premises is prohibited.
- § Residents violating house rules (use of drugs/alcohol) are expelled.
- § Costs of the housing, including fees for rent and utilities, are paid by residents.
- § Residents of house, through majority vote, establish house rules.
- § Residents of house, through majority vote, approve new residents.

- (3) **When** will the activities/services be implemented (date) – for ongoing activities/services, include information on the progress toward meeting the goals including dates on which integral activities/services began or will begin;

Recovery homes are available in Lincoln, Omaha, Grand Island, and Kearney. Loan application materials are available at the state web site: <http://www.dhhs.ne.gov/hew/sua/recvyexp.htm>

- (4) **Where** in the State (geographic area) will the activities/services be undertaken – this may include counties, districts, regions, or cities;

As of July 2010, Nebraska Oxford House International, Inc. operates 23 homes in Omaha (167 beds), 1 home in Lincoln (7 beds) (a new home is scheduled to open on September 15, 2010), two homes in Grand Island (12 beds), and one in Kearney (9 beds). A new home, which is a non-Oxford House model, is scheduled to open on September 15, 2010 in Lincoln.

GOAL # 7: Progress – Development of Group Homes / September 24, 2010 / Page 2

- (5) **How** will the activities/services be operationalized – this may be through direct procurement, subcontractors or grantees, or intra-governmental agreements.

Loans are provided to non-profit entities for the development of self-supporting, self-run group homes for recovering addicts. Loans are provided from the Recovery Home Loan Fund established with the Division of Behavioral Health who also manages/monitors the Recovery Home Loan repayments. The chart below indicates the “loan fund” balances during the progress year.

Date	Loan Fund Balance *
September 30, 2008	\$79,903
December 31, 2008	\$80,643
March 30, 2009	\$78,366
June 30, 2009	\$72,291

* Fund balances are interest and principle derived from the initial deposit to the Oxford House program and do not include State Investment authority interest payments.

Group Home Entities and Programs (formerly Attachment F)

(See 42 U.S.C. §300x-25)

If the State has chosen in FY 2008 to participate and support the development of group homes for recovering substance abusers through the operation of a revolving loan fund, the following information must be provided.

Provide a list of all entities that have received loans from the revolving fund during FY 2008 to establish group homes for recovering substance abusers. In a narrative of **up to two pages**, describe the following:

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

Group Home Entities and Programs

(See 42 U.S.C. §300x-25) / September 27, 2010 / Page 1

If the State has chosen in FY2008 to participate and support the development of group homes for recovering substance abusers through the operation of a revolving loan fund, the following information must be provided.

Provide a list of all entities that have received loans from the revolving fund during FY2008 to establish group homes for recovering substance abusers. In a narrative of **up to two pages**, describe the following:

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

1 - The number and amount of loans made available during the applicable fiscal years.

During FY2008 the State of Nebraska received one new house application. At the end of the fiscal year there were 11 outstanding loans.

Following is a summary of Recovery Home Loan through FY2008:

Active Loans = 6
Paid Loans = 34
Homes closed, Loans being re-paid = 5
Lost Loans = 4

2 - The amount available in the fund throughout the fiscal year.

Considering outstanding loans and potential losses due to non-payment, the following chart depicts the amount of funds available for loans during FY2008.

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

** fund balances are interest and principle derived from the initial deposit to the Oxford House program and do not include State Investment authority interest payments.

3 - The source of funds used to establish and maintain the revolving fund.

Funds are made available from the initial \$100,000 from the Federal Block Grant. Additionally accrued interest from this initial fund of \$100,000 is made available.

4 - The loan requirements, application procedures, the number of loans made, the number of repayments, and any repayment problems encountered.

Loan Requirements:

- Loans are for the costs of establishing housing for individuals recovering from alcohol or drug abuse.
- Loans are made for initial deposit, furnishings and supplies to start a house.
- Not less than six individuals must live in the home.
- Maximum loan is \$4,000.
- Each loan is repaid through monthly installments.
- Penalties are assessed for late payment.

Operational Guidelines Include:

- The use of alcohol or drugs on the premises is prohibited.
- Residents violating use prohibition are expelled.
- Costs of the housing, including fees for rent and utilities, are paid by the residents.
- Residents of the house, through majority vote, establish house rules.
- Residents of the house, through majority vote, approve new residents.

Loan Provisions:

- Loans made only to non-profit, private entities.
- Four percent simple interest is charged.
- Monthly payments are due by the 15th or a \$25.00 late fee is assessed.
- The repayment period is two years.
- In case of default, reclaimable items purchased will revert to the State.
- Non-profit entities are required to supply the State with data on the residents.

Application is made directly to the Division of Behavioral Health. The Division assigns one staff member to oversee the application process and establishment of the loan. Application materials are made available through the Division website:

<http://www.dhhs.ne.gov/hew/sua/recvyexp.htm>.

Loans are provided to non-profit entities for the development of self-supporting, self-run group homes for substance abusers who are in recovery. Loans are provided from the Recovery Home Loan Fund established through the State. One Division of Behavioral Health staff member oversees the recovery home loans repayments.

Repayments are being made by either Oxford House Nebraska, Inc., in the case where a house has been previously closed and the loan was not fully repaid, or through monthly payments by operational houses.

One thousand four hundred thirty-five dollars (\$1,435) were repaid to the loan fund in FY2008.

5 - The private, nonprofit entity selected to manage the fund.

The Division operates the fund directly with Division staff maintaining account information for each loan made. Repayments are shared with Oxford House Nebraska, Inc., for Oxford House affiliated loans and directly with loan guarantors for non-oxford houses. Loans are made on the assumption that homes are in good condition, and the entity operates the home as prescribed by the loan requirements.

6 - Any written agreement that may exist between the State and the managing entity;

The Division entered into a contract with Nebraska Oxford House International, Inc., through the Good Neighbor Foundation, Inc. in Omaha, NE to establish, mentor, and monitor Recovery Homes within Nebraska.

Division staff maintains contact with the Executive Director of the Good Neighborhood Foundation, Inc. The Executive Director of the Good Neighborhood Foundation, Inc. also serves on the Board of Directors of Oxford House Nebraska, Inc., the statewide entity established under the auspices of Oxford House International.

7 - How the State monitors fund and loan operations;

The State maintains an accounting of all funds dispersed and received by the loan applicants. The State also maintains direct communications with Oxford House Nebraska, Inc., and the Good Neighborhood Foundation, Inc. Where necessary, the State will acknowledge loan problems and will communicate with the loan guarantors to establish repayment options suited to the needs of the house, its residents, and to the overall recapture of funds to the program.

8 - Any changes from previous years' operations.

No changes were made in loan procedures, monitoring and accounting in the previous 12 months.

Goal #8: Tobacco Products

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

- Is the State's FY 2011 Annual Synar Report included with the FY 2011 uniform application? (Yes/No)
- If No, please indicate when the State plans to submit the report: (mm/dd/2010)

Note: The statutory due date is December 31, 2010.

No, Nebraska's FY 2011 Annual Synar Report is not included with the FY 2011 uniform application.

Nebraska intends to submit the report by December 1, 2010 or sooner.

Goal #9: Pregnant Women Preferences

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

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Priority admissions; Referral to Interim services; Prenatal care; Provider contracts; Routine reporting; Waiting lists; Screening/assessment; Residential treatment; Counseling; Training/TA Educational materials; HIV/AIDS/TB Testing*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

GOAL #9: Intended Use - Pregnant Women Preferences / September 3, 2010 / Page 1

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

FY2011 – FY2013 (Intended Use/Plan)

On Form 10b (formerly Form 7b), Number of Persons Served for Alcohol and Other Drug Use in State Funded Services, there were 162 pregnant women reported. These women have a Substance Abuse Disorder and are seeking substance abuse treatment. This is an unduplicated count of persons served in FY2009. The goal for FY2011 – FY2013 is to provide immediate admission to treatment.

On July 1, 2010, the following requirements were included in the Division's contracts with the six Regional Behavioral Health Authorities (RBHA's), and were also included in the RBHA's contracts with their contracted treatment providers (subcontractors):

- Pregnant women who have requested treatment, but who have not had a substance abuse assessment completed within the last 6 months, must have an appointment for a Substance Abuse (SA) assessment within 48 hours from time of request, and must receive and complete the actual assessment within 7 business days of the appointment. The waiting list clock starts when a client (pregnant woman) completes the assessment process and a recommendation for treatment is made. This will ensure that pregnant women receive timely access to assessment and treatment services.
- Interim Services must be provided between the time the individual requests treatment and the time they enter treatment. Interim services must be provided within 48 hours and until the pregnant woman can receive the appropriate treatment service, based on the level of care identified in the Substance Abuse Assessment. Examples of Interim Services include but are not limited to: a lower level of care with available capacity, community support, traditional outpatient, or other similar services that assist the individual with continued contemplation and preparation for treatment.
- Interim Services for pregnant women must also include counseling on the effects of alcohol and drug use on the fetus and a referral for prenatal care, counseling and education about HIV and TB, the risks of needle sharing, the risks of transmission to sexual partners and infants, and the steps that can be taken to ensure that HIV and TB transmission does not occur. All referrals and or follow-up information must be documented and made available upon the request of the Contractor and or the Department.
- Regional Behavioral Health Authorities and those they subcontract with (treatment providers) are contractually required to improve/enhance their strategies for publicizing the specific assessment and treatment services they are able to provide to pregnant

GOAL #9: Intended Use - Pregnant Women Preferences / September 3, 2010 / Page 2

women. Marketing strategies must be specific to this population i.e. Pediatric clinics, WIC offices, health clinics. Marketing strategies must also include that pregnant women are giving priority access to assessment and treatment services.

In August 2009, the Division completed a comprehensive review of the existing Waiting List/Interim Services-Capacity Management process. As a result of this review and Technical Assistance (SABTBG 101) the Division received, the Capacity Management process was significantly enhanced. Enhancements were developed in collaboration with the Regional Behavioral Health Authorities and were implemented in October, 2009.

Capacity Management Enhancements: The Waiting List/Interim Services-Capacity Management Report are completed and updated by the Behavioral Health Network Providers who submit the Report to the Regional Behavioral Health Authority each week on the date established by the RBHA. The RBHA collects, analyzes, and aggregates this data. Every Tuesday, the RBHA provides this aggregated Report to the Division of Behavioral Health's designated staff. The Division analyzes and aggregates the data from the 6 RBHA's in order to report on the available statewide capacity (purchased and unpurchased) for substance abuse treatment services. This report also tracks when consumers are placed on the waiting list and when they are able to be removed from the waiting list, as well as the actual "length of time" a consumer waited before receiving treatment services. The Reports also serve as notification to the Division when programs reach 90 percent of capacity. DBH receives such reports within 7 days of programs reaching 90 percent capacity.

This specific type of data significantly assists our system during the annual budget planning process, where decisions are made regarding funding (adding or decreasing capacity/levels of care). The Capacity Management Reports also track to ensure that all individuals who are on the waiting list are also receiving the required interim services.

The Division continues to facilitate a weekly, statewide conference call with each of the six RBHA's. The conference call provides structure to the system review of statewide capacity which assists the Regional Behavioral Health Authorities in determining where available capacity is should a specific level of care not be available in one area of the state. This weekly conference call also serves as a tool to review and ensure the delivery of interim services.

Information provided by the treatment provider to the RBHA on the Weekly SA Reports is done so in a manner that does not identify the individual. A unique consumer identifier containing the first four characters of the last name + date of birth (YYYYMMDD) + the last four numbers of the social security number has been developed to provide the data. The unique identifier also helps DBH sort out individuals who may be duplicated among waiting lists.

Providers (subcontractors) must maintain contact with pregnant women on the waiting list a minimum of every seven (7) days from the initial screening. Providers must maintain documentation of the following:

1. Client unique identifier, DOB, name, address, phone, and alternate address and phone, if applicable;

GOAL #9: Intended Use - Pregnant Women Preferences / September 3, 2010 / Page 3

2. Date of the initial face to face screening and the recommended treatment service and date placed on the waiting list;
3. Priority category for admission;
4. Whether the client was referred to another agency, if they accepted the outside referral, the date the referral was made and the provider to which the individual was referred;
5. Whether the client was placed in interim services and what type of interim services;
6. Counselor/client follow-up (minimum every 7 days from initial screening) including date and type of contact and name of staff person;
7. Number of days before placed in recommended treatment; and
8. Date and reason for removal from the waiting list if the client was not placed into the appropriate recommended treatment.

The formal monitoring of interim service provision is accomplished through the Regional Behavioral Health Authority audit staff. An interim service provision audit tool continues to be utilized at the time of the subcontractor's services purchased and/or fidelity audit. RBHA audit staff provide audit results and technical assistance to the provider, and send this checklist to the assigned DBH staff. DBH data team members aggregate and analyze the audit data and review the data findings with the Network Manager, and make recommendations to the Division Administrator's Management Team (DAMT) regarding system improvements for treatment capacity, interim service delivery, and enhanced waiting list monitoring.

Aggregate data is shared with RBHA staff and treatment providers through the Division's Quality Improvement structure and during weekly conference calls to ensure ongoing improvement and compliance with federal block grant requirements. Reports may include:

- Average wait time for admission by priority population by service by region by state;
- Total capacity by service by region by state;
- Regional Purchased capacity by service by provider by region by state;
- Number of individual on the waiting list by priority by service by region by state;
- Number of individuals receiving interim services within 48 hours;
- Average length of interim services;
- Number of priority population served with 14 days or by 120 days;
- Number of Magellan authorized or registered interim services for individuals on the waiting list by service by region by state; and
- Reason for removal from waiting list by service by provider by region by state.

GOAL #9: Compliance - Pregnant Women Preferences / September 3, 2010 / Page 1

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

FY2009 (Annual Report/Compliance)

In FY2009, the Division of Behavioral Health to Regional Behavioral Health Authority annual contract contained language requiring that providers give preference in admission to pregnant women in the order of pregnant injecting drug abusers followed by pregnant substance abusers. The contract also required providers serving women to publicize the availability of these services, and that pregnant women will receive priority admission. The contract set forth requirements for Women's Set Aside providers including expectations that non-qualifying programs work each year to comply with women and dependent children's service requirements that qualifying programs must meet.

Contract language also included capacity/waiting list requirements such as keeping the Division updated regarding the contractor's capacity/waiting list to meet requirements for pregnant women, IV drug users, and tuberculosis services. Contractors and subcontractors were required to report to the Division whenever full (90%) capacity was reached and an individual identified as priority was unable to be admitted to service.

Contractors were required to admit pregnant IV drug users within 14 days of request for treatment or if no services were available, they must provide interim services within 48 hours and admit to treatment within 120 days.

The Division of Behavioral Health contract did not contain a definition of interim services or specify interim service provision. Referrals for pregnant women for prenatal care were identified, but the Division did not fully implement a monitoring process or tool for interim service provision.

The contract contained language regarding the contractor identifying compliance problems and corrective actions to be taken and develop strategies and activities to monitor program compliance with requirements for the treatment of pregnant women and Women's Set Aside programs. No specific communication process was utilized to aggregate information from the Regional Behavioral Health Authorities.

The Division continued to receive waiting list information from each region on a weekly basis, which identified 90% capacity. The Division did not have the capacity to aggregate and analyze data to identify opportunities for improvement or take an active leadership role in monitoring compliance and ensuring obligations were consistently met. Therefore, it was determined that the Division's policies were in need of updates.

GOAL #9: Compliance - Pregnant Women Preferences / September 3, 2010 / Page 2

The Division's utilization management system was through a contracted Administrative Services Only (ASO) vendor. The Division entered into a new two year contract with the vendor on July 1, 2008. The contract asked the vendor to collaborate with the Division on development of an automated waiting list/capacity management system to assist with compliance and monitoring.

GOAL #9: Progress - Pregnant Women Preferences / September 3, 2010 / Page 1

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

FY2010 (Progress)

183 pregnant women with a Substance Abuse Disorder and seeking substance abuse treatment were served based on the unduplicated count of persons served in SFY2009. In FY2010, 283 pregnant women with a Substance Abuse Disorder and seeking substance abuse treatment were served, based on the unduplicated count of persons served.

In the FY2010 contracts between the Division of Behavioral Health (DBH) and the six Regional Behavioral Health Authorities (RBHA's), the following requirements were included. They were also included in the RBHA's contracts with their sub-contracted treatment providers.

- Pregnant women who have requested treatment, but who have not had a substance abuse assessment completed within the last 6 months, must have an appointment for a Substance Abuse (SA) assessment within 48 hours from time of request, and must receive and complete the actual assessment within 7 business days of the appointment. The waiting list clock starts when a client (pregnant woman) completes the assessment process and a recommendation for treatment is made. This will ensure that pregnant women receive timely access to assessment and treatment services.
- Interim Services must be provided between the time the individual requests treatment and the time they enter treatment. Interim services must be provided within 48 hours and until the pregnant woman can receive the appropriate treatment service, based upon the level of care identified in the Substance Abuse Assessment. Examples of Interim Services include but are not limited to: a lower level of care with available capacity, community support, traditional outpatient, or other like-services that assist the individual with continued contemplation and preparation for treatment.
- Interim Services for pregnant women must also include counseling on the effects of alcohol and drug use on the fetus and a referral for prenatal care, counseling and education about HIV and TB, the risks of needle sharing, the risks of transmission to sexual partners and infants, and the steps that can be taken to ensure that HIV and TB transmission does not occur. All referrals and or follow-up information must be documented and made available upon the request of the Contractor and or the Department.
- Regional Behavioral Health Authorities and those they subcontract with (treatment providers) are contractually required to improve/enhance their strategies for publicizing the specific assessment and treatment services they are able to provide to pregnant women. Marketing strategies must be specific to this population i.e. Pediatric clinics,

GOAL #9: Progress - Pregnant Women Preferences / September 3, 2010 / Page 2

WIC offices, health clinics. Marketing strategies must also include that pregnant women are giving priority access to assessment and treatment services.

In August 2009, the Division completed a comprehensive review of the existing Waiting List/Interim Services-Capacity Management process. As a result of this review and Technical Assistance (SABTBG 101) the Division received, the Capacity Management process was significantly enhanced. The Division provided Capacity Management Report training to the RBHA's and substance abuse providers (subcontractors) in mid-September 2009. Enhancements were developed in collaboration with the Regional Behavioral Health Authorities and implementation of the updated Capacity Management system occurred in October, 2009.

Capacity Management Enhancements: The Waiting List/Interim Services-Capacity Management Report was completed and updated by the Behavioral Health Network Providers who submit the report to the Regional Behavioral Health Authority each week on the date established by the RBHA. The RBHA collects, analyzes, and aggregates this data. Every Tuesday, the RBHA provides this aggregated report to the Division of Behavioral Health's designated staff via email. The Division analyzes and aggregates the data from the 6 RBHA's to report on the available statewide capacity (purchased and unpurchased) for substance abuse treatment services. This report also tracks when consumers are placed on the waiting list and when they are able to be removed from the waiting list, as well as the actual "length of time" a consumer waited before receiving treatment services. The reports also serve as notification to the Division when programs reach 90 percent of capacity, as such reports are received within 7 days of reaching 90 percent capacity.

This specific type of data significantly assists our system during the annual budget planning process, where decisions are made regarding funding (adding or decreasing capacity/levels of care). The Capacity Management Reports also ensure that all individuals who are on the waiting list are also receiving the required interim services.

Since October 2009, the Division facilitates a weekly, statewide conference call with each of the six RBHA's present. The conference call provides structure to the system review of statewide capacity which assists the Regional Behavioral Health Authorities in determining where available capacity is, should a specific level of care not be available in one area of the state. This weekly conference call also serves as a tool to review and ensure the delivery of interim services.

Information provided by the treatment provider to the RBHA on the weekly Substance Abuse Reports are conducted in a manner that does not identify the individual. A unique consumer identifier containing the first four characters of the last name + date of birth (YYYYMMDD) + the last four numbers of the social security number was implemented. The unique identifier helps DBH sort out individuals who may be duplicated among waiting lists.

Providers (subcontractors) must maintain contact with pregnant women on the waiting list a minimum of every seven (7) days from the initial screening. Providers must maintain documentation of the following:

1. Client unique identifier, date of birth, name, address, phone, and alternate address and phone, if applicable;

GOAL #9: Progress - Pregnant Women Preferences / September 3, 2010 / Page 3

2. Date of the initial face to face screening, the recommended treatment service, and date placed on the waiting list;
3. Priority category for admission;
4. Whether the client was referred to another agency, if they accepted the outside referral, the date the referral was made, and the provider to which the individual was referred;
5. Whether the client was placed in interim services and what type of interim services;
6. Counselor/client follow-up (minimum every 7 days from initial screening) including date and type of contact and name of staff person;
7. Number of days before placed in recommended treatment; and
8. Date and reason for removal from the waiting list if the client was not placed into the appropriate recommended treatment.

The Division provided Capacity Management Report training to the RBHA's and substance abuse providers (subcontractors) in mid-September 2009. Implementation of the updated Capacity Management system occurred in October, 2009.

The formal monitoring of the interim service provision will be accomplished through the Regional Behavioral Health Authority audit staff. An interim service provision audit tool was developed during the summer of 2009, which is utilized at the time of the subcontractor's services purchased and/or fidelity audit. RBHA audit staff provides the audit results and technical assistance to the provider and send this checklist to the assigned DBH staff. DBH data team members aggregate and analyze the audit data and review the data findings with the Network Manager, who makes recommendations to the Division Administrator's Management Team (DAMT) regarding system improvements for treatment capacity, interim service delivery, and enhanced waiting list monitoring.

Aggregate data is shared with the RBHA staff and treatment providers through the Division's Quality Improvement structure, and during the Tuesday morning calls to ensure ongoing improvement and compliance with federal block grant requirements. Reports include:

- Average wait time for admission by priority population by service by region by state;
- Total capacity by service by region by state;
- Regional Purchased capacity by service by provider by region by state;
- Number of individual on the waiting list by priority by service by region by state;
- Number of individuals receiving interim services within 48 hours;
- Average length of interim services;
- Number of priority population served with 14 days or by 120 days;
- Number of Magellan authorized or registered interim services for individuals on the waiting list by service by region by state; and
- Reason for removal from waiting list by service by provider by region by state.

During the Spring-Summer of 2009, the Division of Behavioral Health trained over 100 Substance Abuse network providers and RBHA workforce on the SAPT Block Grant requirements, the rationale for revising the Weekly Capacity Reports and Weekly Priority Population Waiting List/Interim Services Report, as well as how these revisions ultimately improve/strengthen our statewide system by improving this priority population's access/admission to treatment services.

Capacity Management and Waiting List Systems (formerly Attachment G)

See 45 C.F.R. §96.122(f)(3)(vi))

For the fiscal year two years prior (FY 2009) to the fiscal year for which the State is applying for funds:

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

<

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

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

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

Capacity Management and Waiting List Systems (formerly Attachment G)

See 45 C.F.R. §96.122(f)(3)(vi))

For the fiscal year two years prior (FY 2009) to the fiscal year for which the State is applying for funds:

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

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

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

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

In 2009, the Division of Behavioral Health (DBH) completed the planning needed to implement a revised capacity management and waiting list systems for intravenous drug users and pregnant women. The new design has the Behavioral Health Network Providers reporting to Regional Behavioral Health Authority (RBHA) who are the intermediaries – regional entity, who then reports to DBH as the Single State Agency. The weekly reports on capacity include priority persons on waiting lists. In August 2009, Waiting List/Capacity Management procedures and forms were approved. Training was completed for RBHA's and Providers on September 25, 2009. Implementation of the revised Waiting List/Capacity Management system was on October 5, 2009.

As originally designed, each program reports via excel spreadsheets the number of persons and percent of total and regional capacity to the RBHA on Monday of each week. Capacity and waiting list forms are forwarded to the Statistical Analyst at the Division of Behavioral Health on Tuesday afternoons. Division Data Team members are assigned primary responsibility to review and aggregate reports and identify opportunities to improve waiting list management and address capacity issues. The information is also reviewed by the Division's Network Management team and with the RBHA's.

The Weekly Substance Abuse Capacity and Waiting List spreadsheets from each region include the total capacity of the agencies, regional purchased capacity at the time of the submission and percent of both total and regional capacity that is occupied. Each agency lists the number of persons on the total and regional waiting lists followed by the number within each priority populations for the regional capacity. The data also contains weekly substance abuse priority waiting list break outs by region by service, interim service provision and reason for removal from the waiting list.

The annual contract between the Division of Behavioral Health and the Regional Behavioral Health Authority establish the reporting requirements. These contracts also contain additional interim service language. Outreach activities continued to be spelled out in the contract. The contracts stated that IV-drug abusing clients shall be admitted within 14 days of request for treatment, or if no services are available, must be provided with interim services within 48 hours and admitted to treatment with 120 days. Interim services were now defined in the contract.

Contractors and subcontractors were required to report to DBH whenever full (90%) capacity is reached and/or if an IV-drug abusing client is unable to be admitted to service.

In 2008, the Division of Behavioral Health (DBH) entered into a contract with an Administrative Services Organization (ASO) vendor. On April 16, 2008, it was announced that Magellan Behavioral Health was selected as the Administrative Service Organization contractor. The contract began on May 1, 2008 and ends on June 30, 2010. There are annual option contract years for State Fiscal Years 2011, 2012 and 2013. The DBH contract liaison is also the data team leader and QI Manager. DBH recently exercised an annual option for SFY 2011.

The operational procedures for the statewide waiting list / capacity management system includes documentation of treatment capacity (total and regional), identification of priority populations, requirements for interim services, documentation of interim service provision, time frames for admission to services, reasons for removal from the waiting list, frequency of contact for a person on the waiting list, interim service provision, and an audit/monitoring process.

The DBH to Regional Behavioral Health Authority contract and provider subcontracts continue to address IV drug users as a priority population, the 90 percent capacity reporting, 14-120 day performance requirement, interim services, outreach activities and monitoring requirements.

The procedures and forms specify that the individuals from the priority populations who have requested treatment, but who have not had a substance abuse assessment completed within the last 6 months, must have an appointment for a substance abuse assessment within 48 hours from time of request, and must receive the actual assessment within 7 business days of the appointment. The waiting list clock starts when a client completes the assessment process and a recommendation for treatment is made. This will ensure

that individuals from the priority populations receive timely access to assessment and treatment services.

When individuals from the priority populations cannot immediately receive treatment as documented in the recommendations of the substance abuse assessment, and as outlined in the ASAM (American Society of Addiction Medicine) Patient Placement Criteria; the individual must receive Interim Services and be placed on waiting list for treatment.

The weekly SA Capacity Report and weekly SA Priority Waiting List/Interim Services Report are completed and updated by the Behavioral Health Network Providers and submitted to the Regional Behavioral Health Authority each week. The Regional Behavioral Health Authorities collect, analyze, and aggregate this data. Every Tuesday, the RBHA provide the aggregated report to the Division of Behavioral Health's Statistical Analyst via email. The Division analyzes and aggregates this data in order to report on the available capacity (purchased and unpurchased) for substance abuse treatment services. The reports serve as notification to the DBH when programs reach 90 percent of its capacity and DBH receives such reports within 7 days of reaching 90 percent capacity.

The Division holds a weekly phone conference to direct both providers and Regional Behavioral Health Authorities to agencies across NE who has available capacity, should a specific level of care not be available in one area of the state.

The Weekly SA Capacity Report and Weekly SA Priority Waiting List/Interim Services Report indicates when individuals are placed on the Waiting List and when individuals are removed from the Waiting List. During the weekly capacity and waiting list calls, interim services are reviewed to ensure each individual is receiving appropriate services to promote engagement and questions and problem solving can occur on a timely basis.

DBH and Regional Behavioral Health Authorities monitor this information in order to track data regarding "length of time" individuals are waiting to access services. This data assist DBH's system during the annual budget planning process. The Capacity Reports also allow tracking of individuals who are on the Waiting List to ensure they are also receiving the required Interim Services.

The total amount of funds expended (or obligated if expenditure data is not available) is not available. The funding is part of the duties expected of the Behavioral Health Network Providers, the six Regional Behavioral Health Authorities and Division of Behavioral Health staff.

Note: All information provided on the Weekly SA Reports will be done so in a manner that does not identify the individual. A unique consumer identifier containing the first four characters of the last name + date of birth (YYYYMMDD) + the last four numbers of the social security number. The unique identifier will assist with identifying individuals who may be duplicated among the regional waiting lists.

Providers must maintain contact with individuals on the waiting list a minimum of every 7 days from the initial screening. Providers must maintain documentation of the following:

1. Client unique identifier, DOB, name, address, phone, and alternate address and phone, if applicable;
2. Date of the initial face to face screening and the recommended treatment service and date placed on the waiting list;
3. Priority category for admission;
4. Whether the client was referred to another agency, if they accepted the outside referral, the date the referral was made and the provider to which the individual was referred;
5. Whether the client was placed in interim services and what type of interim services;
6. Counselor/client follow-up (minimum every 7 days from initial screening) including date and type of contact and name of staff person;
7. Number of days before placed in recommended treatment; and
8. Date and reason for removal from the waiting list if the client was not placed into the appropriate recommended treatment.

The monitoring of interim service provision are accomplished through the Regional Behavioral Health Authority Audit staff. An interim service provision audit tool was developed. It is utilized at the time of each SA provider's services purchased and/or fidelity audit. RBHA Audit staff provide audit results and technical assistance to the provider and then fax or mail the checklist to the assigned DBH staff. DBH data team members aggregate and analyze the audit data and present to the DBH program staff assigned management of the treatment capacity and waiting lists.

Aggregate data are shared with RBHA staff and providers through the Quality Improvement structure, Tuesday morning calls and quarterly and annual capacity and waiting list reports to ensure ongoing improvement and compliance with federal block grant requirements. Reports may include:

- Average wait time for admission by priority population by service by region by state;
- Total capacity by service by region by state;
- Regional Purchased capacity by service by provider by region by state;
- Number of individual on the waiting list by priority by service by region by state;
- Number of priority population served with 14 days or by 120 days;
- Magellan authorized or registered interim services for individuals on the waiting list by service by region by state; and
- Reason for removal from waiting list by service by provider by region by state.

Goal #10: Process for Referring

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

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: Training/TA; Implementation of ASAM criteria; Use of Standardized assessments; Patient placement using levels of care; Purchased/contracted services; Monitoring visits/inspections; Work groups/task forces; Information systems; Reporting mechanisms; Implementation protocols; Provider certifications.

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

GOAL #10: Intended Use – Process for Referring / September 16, 2010 / Page 1

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

FY2011 – FY2013 (Intended Use/Plan)

Placement of consumers in the treatment modality that is most appropriate for the individual is a priority of the State of Nebraska, Magellan Behavioral Health, and the Regional Behavioral Health Authorities. Biopsychosocial assessments are conducted, producing clinical recommendations utilizing the American Society of Addiction Medicine Patient Placement Criteria, 2nd Edition Revised (ASAM PPC-2R). The ASAM PPC-2R is the most widely used and comprehensive national guidelines for placement, continued stay and discharge of patients with substance use disorders.

This criterion assists with determining the most appropriate level of care for the 16,282 individuals accessing the Substance Abuse Service System (FY2010). The specific target population to receive treatment services is individuals who have been assessed as having a Substance Use Disorder diagnosis as described in the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual (DSM).

A. Interim Services: Nebraska received Technical Assistance on the SAPTBG in October, 2008. Since receiving this Technical Assistance, Nebraska has revised a process for whom, when and how Interim Services are provided. Prior to receiving this Technical Assistance, Nebraska did not have a clearly identified process for providing Interim Services for individuals who requested treatment (priority population) and did not have a Chemical Dependency evaluation. Since receiving the Technical Assistance, Nebraska has significantly improved/enhanced our process for whom, when and how Interim Services are to be provided.

Individuals in Nebraska cannot access treatment services without first having a biopsychosocial chemical dependency evaluation, which determines the most appropriate level of care for substance abuse treatment. Through a collaborative effort with the Regional Behavioral Health Authorities, Nebraska has now developed a process to ensure that individuals who are a priority, as determined by the SAPTBG requirements, receive an evaluation and are provided with the right level of substance abuse treatment.

The following language is now included in the Division's contract with the Regional Behavioral Health Authorities:

“If an individual identified as a priority has not received a chemical dependency evaluation and is requesting treatment, the individual shall be given an appointment for an evaluation within 48 hours, and receive the evaluation within 7 business days. Upon completion of the evaluation (written report), the individual should immediately receive treatment. In the event that capacity does not exist for the individual to immediately receive treatment, the individual will receive Interim Services within 48 hours (from the time the evaluation report is documented) and will receive Interim Services until treatment is available.”

The Division has developed clear language outlining Interim Services, which has been incorporated into the contracts with the Regional Behavioral Health Authorities. In addition, the Division has also enhanced the requirements in our Audit Standards to more effectively monitor that Interim Services are being delivered according to Division requirements.

GOAL #10: Intended Use – Process for Referring / September 16, 2010 / Page 2

B. SAPTBG Training: The Division provided formal training on the SAPTBG requirements with Regional Behavioral Health Authorities and the substance abuse provider networks across Nebraska, and continues to provide on-going technical assistance.

C. Consistency with ASAM Criteria: The Division of Behavioral Health and Division of Medicaid and Long-Term Care continue focused conversations with the current Managed Care Company/Administrative Service Organization (ASO) to improve/harmonize the Substance Abuse Service definitions, admission, continued stay and discharge criteria. Current definitions and utilization criteria have been reviewed to ensure they are consistent with ASAM criteria. Consistency of definitions and criteria significantly enhance our process to ensure that individuals receive the right level of care. The ASAM PPC-2R provides a set of guidelines consisting of five broad levels of care for each group. The levels of care are: Level 0.5, Early Intervention; Level I, Outpatient Treatment; Level II, Intensive Outpatient/Partial Hospitalization; Level III, Residential/Inpatient Treatment; and Level IV, Medically-Managed Intensive Inpatient Treatment. Within these broad levels of service is a range of specific levels of care.

For each level of care, a brief overview of the services available for particular severities of addiction and related problems is presented. The overview also consists of a structured description of the settings, staff and services, and admission criteria for the following six dimensions: acute intoxication/withdrawal potential; biomedical conditions and complications; emotional, behavioral or cognitive conditions and complications; readiness to change; relapse, continued use or continued problem potential; and recovery environment. The diagnostic terminology used in the ASAM PPC-2R is consistent with the most recent language of the American Psychiatric Association Diagnostic and Statistical Manual (DSM). The Chemical Dependency Evaluation produces recommendations which suggest the type of clinical modality that would be most appropriate for the individual. Service Definitions also include treatment modalities and both are monitored via the fidelity portion of the Annual Provider Audit.

The activities that Nebraska is currently engaged in are occurring at both the Division level as well as the community level. Division level activities include: monitoring contract requirements with Regional Behavioral Health Authorities, continued conversations with the ASO on service definitions and utilization criteria, and continued technical assistance on SAPTBG requirements. These state-level changes will influence and provide enhanced accountability at the community level and will positively impact the substance abuse delivery system statewide.

These activities will be operationalized in a variety of ways. The Division's contracts with the Regional Behavioral Health Authorities define expectations which are consistent with the SAPTBG. These contracts operationalize what is expected at both the Regional level (management and monitoring) as well as the community/provider level. The Regional Behavioral Health Authorities' responsibility is to operationalize expectations with the specific providers they contract with (service delivery). The Division also operationalizes expectations with the ASO, who interface with the providers to ensure that individuals are accessing and receiving the appropriate level of substance abuse treatment.

To ensure that contract expectations are occurring, Nebraska will continue to utilize an annual auditing process. Nebraska has established an Audit Workgroup that defines the activities, (fiscal, clinical, service fidelity) that each contracted organization must comply with. This process provides a "report card" on each individual provider, as well as an aggregated report on the Region's overall performance.

Goal #11: Continuing Education

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

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: Counselor certification; Co-occurring training; ATTCs training; Motivational interviewing training; HIV/AIDS/TB training; Ethics training; Confidentiality and privacy training; Special populations training; Case management training; Train-the-trainer model; Domestic violence training; Faith-based training; Suicide prevention training; Crisis intervention training.

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

Goal #11: Intended Use - Continuing Education / September 23, 2010 / Page 1

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

Overview

The Department of Health and Human Services-Division of Behavioral Health-Community-Based Services (DHHS-DBH-CBS) ensures that facilities which provide prevention activities or treatment services, and receive funding from the Substance Abuse Prevention and Training Block Grant (SAPTBG), make available Continuing Education in such activities or services for employees of the facility who provide the activities or services. All programs must include a provision for Continuing Education for employees of the facility in its funding agreement. The Behavioral Health and Network Services Contract between the Division of Behavioral Health and Regional Behavioral Health Authority (RBHA) requires that Continuing Education be made available for all employees of facilities that provide prevention activities and treatment services, including post-employment training and staff development.

The Regional Behavioral Health Authorities, through the Division of Behavioral Health Substance Abuse Prevention and Treatment Block Grant Program Fidelity Review, monitor the provision of continuing education by treatment facilities. Any infractions shall be reported to the Division of Behavioral Health and a corrective action plan developed.

DHHS/DBH-CBS Oversight Responsibilities

1. The Division of Behavioral Health is responsible for ensuring the continuing education provision is included in the annual DBH-CBS/RBHA Behavioral Health and Network Services Contract between the Division of Behavioral Health and the Regional Behavioral Health Authority.
2. The Network Management Team is responsible for reviewing the SAPTBG Program Fidelity Review Tool used to audit service providers. Continuing education requirements are included under Additional Requirements in the tool. Facilities not meeting the continuing education requirement will be provided a plan of correction which will be monitored by the RBHA and the Network Management Team.

Counselor Certification

The certification/licensure of Alcohol and Drug Counselors in Nebraska is managed through the Division of Public Health in the Department of Health and Human Services. The Division of Public Health develops the policies and regulations for the certification/licensure of all professions in Nebraska. The Divisions of Behavioral Health and Public Health collaborate and coordinate on policies and regulations when changes are required regarding a behavioral health profession.

Goal #11: Intended Use - Continuing Education / September 23, 2010 / Page 2

FY2011 – FY2013 (Intended Use/Plan)

The Division of Behavioral Health FY2011 contract, effective July 1, 2010, with the Lincoln Medical Education Partnership (LMEP) Training for Addiction Professionals (TAP) program to provide Core and Continuing Education courses that meet the Division of Public Health’s educational requirements for Licensed Alcohol and Drug Counselors (LADCs) has been executed. A provision in the contract requires a select group of courses to be offered via video conferencing across the State, with the main site in Lincoln, NE. This will continue to enhance the Division’s capacity to provide education courses statewide, and to better meet the needs of the workforce. In addition, the Division of Behavioral Health is collaborating with the Office of Probation Administration within the Nebraska Supreme Court to provide the Addictions Severity Index (ASI), the Comprehensive Adolescent Severity Inventory (CASI), and the Standardized Model Training courses to fulfill requirements set forth by the Nebraska Community Corrections Council.

Utilizing the resources of the Administrative Service Organization (ASO), the Division of Behavioral Health and Magellan Behavioral Health will provide training events during FY2011 that introduce clinical and programmatic policy guidance in establishing recovery oriented substance abuse treatment and systems of care.

The Division of Behavioral Health, working in partnership with the Division of Public Health and the Regional Behavioral Health Authorities’ Prevention Coordinators, is re-writing the Community Substance Abuse Prevention Specialist Training curriculum. This will allow the curriculum to be presented to community coalitions and professionals involved in Substance Abuse Prevention so that participants will gain exposure to, and receive knowledge of, the Strategic Prevention Framework, Evidence Based Prevention policies, programs, and practices, as well as community organizing techniques.

The purpose of the FY2011 contract (effective July 1, 2010 through June 30, 2011) between the Nebraska Department of Health and Human Services-Division of Behavioral Health (DHHS-DBH) and the Lincoln Medical Education Partnership-Training for Addictions Professionals (LMEP-TAP) is to provide Substance Abuse Counselor Core Education and Continuing Education services.

LMEP-TAP has agreed to provide a total of **645 hours** of core education courses each fiscal year. A minimum of one core education course will be offered each month. These courses will be offered statewide. The Contractor will determine where to offer the courses based on participant need. Core education courses will not be offered through video conferencing.

The following Core Education classes will be offered two times each fiscal year:

**Counseling Theories and Techniques	45 hours
**Human Growth and Development	30 hours
**Professional Ethics and Issues	15 hours
**Multicultural Counseling	30 hours

Goal #11: Intended Use - Continuing Education / September 23, 2010 / Page 3

**Group Counseling 45 hours

The following Core Education classes will be offered three times each fiscal year:

- **Medical and Psychosocial Aspects of Alcohol/Drug Use, Abuse and Addiction 45 hours
- **Alcohol/Drug Assessment, Case Planning and Management 30 hours
- **Clinical Treatment Issues in Chemical Dependency 30 hours

The following Core Education classes must be offered in Region 1, 2, or 3 a minimum of once each fiscal year:

- **Medical and Psychosocial Aspects of Alcohol/Drug Use, Abuse and Addiction
- **Medical and Psychosocial Aspects of Alcohol/Drug Use, Abuse
- **Alcohol/Drug Assessment, Case Planning and Management
- **Clinical Treatment Issues in Chemical Dependency

LMEP-TAP has agreed to provide a total of **66 hours** of continuing education courses each fiscal year for counselors to renew licensure as a Licensed Alcohol/Drug Counselor (LADC). The focus of these courses will be alcohol/drug specific, unless otherwise approved by DHHS. Specific courses will be developed according to, but not limited to, the following topic areas, and will be offered once each fiscal year:

- Gender and Cultural Competence
- Screening and Referral
- Co-Occurring Disorders
- Evidence-Based Treatment
- Trauma-Informed

To the extent possible, these courses will be offered through video conferencing in Regions 1, 2, 3, 4, and 6. All courses that are offered through video conferencing will be hosted utilizing videoconferencing networks with main sites located in Region 5 (Lincoln, NE).

LMEP-TAP has agreed to provide the course, Roles and Responsibilities of Licensed Alcohol and Drug Counselors, two (2) times each fiscal year for a total of **12 hours** of continuing education. This course will be offered up to four (4) weeks prior to two (2) of the four (4) written examination dates during the fiscal year. This course will be hosted at a site in Region 5 (Lincoln, NE), and will be offered through video conferencing in Regions 1, 2, 3, 4, 6, subject to venue availability.

LMEP-TAP has agreed to provide the course, An Entry into ASAM (American Society of Addictions Medicine) Criteria, two (2) times each fiscal year for a total of **12 hours** of continuing education. This course will be hosted at a site in Region 5 (Lincoln, NE), and

Goal #11: Intended Use - Continuing Education / September 23, 2010 / Page 4

will be offered through video conferencing in Regions 1, 2, 3, 4, and 6, subject to venue availability.

LMEP-TAP has agreed to provide the course, Counselor Competency and Preparation for the LADC Examination, two (2) times each fiscal year for a total of **12 hours** of continuing education. This course will be offered up to four (4) weeks prior to two (2) of the four (4) written examination dates during the fiscal year. This course will be hosted at a site in Region 5 (Lincoln, NE), and will be offered through video conferencing in Regions 1, 2, 3, 4, 6, subject to venue availability.

LMEP-TAP has agreed to provide the course, Clinical Supervision of Licensed Alcohol and Drug Counselors, one (1) time each fiscal year for a total of **6 hours** of continuing education. This course will be hosted at a site in Region 5 (Lincoln, NE), and will be offered through video conferencing in Regions 1, 2, 3, 4, 6, subject to venue availability.

LMEP-TAP has agreed to provide **up to 120 hours** of Addictions Severity Index (ASI) continuing education courses each fiscal year. These courses will enable Licensed Alcohol/Drug Counselors (LADC) or Provisional Licensed Alcohol/Drug Counselors (PLADC) to become registered on the substance abuse/criminal justice Approved Provider List. These courses will not be offered through video conferencing.

LMEP-TAP has agreed to provide **up to 100 hours** of Comprehensive Adolescent Severity Inventory (CASI) continuing education courses each fiscal year. These courses will enable Licensed Alcohol/Drug Counselors (LADC) or Provisional Licensed Alcohol/Drug Counselors (PLADC) to become registered on the substance abuse/criminal justice Approved Provider List. These courses will not be offered through video conferencing.

LMEP-TAP has agreed to provide **up to 48 hours** of Criminogenics and Criminal Thinking/Behaviors as applied to Substance Abuse Treatment Continuing Education courses each fiscal year. These courses will enable Licensed Alcohol/Drug Counselors (LADC) or Provisional Licensed Alcohol/Drug Counselors (PLADC) to become registered on the substance abuse/criminal justice Approved Provider List. These courses will be offered through video conferencing, to the extent possible, in Regions 1, 2, 3, 4, and 6. All courses that are offered through video conferencing will be hosted utilizing video conferencing networks with main sites located in Region 5 (Lincoln, NE).

LMEP-TAP has agreed to develop additional continuing education courses, and/or incorporate additional initiatives and topics into other applicable coursework, as necessary. LMEP-TAP has further agreed to include criminal justice topics into the continuing education courses listed above.

A new initiative over the next three years is the advancement of web-based courses for workforce development in the field of substance use/co-occurring disorders and the criminal justice system. The development of these courses will create a foundation to

Goal #11: Intended Use - Continuing Education / September 23, 2010 / Page 5

offer training that is available for providers to access in all areas of the state, will allow contract funds to be utilized for more skill-based training, and will strengthen partnerships between multi-systems by providing training courses that could be used by providers, judges, attorneys, law enforcement, local jails, DHHS workforce, and other stakeholders.

A total of \$170,426 has been allocated and contracted for to provide Substance Abuse Counselor Core and Continuing Education activities during FY2011. The source of the funds to be expended is the Federal Substance Abuse Prevention and Training Block Grant.

(Information source: DHHSBH-FY11-SA Counselor Training Contract between the Nebraska Department of Health and Human Services and the Lincoln Medical Education Partnership, effective July 1, 2010 through June 30, 2011.)

Goal #11: Compliance – Continuing Education / September 7, 2010 / Page 1

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

Overview

The Department of Health and Human Services-Division of Behavioral Health-Community-Based Services (DHHS-DBH-CBS) ensures that facilities which provide prevention activities or treatment services, and receive funding from the Substance Abuse Prevention and Training Block Grant (SAPTBG), make available Continuing Education in such activities or services for employees of the facility who provide the activities or services. All programs must include a provision for Continuing Education for employees of the facility in its funding agreement. The Behavioral Health and Network Services Contract between the Division of Behavioral Health and Regional Behavioral Health Authority (RBHA) requires that Continuing Education be made available for all employees of facilities that provide prevention activities and treatment services, including post-employment training and staff development.

The Regional Behavioral Health Authorities, through the Division of Behavioral Health Substance Abuse Prevention and Treatment Block Grant Program Fidelity Review, monitor the provision of continuing education by treatment facilities. Any infractions shall be reported to the Division of Behavioral Health and a corrective action plan developed.

DHHS/DBH-CBS Oversight Responsibilities

1. The Division of Behavioral Health is responsible for ensuring the continuing education provision is included in the annual DBH-CBS/RBHA Behavioral Health and Network Services Contract between the Division of Behavioral Health and the Regional Behavioral Health Authority.
2. The Network Management Team is responsible for reviewing the SAPTBG Program Fidelity Review Tool used to audit service providers. Continuing education requirements are included under Additional Requirements in the tool. Facilities not meeting the continuing education requirement will be provided a plan of correction which will be monitored by the RBHA and the Network Management Team.

FY2009 (Annual Report/Compliance)

The Training for Addiction Professionals (TAP), administered through the Lincoln Medical Education Partnership (LMEP), continued to fulfill its current commitment to the Department of Health and Human Services-Division of Behavioral Health by providing substance abuse counselor education during FY2009 (July 1, 2008 – June 30, 2009). To continue to be relevant with growing studies in this field, TAP expanded the continuing education and criminal justice topics into areas such as, Gender Specific, Trauma-Informed, Co-Occurring Disorders, and Multicultural Dialogue. In July 2008,

Goal #11: Compliance – Continuing Education / September 7, 2010 / Page 2

TAP implemented a new database for registering participants in workshops. This database allows the TAP program to easily access all information regarding past and present workshops and participants in one program.

During the FY2009 contract year (July 1, 2008 – June 30, 2009), the TAP program completed 645 hours of **Core Education** courses for individuals desiring to become Licensed Alcohol and Drug Counselors (LADCs). All Core Education courses required for licensure were offered a minimum of two (2) times, with a minimum of one (1) Core Education course offered per month. As required by the contract, three alcohol specific classes must be offered three (3) times each fiscal year, and one training must be in the western/central part of the State. *Alcohol/Drug Assessment, Case Planning and Management* was presented in Sidney, NE (Region 1) in July, 2008; *Clinical Treatment Issues in Chemical Dependency* was presented in North Platte, NE (Region 2) in August, 2008; and *Medical and Psychosocial Aspects of Alcohol/Drug and Addictions* was presented in Kearney, NE (Region 3) in May, 2008.

Following is a list of the **Core Education** courses:

- Alcohol/Drug Assessment, Case Planning and Management
- Multicultural Counseling
- Clinical Treatment Issues in Chemical Dependency
- Medical and Psychosocial Aspects of Alcohol/Drug and Addictions
- Counseling Theories and Techniques
- Human Growth and Development
- Professional Ethics and Issues
- Group Counseling

The TAP program provided 108 hours of **Continuing Education** courses for Licensed Alcohol and Drug Counselors (LADCs) to renew their licensure. Of the 108 hours, the following specifications must be met:

- Thirty-six (36) hours were designated to criminal behaviors, criminal thinking and substance abuse. One of the trainings must be held in the western/central part of the State, and was presented in Grand Island, NE (Region 3).
- Six (6) hours must be designated to clinical supervision of Licensed Alcohol and Drug Counselors.
- The remaining sixty-six (66) hours must be other alcohol and drug specific topics. A minimum of one (1) training must be held in Region 1 or Region 2 (one training was presented in Scottsbluff, NE—Region 1), two (2) trainings must be held in Region 3 or Region 4 (one training was presented in Norfolk—Region 4, and one was held in Grand Island—Region), and six (6) trainings must be held in Region 5 or Region 6 each fiscal year (48 hours of training were presented in Lincoln—Region 5 and in Omaha—Region 6).

Following is a list of the **Continuing Education** courses:

- Meeting the Criminogenic Needs of Adolescent Offenders
- Substance Abuse and Trauma
- Dynamite Group Activities for Addiction Treatment Clients

Goal #11: Compliance – Continuing Education / September 7, 2010 / Page 3

- Families and Substance Abuse
- Broadening the Context of Multicultural Dialogue in Substance Abuse Treatment
- Drug Culture and Rituals of Gang Society
- Clinical Supervision in the 12 Core Functions
- Creating a Sacred Space in an Addiction Treatment Setting
- Evidence Based Practices in Addictions Treatment for Offenders
- Foundations of Substance Use, Abuse, and Dependence – Trainer of Trainers
- Motivational Interviewing for Juvenile Offenders
- Gender Matters: Making the Case for Gender Specific Treatment
- Treatment Approaches to Co-Occurring Disorders
- Adult Children of Alcoholics in Substance Abuse Treatment
- Screening and Referral of Mental Health Disorders
- Adult Offenders: Understanding and Utilizing Criminogenic Needs in Treatment
- Being Trauma-Informed: Understanding the Impact of Trauma and the Co-Occurrence of Substance Misuse

The TAP program provided 80 hours of **Addictions Severity Index (ASI)** courses and 20 hours of **Comprehensive Adolescent Severity Inventory (CASI)** courses. ASI/CASI trainings are offered to provide substance abuse professionals the opportunity to be eligible for the Substance Abuse/Criminal Justice Approved Provider List. Each course is required to be provided a minimum of one (1) time annually.

With the removal of the Oral Examination requirement from the State Licensure Policies and Procedures, the TAP program developed a new six (6) hour *Counselor Competency in Preparation for the Licensed Alcohol and Drug Counselor (LADC) Examination* course that instructs participants on tips for how to be successfully prepared for the Written Examination. Along with the six (6) hour *Core Functions of the Substance Abuse Counselor* course, TAP provided twenty-four (24) hours of **licensure examination preparation** courses.

All TAP courses are currently offered in a classroom setting across the State of Nebraska.

A total of \$150,805.00 was expended on providing these Core/Continuing Education activities during FY2009. The source of the funds expended is the Federal Substance Abuse Prevention and Training Block Grant. (*Information source: compiled from FY2009 Monthly Service Contract-Purchase Order Authorizations.*)

Prevention Education

In Nebraska, there is no certification or recognized and monitored status for prevention specialists. As a result, there is no formal educational programming hosted via any educational institutions with the exception of related coursework facilitated in public health programs. Because of the lack of community availability for prevention trainings, the DHHS-DBH-CBS has made available training for prevention specialists and community prevention participants/stakeholders in a variety of ways. In the recent past,

Goal #11: Compliance – Continuing Education / September 7, 2010 / Page 4

the Substance Abuse Prevention Specialist Training 101 was offered in regular rotation. This comprehensive curriculum was sponsored by the Division and created based upon the Southwest Center for the Application of Prevention Technologies material with inclusion of Nebraska specific information.

As the prevention system shifted to mobilizing local community coalitions through the State Incentive Cooperative Agreement (SICA) and the Strategic Prevention Framework-Statewide Infrastructure Grant (SPF-SIG), it became increasingly difficult to provide training for the growing body of volunteers in the traditional settings. The DHHS-DBH-CBS staff and the SPF-SIG staff within the Division of Public Health (DPH) reconvened to identify alternative strategies to meet the objectives of initial and continuing education, to review current requirements, best approach to roll out field trainings, identify needs for technical assistance and use of regional prevention coordinators. And so began a new ‘workgroup’ to address prevention training needs.

The strategies identified were to:

1. Jointly provide funding towards an Annual Statewide Prevention Conference and require all programs, coalitions and regional staff funded by the SPF-SIG and/or the SAPTBG to attend in calendar year 2008 and encouraged in 2009. This conference was utilized to provide updated information about SPF-SIG, the Nebraska prevention system direction, as well as specialty topics such as recent trends, evidence bases strategies/programs, population based approaches, etc.
2. DHHS-DBH-CBS provide funding in the amount of \$20,000 directly to each Region in contract years FY2009 and FY2010 to use for training in support of additional regional/local needs. This funding was to be utilized as each Regional Prevention Coordinator best identified based upon coalition requests, capacity building needs, professional and volunteer education needs, and in collaboration with other Regions. For example, Region 5 and Region 6 collaborated in a joint effort to host a two day Cultural Competency Summit. These training efforts were also utilized to replace the several day educational venues previously provided and now offered in trial settings to pilot smaller settings, singular modules, etc.
3. Identify appropriate continued policy language on the requirement of educational training for those receiving SPF-SIG and/or SAPTBG funding.
4. A joint contract was established with a technical assistance provider with significant historical experience in the prevention field including having worked with the SW-CAPT with curriculum design. The purpose of this contract is to utilize expertise in further identifying training needs and then assist in the facilitation of the ‘education workgroup’ to craft strategies for the revision of the previously utilized Substance Abuse Prevention Specialist Training 101. This work group assessed that the current curriculum needed revisions in order to be inclusive of new trends, process and SPF-SIG materials, to be current with trends and data, to increase Nebraska specific information and most importantly to create a format for facilitation designed to accommodate the multiple audiences. This contract was renewed to continue the progress. Potential modules may include but are not limited to:

Goal #11: Compliance – Continuing Education / September 7, 2010 / Page 5

- a. Introduction to Prevention
- b. Brain and drugs
- c. SPF Process and planning
- d. Cultural Competency
- e. Community Mobilization
- f. Youth Leadership
- g. Evidence Based Strategies
- h. Environmental Strategies
- i. Sustainability
- j. Data Collection
- k. Evaluation

To date, significant progress has been made in the revised Nebraska Substance Abuse Prevention Training. The material has been developed into modules that may be facilitated in singular events, may build upon each other, or may be offered in 101 and 201 versions to accommodate the needs of growing prevention specialist professionals as well as local volunteer based prevention coalition members. It is anticipated that this curriculum will be rolled out by spring of 2010. In the interim, the education workgroup is finalizing content, identifying appropriate training of trainer activities, receiving significant technical assistance regarding content and piloting modules at a time for content, style, format and venue success. The DHHS-DBH-CBS is working hard to collaborate with our SPF-SIG partners in the development and coordination of prevention system needs and will continue to operate with the needs of individuals, coalitions and communities in mind.

Goal #11: Progress – Continuing Education / September 7, 2010 / Page 1

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

Overview

The Department of Health and Human Services-Division of Behavioral Health-Community-Based Services (DHHS-DBH-CBS) ensures that facilities which provide prevention activities or treatment services, and receive funding from the Substance Abuse Prevention and Training Block Grant (SAPTBG), make available Continuing Education in such activities or services for employees of the facility who provide the activities or services. All programs must include a provision for Continuing Education for employees of the facility in its funding agreement. The Behavioral Health and Network Services Contract between the Division of Behavioral Health and Regional Behavioral Health Authority (RBHA) requires that Continuing Education be made available for all employees of facilities that provide prevention activities and treatment services, including post-employment training and staff development.

The Regional Behavioral Health Authorities, through the Division of Behavioral Health Substance Abuse Prevention and Treatment Block Grant Program Fidelity Review, monitor the provision of continuing education by treatment facilities. Any infractions shall be reported to the Division of Behavioral Health and a corrective action plan developed.

DHHS/DBH-CBS Oversight Responsibilities

1. The Division of Behavioral Health is responsible for ensuring the continuing education provision is included in the annual DBH-CBS/RBHA Behavioral Health and Network Services Contract between the Division of Behavioral Health and the Regional Behavioral Health Authority.
2. The Network Management Team is responsible for reviewing the SAPTBG Program Fidelity Review Tool used to audit service providers. Continuing education requirements are included under Additional Requirements in the tool. Facilities not meeting the continuing education requirement will be provided a plan of correction which will be monitored by the RBHA and the Network Management Team.

FY2010 Progress

The Division of Behavioral Health contracted with the Lincoln Medical Education Partnership (LMEP) Training for Addiction Professionals (TAP) program to provide Core and Continuing Education courses that meet the Division of Public Health's educational requirements for Licensed Alcohol and Drug Counselors (LADCs). A new provision in the contract this year required a select group of courses to be offered via video conferencing across the State, with the main site in Lincoln, NE. This has enhanced the Division's capacity to provide education courses statewide, and to better meet the needs of the workforce. In addition, the Division of Behavioral Health

Goal #11: Progress – Continuing Education / September 7, 2010 / Page 2

collaborated with the Office of Probation Administration within the Nebraska Supreme Court to provide the ASI/CASI and Standardized Model Training courses to fulfill requirements set forth by the Nebraska Community Corrections Council.

Utilizing the resources of the Administrative Service Organization (ASO), the Division of Behavioral Health and Magellan Behavioral Health provided training events during FY2010 that introduced clinical and programmatic policy guidance in establishing recovery oriented substance abuse treatment and systems of care.

The Division of Behavioral Health, working in partnership with the Division of Public Health and the Regional Behavioral Health Authorities' Prevention Coordinators, re-wrote the Community Substance Abuse Prevention Specialist Training curriculum. The curriculum continues to be presented to community coalitions and professionals involved in Substance Abuse Prevention so that participants gain exposure to, and receive knowledge of, the Strategic Prevention Framework, Evidence Based Prevention policies, programs, and practices, as well as community organizing techniques.

The FY2010 contract between the Nebraska Department of Health and Human Services-Division of Behavioral Health (DHHS-DBH) and the Lincoln Medical Education Partnership-Training for Addictions Professionals (LMEP-TAP) provided Substance Abuse Counselor Core Education and Continuing Education courses.

LMEP-TAP provided a total of **645 hours** of **Core Education** courses during the fiscal year. These courses were offered statewide with locations determined by participant need, as well as attention given to rural areas. Core Education courses are not offered through video conferencing.

The following **Core Education** courses were offered during the fiscal year:

- Counseling Theories and Techniques
- Human Growth and Development
- Professional Ethics and Issues
- Multicultural Counseling
- Group Counseling
- Medical and Psychosocial Aspects of Alcohol/Drug Use, Abuse, and Addiction
- Alcohol/Drug Assessment, Case Planning and Management
- Clinical Treatment Issues in Chemical Dependency

LMEP-TAP provided a total of **66 hours** of **Continuing Education** courses during the fiscal year for counselors to renew licensure as a Licensed Alcohol/Drug Counselor (LADC). The focus of these courses is alcohol/drug specific, unless otherwise approved by the Division of Behavioral Health. Continuing Education courses were offered statewide through video conferencing.

Courses were developed according to, but not limited to, the following topic areas:

- Gender and Cultural Competence

Goal #11: Progress – Continuing Education / September 7, 2010 / Page 3

- Screening and Referral
- Co-Occurring disorders
- Evidence-Based Treatment
- Trauma-Informed

LMEP-TAP provided the course, *Core Functions of Licensed Alcohol and Drug Counselors*, twice during the fiscal year for a total of **12 hours** of Continuing Education.

LMEP-TAP provided the course, *Examination Preparation*, twice during the fiscal year for a total of **12 hours** of Continuing Education.

LMEP-TAP provided the course, *Clinical Supervision of Licensed Alcohol and Drug Counselors*, once during the fiscal year for a total of **6 hours** of Continuing Education.

LMEP-TAP provided **100 hours** of *Addictions Severity Index (ASI)* Continuing Education courses during the fiscal year. These courses enabled Licensed Alcohol/Drug Counselors (LADCs) or Provisional Licensed Alcohol/Drug Counselors (PLADCs) to become registered on the substance abuse/criminal justice Approved Provider List. ASI courses are not offered through video conferencing.

LMEP-TAP provided **80 hours** of *Comprehensive Adolescent Severity Inventory (CASI)* Continuing Education courses during the fiscal year. These courses enabled Licensed Alcohol and Drug Counselors (LADCs) or Provisional Licensed Alcohol and Drug Counselors (PLADCs) to become registered on the substance abuse/criminal justice Approved Provider List. CASI courses were not offered through video conferencing.

LMEP-TAP provided **36 hours** of *Criminogenics and Criminal Thinking/Behaviors as applied to Substance Abuse Treatment* Continuing Education courses during the fiscal year. These courses enabled Licensed Alcohol and Drug Counselors (LADCs) or Provisional Licensed Alcohol and Drug Counselors (PLADCs) to become registered on the substance abuse/criminal justice Approved Provider List. This course was offered statewide through video conferencing.

LMEP-TAP agreed to develop additional Continuing Education courses, and/or incorporate additional initiatives and topics into other applicable coursework, as necessary. LMEP-TAP included criminal justice topics into the Continuing Education course topics listed above.

A total of \$150,000 was allocated and contracted for to provide Substance Abuse Counselor Core and Continuing Education activities during FY2010. The source of the funds expended is the Federal Substance Abuse Prevention and Training Block Grant. *(Information source: DHHSBH-FY10-SA Counselor Training Contract between the Nebraska Department of Health and Human Services and the Lincoln Medical Education Partnership effective September 1, 2009 through June 30, 2010.)*

Goal #12: Coordinate Services

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

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: Convened work groups/task force/councils; Conduct training/TA; Partnering with association(s)/other agencies; Coordination of prevention and treatment activities; Convening routine meetings; Development of policies for coordination; Convening town hall meetings to raise public awareness; Implementation of evidence-based services.

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

GOAL #12: Intended Use - Coordinate Services / September 16, 2010 / Page 1

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

FY 2011- FY 2013 (Intended Use/Plan):

(1) Who – The Division of Behavioral Health Services (DBH) will coordinate prevention and treatment activities with the provision of other appropriate services (including health, social, correctional and criminal justice, educational, vocational rehabilitation, and employment services).

(2) What – The Division of Behavioral Health has a working relationship with the Division of Children & Family Services (social services), Division of Medicaid & Long-Term Care, and Division of Public Health (health) within the NE Department of Health and Human Services; Department of Correctional Services, NE Crime Commission, Community Corrections Council (as well as the Justice Behavioral Health Committee under this Council), and Office of Probation Administration under the Nebraska Supreme Court (criminal justice); Vocational Rehabilitation (employment) and related agencies.

The Division will continue to work collaboratively with agencies that have a direct impact upon DBH ability to ensure that prevention activities and treatment services are delivered in an integrated and coordinated fashion.

(3) When – The coordination activities will be implemented for the time period covering FY 2011 to FY 2013.

(4) Where in the State (geographic area) – The coordination of services is undertaken in each of the six behavioral health regions in Nebraska. These are described in GOAL #1 (Intended Use) – Continuum of services in Nebraska under the section on Regional Behavioral Health Authorities. It is also accomplished statewide via coordination with State agencies.

(5) How will the coordination be operationalized

§96.132(a) -- the improvement of the referral process and the coordination of prevention activities and treatment services with other public and private nonprofit entities,

The Nebraska Division of Behavioral Health continues to have the goal of improving the referral process and the coordination of prevention activities and treatment services with other public and private nonprofit entities. To accomplish this goal, the Division of Behavioral Health has a working relationship with the Division of Children & Family Services (social services), the Division of Medicaid & Long-Term Care, and the Division of Public Health (health) within the Nebraska Department of Health and Human Services; the Department of Correctional Services, the Nebraska Crime Commission, Community Corrections Council (as well as the Justice Behavioral Health Committee under this Council), and the Office of Probation Administration under the Nebraska Supreme Court (criminal justice); Vocational Rehabilitation (employment) and related agencies. The Division will continue to work collaboratively with our sister agencies as these conversations have a direct impact on our ability to ensure that services delivered are integrated and coordinated.

GOAL #12: Intended Use - Coordinate Services / September 16, 2010 / Page 2

Examples of State Level coordination to improve the referral process include:

- The In Depth Technical Assistance (IDTA) is designed to improve access to and retention while in treatment. The partners on this include the Division of Behavioral Health (DBH), Division of Medicaid and Long-Term Care (DMLTC), Division of Children and Family Services (DCFS), Office of Probation Administration (Probation), Juvenile Courts, and Division of Public Health (DPH). The ultimate goal is to improve the system’s response when serving substance abusing parents who have children in the Child Welfare System.
- The Division meets regularly with the Divisions of Developmental Disabilities, Medicaid and Long-Term Care, and Children and Family Services to improve systems coordination relating to behavioral health.
- The Division of Behavioral Health has been meeting with the Nebraska Department of Correctional Services on a variety of issues for a number of years. At this time, the meetings include work on implementing a U.S. Department of Justice / Office of Justice Programs / Bureau of Justice Assistance “Justice and Mental Health Collaboration Program” (CDFA #16.745) grant. The Division is implementing a Category II: Planning and Implementation (\$250,000 from 9/01/2008 to 8/31/2011).
 - > Goal 1: Provide statewide Crisis Intervention Team (CIT) training for Law Enforcement officers and make clear linkages with local crisis response teams.
 - > Goal 2: Expand or improve access to crisis stabilization services with improved coordination with law enforcement officers.
 - > Goal 3: Implement standardized mental health and substance abuse screening instruments in the jails that prompt referrals for services.
 - > Goal 4: Increase resources to community mental health to provide diversion services through the use of Forensic Intensive Case Management.
 - > Goal 5: Enhance affordable supportive housing for justice involved youth transitioning to adulthood.
- The Division of Behavioral Health regularly participates on the Community Corrections Council (as well as the Justice Behavioral Health Committee under this Council)
- Under the Justice Behavioral Health Committee, the Division has a working relationship with the Office of Probation Administration. This includes several functions covered under the §96.132(b) such as the Addictions Severity Index (ASI) and the Comprehensive Adolescent Severity Inventory (CASI) Continuing Education Courses (see below).
- Criminal Justice Electronic Data Transfer Interagency Agreement – In June 2009, the Nebraska Department of Health and Human Services - Division Of Behavioral Health (DHHS), the Nebraska Department of Correctional Services (DCS) and the Nebraska Commission on Law Enforcement and Criminal Justice (Crime Commission) signed Electronic Data Transfer Interagency Agreements. The final agreements were officially approved on June 9, 2009. These agreements require these three state agencies to transfer their data to the Division of Epidemiology, College of Public Health at the University of Nebraska Medical Center in Omaha, NE for the purpose of analysis, compilation and reporting for the mutual benefit of the parties. Before public release, the report(s) produced under these agreements must be acceptable to the DHHS, DCS and the Crime Commission. The report(s) remain in draft status until these three code level agencies approve the document. This requirement is due to the sensitive nature of the content of the report(s) using these data.
- Memorandum of Understanding (MOU) for Supported Employment Services – The Division of Behavioral Health and the Nebraska Department of Education, Vocational Rehabilitation have a MOU to increase employment opportunities for people with behavioral health (BH)

GOAL #12: Intended Use - Coordinate Services / September 16, 2010 / Page 3

problems. The purpose of the MOU is to coordinate and cooperate in the development and implementation of Supported Employment services for persons experiencing behavioral health disorders.

- The Division initiated meetings with the Division of Developmental Disabilities to improve systems coordination for those individuals who have both a developmental disability and a behavioral health disorder.
- Division initiated a collaborative effort with the Department of Education to explore additional opportunities to expand current prevention and treatment efforts within the local school systems across the state.
- The Division also supports the regional prevention coordinators continued collaboration with the Division of Public Health to strengthen the community development of prevention coalitions under the strategic prevention framework of the SPF-SIG.
- "Nebraska Network of Care" – The Division contracted with Trilogy Integrated Resource, LLC of San Rafael, CA to establish a new resource called the "Nebraska Network of Care". An official public launch event with Governor Heineman was March 18, 2009. The Network of Care continues as an online resource for individuals, families and agencies concerned with behavioral health. Consumer Advocates and Organizations and Family Representatives encouraged Administrators at the Division of Behavioral Health to implement the Network of Care. Trilogy Integrated Resource, LLC of San Rafael, CA created and will maintain the website for the Division of Behavioral Health and has similar sites in several other states. The website provides information about behavioral health services, laws and related news, as well as communication tools and many other features including:
 - > Individuals and agencies can build their own free web sites in the "For Providers" section.
 - > Easy-to-use search libraries, information about specific Behavioral Health disorders, pending legislation and advocacy, and daily news articles from around the world concerning mental and substance abuse.
 - > Personal Health Record section where consumers can organize and store medical healthcare-related information.
 - > The site is fully ADA-compliant and available in multiple language and offers a text only-version of the site.

The Nebraska Division of Behavioral Health has a contract with Magellan Behavioral Health for Administrative Services Only (ASO) Managed Care Services. This contract includes the following the ASO functions for the Nebraska Behavioral Health System:

- Training and Technical Support
- Consumer Eligibility Determination
- Utilization Management
- Information Management
- Data Capture and Transfer Requirements
- Information Reporting
- Claims and Payment Information
- Quality Improvement

The Magellan Behavioral Health contract is monitored by the position created within the Division and is responsible for ensuring the ASO functions purchased are consistent with State of Nebraska requirements.

GOAL #12: Intended Use - Coordinate Services / September 16, 2010 / Page 4

The six Regional Behavioral Health Authorities have substance abuse treatment providers and prevention organizations under contract. The Regions work with the providers to improve the referral process and the coordination of prevention activities and treatment services with other public and private nonprofit entities.

§96.132(b) -- the provision of continuing education in treatment services and prevention activities for the employees of the facilities who provide the services or activities.

The Division of Behavioral Health has a contract with the Lincoln Medical Education Partnership-Training for Addiction Professionals (LMEP-TAP) program to provide Core and Continuing Education courses that meet the Division of Public Health's educational requirements for Licensed Alcohol and Drug Counselors (LADCs). The current contract term is from July 1, 2010 to June 30, 2011. A provision in the contract requires a select group of courses to be offered via video conferencing across the State, with the main site in Lincoln, NE. In addition, the Division of Behavioral Health is collaborating with the Office of Probation Administration within the Nebraska Supreme Court to provide the ASI/CASI and Standardized Model Training courses to fulfill requirements set forth by the Nebraska Community Corrections Council. A recent development is that the Division of Behavioral Health, the Division of Public Health, and the Office of Probation Administration are collaborating to develop on-line continuing education courses. The outlook of preliminary discussions is promising, and we are hopeful that the first on-line course will be launched during FY2012.

For more details on the provision of continuing education see Goal 11 Intended Use Continuing Education August 31, 2010.

§96.132(c) -- the coordination of prevention activities and treatment services with the provision of other appropriate services.

The coordination of prevention activities and treatment services with the provision of other appropriate services is completed by the six Regional Behavioral Health Authorities. These Regions manage both the substance abuse treatment funds as well as some of the prevention funds.

The Division will continue the collaborative effort with the Department of Education to explore additional opportunities to expand current prevention and treatment efforts within the local school systems across the state.

For more details on Prevention Coordination see Goal 2 Intended Use Providing Primary Prevention Services.

GOAL#12: Annual Report/Compliance – Coordinate Prevention Activities & Treatment Services
/ Sept 16, 2010 /

Page 1

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

FY 2008 (Annual Report/Compliance)

(1) Who – The Division of Behavioral Health Services (DBH) coordinated prevention and treatment activities with the provision of other appropriate services (including health, social, correctional and criminal justice, educational, vocational rehabilitation, and employment services).

(2) What – The Division of Behavioral Health has a working relationship with the Division of Children & Family Services (social services), Division of Medicaid & Long-Term Care, and Division of Public Health (health) within the NE Department of Health and Human Services; Department of Correctional Services, NE Crime Commission, Community Corrections Council (as well as the Justice Behavioral Health Committee under this Council), and Office of Probation Administration under the Nebraska Supreme Court (criminal justice); Vocational Rehabilitation (employment) and related agencies.

The Division worked collaboratively with agencies that have a direct impact upon DBH ability to ensure that prevention activities and treatment services are delivered in an integrated and coordinated fashion.

(3) When:

The coordination activities were implemented for the time period covering FY 2008.

(4) Where in the State (geographic area)

The coordination of services is undertaken in each of the six behavioral health regions in Nebraska. These are described in GOAL #1 (Intended Use) – Continuum of services in Nebraska under the section on Regional Behavioral Health Authorities. It is also accomplished statewide via coordination with State agencies.

(5) How the coordination was operationalized

§96.132(a) -- the improvement of the referral process and the coordination of prevention activities and treatment services with other public and private nonprofit entities,

The Nebraska Division of Behavioral Health continues to have the goal, (relative to fiscal year 1992), to improve the referral process and the coordination of prevention activities and treatment services with other public and private nonprofit entities. To accomplish this goal, the Division of Behavioral Health has a working relationship with the Division of Children &

GOAL#12: Annual Report/Compliance – Coordinate Prevention Activities & Treatment Services
/ Sept 16, 2010 /

Page 2

Family Services (social services), Division of Medicaid & Long-Term Care, and Division of Public Health (health) within the Nebraska Department of Health and Human Services; Department of Correctional Services, Nebraska Crime Commission, Community Corrections Council (as well as the Justice Behavioral Health Committee under this Council), and Office of Probation Administration under the Nebraska Supreme Court (criminal justice); Vocational Rehabilitation (employment); and related agencies. The Division will continue to work collaboratively with our sister agencies as these conversations have a direct impact on our ability to ensure that services delivered are integrated and coordinated. Some examples of State Level coordination in order to improve the referral process include:

- In September 2008, the Division initiated monthly meetings with the Division of Medicaid and Long-Term Care. Division Director's as well as several key staff from both Divisions meet to problem-solve systemic challenges that the two divisions have experienced. Examples of agenda items have included: Memorandum of Understanding (MOU) for Substance Abuse waiver services-Behavioral Health Matching Funds for Substance Abuse Waiver Services, Secure Residential Reimbursement, Special Populations-Medicaid Reimbursement, and Substance Abuse Waiver Services-Review.
- The Division will continue to meet with the Divisions of Developmental Disabilities, Medicaid and Long Term Care, and Children and Family Services to improve systems coordination relating to behavioral health.
- The Division of Behavioral Health has been meeting with the Nebraska Department of Corrections Services on a variety of issues for a number of years. At this time, the meetings include work on implementing a U.S. Department of Justice / Office of Justice Programs / Bureau of Justice Assistance "Justice and Mental Health Collaboration Program" (CDFA #16.745) grants. The Division of Behavioral Health just completed the development of a strategic plan under a Category I: Planning grant (\$50,000 from 11/01/2007 to 10/31/2008). At this time, the Division is implementing a Category II: Planning and Implementation (\$250,000 from 11/01/2008 to 10/31/2011). Over the next three years, the Division will implement the goals listed below during the project period (November 1, 2008 to October 31, 2011):
 - > Goal 1: Provide statewide Crisis Intervention Team (CIT) training for Law Enforcement officers and make clear linkages with local crisis response teams.
 - > Goal 2: Expand or improve access to crisis stabilization services with improved coordination with law enforcement officers.
 - > Goal 3: Implement standardized mental health and substance abuse screening instruments in the jails that prompt referrals for services.
 - > Goal 4: Increase resources to community mental health to provide diversion services through the use of Forensic Intensive Case Management.
 - > Goal 5: Enhance affordable supportive housing for justice involved youth transitioning to adulthood.

The "Nebraska Justice Behavioral Health Initiative Strategic Plan" (October 31, 2008) is posted on the NE Division of Behavioral Health website under recent reports:

[http://www.dhhs.ne.gov/beh/Reports.htm/ NE Justice MH Strategic Plan - UN PPC](http://www.dhhs.ne.gov/beh/Reports.htm/NE%20Justice%20MH%20Strategic%20Plan%20-%20UN%20PPC)

Final Report - October 2008.

- The Division of Behavioral Health participates regularly on Community Corrections Council (as well as the Justice Behavioral Health Committee under this Council)
- Under the Justice Behavioral Health Committee, the Division has a working relationship with the Office of Probation Administration. This includes several functions covered under the §96.132(b) such as the ASI and the CASI continuing Education Courses (see below).
- Memorandum of Understanding (MOU) for Supported Employment Services – Division of Behavioral Health and the Nebraska Department of Education, Vocational Rehabilitation have a MOU to increase employment opportunities for people with behavioral health (BH) problems. The purpose of the MOU is to coordinate and cooperate in the development and implementation of Supported Employment services for persons with behavioral health disorders. The MOU was officially signed in August 2008. It was specifically discussed at the August 14, 2008 meeting of the State Advisory Committee on Mental Health Services.
- In October of 2008, the Division initiated monthly meetings with the Division of Developmental Disabilities to improve systems coordination for those individuals who have both a developmental disability and a behavioral health disorder. These monthly meetings, while new, have already significantly improved relationships at the Division level and have led to positive outcomes for consumers receiving services from both divisions.
- In August 2008, the Division initiated bi-monthly meetings with the Divisions of Developmental Disabilities, Medicaid and Long Term Care, and Children and Family Services to improve systems coordination relating to children's behavioral health.
 - > In September 2008, the Division developed a statewide Youth Systems Team in partnership with the Nebraska Federation of Families for Children's Mental Health to strengthen system coordination and strategic service planning for youth behavioral health.
 - > In December 2008, the Division initiated a collaborative effort with the Department of Education to explore additional opportunities to expand current prevention and treatment efforts within the local school systems across the state.
- The Division evaluated the effectiveness of the current audit tool used to capture and report prevention activities and progress at the community level. This component of service delivery will be further explored in review of the overall collaborative prevention efforts of additional state partners such as the Nebraska Partners in Prevention, DFC funded programs and the local school systems.
- The Division also support the regional prevention coordinators continued collaboration with the Division of Public Health to strengthen the community development of prevention coalitions under the strategic prevention framework of the SPF-SIG.
- "Nebraska Network of Care" – The Division contracted with Trilogy Integrated Resource, LLC of San Rafael, CA to establish a new resource called the "Nebraska Network of Care". The official major public launch event held with Governor Heineman on March

GOAL#12: Annual Report/Compliance – Coordinate Prevention Activities & Treatment Services
/ Sept 16, 2010 /

Page 4

18, 2009. The Network of Care is an online resource for individuals, families and agencies concerned with behavioral health. Consumer Advocates and Organizations and Family Representatives encouraged Administrators at the Division of Behavioral Health to implement the Network of Care. Trilogy Integrated Resource, LLC of San Rafael, CA created and will maintain the website for the Division of Behavioral Health and has similar sites in several other states. The website provides information about behavioral health services, laws and related news, as well as communication tools and many other features including:

- > Individuals and agencies can build their own free web sites in the “For Providers” section.
- > Easy-to-use search libraries, information about specific Behavioral Health disorders, pending legislation and advocacy, and daily news articles from around the world concerning mental and substance abuse.
- > Personal Health Record section where consumers can organize and store medical healthcare-related information.
- > The site is fully ADA-compliant and available in multiple language and offers a text only-version of the site.

The Nebraska Division of Behavioral Health has a contract with Magellan Behavioral Health for Administrative Services Only (ASO) Managed Care Services. This contract includes the following the ASO functions for the Nebraska Behavioral Health System:

- Training and Technical Support
- Consumer Eligibility Determination
- Utilization Management
- Information Management
- Data Capture and Transfer Requirements
- Information Reporting
- Claims and Payment Information
- Quality Improvement

The Magellan Behavioral Health contract is monitored by the position created within the Division and is responsible for ensuring the ASO functions purchased are consistent with State of Nebraska requirements.

The six Regional Behavioral Health Authorities have substance abuse treatment providers and prevention organizations under contract. The Regions work with the providers to improve the referral process and the coordination of prevention activities and treatment services with other public and private nonprofit entities using quality improvement methods, the audit

§96.132(b) -- the provision of continuing education in treatment services and prevention activities for the employees of the facilities who provide the services or activities.

The Division of Behavioral Health has a contract with the Lincoln Medical Education Partnership to provide statewide core course training, continuing education and licensure training scholarships for people working in the treatment services or providing prevention activities. The current contract term is from July 1, 2007 to June 30, 2009. The contract includes:

- Core Education Courses needed for alcohol/drug counselor licensure
- Continuing Education Courses, including “How Criminal Behaviors and Criminal Thinking are Impacted by Substance Abuse” for persons to be included on the substance abuse/criminal justice approved provider list.
- Annual Addiction Severity Index (ASI) and the Comprehensive Adolescent Severity Inventory (CASI) continuing Education Courses to Meet Standardized Model Provider Criteria
- Annual Continuing Education Summary Course for the “Core Functions of the Substance Abuse Counselor” and
- Annual National Consultation and Specialized Continuing Education Training

Due to the term of the contract ending June 30, 2009, the Division of Behavioral Health re-bid and re-negotiated this contract. In the process of this, the Division worked with the Office of Probation Administration.

§96.132(c) -- the coordination of prevention activities and treatment services with the provision of other appropriate services.

The coordination of prevention activities and treatment services with the provision of other appropriate services is completed by the six Regional Behavioral Health Authorities. These Regions manage both the substance abuse treatment funds as well as some of the prevention funds.

The Division continues the collaborative effort with the Department of Education to explore additional opportunities to expand current prevention and treatment efforts within the local school systems across the state. For example, the Division will provide technical assistance and support to an urban school system’s application for the Safe and Health School Initiative in order to increase service delivery of both prevention and behavioral health treatment programming and strengthen the partnership of local schools, community coalitions and overall system coordination. The Division also provides introductory training in April 2009 on wrap-around to the Department of Education and a select group of schools who pilot this program with the implementation of Positive Behavioral Supports.

The Division will continue strategic planning efforts with the Youth Systems Team as noted in §96.132(a). This Team now includes regional Family Organizations, regional youth specialists, program providers, advocacy groups, the Consumer Advocate from Magellan, and

GOAL#12: Annual Report/Compliance – Coordinate Prevention Activities & Treatment Services
/ Sept 16, 2010 /

Page 6

invited guests in efforts to strengthen the system of care and delivery planning for a continuum of service delivery from prevention to treatment.(Invited guests include youth, Vocational Rehab, Educational Service Units, local providers, speakers and others.)

The Division provides technical assistance to the regional systems of care teams to strengthen the service delivery of behavioral health prevention and treatment for youth. We will be providing training for trainers, training for providers and technical assistance to local systems of care groups on a variety of topics. In addition, technical assistance is provided to the new Transition Teams whose members include youth specialists, providers, Voc Rehab and others who will be addressing the needs of transition aged youth to prevent future risky behavior and ensure a smooth transition into adult treatment services.

The Division is preparing an RFP for the prevention/intervention programming it has funded in the form of Student Assistance Programs and School/Community Intervention Programs. These programs serve school systems to identify and supplant services for at risk youth and/or risk experiencing a behavior disorder. These programs are a valuable component of local prevention efforts that empower community coalitions located around or within schools and are critical to the intervention and management of risky behaviors that impede a student's success.

GOAL #12: Progress - Coordinate Services / September 17, 2010 / Page 1

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

FY 2010 (Progress)**§96.132(a) -- the improvement of the referral process and the coordination of prevention activities and treatment services with other public and private nonprofit entities.**

The Nebraska Division of Behavioral Health continues to have the goal of improving the referral process and the coordination of prevention activities and treatment services with other public and private nonprofit entities. To accomplish this goal, the Division of Behavioral Health has a working relationship with the Division of Children and Family Services (social services), Division of Medicaid and Long-Term Care, and Division of Public Health (health) within the Nebraska Department of Health and Human Services (DHHS); the Department of Correctional Services (DCS), the Nebraska Crime Commission, the Community Corrections Council (as well as the Justice Behavioral Health Committee under this Council), and the Office of Probation Administration under the Nebraska Supreme Court (criminal justice); and Vocational Rehabilitation (employment) and related agencies. The Division will continue to work collaboratively with our sister agencies as these conversations have a direct impact on our ability to ensure that services delivered are integrated and coordinated.

Examples of State Level coordination to improve the referral process include:

- In September 2008, the Division initiated monthly meetings with the Division of Medicaid and Long-Term Care. Division Directors, as well as several key staff from both Divisions, meet to problem-solve systemic challenges the two divisions have experienced. Examples of agenda items have included: Memorandum of Understanding (MOU) for Substance Abuse Waiver Services, Behavioral Health Matching Funds for Substance Abuse Waiver Services, Secure Residential Reimbursement, Special Populations-Medicaid Reimbursement, and Substance Abuse Waiver Services-Review.
- The Division continues to meet with the Divisions of Developmental Disabilities, Medicaid and Long-Term Care, and Children and Family Services to improve systems coordination relating to behavioral health.
- The Division of Behavioral Health continues to meet with the Nebraska Department of Correctional Services on a variety of issues. The meetings include work on implementing a U.S. Department of Justice / Office of Justice Programs / Bureau of Justice Assistance “Justice and Mental Health Collaboration Program” (CDFA #16.745) grant. The Division of Behavioral Health completed the development of a strategic plan under a Category I: Planning grant (\$50,000 from 11/01/2007 to 10/31/2008). The Division is continuing to implement the goals listed below for a Category II: Planning and Implementation grant (\$250,000 from 11/01/2008 to 10/31/2011).
 - > Goal 1: Provide statewide Crisis Intervention Team (CIT) training for Law Enforcement officers, and make clear linkages with local crisis response teams.
 - > Goal 2: Expand or improve access to crisis stabilization services with improved coordination with law enforcement officers.
 - > Goal 3: Implement standardized mental health and substance abuse screening instruments in the jails that prompt referrals for services.
 - > Goal 4: Increase resources to community mental health to provide diversion services through the use of Forensic Intensive Case Management.

GOAL #12: Progress - Coordinate Services / September 17, 2010 / Page 2

- > Goal 5: Enhance affordable supportive housing for justice involved youth transitioning to adulthood.

The "Nebraska Justice Behavioral Health Initiative Strategic Plan" (October 31, 2008) is posted on the Nebraska Division of Behavioral Health website under recent reports:

[http://www.dhhs.ne.gov/beh/Reports.htm/ NE Justice MH Strategic Plan - UN PPC Final Report - October 2008.](http://www.dhhs.ne.gov/beh/Reports.htm/NE%20Justice%20MH%20Strategic%20Plan%20-%20UN%20PPC%20Final%20Report%20-%20October%202008)

- The Division of Behavioral Health regularly participates on Community Corrections Council (as well as the Justice Behavioral Health Committee under this Council)
- Under the Justice Behavioral Health Committee, the Division has a working relationship with the Office of Probation Administration. This includes several functions covered under the §96.132(b) such as the Addictions Severity Index (ASI) and the Comprehensive Adolescent Severity Inventory (CASI) Continuing Education Courses (see below).
- Criminal Justice Electronic Data Transfer Interagency Agreement – In June 2009, the Nebraska Department of Health and Human Services - Division Of Behavioral Health (DHHS), the Nebraska Department of Correctional Services (DCS) and the Nebraska Commission on Law Enforcement and Criminal Justice (Crime Commission) signed Electronic Data Transfer Interagency Agreements. These agreements require these three state agencies to transfer their data to the Division of Epidemiology, College of Public Health at the University of Nebraska Medical Center in Omaha, NE for the purpose of analysis, compilation and reporting for the mutual benefit of the parties. The initial data covered the time period from January 1, 2005 to December 31, 2008. Before public release, the report(s) produced under these agreements must be acceptable to DHHS, DCS and the Crime Commission. The report(s) remain in draft status until these three agencies approve the document. This requirement is due to the sensitive nature of the content of the report(s) using these data.
- Memorandum of Understanding (MOU) for Supported Employment Services – The Division of Behavioral Health and the Nebraska Department of Education-Vocational Rehabilitation signed a MOU in August, 2008 to increase employment opportunities for people experiencing behavioral health problems. The purpose of the MOU is to coordinate and cooperate in the development and implementation of Supported Employment services for persons with behavioral health disorders. The MOU was presented at the August 14, 2008 meeting of the State Advisory Committee on Mental Health Services.
- In October of 2008, the Division initiated monthly meetings with the Division of Developmental Disabilities to improve systems coordination for those individuals who have both a developmental disability and a behavioral health disorder. These monthly meetings have significantly improved relationships at the Division level and have led to positive outcomes for consumers receiving services from both divisions.
- In August 2008, the Division initiated bi-monthly meetings with the Divisions of Developmental Disabilities, Medicaid and Long-Term Care, and Children and Family Services to improve systems coordination relating to children's behavioral health.
 - > In September 2008, the Division developed a statewide Youth Systems Team in partnership with the Nebraska Federation of Families for Children's Mental Health to strengthen system coordination and strategic service planning for youth behavioral health.
 - > In December 2008, the Division initiated a collaborative effort with the Department of Education to explore additional opportunities to expand current prevention and

GOAL #12: Progress - Coordinate Services / September 17, 2010 / Page 3

treatment efforts within the local school systems across the state.

- The Division continues to evaluate the effectiveness of the current audit tool used to capture and report prevention activities and progress at the community level. This component of service delivery will be further explored in review of the overall collaborative prevention efforts of additional state partners such as the Nebraska Partners in Prevention, Drug Free Communities (DFC) funded programs and the local school systems.
- The Division also supports the regional prevention coordinators continued collaboration with the Division of Public Health to strengthen the community development of prevention coalitions under the strategic prevention framework of the Strategic Prevention Framework-State Incentive Grant (SPF-SIG).
- "Nebraska Network of Care" – The Division contracted with Trilogy Integrated Resource, LLC of San Rafael, CA to establish a new resource called the "Nebraska Network of Care". An official public launch event with Governor Heineman was March 18, 2009. The Network of Care is an online resource for individuals, families and agencies concerned with behavioral health matters. Consumer advocates, organizations and family representatives encouraged Administrators at the Division of Behavioral Health to implement the Network of Care. Trilogy Integrated Resource, LLC of San Rafael, CA created and maintains the website for the Division of Behavioral Health and has similar sites in several other states. The website provides information about behavioral health services, laws and related news, as well as communication tools and many other features including:
 - > Individuals and agencies can build their own free web sites in the "For Providers" section.
 - > Easy-to-use search libraries, information about specific Behavioral Health disorders, pending legislation and advocacy, and daily news articles from around the world concerning mental and substance abuse.
 - > Personal Health Record section where consumers can organize and store medical healthcare-related information.
 - > The site is fully ADA-compliant, available in multiple languages, and offers a text only-version of the site.

The Nebraska Division of Behavioral Health has a contract with Magellan Behavioral Health for Administrative Services Only (ASO) Managed Care Services. This contract includes the following the ASO functions for the Nebraska Behavioral Health System:

- Training and Technical Support
- Consumer Eligibility Determination
- Utilization Management
- Information Management
- Data Capture and Transfer Requirements
- Information Reporting
- Claims and Payment Information
- Quality Improvement

The Magellan Behavioral Health contract is monitored by the Data and Quality Improvement Manager within the Division of Behavioral Health who is also responsible for ensuring the ASO functions purchased are consistent with State of Nebraska requirements.

GOAL #12: Progress - Coordinate Services / September 17, 2010 / Page 4

The six Regional Behavioral Health Authorities have substance abuse treatment providers and prevention organizations under contract. The Regions work with the providers to improve the referral process and the coordination of prevention activities and treatment services with other public and private nonprofit entities.

§96.132(b) -- the provision of continuing education in treatment services and prevention activities for the employees of the facilities who provide the services or activities.

The Division of Behavioral Health has a contract with the Lincoln Medical Education Partnership-Training for Addiction Professionals (LMEP-TAP) program to provide Core and Continuing Education courses that meet the Division of Public Health's educational requirements for Licensed Alcohol and Drug Counselors (LADCs). The current contract term is from July 1, 2010 to June 30, 2011. A provision in the contract requires a select group of courses to be offered via video conferencing across the State, with the main site in Lincoln, NE. In addition, the Division of Behavioral Health is collaborating with the Office of Probation Administration within the Nebraska Supreme Court to provide the Addictions Severity Index (ASI), the Comprehensive Adolescent Severity Inventory (CASI), and the Standardized Model training courses to fulfill requirements set forth by the Nebraska Community Corrections Council. A recent development is that the Division of Behavioral Health, the Division of Public Health, and the Office of Probation Administration are collaborating to develop on-line continuing education courses.

§96.132(c) -- the coordination of prevention activities and treatment services with the provision of other appropriate services.

The coordination of prevention activities and treatment services with the provision of other appropriate services is completed by the six Regional Behavioral Health Authorities. These Regions manage both the substance abuse treatment funds as well as some of the prevention funds.

The Division continues to collaborate with the Department of Education to explore additional opportunities to expand current prevention and treatment efforts within the local school systems across the state. For example, the Division will provide technical assistance and support to an urban school system's application for the Safe and Healthy School Initiative to increase service delivery of both prevention and behavioral health treatment programming and strengthen the partnership of local schools, community coalitions and overall system coordination.

The Division continues strategic planning efforts with the Youth Systems Team as noted in §96.132(a). This Team now includes regional Family Organizations, regional youth specialists, program providers, advocacy groups, the Consumer Advocate from Magellan, and invited guests in efforts to strengthen the system of care and delivery planning for a continuum of service delivery from prevention to treatment. (Invited guests include youth, Vocational Rehabilitation, Educational Service Units, local providers, speakers and others.)

The Division continues to provide technical assistance to the regional systems of care teams to strengthen the service delivery of behavioral health prevention and treatment for youth. We will be providing training for trainers, training for providers and technical assistance to local systems of care groups on a variety of topics. In addition, technical assistance is provided to the

GOAL #12: Progress - Coordinate Services / September 17, 2010 / Page 5

Transition Teams whose members include youth specialists, providers, Vocational Rehabilitation and others who address the needs of transition aged youth to prevent future risky behavior and ensure a smooth transition into adult treatment services.

The Division continues the prevention/intervention programming it has funded in the form of Student Assistance Programs and School/Community Intervention Programs. These programs serve school systems to identify and supplant services for at risk youth and/or risk experiencing a behavior disorder. These programs are a valuable component of local prevention efforts that empower community coalitions located around or within schools and are critical to the intervention and management of risky behaviors that impede a student's success.

As noted above under §96.132(a), the Division of Behavioral Health continues the coordination of prevention activities and treatment services with other public and private nonprofit entities. The Prevention Program works with the Division of Public Health across organizational boundaries to provide leadership in creating a state behavioral health system that can support community efforts to diminish risk and increase protective factors within communities.

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

The Division of Behavioral Health continues to work with the Justice Behavioral Health Committee to support the review of the Standardized Model for Assessing Individuals in the Criminal Justice System, and to work toward creating a similar model for mental health.

Continuing with the recommendations of the State Advisory Committee on Substance Abuse Services, and through the Community Corrections Council the Division works to strengthen the processes of the Standardized Model for Assessing Substance Abusers; and continues to maintain a list of persons who have achieved proficiency in the Standardized Model, Addiction Severity Index (ASI) and the Comprehensive Adolescent Severity Inventory (CASI).

Division of Behavioral Health Services staff meet with the Regional Prevention Coordinators monthly to update them on prevention activities and encourage coordination of treatment and prevention activities in each region. In collaboration with the Statewide Audit Workgroup and the Regional Prevention Coordinators, the Division monitors and assesses the Region's prevention providers/coalition's performance activities outlined in the coalitions' work plan. In addition, the Division has implemented the requirement of assessing the performance of the prevention provider/coalitions fiscal agent through annual expense verification process.

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

Goal #13: Assessment of Need

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

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: Data-based planning; Statewide surveys; Youth survey(s); Archival/social indicator data; Data work groups; Risk and protective factors Household survey data utilization; Prioritization of services; Provider surveys; Online surveys/Web-based reporting systems; Site visits.

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

FY 2011-2013 (Intended Use/Plan)

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

SUBSTANCE ABUSE NEEDS ASSESSMENT ON PREVENTION SERVICES:

Substance abuse is a growing problem in Nebraska, which places an enormous strain on the healthcare system, the criminal justice system, and the substance abuse treatment system. The Nebraska Substance Abuse Epidemiology Workgroup (NSAEW), formed in March 2007, is a workgroup of administrators, epidemiologists, and key decision makers who collaborate to make decisions regarding the collection and reporting of data related to substance use, consequences of substance abuse, and factors that contribute to substance abuse in the state of Nebraska. One of the main functions of the NSAEW is to identify and prioritize substance abuse data gaps, including missing or incomplete data, availability of data, and utilization of data. Through the Epidemiological Profile Report and the Prevention Strategic Plan, the Nebraska Department of Health and Human Services (DHHS) Divisions of Behavioral Health and Public Health are working together to coordinate a unified Prevention System with diverse funding streams that produce outcomes in reducing substance abuse and related problems.

In December of 2007, the NSAEW published the *Substance Abuse and Associated Consequences in Nebraska –An Epidemiological Profile*. The following information highlights some of the most recent findings that drive our decision making and focus on underage drinking:

Consequences of Substance Abuse in Nebraska

Substance abuse is a major contributor to death and medical care

- In 2004, there were an estimated 392 alcohol-related deaths, an estimated 2,115 smoking-related deaths, and 61 deaths in which drugs were listed as the primary cause of death.
- In 2003, there were 4,948 alcohol-attributable hospitalizations, an estimated 8,517 smoking-related hospitalizations and 2,887 drug-attributable hospitalizations.

Alcohol impaired driving is particularly high and is common in fatal motor vehicle crashes

- High school students in Nebraska were 1.7 times more likely than students nationally to report driving after drinking in the past month (17.3% and 9.9%, 2005) while adults were 1.6 times more likely than adults nationally to report past month alcohol impaired driving (3.9% and 2.5%, 2008).
- In 2009, more than one-third of all fatal motor vehicle crashes in Nebraska involved alcohol (35.6%), killing 79 individuals in 73 alcohol-involved fatal crashes.

Substance abuse places a tremendous strain on the criminal justice system

- In 2006, there were 13,409 arrests for DUI, 12,714 arrests for non-DUI alcohol-related crime, and 10,502 arrests for possession or sales/manufacturing of illicit drugs in Nebraska. These were the top three arrest offenses in 2006 and together accounted for 2 in every 5 arrests (39.4%).
- Of all adults sentenced to probation in Nebraska during 2006, more than half (55.3%) were sentenced for DUI, a substantial increase since 2000 (37.6%), while about 1 in every 17 were sentenced for a drug-related offense (5.9%), a stable trend since 2000 (5.4%).
- There were 20 times the number of incarcerations for drug offenses in 2006 (1,171) than 1980 (60).

Alcohol is the primary drug of choice in substance abuse treatment admissions

- In 2006, alcohol was listed as the primary drug of choice during 7 in every 10 substance abuse treatment admissions (70.9%) in Nebraska, followed by methamphetamine (12.5%), marijuana (9.1%), and cocaine (4.7%).

Substance Use in Nebraska

Substance use is common in Nebraska with alcohol being the substance of choice

- In 2005, more than 2 in every 5 Nebraska high school students (42.9%) drank alcohol during the past month, about 1 in every 5 smoked cigarettes (21.8%), and approximately 1 in every 6 used marijuana (17.5%).
- During the combined years of 2007 and 2008, more than half of all persons ages 12 years and older in Nebraska drank alcohol in the past month (55.8%) while one-quarter of all persons binge drank (25.3%). In addition, one-quarter (24.7%) smoked cigarettes and approximately 1 in every 15 used illicit drugs (6.4%). (Source: 2007/2008 National Survey on Drug Use and Health)

Compared to the U.S., alcohol use in Nebraska is high while smoking and most drug use is similar

- Binge drinking among Nebraska residents was higher than residents nationally across the three data sources presented in this report that contained information on self-reported binge drinking, (although the difference for high school students was non-significant).
- Cigarette smoking among Nebraska residents was nearly identical to residents nationally while drug use tended to be slightly lower (although the differences were generally non-significant); however, past year methamphetamine use was higher among Nebraska residents 12 and older.
- Among persons 12 and older during the combined years of 2007 and 2008, cigarette smoking among Nebraska residents was nearly identical to residents nationally while marijuana and non-marijuana illicit drug use was lower (although the differences were not significantly lower). (Source: 2007/2008 National Survey on Drug Use and Health)

NOTE: The Division of Behavioral Health contracts with the six Regional Behavioral Health Authorities for community substance abuse treatment services. Regional budget plan guidelines are developed annually by the Division. These guidelines will direct Regional Behavioral Health Authorities in their efforts to develop and maintain a continuum of care which addresses the needs of Nebraska. Statewide goals and objectives will be based on strategic planning sessions and target variables which will impact the efficacy and effectiveness of alcohol treatment in Nebraska.

Substance use among youth has changed both positively and negatively over the past 15 years

- Alcohol use (including binge drinking) and cigarette smoking among Nebraska high school students declined since the early 1990s, but remained stable among adults during the same time period.
- Marijuana use among Nebraska high school students increased since the early 1990s; however, more recent estimates of use among all persons 12 and older, between 2002 and 2005, were stable and may have begun to decline (although the decline was non-significant).
- Overall, non-marijuana illicit drug use among all persons 12 and older in Nebraska remained virtually unchanged between 2002 and 2005.

Demographic Differences in Nebraska

Differences by age

- Residents in their late teens and early 20's were the most likely age group to binge drink as well as use tobacco and illicit drugs. In addition, they were also more likely than other age groups to drive after drinking, to die or be injured in an alcohol-involved crash, to be arrested for alcohol or drug related offenses, and to be admitted into substance abuse treatment.

Differences by gender

- Among Nebraska high school students, males and females reported similar percentages for alcohol use, cigarette smoking, and illicit drug use. However, among adults, men were more likely than women to binge drink, to drive after drinking, to use smokeless tobacco products, to experience legal consequences from alcohol and drug use, and to be admitted into substance abuse treatment.

Differences by urban/rural

- Residents of the most rural Nebraska counties reported the highest percentage for alcohol impaired driving and smokeless tobacco use; however, alcohol use and cigarette smoking were relatively similar across urban/rural counties while differences for illicit drug use were largely unavailable.

Differences by race/ethnicity

- Among Nebraska adults, Native Americans reported the highest percentage for binge drinking and cigarette smoking (although the binge drinking percentage was not significantly higher than Whites) as well as had the highest death rates for chronic liver disease and alcohol-related death overall. Racial and ethnic differences for illicit drug use were largely unavailable.

Substance abuse prevention efforts occur at both the state and community levels within Nebraska.

State level: As part of the SPF SIG efforts, Nebraska's external evaluator, Research Triangle Institute (RTI) is conducting annual data collection at the state level using the SAMHSA developed Grantee Level Instrument (GLI) as well as the Systems Integration Interview (SII) tool that was developed by RTI. The SII is designed to measure how well the DHHS Divisions of Public Health and Behavioral Health collaborate on SA prevention as well as how both divisions interact with the Behavioral Health Regional Prevention staff.

Community level: Under the SPF SIG, each community has hired an external evaluator to assist them with data collection and reporting. Coalition staff and local evaluators work together to develop evaluation plans for the community as well as collect and report evaluation related data to the coalition and to the state and RTI. As part of the broader evaluation, the SPF SIG and Block Grant programs have been collaborating to assess the policies, programs, and practices currently being used within Nebraska in an effort to ensure that prevention and evaluation are coordinated to the best extent possible across the state. To help accomplish this, both divisions are currently working on improving the www.npirs.org website, the online reporting site for block grant and eventually SPF SIG recipients.

The initial tasks of the NSAEW included creating an epidemiological profile report on substance abuse in Nebraska and establishing a set of criteria to facilitate the selection of the SPF SIG substance abuse prevention priorities. This information served as the foundation for the development of the Nebraska Substance Abuse Strategic Plan.

GOAL # 13. Intended Use - Assessment of Need for Treatment & Prevention | Oct 1, 2010 | pg 4

To complete this work, the NSAEW completed the following steps. First, substance abuse data sources within Nebraska were identified by completing an inventory of available data. Second, data constructs were identified and used to organize data sources and data reporting. The constructs were separated by consequences (e.g., mortality, medical care, motor vehicle crashes, legal consequences, etc.) and consumption (e.g., lifetime use, current use, excessive use, etc.). Lastly, data indicators were selected through group discussion and NSAEW member supplemental online indicator scoring. The following items were considered as part of the indicator selection process: data quality, state level data availability, national comparison, trend availability, future collection plans, and sample size or number of cases.

The NSAEW continues to discuss data sources and gaps and their relation to ongoing data planning and reporting. As part of this process, the NSAEW will be updating the content of the epidemiology profile report within the next year and will continue to pursue opportunities to collect and report both state and community level data. For example, the Nebraska Department of Education (NDE) and DHHS coordinates the administration of the Youth Risk Behavior Survey (YRBS), Youth Tobacco Survey (YTS), and Nebraska Risk and Protective Factor Student Survey (NRPFSS) which make up the Student Health And Risk Prevention (SHARP) survey. The YRBS, YTS, and NRPFSS have been administered separately in the past. Now, all three surveys are administered in the fall of even calendar years, which began in the fall of 2010. The Bureau of Sociological Research (BOSR) will manage these surveys on behalf of NDE and DHHS. The goal of SHARP is to minimize interruption of school schedules and improve overall school participation in all three surveys.

Based on the Form 6a Prevention Strategy Report (as of 9/27/2010) the risk populations include but are not limited to, Children of Substance Abusers, Pregnant Women/Teens, Violent and Delinquent Behavior, Mental Health Problems, Economically Disadvantaged, Physically Disabled, People Already Using Substances, Homeless and/or Run away Youth, Business and Industry, Civic Groups/Coalitions, College Students, Older Adults, Elementary School Students, Health Professionals, High School Students, Middle/Junior High School Students, Parents/Families, Preschool Students, Prevention/Treatment Professionals, Religious Groups, Teachers/Administrators/Counselors, Youth/Minors, and Law Enforcement/Military. See Form 6a Prevention Strategy Report for more details.

Primary Prevention Activities / A summary of Form 6ab (formerly Form 11ab) – Primary Prevention Planned Expenditure Checklist is below

FY11 Intended Use - Primary Prevention Form 6a

	SAPTBG	
Information Dissemination	83,023	5%
Education	219,704	13%
Alternative Activities	82,710	5%
Problem Identification/Referral	98,856	6%
Community-Based Processes	520,199	31%
Environmental	583,025	35%
Other		0%
Section 1926-Tobacco	86,450	5%
Total	1,673,967	100%

Source: FY11 Regional Budget Plans, Submitted by Regional Behavioral Health Authorities, April-May, 2010

* Division of Behavioral Health Contracts for FY11

GOAL # 13. Intended Use - Assessment of Need for Treatment & Prevention | Oct 1, 2010 | pg 5

In addition to these efforts, Nebraska facilitates a number of other strategies as noted on Form 6a Prevention Strategy Report, primary prevention activities include Disseminate A/V Material, Printed Material, Curricula, Newsletters and related content; Accessing services and funding; use of clearinghouse/information resources centers; community and volunteer training (such as neighborhood action training, impactor training, staff/officials training); Community drop-in centers, Community service activities, Community team-building; education programs for those who were driving while under the influence and/or driving while intoxicated; drug free dances and parties; education programs for youth groups; employee Assistance Programs; guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use; health fairs and other health promotion, e.g., conferences, meetings, seminars; Information lines/Hot lines; media campaigns; ongoing classroom and/or small group sessions; parenting and family management; Peer leader/helper programs; Preventing Underage Sales of Tobacco and Tobacco Products per the Synar Amendment; Prevention Assessment and Referral Attendees; Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools; Recreation activities; Resources directories; Speaking engagements; Student Assistance Programs; Systematic planning; Technical Assistance Services; tobacco, and drug use policies in schools; Youth/adult leadership activities; and related activities.

SUBSTANCE ABUSE NEEDS ASSESSMENT ON TREATMENT SERVICES:

The Nebraska Behavioral Health Services Act (Neb. Rev. Stat. §§ 71-801 to 71-830) defines the term "Behavioral health disorder" as mental illness or alcoholism, drug abuse, problem gambling, or other addictive disorder [Neb. Rev. Stat. §71-804(1)].

Illicit Drug or Alcohol Use Treatment and Treatment Need

According to the National Survey on Drug Use and Health:

- In 2008, 23.1 million persons aged 12 or older needed treatment for an illicit drug or alcohol use problem (9.2 percent of the persons aged 12 or older). Of these, 2.3 million (0.9 percent of persons aged 12 or older and 9.9 percent of those who needed treatment) received treatment at a specialty facility. Thus, 20.8 million persons (8.3 percent of the population aged 12 or older) needed treatment for an illicit drug or alcohol use problem but did not receive treatment at a specialty substance abuse facility in the past year. These estimates are similar to the estimates for 2007 and for 2002.
- Of the 2.3 million people aged 12 or older who received specialty substance use treatment in 2008, 983,000 received treatment for alcohol use only, 632,000 received treatment for illicit drug use only, and 577,000 received treatment for both alcohol and illicit drug use. These estimates are similar to the estimates for 2007 and for 2002.
- In 2008, among persons who received their most recent substance use treatment at a specialty facility in the past year, 49.5 percent reported using their "own savings or earnings" as a source of payment for their most recent specialty treatment, 36.1 percent reported using private health insurance, 24.7 percent reported using Medicaid, 22.3 percent reported using public assistance other than Medicaid, 17.5 percent reported using Medicare, and 16.5 percent reported using funds from family members. None of these estimates changed significantly between 2007 and 2008 and between 2002 and 2008. (Note that persons could report more than one source of payment.)
- Of the 20.8 million persons in 2008 who were classified as needing substance use treatment but not receiving treatment at a specialty facility in the past year, 1.0 million persons (4.8 percent) reported that they perceived a need for treatment for their illicit drug or alcohol use problem (Figure 7.10). Of these 1.0 million persons who felt they needed treatment but did

GOAL # 13. Intended Use - Assessment of Need for Treatment & Prevention | Oct 1, 2010 | pg 6

not receive treatment in 2008, 233,000 (23.3 percent) reported that they made an effort to get treatment, and 766,000 (76.7 percent) reported making no effort to get treatment. These estimates remained stable between 2007 and 2008, except that the number of persons who felt they needed treatment, made an effort to get treatment, but did not receive treatment in 2008 decreased from 380,000 persons in 2007 to 233,000 persons in 2008, and the percentage of persons who felt they needed treatment among those who were classified as needing substance use treatment declined from 6.4 percent in 2007 to 4.8 percent in 2008.

Source: Substance Abuse and Mental Health Services Administration. (2009). Results from the 2008 National Survey on Drug Use and Health: National Findings (Office of Applied Studies, NSDUH Series H-36, HHS Publication No. SMA 09-4434). Rockville, MD.
<http://www.oas.samhsa.gov/nsduh/2k8nsduh/2k8Results.htm#Fig7-5>
 accessed on October 1, 2010

The Division of Behavioral Health needs assessment work includes the Substance Abuse Prevention and Treatment Block Grant Form 4 (formerly Form 8) – Treatment Needs Assessment Summary Matrix, Form 5 (former Form 9) – Treatment Needs by Age, Sex and Race/Ethnicity and How your State determined the estimates for Form 4 and Form 5. Under Form 4 (Treatment Needs Assessment Summary Matrix), the Division of Behavioral Health shows the incidence and prevalence in the State of drug abuse, alcohol abuse and alcoholism. This is summarized below under the column 3. Total Population In Need.

Form 4 (formerly Form 8)
 Treatment Needs Assessment Summary Matrix

Region	1. Substate planning area	2. Total population Census data (estimated 2009)	3. Total population in need	
			A. Needing treatment services	B. That would seek treatment
1	Panhandle	85,468	7,607	487
2	Southwest	99,040	8,815	564
3	South Central	223,970	19,933	1,276
4	North East	205,596	18,298	1,171
5	South East	437,999	38,982	2,495
6	Omaha Metro	744,546	66,265	4,241
	State Total	1,796,619	159,899	10,234

Treatment Utilization

Form 10a (formerly Form 7a) Treatment Utilization Matrix

Substance Abuse Services Funded by the Division of Behavioral Health

For treatment services provided with an initial admission to an episode of care during the 12-month State Expenditure Period of FY2009

Level of Care	A. Number of Admissions	B. Number of Persons Served
Detoxification (24-Hour Care)		
1. Hospital Inpatient	0	0
2. Free-Standing Residential	10,586	6,128
Rehabilitation/Residential		
3. Hospital Inpatient	381	320
4. Short-term (up to 30 days)	1,600	831

GOAL # 13. Intended Use - Assessment of Need for Treatment & Prevention | Oct 1, 2010 | pg 7

5. Long-term (over 30 days)	1,194	665
Ambulatory (Outpatient)		
6. Outpatient	10,711	8,011
7. Intensive Outpatient	1,530	831
8. Detoxification	0	0
9. Opioid Replacement Therapy	299	279

Source: Division of Behavioral Health (September 2010)

Form 10b Number of persons served for alcohol and other drug use in state funded services
Unduplicated Count of Persons Served in State Expenditure Period of FY2009 in Substance Abuse Programs Funded by the Division of Behavioral Health (N=16,771)

Form 10b (formerly Form 7b) Number of persons served for alcohol and other drug use in state funded services

	Total
17 Years & Under	454
18 to 24 Years	4,457
25 to 44 Years	8,274
45 to 64 Years	3,449
65 + Years	128
Total	16,771
Pregnant Women	162

Footnotes to Form 10b (formerly Form 7b)

- (1) In January 2009, the Division of Behavioral Health cleaned its data system by administratively discharging nearly 18,000 records of admission to program prior to November 2003 and of which had no activity in the last year. This reduced the number of active cases in the system.
- (2) For FY2010, with the community based services (Magellan Health) data, only the persons admitted to a Substance Abuse service or a dual service (consumers who received a specialized program including both mental health and substance abuse services) were counted. In the past, persons served in mental health services with a substance abuse diagnosis or reason for admission field showing "substance abuse" were included. As a result, the counts in FY2010 will drop. However, the Division of Behavioral Health believes this is a more accurate method for reporting persons served.
- (3) To obtain unduplicated count of persons served, the Division used social security numbers and dates of birth to identify unique clients in the data system.

Treatment Capacity.

Details of treatment capacity are reported on Form 9 (formerly Form 6) – Substance Abuse Entity Inventory. This report includes the Entity Number, I-SATS ID, the Area Served, the State Funds allocated, the SAPT Block Grant Funds for Substance Abuse Prevention and Treatment Services allocated, a specific report of the SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children, funds for the SAPT Block Grant Funds for Primary Prevention. There are no funds allocated from the SAPT Block Grant Funds for Early Intervention Services for HIV.

GOAL # 13. Intended Use - Assessment of Need for Treatment & Prevention | Oct 1, 2010 | pg 8

When

This work is continuously being addressed. For the purposes of this document, Goal 13 Intended Use time period covers from July 1, 2010 to September 30, 2013. That includes both the Federal Fiscal Year of October 1, 2010 to September 30, 2011 and the State fiscal year (starting July 1, 2010). Almost everything the NE Division of Behavioral Health does is organized around the State Fiscal Year (July 1 to June 30), so that becomes the natural reporting cycle. If the reporting time frame is done consistently over time, then everything needed falls into place and is fully addressed.

How

The Intended Use of the funds relating to prevention and treatment are reported on Form 6 as the Intended Use Plan for FY2011

Form 6				
Intended Use Plan - FY11				
Activity	SAPTBG	Medicaid	Other Fed Funds	State Funds
Substance Abuse Prev & Treatment (non primary prev)	5,824,315			24,481,464
Primary Prevention	1,673,967			173,291
Tuberculosis Services				
HIV Early Intervention Services				
Administration (excluding program/provider level)	394,646			
Totals	7,892,928	-	-	24,654,755
Source:				
Division of Behavioral Health FY11 Program 268 Expenditures; prorated for separation of MH/SA				
Division of Behavioral Health FY11 Program 038 Summary of Expenditures				

The Division of Behavioral Health contracts most of the funds to the six Regional Behavioral Health Authorities. For the FY2011 SAPTBG, Nebraska received a total of \$7,892,928. These funds were allocated \$5,824,315 (73.8%) for Substance Abuse Treatment, \$1,673,967 (21.2%) for Primary Prevention, and \$394,646 (5%) Administration (excluding program/provider level). No SAPTBG funds are used in either Tuberculosis Services or HIV Early Intervention Services.

NEED FOR TECHNICAL ASSISTANCE

NE is considering Technical Assistance in the following areas:

- Co-Occurring Mental Health / Substance Abuse issues – the Unduplicated Count of Persons Receiving Services Funded by the Division of Behavioral Health in SFY2009, all clients served in mental health and/or substance abuse services was 37,669. Of this number, 19,949 (53%) were Substance Abuse ONLY Clients or Co-occurring Clients. Only 5,095 (14%)

GOAL # 13. Intended Use - Assessment of Need for Treatment & Prevention | Oct 1, 2010 | pg 9

were reported as "Substance Abuse ONLY Clients". This suggests the Division of Behavioral Health needs to improve upon the services available for this population.

- Rate Setting Methods for Community Substance Abuse Services – the Division of Behavioral Health needs assistance on updating the rate setting methods used for purchasing substance abuse services in Nebraska. This rate setting method needs to take into account the issues involved in providing proper services to people with Co-occurring substance abuse and mental health problems.
- Recovery Oriented Systems of Care (ROSC) – part of Behavioral Health Reform included a focus on consumers of Behavioral Health services, including substance abuse. The Division of Behavioral Health would like to enhance/expand our subject area expertise in ROSC. This needs to include help to plan and implement systems using the ROSC approach, a community level focus on recovery oriented systems of care, peer support and other related areas now being developed under the leadership of the Office of Consumer Affairs (in the Division of Behavioral Health) as well as the Consumer Specialists within the six Regional Behavioral Health Authorities. The technical assistance would be used to generate a dialogue on ways to move from acute care models to using recovery as a driving force for service design.
- Development of a Data Strategy – the Division of Behavioral Health needs to develop a long term data strategy in order to work with the rate setting mechanism as well as a sustainable method for collecting the data needed for the National Outcome Measures. This needs to include improving the infrastructure for collecting, storage, analysis and reporting of the data to be used in program development as well as quality improvement.
- Healthcare Reform – Ensure the Division of Behavioral Health, through strategic planning and related efforts, is focused on positioning Nebraska to successfully implement mandatory elements of National Healthcare Reform by January 1, 2014. Federal legislation regarding the combination of Parity (2008) plus Healthcare Reform (2010) means the systems for delivering community based substance abuse services will be changing. It is essential for Nebraska to continue to focus on how those individuals in the priority populations will receive substance abuse treatment services. Aligning with healthcare organizations will remain a priority.

Goals and Objectives

The Division of Behavioral Health State Priorities for the intended use time period (FY2011 to FY2013) is reported on Form 7. The Form is based on the Nebraska's informed planning process and the self-identified service needs. The list was developed for the purposes of prioritizing system initiatives in the substance abuse system. However, the Division of Behavioral Health is currently engaged in a major strategic planning effort. The preliminary draft is due in November 2010.

1. Access/ Block Grant Requirement – Priority Populations
2. Access/ Block Grant Requirement – Interim Services Within 48 Hours
3. Access /System Coordination
4. Enhance Continuing Education / Capacity & Partnerships
5. Data Utilization / Partnership / ASI-CASI & Other Instruments
6. Focus on Prevention
7. Access and Retention / Technical Assistance
8. Waiting List / Data Management
9. Co-Occurring System of Care
10. Justice Behavioral Health
11. Data Management
12. Healthcare Reform

The Nebraska Form 7 – State Priorities for the intended use time period (FY2011 to FY2013) place a special focus on the four priority populations:

1. Pregnant Injecting Drug Users
2. Pregnant Substance Abusers
3. Injecting Drug Users
4. Women with Dependent Children

Continuous Quality Improvement Program

The Division of Behavioral Health has a Quality Improvement (QI) Program. The QI Manager is responsible to develop and implement the Continuous Quality Improvement (CQI) Program Plan. Under the Continuous Quality Improvement (CQI) Program Plan, this year there are two Quality Initiative Workgroups. One is on Co-Occurring Disorders Service Delivery and the other on a Performance Measure Proposal.

The Director and Administrator establish the priorities for the Annual CQI Plan. The Divisions Quality Improvement Team (DQIT) provides ongoing operational leadership of CQI activities. DBH staff members comprise the team and meetings are held on a bi-weekly basis. The Division of Behavioral Health’s Advisory Committees for Mental Health, Substance Abuse and the Gambler’s Assistance Program contribute to the development and implementation of the annual CQI plan and activities. The committees meet quarterly and advise DBH on the CQI Plan and initiatives.

The Stateside Quality Improvement Team (SQIT) was developed in 2009 in order to implement statewide quality initiatives that provide strategies aimed at improving the overall behavioral health system. The SQIT is comprised of consumers (50%), Regional Behavioral Health Authority staff, providers, the ASO, and representative from DHHS Division of Medicaid and Long-Term Care. This year the two initiatives that have been identified are

- 1) Co-Occurring Disorders Service Delivery
- 2) Consumer Survey Instruments(s) Review

Co-Occurring Disorders Service Delivery

The Division of Behavioral Health has a responsibility to meet consumer needs wherever they present in the DBH funded service system to promote recovery in those served. Through a collaborative effort, this quality initiative is intended to improve services to adults with co-occurring mental health and substance abuse disorders and their families.

- Goals/Desired Outcome: The Co-Occurring Disorders Quality Initiative will promote recovery of individuals and families by creating a statewide road map to a statewide, integrated co-occurring service delivery system.
- Work Plan and Timelines: The Workgroup will produce the following products by June 1, 2011:
 1. Current strengths of the service delivery system for serving individuals with co-occurring disorders
 2. Current barriers to the service delivery system for serving individuals with co-occurring disorders
 3. Recommended definitions related to co-occurring disorder treatment
 4. Recommended process and tools for identifying dual-capable and dual enhanced status of providers
 5. Recommended work plan for improving infrastructure that supports recovery for individuals with co-occurring disorders including:
 - a. Models to be considered

GOAL # 13. Intended Use - Assessment of Need for Treatment & Prevention | Oct 1, 2010 | pg 11

- b. Priority populations and service responsibilities
- c. Identification, welcoming and accessibility
- d. Standards of Care
- e. Workforce development, clinical competencies
- f. Clinical Infrastructure for continued improvement and case coordination
- g. Statewide training plan
- h. Funding/Financial reimbursement/processes
- i. Establishing/Monitoring performance improvements

The Chair of the Co-Occurring Disorders Service Delivery Quality Initiative Workgroup is Blaine Shaffer, MD, Chief Clinical Officer for the Division of Behavioral Health. Meetings will be held monthly in person when possible with the availability of webinar/videoconferencing and phone conferencing. Additional small group meetings may be needed. Subject matter experts may be invited to various meetings. The Team Members will be invited by DBH to ensure broad representation of participants.

Consumer Survey Instruments(s) Review

The SQIT Performance Measure Proposal involves the Priority Question of, “Do consumers perceive the services they receive have improved their quality of life?” This is consistent with the National Outcome Measure “Perception of Services/Care”.

Goal: 75% of consumers report services received improved their quality of life

Performance Measure:

$$\frac{\text{Numerator: Number of individuals responding with strongly agree or agree to question on Annual DBH survey}}{\text{Denominator: Total Number of Individuals Responding to Survey}}$$

Data Source: DBH – Annual Survey for Adults and Youth Contractor is DHHS Public Health/UNMC

Methodology:

- Question will be added to the DBH Annual Consumer Survey for Adults and Consumers. The survey will be administered by the contractor April 1, 2010 through September 2010.
- Random Sample of individuals that utilized a service during FY09 through December 31, 2010. Percentage of random sample based on utilization for MH/SA, youth/adult and capture for each region.
- Exclusions: Emergency services Not required

Reporting: Aggregate Summary to DBH analysis team by Fall 2010.

Community Quality Improvement Teams (CQIT) contributes to the development and implementation of CQI activities at the local level (provider, regional, organizational). Representatives will provide ongoing information and data exchange between the local level and the SQIT. The DBH QI Manager will coordinate technical assistance and QI study groups to ensure improvements are made at the local level on a timely basis.

M-QIT (Magellan Quality Improvement Team) is another important part of the system’s CQI effort. Magellan Behavioral Health provides Administrative Services Organization (ASO) under contract with DHHS. The Magellan contract required Division participation in the vendor’s Quality

[GOAL # 13. Intended Use - Assessment of Need for Treatment & Prevention | Oct 1, 2010 | pg 12](#)

Improvement Committee. DBH establish the M-QIT to improve data entry and data quality related issues. Goals of the Committee include:

- Improving communication and coordination between the Division, Regions, Providers and Magellan;
- Developing an understanding of the work flows, systems and processes related to data and making recommendations for improvement;
- Establishing a mechanism for the identification, review and resolution of issues; and
- Reviewing reports and recommending content and format improvements to ensure the presentation of meaningful data.

Stakeholders on MQIT include providers, regions, consumers and staff from the vendor. The committee meets monthly. Participants have continued to voice an improved understanding of the data processes and have focused work in cleaning up the existing data system. The focus in the next year will be on understanding existing data reports and utilizing them to improve the services. Through the formal structure, on an annual basis, leaders and stakeholders will identify priority questions the system should answer to improve service delivery and outcomes for consumers and families. Annual goals will be established, performance measures selected, data will be reviewed and provide information for decision making and improvement.

Prevention Goals

1. Prevent the onset and reduce the progression of substance abuse, including underage drinking;
2. Reduce substance abuse related problems in communities; and
3. Build prevention capacities and infrastructure at the state/tribal and community levels;

Coalition County/Name	Priority Issue/Area		
	Underage Drinking	Binge Drinking	Impaired Driving
Sherman County	x		
Lancaster County/LAAP	x	x	x
Grand Island/Central NE	x		x
Southeast Nebraska	x	x	x
Holdrege/CNCASA	x		
Buffalo/Kearney	x	x	x
Panhandle	x	x	x
Lincoln County/North Platte	x	x	x
Ponca	x		
Elkhorn/HCI	x	x	x
North Central/O'Neill	x		x
Hastings/AASAP/South Central	x	x	
LiveWise		x	
Otoe/Nebraska City/People United	x		x
East Central/Columbus	x		
Omaha Nation	x		
	15	8	9

Source: Nebraska SPF-SIG: Evaluation Update Prepared by: Mindy Anderson-Knott, Phillip W. Graham & Monique Clinton-Sherrod, RTI International & UNL (September 23, 2010)

[GOAL # 13. Intended Use - Assessment of Need for Treatment & Prevention | Oct 1, 2010 | pg 13](#)

The Division of Behavioral Health is committed to meeting the requirements of the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) promoting improved services and efficiency.

1. The array of substance abuse services are based on a documented needs assessment and corresponding strategic planning.
2. The Nebraska Behavioral Health System collects and utilizes data in the planning and monitoring of substance abuse services.
3. Regional staff and providers demonstrate knowledge of SAPTBG requirements concerning interim services. Waitlist management occurs, and interim services are provided to priority populations. This is documented and made easily accessible. The Annual Summary for the Nebraska Substance Abuse Capacity and Waiting List Report as of September 2010 is under [Appendix / Addendum - Additional Supporting Documents \(Optional\)](#).
4. Regions encourage and assist providers offering services to pregnant women and women with dependent children to:
 - a. Be qualified as defined by federal regulation, and
 - b. Demonstrate continuity of care in the consumer's written record.

Capacity and Waiting Lists

In 2009, the Division of Behavioral Health (DBH) completed the planning needed to implement a revised capacity management and waiting list systems for intravenous drug users and pregnant women. The new design has the Behavioral Health Network Providers reporting to Regional Behavioral Health Authority (RBHA) who are the intermediaries – regional entity, who then reports to DBH as the Single State Agency. The weekly reports on capacity include priority persons on waiting lists. In August 2009, Waiting List/Capacity Management procedures and forms were approved. Training was completed for RBHA's and Providers on September 25, 2009. Implementation of the revised Waiting List/Capacity Management system was on October 5, 2009.

As originally designed, each program reports via excel spreadsheets the number of persons and percent of total and regional capacity to the RBHA on Monday of each week. Capacity and waiting list forms are forwarded to the Statistical Analyst at the Division of Behavioral Health on Tuesday afternoons. Division Data Team members are assigned primary responsibility to review and aggregate reports and identify opportunities to improve waiting list management and address capacity issues. The information is also reviewed by the Division's Network Management team and with the RBHA's.

The Weekly Substance Abuse Capacity and Waiting List spreadsheets from each region include the total capacity of the agencies, regional purchased capacity at the time of the submission and percent of both total and regional capacity that is occupied. Each agency lists the number of persons on the total and regional waiting lists followed by the number within each priority populations for the regional capacity. The data also contains weekly substance abuse priority waiting list break outs by region by service, interim service provision and reason for removal from the waiting list.

The annual contract between the Division of Behavioral Health and the Regional Behavioral Health Authority establish the reporting requirements. These contracts also contain additional interim service language. Outreach activities continued to be spelled out in the contract. The contracts stated that IV-drug abusing clients shall be admitted within 14 days of request for treatment, or if no services are available, must be provided with interim services within 48 hours and admitted to treatment with 120 days. Interim services were now defined in the contract.

[GOAL # 13. Intended Use - Assessment of Need for Treatment & Prevention | Oct 1, 2010 | pg 14](#)

Contractors and subcontractors were required to report to DBH whenever full (90%) capacity is reached and/or if an IV-drug abusing client is unable to be admitted to service.

For more details, see Capacity Management and Waiting List Systems (formerly Attachment G).

Summary Reports from the Waiting List and Capacity Management Systems

The Division of Behavioral Health implemented a revised Capacity Management and Waiting List System on October 5, 2009. To see the Annual Summary for the Nebraska Substance Abuse Capacity and Waiting List Report as of September 2010 go to [https://bgas.samhsa.gov/2011/Appendix / Addendum - Additional Supporting Documents \(Optional\)](https://bgas.samhsa.gov/2011/Appendix%20-%20Addendum%20-%20Additional%20Supporting%20Documents%20(Optional)).

List Of The Entities That Provide The Services With Description Of The Services Provided.

Nebraska Substance Abuse Treatment and Prevention Providers Approved by the Regional Behavioral Health Authority and Funded by Division of Behavioral Health as of September 27, 2010 are listed in **Appendix A - Additional Supporting Documents (Optional)**.

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

FY 2008 (Annual Report/Compliance)

Who

(1) The State is required to submit to the Secretary an assessment of the need in the State for authorized activities, both by locality and by the State in general. The State is to submit data which shows the incidence and prevalence in the State of drug abuse and the incidence and prevalence in the State of alcohol abuse and alcoholism.

The Division of Behavioral Health completed an assessment of the need by locality and by the State in general. This work was completed with the Nebraska Behavioral Health Services Act (Neb. Rev. Stat. §§ 71-801 to 71-830) definition of the term "Behavioral Health Disorder" in mind. Under the Act, the term "Behavioral Health Disorder" means mental illness or alcoholism, drug abuse, problem gambling, or other addictive disorder [Neb. Rev. Stat. §71-804(1)].

As reported under Form 8 (Treatment Needs Assessment Summary Matrix), the Division of Behavioral Health shows the incidence and prevalence in the State of drug abuse, alcohol abuse and alcoholism. This is summarized below under Column 3: Total Population In Need.

Region	1. Substate planning area	2. Total population Census data (estimated 2008)	3. Total Population In Need	
			A. Needing treatment services	B. That would seek treatment
1	Panhandle	85,813	7,723	494
2	Southwest	99,148	8,923	571
3	South Central	223,379	20,104	1,287
4	Northeast	204,799	18,432	1,180
5	Southeast	436,512	39,286	2,514
6	Omaha Metro	733,781	66,040	4,227
	State Total	1,783,432	160,509	10,273

Number of persons to be served

The estimated 2008 population for the State of Nebraska is 1,783,432. The National Survey on Drug Use and Health (NSDUH) data estimated 9.0 percent of the population aged 12 or older needed treatment services. Using 2008 estimated Nebraska census data, that means 160,509 people need treatment. Within this group, NSDUH estimated 93.6% did not feel they needed treatment. Of the remaining group, 4.6 percent felt they needed treatment and did not make an effort to get treatment, and 1.8 percent felt they needed treatment and made an effort to get treatment. Based on that number, it suggests 6.4% would seek treatment, suggesting 10,273 could potentially do so voluntarily. Many in the 93.6% that did not feel they needed treatment and the 4.6 percent that felt they needed treatment and did not make an effort could end up in services due to involuntary mechanisms such as court orders. (For more details, see forms 8 & 9.)

During January 2008 through June 2009, preliminary data for the Gamblers Assistance Program (GAP) shows a high proportion of clients with gambling addictions and substance abuse problems.

GOAL #13: Compliance - Assessment Of Need For Both Treatment And Prevention /
September 27, 2010 / Page 2

Current findings show that 36.8% (n = 134 of 364) of GAP consumers treated reported problems related to substance use. The most frequent substance used by GAP clients is alcohol (53.7%), followed by marijuana/hashish/pot (17.2%) and methamphetamine (14.2%). Reported data warrants further development and research of co-occurring disorders among those experience problem gambling and substance abuse.

(2) The State shall provide a description on current substance abuse prevention and treatment activities

Nebraska Behavioral Health Services Act (Neb. Rev. Stat. §§ 71-801 to 71-830) establishes the framework for the provision of behavioral health services in Nebraska. For example, § 71-806 (1) designates the Division of Behavioral Health as the Chief Behavioral Health Authority for the State of Nebraska. The primary role involves State administration and management of non-Medicaid public behavioral health services through Regional Behavioral Health Authority and direct service contracts. In that capacity, the Division provides a state leadership role as the Single State Authority.

The Nebraska Behavioral Health Services Act established the Regional Behavioral Health Authority (RBHA). Under §71-807, the Act assigns all 93 counties to one of six Behavioral Health Regions. Each RBHA is governed by a Regional Governing Board consisting of one county board member (locally elected official) from each county in the region. The administrator of the RBHA is appointed by the Regional Governing Board.

Region	Substate Planning Area (SPA)	Regional Office	Counties	Total population Census data (estimated 2008)	% of population
1	Panhandle	Scottsbluff	11	85,813	4.80%
2	West Central	North Platte	17	99,148	5.60%
3	South Central	Kearney	22	223,379	12.50%
4	Northeast & North Central	Norfolk	22	204,799	11.50%
5	Southeast	Lincoln	16	436,512	24.50%
6	Eastern	Omaha	5	733,781	41.10%
Totals			93	1,783,432	100%

The Division of Behavioral Health contracts with the six Regional Behavioral Health Authorities for community substance abuse services. Each county in a behavioral health region provides funding as match against state general funds for the operation of the behavioral health authority and for the provision of behavioral health services in the region. The Act prohibits the Regions from directly providing services except under very limited circumstances. §71-809 (2) does provide exceptions. One exception is a Regional Behavioral Health Authority may continue to directly provide services it operated on July 1, 2004.

What

The RBHA is responsible for the development and coordination of publicly funded behavioral health services in the region pursuant to rules and regulations of the Department (DHHS). The Division of Behavioral Health contracts with the RBHA to purchase services using the funds received under the Federal Substance Abuse Prevention and Treatment Block Grant (SAPTBG).

Under Form 7b (Number of persons served for alcohol and other drug use in state funded services) for FY2009 there were 19,949 Unduplicated Count of Persons Served in Substance Abuse Programs funded by the Division of Behavioral Health. This includes clients who received only substance abuse services and clients who received mental health and substance abuse services.

Current Substance Abuse Treatment Activities

Target Population:

The DBH provides treatment services through contracts with the six Regional Behavioral Health Authorities (RBHA) who contract with community providers to serve individuals who meet the clinical criteria for substance dependence as outlined in Diagnostic and Statistical Manual, Fourth Edition, Text Revision (DSM-IV-TR).

Access to treatment is prioritized giving preference to the following priority populations:

1. Pregnant Injecting IV Drug Users
2. Pregnant Substance Users
3. Injecting Drug Users
4. Women with Dependent Children

Initial Adult Substance Abuse Assessment/Clinical Assessment and Placement

On July 1, 2009, the DBH implemented a new strategy to improve the process for priority populations to access treatment services who had not received a substance abuse assessment. Individuals from the 4 identified priority populations will now be given an appointment for an evaluation within 48 hours of their request for treatment and will receive a substance abuse evaluation within 7 business days. Based upon the Adult Criteria of the Patient Placement Criteria for the Treatment of Substance-Related Disorders of the American Society of Addiction Medicine, Second Edition Revised (ASAM PPC-2R), individuals will be referred to the appropriate level of care and receive treatment immediately. All Initial Adult Substance Abuse Assessment Reports must include the use AND results of at least one of the following nationally accepted screening instruments. The instruments may be electronically scored if indicated acceptable by author:

- SASSI (Substance Abuse Subtle Screening Inventory)
- TII (Treatment Intervention Inventory)
- SUDDS (Substance Use Disorder Diagnostic Schedule)
- MADIS (Michigan Alcohol Drug Inventory Screen)
- MAST (Michigan Alcoholism Screening Test)
- MINI (Mini International Neuropsychiatric Interview)
- WPI (Western Personality Interview)
- PBI (Problem Behavior Inventory)
- RAATE (Recovery Attitude and Treatment Evaluator)
- CIWA (Clinical Institute Withdrawal Assessment)

The ASI (Addiction Severity Index) is required to be used as a face-to-face structured interview guide, to be scored and utilized to provide information for the biopsychosocial assessment/substance abuse evaluation and the multidimensional risk profile.

Level I: Outpatient (Individual, Family, Group and Community Support)

Level II.1: Intensive Outpatient

Level II.5: Partial Hospitalization (Partial Care)

Level III.1: Clinically Managed Low Intensity Residential (Halfway House)
 Level III.3: Clinically Managed Medium Intensity Residential
 (Intermediate Residential, Therapeutic Community)
 Level III.5: Clinically Managed High Intensity Residential (Short Term
 Residential, Dual Disorder Residential – III.5 Enhanced)
 Level III.7: Medically Monitored Intensive Inpatient Services
 Level II.D: Ambulatory Detoxification
 Level III.2D: Clinically Monitored Residential Detoxification (Social Detox)
 Level III.7D: Medically Monitored Inpatient Detoxification
 Opioid Replacement Therapy - Identifies whether or not the use of methadone or buprenorphine is
 part of the client's treatment plan for opioid addiction.

(For more details, see Goal #1: Continuum of Substance Abuse Treatment Services)

Current Substance Abuse Prevention Activities

As DHHS moves forward with a new direction for children's behavioral health, the prevention system will be interwoven as an integral component of this vision. To this end, the current activities of recent years will continue, but with a particular emphasis on strategic planning as the SPF-SIG coalitions move into implementation, as our Regional Prevention System Coordination further develops their role and as we utilize planning with our multiple system partners to identify the strengths and opportunities across the state. Attention will be paid to the Epidemiological Study, a Substance Abuse Needs Assessment, the SPF-SIG process results and other prevention partner's initiatives as well as the entire behavioral health system's structure. The result will be a more defined prevention system goal.

The Division of Behavioral Health activities include but are not limited to:

- facilitate the ongoing work of a State SYNAR/Tobacco Work Group in order to reduce the number of such illegal sales to minors.
- collaborate with Tobacco Free Nebraska and other State Prevention System partners to develop additional strategies to promote regional and local participation in SYNAR compliance, including environmental and merchant education strategies.
- contract with the Nebraska State Patrol, local law enforcement agencies, and other appropriate substance abuse prevention entities to coordinate and/or conduct compliance checks on tobacco retailers.
- contract with Regional Behavioral Health Authorities for prevention system coordination, training and technical assistance via a Prevention Coordinator in each of the six regions.
- participate in development of the epidemiological study for the state and for the regions that identifying areas of greatest need.
- with regional Prevention Coordinators will fund training events throughout the state to introduce, enhance and improve the use of evidence based, promising and local prevention strategies; in particular to support their local community goals for the reduction of underage drinking, reduction of driving under the influence and reduction of binge drinking.
- collaborate with the Division of Public Health and the Division of Children and Family Services to promote a system of care that includes prevention activities. This will support the 'flip of the pyramid' with a purposeful intention of providing a more integrated and comprehensive behavioral health system of care for children, youth and adolescents.

- The Divisions of Behavioral Health and Public Health will
 - o make available data for community planning designed to provide decision making support to community coalitions.
 - o support the Nebraska Prevention Information Reporting System
 - o provide guidance and funding in support of a statewide prevention conference that invites all prevention entities to foster networking among community coalitions, prevention professionals and agencies.
 - o facilitate the implementation of the Nebraska Risk and Protective Factor Survey in FY2010.

(For more information, see Goal #2 on primary prevention programs and the activities for each of the strategies.)

When

This work is continuously being addressed.

How

Description of current prevention and treatment activities in the State

The funds related to prevention and treatment were used for the following activities:

- Substance Abuse Prevention and Treatment
- Primary Prevention
- Tuberculosis Services
- HIV Early Intervention Services

Description of Treatment Capacity

Details of treatment capacity are reported on Form 6 - Substance Abuse Entity Inventory. This report includes the Entity Number, I-SATS ID, the Area Served, the State Funds allocated, the SAPT Block Grant Funds for Substance Abuse Prevention and Treatment Services allocated, a specific report of the SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children, funds for the SAPT Block Grant Funds for Primary Prevention. There are no funds allocated from the SAPT Block Grant Funds for Early Intervention Services for HIV.

Primary Prevention Activities

Nebraska facilitates a number of strategies as noted on Form 6a Prevention Strategy Report (as of 9/2/2009), primary prevention activities include Disseminate A/V Material, Printed Material, Curricula, Newsletters and related content; Accessing services and funding; use of clearinghouse/information resources centers; community and volunteer training (such as neighborhood action training, impactor training, staff/officials training); Community drop-in centers, Community service activities, Community team-building; education programs for those who were driving while under the influence and/or driving while intoxicated; drug free dances and parties; education programs for youth groups; Employee Assistance Programs; guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use; health fairs and other health promotion, e.g., conferences, meetings, seminars; Information lines/Hot lines; media campaigns; ongoing classroom and/or small group sessions; parenting and family management; Peer leader/helper programs; Preventing Underage Sales of Tobacco and Tobacco Products per the SYNAR Amendment; Prevention Assessment and Referral Attendees; Promoting the establishment of review of alcohol, tobacco, and drug use

GOAL #13: Compliance - Assessment Of Need For Both Treatment And Prevention /
September 27, 2010 / Page 6

policies in schools; Recreation activities; Resources directories; Speaking engagements; Student Assistance Programs; Systematic planning; Technical Assistance Services; tobacco, and drug use policies in schools; Youth/adult leadership activities; and related activities.

(3) The State shall provide the identities of the entities that provide the services and describe the services provided.

The current list of substance abuse providers can be found under the Provider Table including the Inventory of Substance Abuse Treatment Services (I-SATS) ID number. That table is attached to this document. Form 6 – Substance Abuse Entity Inventory provides

- SAPT Block Grant Funds for Substance Abuse Prevention and Treatment Services
- SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children
- SAPT Block Grant Funds for Primary Prevention

(4) The State shall submit information on **treatment utilization** to describe the type of care and the utilization according to primary diagnosis of alcohol or drug abuse, or a dual diagnosis of drug and alcohol abuse.

Form 7A - Levels of Care (Treatment Utilization Matrix)

Substance Abuse Services Funded by the Division of Behavioral Health

For treatment services provided with an initial admission to an episode of care during the 12-month State Expenditure Period of FY2008

Level of Care	A. Number of Admissions	B. Number of Persons Served
Detoxification (24-Hour Care)		
1. Hospital Inpatient	0	0
2. Free-Standing Residential	6,429	4,363
Rehabilitation/Residential		
3. Hospital Inpatient	259	149
4. Short-term (up to 30 days)	1,590	999
5. Long-term (over 30 days)	1,156	328
Ambulatory (Outpatient)		
6. Outpatient	13,872	9,951
7. Intensive Outpatient	1,851	1,287
8. Detoxification	0	0
Opioid Replacement Therapy		
9. Opioid Replacement Therapy	300	280

Source: Division of Behavioral Health (September 2009)

Footnote for Form 7a: As part of a quality initiative regarding data (January 2009), the Division of Behavioral Health administratively discharged nearly 18,000 admissions from our data system. These admission records had no activity in the last year. The DBH worked closely with providers, the six Regional Behavioral Health Authorities (RBHA), and the DBH Administrative Services Only (ASO)/Managed Care Company throughout this process in an attempt to update our data system and ensure the most accurate data possible.

Opioid Replacement Therapy - Identifies whether or not the use of methadone or buprenorphine is part of the client’s treatment plan for opioid addiction.

(The DBH is considering changing the terminology “Opioid Replacement Therapy” to “Medication Assisted Treatment” at the recommendation of the Division’s Chief Clinical Officer. This recommendation will be reviewed in 2010. The SAPT Block Grant, under the Treatment Episode Data Set (TEDS), uses the term "Opioid Replacement Therapy" (ORT). Under TEDS, ORT “Identifies whether or not the use of methadone or buprenorphine is part of the client’s treatment plan for opioid addiction.”)

(5) The State may describe the **need for technical assistance** to carry out Block Grant activities, including activities relating to the collection of incidence and prevalence data identified in paragraph (a)(1) of this section.

- **Technical Assistance on Strategic Planning**. The Division of Behavioral Health completed Behavioral Health Reform by downsizing state psychiatric hospitals and moving the funds into the community. Substance Abuse was included in the effort, however, the primary emphasis was on the mental health system. This should include exploring the further use of telemedicine and related communications technology to expand the reach of substance abuse treatment. This should also include improvement in the use of data for program development and improvement.
- **Co-Occurring Mental Health / Substance Abuse issues** – the Unduplicated Count of Persons Receiving Services Funded by the Division of Behavioral Health in SFY2009, all clients served in mental health and/or substance abuse services was 37,669. Of this number, 19,949 (53%) were Substance Abuse ONLY Clients or Co-occurring Clients. Only 5,095 (14%) were reported as "Substance Abuse ONLY Clients". This suggests the Division of Behavioral Health needs to improve upon the services available for this population.
- **Rate Setting Methods for Community Substance Abuse Services** – the Division of Behavioral Health needs assistance on updating the rate setting methods used for purchasing substance abuse services in Nebraska. This rate setting method needs to take into account the issues involved in providing proper services to people with Co-occurring substance abuse and mental health problems.
- **Recovery Oriented Systems of Care** – part of Behavioral Health Reform included a focus on consumers of Behavioral Health services, including substance abuse. The Division of Behavioral Health needs to improve its oriented to the basic concepts of Recovery Oriented Systems of Care. This needs to include a community level focus on recovery oriented systems of care, peer support and other related areas now being developed under the leadership of the Office of Consumer Affairs (in the Division of Behavioral Health) as well as the Consumer Specialists within the six Regional Behavioral Health Authorities.
- **Development of a Data Strategy** – the Division of Behavioral Health needs to develop a long term data strategy in order to work with the rate setting mechanism as well as a sustainable method for collecting the data needed for the National Outcome Measures. This needs to include improving the infrastructure for collecting, storage, analysis and reporting of the data to be used in program development as well as quality improvement.

(6) The State shall establish **goals and objectives** for improving substance abuse treatment and prevention activities and shall report activities taken in support of these goals and objectives in its application.

Goal: develop a better approach to make data driven decisions as part of the Division of Behavioral Health’s Quality Improvement work:

1. Development of a National Outcome Measures (NOMs) report for the Regions and providers. The Division of Behavioral Health is committed to improving the quality of substance abuse services. This needs to include providing a feedback loop to the Regional Behavioral Health Authorities and the providers. This focus will also support the efforts to improvement the needs assessment both by locality and by the State in general.
2. Co-occurring Mental Illness and Substance Use Disorders – as reported above, the Unduplicated Count of Persons Receiving Services Funded by the Division of Behavioral Health in SFY2009, only 5,095 (14%) were "Substance Abuse ONLY Clients". This suggests the Division of Behavioral Health needs to improve the capacity to serve this population.
3. Consumer survey – the Division of Behavioral Health needs to review and update methods used to collect and report the consumer survey. The Division of Behavioral Health has received reports from various sources about the number of different consumer surveys completed annually. Each provider needs to complete a form of consumer survey. The Division of Medicaid and Long Term Care uses the Magellan Health Services, the Administrative Services Only Managed Care provider, to do a consumer survey. The Division of Behavioral Health completes an annual survey, which includes substance abuse clients, for the Federal Community Mental Health Services Block Grant. The Division of Behavioral Health intends to review these surveys and explore the possibility of streamlining the survey process. The improved survey method should then produce data that can be used at the local, Regional and State levels for quality improvement. It should also provide a feedback loop to the Nebraska Behavioral Health System.

GOAL: Standards of Care by Episodes of Care. This is the updating and development of the appropriate standards of care. There are already service definitions. These need to be updated. In addition, the system for the Standards of Care by Episodes of Care being used by the Administrative Services Only Managed Care provider need to be improved.

Prevention Goals

1. Prevent the onset and reduce the progression of substance abuse, including underage drinking;
2. Reduce substance abuse related problems in communities; and
3. Build prevention capacities and infrastructure at the state/tribal and community levels;

The Division of Behavioral Health is committed to meeting the requirements of the Substance Abuse Prevention and Treatment Block Grant (SAPTBG). Areas of deficiency noted in the 2007 Core Technical Review will be resolved, promoting improved services and efficiency.

1. The array of substance abuse services will be based on a documented needs assessment and corresponding strategic planning.
2. The Nebraska Behavioral Health System will collect and utilize data in the planning and monitoring of substance abuse services.
3. Regional staff and providers will demonstrate knowledge of SAPTBG requirements concerning interim services. Waitlist management will occur, and interim services will be provided to priority populations. This will be documented and made easily accessible.
4. Regions will encourage and assist providers offering services to pregnant women and women with dependent children to:
 - a. Become qualified as defined by federal regulation, and
 - b. Demonstrate continuity of care in the consumer's written record.

Capacity and Waiting Lists

The Division of Behavioral Health is implementing an improved method for collecting and managing the capacity monitoring and waiting list. This new approach is being implemented starting on October 5, 2009. The first data reports will be received October 12, 2009. As a result, for the intended use time period, there are no data for a summary of such information for admissions / discharges or to indicate areas availability of prevention and treatment activities of insufficient capacity to meet the need. As these reports become available, there will be special attention should be provided to the following groups:

1. Pregnant Injecting Drug Users
2. Pregnant Substance Abusers
3. Injecting Drug Users
4. Women with Dependent Children

This is a description of the State's management information system pertaining to capacity and waiting lists. Under Attachment G: Capacity Management and Waiting List Systems, there is the description of how the Division of Behavioral Health is implementing the new methods. As the system is implemented, there will be documentation on when services are insufficient to meet the need and a summary of such information capacity and waiting lists. The official start of this new waiting list system is October 5, 2009. The first data will be reported to the Division of Behavioral Health on October 12, 2009. Once the data reporting starts, it will be review on the weekly conference call with the six Regional Behavioral Health Authorities. Also, there will be monthly data reports to summarize the trends prepared by the Division of Behavioral Health.

This is part of the plan of correction efforts. In April 2009, the Division of Behavioral Health worked with the Regional Behavioral Health Authorities (RBHA) to amend the annual contract. The RBHA also amended their provider subcontracts. Contracts contained additional interim service language. Outreach activities continued to be spelled out in the contract. The contracts stated that IV-drug abusing clients shall be admitted within 14 days of request for treatment, or if no services are available, must be provided with interim services within 48 hours and admitted to treatment with 120 days. Interim services were now defined in the contract.

The RBHA and subcontractors were required to report to DBH whenever full (90%) capacity is reached and/or if an IV-drug abusing client is unable to be admitted to service.

In August 2009, a Waiting List/Capacity Management procedures and forms were approved. Training was completed for RBHA's and providers on September 25, 2009. Implementation of the new Waiting List/Capacity Management system will be October 5, 2009.

The procedures and forms specify that the individuals from the priority populations who have requested treatment, but who have not had a substance abuse assessment completed within the last 6 months, must have an appointment for a substance abuse assessment within 48 hours from time of request, and must receive the actual assessment within 7 business days of the appointment. The waiting list clock starts when a client completes the assessment process and a recommendation for treatment is made. This will ensure that individuals from the priority populations receive timely access to assessment and treatment services.

When individuals from the priority populations cannot immediately receive treatment as documented in the recommendations of the substance abuse assessment, and as outlined in the

**GOAL #13: Compliance - Assessment Of Need For Both Treatment And Prevention /
September 27, 2010 / Page 10**

ASAM (American Society of Addiction Medicine) Patient Placement Criteria; the individual must receive Interim Services and be placed on waiting list for treatment.

The weekly SA Capacity Report and weekly SA Priority Waiting List/Interim Services Report will be completed and updated by the Behavioral Health Network Providers and be submitted to the Regional Behavioral Health Authority each week on the date established by the region. The Regional Behavioral Health Authorities will collect, analyze, and aggregate this data. Every Tuesday, the RBHA will provide the aggregated report to the Division of Behavioral Health’s designated staff via email. The Division will analyze and aggregate this data in order to report on the available capacity (purchased and unpurchased) for substance abuse treatment services. The reports serve as notification to the DBH when programs reach 90 percent of its capacity and DBH will receive such reports within 7 days of reaching 90 percent capacity.

The Division will hold a weekly phone conference to direct both providers and Regional Behavioral Health Authorities to agencies across Nebraska who has available capacity, should a specific level of care not be available in one area of the state.

Information will also be monitored via the Weekly SA Capacity Report and Weekly SA Priority Waiting List/Interim Services Report that indicate when individuals are placed on the waiting list and when individuals are able to be removed from the waiting list.

Regional Behavioral Health Authorities will monitor this information in order to track data regarding “length of time” individuals are waiting to access services. This data will assist our system during our annual budget planning process. The Capacity Reports will also track to ensure that all individuals who are on the waiting list are also receiving the required Interim Services.

Note: All information provided on the Weekly SA Reports will be done so in a manner that does not identify the individual. A unique consumer identifier containing the first four characters of the last name + date of birth (YYYYMMDD) + the last four numbers of the social security number. The unique identifier should help DBH sort out individuals who may be duplicated among waiting lists.

Providers must maintain contact with individuals on the waitlist a minimum of every 7 days from the initial screening.

Summary Reports from the Waiting List and Capacity Management Systems

As demonstrated in the table below the State of Nebraska’s capacity and waiting list information system is documenting the continued need for additional treatment expansion and that agencies are maintaining waiting lists. Each of the Regions is experiencing waiting lists with Region 5 and 6 having the largest proportion of persons waiting for services. The table below is a demonstration for selected months in the compliance and progress years showing a combination of Residential and Non-residential waiting list size. Residential capacity has been steady over the time period with the distribution of additional funds from LB1083 and emphasis by the state on the priority populations.

RESIDENTIAL

REGION	OCTOBER 06	JANUARY 07	APRIL 07	JUNE 07	JULY 07	OCTOBER 07	JANUARY 08
1	21	19	26	18	35	34	9
2	10	7	7	12	11	9	10

GOAL #13: Compliance - Assessment Of Need For Both Treatment And Prevention /
September 27, 2010 / Page 11

3	86	75	66	84	107	78	53
4		47		0	62	58	29
5	158	162	201	172	179	182	162
6	118	93	83	74	69	45	42
TOTALS	393	403	383	360	463	406	305

NON-RESIDENTIAL

REGION	OCTOBER 06	JANUARY 07	APRIL 07	JUNE 07	JULY 07	OCTOBER 07	JANUARY 08
1	5	5	5	0	0	0	0
2	0	0	0	0	0	0	0
3	73	56	55	80	38	42	41
4		66		0	21	22	31
5	209	236	261	209	210	191	173
6	176	128	213	211	204	434	349
TOTALS	463	491	534	500	473	689	594

RESIDENTIAL & NON-RESIDENTIAL COMBINED

REGION	OCTOBER 06	JANUARY 07	APRIL 07	JUNE 07	JULY 07	OCTOBER 07	JANUARY 08
1	26	24	31	18	35	34	9
2	10	7	7	12	11	9	10
3	159	131	121	164	145	120	94
4	0	113	0	0	83	80	60
5	367	398	462	381	389	373	335
6	294	221	296	285	273	479	391
TOTALS	856	894	917	860	936	1095	899

As demonstrated in the tables above the State of Nebraska continues to experience capacity issues as reflected in nearly 900 persons waiting to access the treatment system in January 2008. This continues to demonstrate the need for additional coordination of activities among treatment providers and the relative capabilities of the providers to address priority populations. Special emphasis has been given to priority populations, but with waiting lists as extensive as those presented, last minute admissions have been the norm rather than the exception.

(7) As to prevention activities, the report shall include a description of the populations at risk of becoming substance abusers.

Based on the Form 6a Prevention Strategy Report (as of 9/2/2009) the risk populations include but are not limited to, Children of Substance Abusers, Pregnant Women/Teens, Violent and Delinquent Behavior, Mental Health Problems, Economically Disadvantaged, Physically Disabled, People Already Using Substances, Homeless and/or Run away Youth, Business and Industry, Civic Groups/Coalitions, College Students, Older Adults, Elementary School Students, Health Professionals, High School Students, Middle/Junior High School Students, Parents/Families, Preschool Students, Prevention/Treatment Professionals, Religious Groups,

Teachers/Administrators/Counselors, Youth/Minors, and Law Enforcement/Military. See Form 6a Prevention Strategy Report for more details.

Substance abuse prevention efforts occur at both the state and community levels within Nebraska.

State level: As part of the Strategic Prevention Framework-State Incentive Grant (SPF-SIG) efforts, Nebraska's external evaluator, Research Triangle Institute (RTI) is conducting annual data collection at the state level using the SAMHSA developed Grantee Level Instrument (GLI) as well as the Systems Integration Interview (SII) tool that was developed by RTI. The SII is designed to measure how well the NDHHS Divisions of Public Health and Behavioral Health collaborate on substance abuse prevention as well as how both divisions interact with the Behavioral Health Regional Prevention staff.

Community level: Under the SPF-SIG, each community has hired an external evaluator to assist them with data collection and reporting. Coalition staff and local evaluators work together to develop evaluation plans for the community as well as collect and report evaluation related data to the coalition and to the state and RTI. As part of the broader evaluation, the SPF-SIG and Block Grant programs have been collaborating to assess the policies, programs, and practices currently being used within Nebraska in an effort to ensure that prevention and evaluation are coordinated to the best extent possible across the state. To help accomplish this, both divisions are currently working on improving the www.npirs.org website, the online reporting site for block grant and eventually SPF-SIG recipients.

The Nebraska Substance Abuse Epidemiology Workgroup (NSAEW), formed in March 2007, is a workgroup of administrators, epidemiologists, and key decision makers who collaborate to make decisions regarding the collection and reporting of data related to substance abuse, consequences of substance abuse, and factors that contribute to substance abuse in the State of Nebraska. Work completed by the NSAEW has and will continue to guide decision making around substance abuse prevention in the state, including decisions made by the Nebraska Partners in Prevention (NEPiP), the Governor's Advisory Council for substance abuse prevention.

The initial tasks of the NSAEW included creating an epidemiological profile report on substance abuse in Nebraska and establishing a set of criteria to facilitate the selection of the SPF-SIG substance abuse prevention priorities. This information served as the foundation for the development of the Nebraska Substance Abuse Strategic Plan.

To complete this work, the NSAEW completed the following steps. First, substance abuse data sources within Nebraska were identified by completing an inventory of available data. Second, data constructs were identified and used to organize data sources and data reporting. The constructs were separated by consequences (e.g., mortality, medical care, motor vehicle crashes, legal consequences, etc.) and consumption (e.g., lifetime use, current use, excessive use, etc.). Lastly, data indicators were selected through group discussion and NSAEW member supplemental online indicator scoring. The following items were considered as part of the indicator selection process: data quality, state level data availability, national comparison, trend availability, future collection plans, and sample size or number of cases.

The NSAEW continues to discuss data sources and gaps and their relation to ongoing data planning and reporting. As part of this process, the NSAEW will be updating the content of the

epidemiology profile report within the next year and will continue to pursue opportunities to collect and report both state and community level data.

Attachment

Inventory of Substance Abuse Treatment Services (I-SATS) ID number

Region Approved Providers

Substance Abuse Service

Funded by Division of Behavioral Health

Region	Provider (ISATS NUMBER)	SA Approved Service
1	Region 1 Behavioral Health Authority (NE300205) 4110 Avenue 'D' Scottsbluff, NE 69361 (308) 635-3171	Emergency Community Support -- MH or SA House Related Service -- SA Crisis Response Peer Support -- MH or SA Regional Prevention Coordination - SA
1	Behavioral Health Specialists (NE301302) 600 S. 13th Norfolk, NE 68701 (402) 370-3140	Short Term Residential - SA
1	Human Services, Inc.(NE900699) 419 West 25th Street Alliance, NE 69301 (308) 762-7177	24 Hour Crisis Phone Crisis Assessment/Evaluation - SA (LADC) Social Detoxification Community Support - SA Short Term Residential - SA Intensive Outpatient - SA Outpatient Therapy - SA
1	North East Panhandle Substance Abuse Center (NE100605) 305 Foch St. P.O. Box 428 Gordon, NE 69343 (308) 282-1101	Social Detoxification Short Term Residential - SA Intensive Outpatient - SA Outpatient Therapy - SA Community Support - SA
1	Panhandle Mental Health Center (NE100596) 212 Box Butte Ave. Alliance, NE 69301 (308) 635-3171	Outpatient Therapy - SA
1	Panhandle Mental Health Center (NE300205) 4110 Avenue 'D' Scottsbluff, NE 69361 (308) 635-3171	24 Hour Crisis Phone Crisis Assessment/Evaluation - SA Community Support - SA Intensive Outpatient - SA Outpatient Therapy - SA Youth Outpatient Therapy - SA
1	Panhandle Mental Health Center (NE100408) 2246 Jackson Avenue Sidney, NE 69162 (308) 635-3171	Outpatient Therapy - SA Intensive Outpatient - SA
1	Panhandle Substance Abuse Council (NE900863) 1517 Broadway, Suite 124	Regional Prevention Coordination - SA Community Prevention - Panhandle

**GOAL #13: Compliance - Assessment Of Need For Both Treatment And Prevention /
September 27, 2010 / Page 15**

Region	Provider (ISATS NUMBER) Scottsbluff, NE 69361 (308) 632-3044	SA Approved Service
1	Regional West Medical Center (NE101215) 4021 Avenue 'B' Scottsbluff, NE 69361 (308) 630-1500	Dual Residential (SPMI & CD)
2	Region II Human Services (NE900525) 307 E. 5th Lexington, NE 68850 (308) 324-6754	Regional Prevention Coordination - SA Crisis Assessment/Evaluation - SA (LADC) Urgent Assessment/Evaluation - MH or SA Urgent Outpatient Therapy - MH or SA (LADC) Emergency Community Support - MH or SA Community Support - SA Assessment/Evaluation - SA Outpatient Therapy - SA Outpatient Therapy Dual (SPMI & CD) Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA Youth Outpatient Therapy Dual (SED & CD)
2	Region II Human Services (NE900392) 1012 W. 3rd McCook, NE 69001 (308) 345-2770	Prevention Services Crisis Assessment/Evaluation - SA (LADC) Urgent Assessment/Evaluation - MH or SA Urgent Outpatient Therapy - MH or SA (LADC) Emergency Community Support - MH or SA Community Support - SA Day Rehabilitation Assessment/Evaluation - SA Outpatient Therapy - SA Outpatient Therapy Dual (SPMI & CD) Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA Youth Outpatient Therapy Dual (SED & CD)
2	Region II Human Services (NE900566) 110 N. Bailey Street North Platte, NE 69103 (308) 534-0440	Prevention Services Crisis Assessment/Evaluation - SA (LADC) Urgent Assessment/Evaluation - MH or SA Urgent Outpatient Therapy - MH or SA (LADC) Emergency Community Support - MH or SA Community Support - SA Assessment/Evaluation - SA Outpatient Therapy - SA Outpatient Therapy Dual (SPMI & CD) Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA Youth Outpatient Therapy Dual (SED & CD)
2	Region II Human Services (NE900574) 401 W. 1st	Prevention Services Crisis Assessment/Evaluation - SA (LADC)

GOAL #13: Compliance - Assessment Of Need For Both Treatment And Prevention /
September 27, 2010 / Page 16

Region	Provider (ISATS NUMBER) Address City, NE ZIP (Area) Phone-XXXX	SA Approved Service
	Ogallala, NE 69153 (308) 284-6767	Urgent Assessment/Evaluation - MH or SA Urgent Outpatient Therapy - MH or SA (LADC) Emergency Community Support - MH or SA Community Support - SA Assessment/Evaluation - SA Outpatient Therapy - SA Outpatient Therapy Dual (SPMI & CD) Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA Youth Outpatient Therapy Dual (SED & CD)
2	CenterPointe (NE301401) 2633 'P' Street Lincoln, NE 68503 (402) 475-8717	Dual Residential (SPMI & CD)
2	Great Plains Regional Medical Center (NE100213) 601 W. Leota St. North Platte, NE 69101 (308) 696-8000	Crisis Assessment/Evaluation - SA (LADC)
2	Regional West (NE101215) 4021 Ave. 'B' Scottsbluff, NE 69361 (308) 630-1500	Crisis Assessment/Evaluation - SA (LADC)
2	Richard Young Hospital (NE100118) 4600 17th Avenue Kearney, NE 68848 (308) 865-2202	Crisis Assessment/Evaluation - SA (LADC)
2	St Monica's Behavioral Health (NE101645) 120 Wedgewood Dr Lincoln, NE 68510 (402) 441-3767	Short Term Residential - SA Therapeutic Community - SA
2	Touchstone (NE000081) 1100 Military Road Lincoln, NE 68508 (402) 435-3165	Short Term Residential - SA
2	Goodwill Industries of Greater NE (NE100279) 1804 S. Eddy Grand Island NE 68801 (308) 384-7896	Emergency Community Support - MH/SA Community Support - SA
2	Houses of Hope (NE901242) 601 Cotner Blvd Lincoln, NE 68502 (402) 435-3165	Halfway House - SA

GOAL #13: Compliance - Assessment Of Need For Both Treatment And Prevention /
September 27, 2010 / Page 17

Region	Provider (ISATS NUMBER)	SA Approved Service
3	Region 3 Behavioral Services (NE100803) 4009 6th Avenue, Suite 65 Kearney, NE 68845 (308) 237-5113	Emergency Community Support - MH or SA Regional Prevention Coordination - SA
3	Behavioral Health Specialists/SOS (NE900707) 4432 Sunrise Place Columbus, NE 68601 (402) 564-9994	Social Detoxification Short Term Residential - SA
3	Buffalo County Community Partners Positive Pressure (NE100801) PO Box 1466 Kearney, NE 68848 (308) 865-2283	Prevention Services
3	Catholic Charities (NE100126) 3020 18th Street Columbus, NE 68601 (402) 829-9301	Dual Residential (SPMI & CD)
3	Central Nebraska Council on Alcoholism (NE750144) 219 W. 2nd Street Grand Island, NE 68801 (308) 385-5520	Prevention Services
3	Friendship House/Milne Detox (NE750151) 406 W. Koenig Street Grand Island, NE 68801 (308) 382-0422 / (308) 382-9451	Social Detoxification Halfway House - SA
3	Grand Island Substance Abuse Prevention Coalition (NE750144) 219 West 2nd St. Grand Island, NE 68801 (308) 385-5520	Prevention Services
3	Mary Lanning Memorial Hospital (NE100100) 715 N. St. Joseph Ave. Hastings, NE 68901 (402) 463-5973	Crisis Assessment/Evaluation - SA (LADC) Emergency Community Support - MH or SA
3	Mid-Plains Center for Behavioral Healthcare Services (NE301500) 914 Baumann Dr. Grand Island, NE 68801 (308) 385-5250	Outpatient Therapy Dual (SPMI & CD)
3	South Central Behavioral Services, Inc. (NE901192) 121 15th Ave.	Assessment/Evaluation - SA Outpatient Therapy - SA

**GOAL #13: Compliance - Assessment Of Need For Both Treatment And Prevention /
September 27, 2010 / Page 18**

Region	Provider (ISATS NUMBER) Franklin, NE 68939 (308) 237-5951	SA Approved Service Youth Outpatient Therapy - SA Youth Assessment/Evaluation - SA
3	South Central Behavioral Services, Inc. (NE750946) 616 W. 5th St. Hastings, NE 68901 (402) 463-5684	Intensive Outpatient - SA Assessment/Evaluation - SA Outpatient Therapy - SA Youth Intensive Outpatient - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
3	South Central Behavioral Services, Inc. (NE900517) 701 4th Ave., Suite 7 Holdrege, NE 68949 (308) 995-6597	Assessment/Evaluation - SA Outpatient Therapy - SA Youth Outpatient Therapy - SA Youth Assessment/Evaluation - SA
3	Goodwill Industries of Greater NE (NE100279) 1804 S. Eddy Grand Island NE 68801 (308) 384-7896	Emergency Community Support - MH/SA Community Support - SA
3	Garfield-Wheeler-Loop (GLW) Children's Council (NE100804) PO Box 638 455 Grand Avenue Burwell NE 68823 (308) 346-4284	SA Community Coalition
3	Mid Plains Center - Dual Program Box 34 Mason City NE 68855 (308) 385-5250	Dual Outpatient - MH/SA
3	South Central Behavioral Services, Inc. (NE301708) 3810 Central Avenue Kearney, NE 68847 (308) 237-5951	Community Support - SA Intensive Outpatient - SA Assessment/ Evaluation - SA Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Intensive Outpatient - SA Youth Outpatient Therapy - SA
3	South Central Behavioral Services, Inc. (NE900632) 510 East 10th St. Superior, NE 68978 (402) 463-5684	Assessment/Evaluation - SA Outpatient Therapy - SA Youth Outpatient Therapy - SA Youth Assessment/Evaluation - SA
3	South Central Substance Abuse Prevention Coalition (NE900921) 835 South Burlington, Suite 114 Hastings, NE 68901	Prevention Services

**GOAL #13: Compliance - Assessment Of Need For Both Treatment And Prevention /
September 27, 2010 / Page 19**

Region	Provider (ISATS NUMBER) (402) 463-0524	SA Approved Service
3	St. Francis Alcohol Drug Treatment Center (NE100216) 314 S. 14th St. Ord, NE 68862 (308) 728-3678	Assessment/Evaluation - SA Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
3	St. Francis Alcohol and Drug Treatment Center (NE100144) 315 S. 8th Broken Bow, NE 68822 (308) 872-6449	Assessment/Evaluation - SA Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
3	St. Francis Alcohol and Drug Treatment Center (NE900731) 2620 W. Faidley Ave Grand Island, NE 68801 (308) 398-5427	Short Term Residential - SA Intensive Outpatient - SA Assessment/Evaluation - SA Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
3	St. Francis Alcohol and Drug Treatment Center (NE100118) 4600 17th Avenue Kearney, NE 68847 (308) 865-2000	Assessment/Evaluation - SA Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
3	The Bridge (NE900335) 922 N. Denver St. Hastings, NE 68901 (402) 462-4677	Therapeutic Community - SA
4	Region IV Behavioral Health System (NE100811) 206 Monroe Ave. Norfolk, NE 68701 (402) 370-3100	Emergency Community Support - MH or SA Regional Prevention Coordination - SA
4	Behavioral Health Specialists, Inc. (NE301302) 600 S. 13th Street Norfolk, NE 68701 (402) 370-3140	Community Support - SA Intensive Outpatient - SA Outpatient Therapy - SA Youth Community Support - SA Youth Outpatient Therapy - SA
4	S.O.S. Place (NE900707) 4432 Sunrise Place Columbus, NE 68601 (402) 564-9994	Social Detoxification Short Term Residential - SA
4	Catholic Charities (NE100126) 3020 18th Street, Suite 17 Columbus, NE 68601 (402) 563-3833	Urgent Assessment/Evaluation - MH or SA Community Support - SA Dual Residential (SPMI & CD) Intensive Outpatient - SA

GOAL #13: Compliance - Assessment Of Need For Both Treatment And Prevention /
September 27, 2010 / Page 20

Region	Provider (ISATS NUMBER)	SA Approved Service
		Outpatient Therapy - SA Youth Intensive Outpatient - SA Youth Assessment/ Evaluation - SA Youth Outpatient Therapy - SA
4	Heartland Counseling Services, Inc.(NE900491) 917 W. 21st St. South Sioux City, NE 68776 (402) 494-3337	Community Support - SA Intensive Outpatient - SA Outpatient Therapy - SA Youth Intensive Outpatient - SA Youth Assessment/ Evaluation - SA Youth Outpatient Therapy - SA
4	Heartland Solutions (NE100614) 318 E. Highway 20 P.O. Box 246 O'Neill, NE 68763 (402) 336-2800	Urgent Assessment/Evaluation - MH or SA Emergency Community Support - MH or SA Community Support - SA Day Rehabilitation Outpatient Therapy - SA Youth Outpatient Therapy - SA
4	North East Panhandle Substance Abuse Center (NE100605) 305 Foch St. P.O. Box 428 Gordon, NE 69343 (308) 282-1101	Social Detoxification Short Term Residential - SA
4	The Link (NE900418) 1001 Norfolk Avenue Norfolk, NE 68701 (402) 371-5310	Halfway House - SA
4	Women's Empowering Life Line (NE100622) 305 North 9th Street Norfolk, NE 68701 (402) 844-4710	Dual Residential (SPMI & CD) Halfway House - SA
5	Blue Valley Behavioral Health (NE750953) 1123 S. 9th St. Beatrice, NE 68310 (402) 228-3386	Intensive Outpatient - SA Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA 24 Hour Crisis Phone
5	Blue Valley Behavioral Health (NE750045) 820 Central Ave. Auburn, NE 68305 (402) 274-4373	Intensive Outpatient - SA Outpatient Therapy - SA Youth Outpatient Therapy - SA Youth Assessment/ Evaluation - SA
5	Blue Valley Behavioral Health (901184) 225 East 9th, Suite 1 Crete, NE 68333 (402) 826-2000	Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA

GOAL #13: Compliance - Assessment Of Need For Both Treatment And Prevention /
September 27, 2010 / Page 21

Region	Provider (ISATS NUMBER)	SA Approved Service
5	Blue Valley Behavioral Health (750102) 367 'E' Street David City, NE 68632 (402) 367-4216	SA Approved Service Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
5	Blue Valley Behavioral Health (NE750110) 521 'E' Street Fairbury, NE 68352 (402) 729-2272	Outpatient Therapy - SA Youth Outpatient Therapy - SA
5	Blue Valley Behavioral Health (NE750128) 116 W. 19th Street Falls City, NE 68355 (402) 245-4458	Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
5	Blue Valley Behavioral Health (NE900913) 831 'F' Street Geneva, NE 68361 (402) 759-4761	Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
5	Blue Valley Behavioral Health (NE750201) 141 N. 4TH Hebron, NE 68370 (402) 759-4761	Outpatient Therapy - SA Youth Outpatient Therapy - SA
5	Blue Valley Behavioral Health (NE750409) 1903 4th Corso Nebraska City, NE 68410 (402) 873-5505	Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
5	Blue Valley Behavioral Health (NE750581) 531 Beebe Osceola, NE 68561 (402) 362-6128	Outpatient Therapy - SA Youth Outpatient Therapy - SA
5	Blue Valley Behavioral Health (NE750599) 600 "I" Street Pawnee City, NE 68420 (402) 245-4458	Outpatient Therapy - SA Youth Outpatient Therapy - SA
5	Blue Valley Behavioral Health (750631) 459 S. 6th St. Seward, NE 68434 (402) 643-3343	Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
5	Blue Valley Behavioral Health (NE750409) Johnson County Hospital 202 High Street Tecumseh, NE 68450 (402) 228-3386	Outpatient Therapy - SA Youth Outpatient Therapy - SA
5	Blue Valley Behavioral Health (NE750672)	Outpatient Therapy - SA

**GOAL #13: Compliance - Assessment Of Need For Both Treatment And Prevention /
September 27, 2010 / Page 22**

<p>Region</p> <p>Provider (ISATS NUMBER)</p> <p>543 N. Linden Street</p> <p>Wahoo, NE 68066</p> <p>(402) 443-4414</p>	<p>SA Approved Service</p> <p>Youth Assessment/Evaluation - SA</p> <p>Youth Outpatient Therapy - SA</p>
<p>5 Blue Valley Behavioral Health (NE901382)</p> <p>722 S. Lincoln Ave, Suite 1</p> <p>York, NE 68467</p> <p>(402) 362-6128</p>	<p>Intensive Outpatient - SA</p> <p>Outpatient Therapy - SA</p> <p>Youth Assessment/Evaluation - SA</p> <p>Youth Outpatient Therapy - SA</p>
<p>5 CenterPointe (NE301401)</p> <p>1000 South 13th Street</p> <p>Lincoln, NE 68508</p> <p>(402) 475-5161</p>	<p>Community Support - SA</p> <p>Day Rehabilitation</p> <p>Outpatient Therapy - SA</p> <p>Youth Outpatient Therapy - SA</p> <p>Recovery Support - SA</p>
<p>5 CenterPointe (NE100436)</p> <p>2220 S. 10th St.</p> <p>Lincoln, NE 68502</p> <p>(402) 475-5161</p>	<p>Youth Therapeutic Community - SA</p>
<p>5 CenterPointe (NE302219)</p> <p>2633 'P' St.</p> <p>Lincoln, NE 68503</p> <p>(402) 475-8748</p>	<p>Dual Residential (SPMI & CD)</p>
<p>5 CFSTAR</p> <p>2900 'O' Street, Suite 200</p> <p>Lincoln, NE 68510</p> <p>(402) 435-2910</p>	<p>Outpatient Therapy - SA</p>
<p>5 Child Guidance Center (NE100563)</p> <p>2444 'O' Street</p> <p>Lincoln, NE 68510</p> <p>(402) 475-7666</p>	<p>Youth Assessment/Evaluation - SA</p> <p>Youth Outpatient Therapy - SA</p> <p>Therapeutic Consultation - SA</p>
<p>5 Community Mental Health Center (NE750938)</p> <p>2201 S. 17th St.</p> <p>Lincoln, NE 68502</p> <p>(402) 441-7940</p>	<p>Crisis Assessment/Evaluation - SA (LADC)</p> <p>24 Hour Crisis Phone</p>
<p>5 Cornhusker Place (NE750250)</p> <p>721 'K' Street</p> <p>Lincoln, NE 68508</p> <p>(402) 477-3951</p>	<p>Social Detoxification</p> <p>CPC Services (Involuntary)</p> <p>Intermediate Residential - SA</p> <p>Short Term Residential - SA</p> <p>Recovery Support - SA</p>
<p>5 Houses of Hope (NE901242)</p> <p>601 Cotner Blvd</p> <p>Lincoln, NE 68502</p> <p>(402) 435-3165</p>	<p>Halfway House - SA</p>
<p>5 Lincoln Medical Education Partnership</p>	<p>Prevention Services</p>

**GOAL #13: Compliance - Assessment Of Need For Both Treatment And Prevention /
September 27, 2010 / Page 23**

Region	Provider (ISATS NUMBER) (NE100415)	SA Approved Service
	4600 Valley Road Lincoln, NE 68510 (402) 483-4581	Outpatient Therapy - SA
5	Lutheran Family Services (NE900962) 2900 'O' Street, Suite 200 Lincoln, NE 68510 (402) 435-2910	Intensive Outpatient - SA Outpatient Therapy - SA
5	St. Monica's Behavioral Health Services for Women (NE101464) 120 Wedgewood Dr. Lincoln, NE 68510 (402) 441-3768	Community Support - SA Intensive Outpatient - SA Outpatient Therapy - SA Short Term Residential - SA
5	St. Monica's Behavioral Health Services for Women (NE900038) Project Mother Child 219 S 24 Lincoln, NE 68510 (402) 441-3755	Therapeutic Community - SA
5	St. Monica's Behavioral Health Services for Women (NE100556) 4555 S. 25th St. Lincoln, NE 68510 (402) 434-8475	Therapeutic Community - SA
5	Touchstone (NE000081) 1100 Military Rd. Lincoln, NE 68508 (402) 474-4343	Short Term Residential - SA
5	Lincoln Council of Alcoholism and Drugs (NE900350) 914 L Street Lincoln NE 68510 (402) 475-2694	Assessment Evaluation - SA
6	Region 6 (NE100837) 3801 Harney Street Omaha, NE 68131 (402) 444-6534	Regional Prevention Center
6	Alegent Health, Inc. (NE750904) 6901 N. 72nd St. Omaha, NE 68122 (402) 572-2936	Assessment/Evaluation - SA Outpatient Therapy - SA
6	Alegent Health, Inc. (NE101827) 1309 Harlen Drive	Assessment/Evaluation - SA Outpatient Therapy - SA

GOAL #13: Compliance - Assessment Of Need For Both Treatment And Prevention /
September 27, 2010 / Page 24

Region	Provider (ISATS NUMBER)	SA Approved Service
	Bellevue, NE 68005 (402) 572-2936	
6	ARCH (NE750441) 604 S. 37th St. Omaha, NE 68105 (402) 346-8898	Halfway House - SA
6	ARCH (NE100496) 1502 N. 58th St. Omaha, NE 68114 (402) 346-8898	Halfway House - SA
6	BAART (NE100781) 1941 Center, Suite 210 Omaha, NE 68105 341-6220	Methadone Maintenance - SA
6	Catholic Charities (NE100431) 1490 N. 16th St. Omaha, NE 68102 (402) 554-0520	Crisis Assessment/Evaluation - SA (LADC) Social Detoxification CPC Services (Involuntary) Community Support - SA Short Term Residential - SA Dual Residential (SPMI & CD) Intensive Outpatient - SA
6	Catholic Charities (NE900665) 3300 N. 60th St. Omaha, NE 68104 (402) 554-0520	Assessment/Evaluation - SA Outpatient Therapy - SA
6	Catholic Charities (NE901333) 4430 S. 33rd St. Omaha, NE 68107 (402) 554-0520	Intermediate Residential - SA
6	Douglas County Community MH Center (NE100810) 4102 Woolworth Ave Omaha NE 68105 (402) 444-7698	CPC Services - Assessment Evaluation - SA Outpatient - SA
6	Heartland Family Services (NE100624) 116 E. Mission Ave. Bellevue, NE 68005 (402) 552-7445	Assessment/Evaluation - SA Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
6	Heartland Family Services (NE100103) 2101 S. 42nd St. Omaha, NE 68105 (402) 552-7445	Assessment/Evaluation - SA Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA

GOAL #13: Compliance - Assessment Of Need For Both Treatment And Prevention /
September 27, 2010 / Page 25

Region	Provider (ISATS NUMBER)	SA Approved Service
6	Heartland Family Services (NE100317) 11212 Davenport St. Omaha, NE 68154 (402) 552-7445	Assessment/Evaluation - SA Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
6	Heartland Family Services (NE100625) 1246 Golden Gate Dr. Papillion, NE 68046 (402) 552-7445	Assessment/Evaluation - SA Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
6	Heartland Family Services (NE100799) 1016 Park Ave., #221 Omaha, NE 68105 (402) 552-7445	Therapeutic Community - SA
6	Latino Center of the Midlands (NE901051) 4821 S. 24th St Omaha, NE 68107 (402) 733-2720	Outpatient Therapy - SA
6	Lutheran Family Services (NE100332) 730 N. Fort Crook Road Bellevue, NE 68005 (402) 978-5621	Assessment/Evaluation - SA Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
6	Lutheran Family Services (NE100220) 403 S. 16th St. Blair, NE 68008 (402) 978-5621	Assessment/Evaluation - SA Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
6	Lutheran Family Services (NE101686) 510 'D' St. Fremont, NE 68025 (402) 978-5621	Assessment/Evaluation - SA Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
6	Lutheran Family Services (NE101763) 124 S. 24th, Suite 100 Omaha, NE 68102 (402) 978-5621	Crisis Assessment/Evaluation - SA (LADC) Urgent Assessment/Evaluation - MH or SA Urgent Outpatient Therapy - MH or SA (LADC) Assessment/Evaluation - SA Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
6	Lutheran Family Services (NE100163) 2505 N. 24th Omaha, NE 68110 (402) 978-5621	Intensive Outpatient - SA Assessment/Evaluation - SA Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
6	Lutheran Family Services (NE100688) 415 South 25 Avenue Omaha, NE 68131	Assessment/Evaluation - SA Outpatient Therapy - SA Youth Assessment/Evaluation - SA

GOAL #13: Compliance - Assessment Of Need For Both Treatment And Prevention /
September 27, 2010 / Page 26

Region	Provider (ISATS NUMBER) (402) 978-5621	SA Approved Service Youth Outpatient Therapy - SA
6	Lutheran Family Services (NE100688) 401 E. Gold Coast Rd. Papillion, NE 68046 (402) 978-5621	Assessment/Evaluation - SA Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
6	Lutheran Family Services (NE100340) 546 Avenue A Plattsmouth, NE 68048 (402) 978-5621	Assessment/Evaluation - SA Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
6	Nebraska Urban Indian Health (NE101298) 2240 Landon Court Omaha, NE 68108 (402) 346-0902	Assessment/Evaluation - SA Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
6	NOVA Therapeutic Community (NE101405) 1915 S. 38th St. Omaha, NE 68105 (402) 455-8303	Youth Intensive Outpatient - SA
6	NOVA Therapeutic Community (NE300072) 3483 Larimore Ave. Omaha, NE 68111 (402) 455-8303	Short Term Residential - SA Therapeutic Community - SA Youth Therapeutic Community - SA
6	Salvation Army (NE750532) 3612 Cuming St. Omaha, NE 68131 (402) 898-5940	Emergency Community Support - MH or SA Intensive Case Management - MH or SA
6	Santa Monica (NE750540) 130 N. 39th St. Omaha, NE 68131 (402) 558-7088	Intermediate Residential - SA Halfway House - SA
Tribal Programs Funded Direct By Division		
4	**Omaha Tribe of Nebraska (NE100381) PO Box 368 Macy NE 68039	Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA Halfway House - SA Assessment/Evaluation - SA Outpatient Therapy - SA
4	**Ponca Tribe Of Nebraska (NE100121) 201 Miller Avenue Norfolk NE 68701	Assessment/Evaluation - SA Outpatient Therapy - SA
4	**Santee Sioux Tribe of Nebraska (NE750607) 425 Fraser Avenue No Suite 2 RR 2	Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA

GOAL #13: Compliance - Assessment Of Need For Both Treatment And Prevention /
September 27, 2010 / Page 27

Region	Provider (ISATS NUMBER) Niobrara NE 68760	SA Approved Service Assessment/Evaluation - SA Outpatient Therapy - SA
4	**Winnebago Tribe of Nebraska (NE750706) PO Box 687 Winnebago NE 68071	Assessment/Evaluation - SA Outpatient Therapy (Adult)

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

SUBSTANCE ABUSE NEEDS ASSESSMENT ON PREVENTION SERVICES:

Through Epidemiological Profile Report and the Prevention Strategic Plan, the Nebraska Department of Health and Human Services Divisions of Behavioral Health and Public Health are working together to coordinate a unified Prevention System with diverse funding streams that produce outcomes in reducing substance abuse and related problems.

Summary of Findings from the Epidemiology Profile Report, entitled “Substance Abuse and Associated Consequences in Nebraska, an Epidemiological Profile”

Nebraska Department of Health and Human Services, Lincoln, NE: 2007.

<http://www.dhhs.ne.gov/srd/SubstanceAbuseReport07.pdf>

Accessed September 30, 2009

In Nebraska, substance abuse continues to be a problem, placing an enormous strain on the health care system, the criminal justice system, and the substance abuse treatment system. The following is a summary of the key findings for substance abuse and its associated consequences in Nebraska.

Consequences of Substance Abuse in Nebraska

Substance abuse is a major contributor to death and medical care

- In 2004, there were an estimated 392 alcohol-related deaths, an estimated 2,115 smoking-related deaths, and 61 deaths in which drugs were listed as the primary cause of death.
- In 2003, there were 4,948 alcohol-attributable hospitalizations, an estimated 8,517 smoking-related hospitalizations and 2,887 drug-attributable hospitalizations.

Alcohol impaired driving is particularly high and is common in fatal motor vehicle crashes

- High school students in Nebraska were 1.7 times more likely than students nationally to report driving after drinking in the past month (17.3% and 9.9%, 2005) while adults were 1.7 times more likely than adults nationally to report past month alcohol impaired driving (4.2% and 2.5%, 2006).
- In 2006, more than one-third of all fatal motor vehicle crashes in Nebraska involved alcohol (34.1%), killing 86 individuals in 77 alcohol-involved fatal crashes.

Substance abuse places a tremendous strain on the criminal justice system

- In 2006, there were 13,409 arrests for DUI, 12,714 arrests for non-DUI alcohol-related crime, and 10,502 arrests for possession or sales/manufacturing of illicit drugs in Nebraska. These were the top three arrest offenses in 2006 and together accounted for 2 in every 5 arrests (39.4%).
- Of all adults sentenced to probation in Nebraska during 2006, more than half (55.3%) were sentenced for DUI, a substantial increase since 2000 (37.6%), while about 1 in every 17 were sentenced for a drug-related offense (5.9%), a stable trend since 2000 (5.4%).
- There were 20 times the number of incarcerations for drug offenses in 2006 (1,171) than 1980 (60).

GOAL # 13. Progress - Assessment of Need for Treatment & Prevention | Sept 27, 2010 | pg 2

NOTE: The Division of Behavioral Health is working to address the complex issues involved with substance abuse, which places a tremendous strain on the criminal justice system. Below are several examples of the Division strategies that will continue into 2010:

- Scot Adams, Director of the Division of Behavioral Health, was recently selected to serve as the Chair of the Community Corrections Council (CCC). The CCC was established by the Nebraska Unicameral in 2003. The Council was created to coordinate the effort of establishing community correctional programs across the state, to assure the necessary supervision and services to adult felony offenders in the community, to reduce reliance upon incarceration as a means of managing low risk offenders, and to decrease the probability of criminal behavior while maintaining public safety.
- In 2006, The Division of Behavioral Health signed a Memorandum of Agreement (MOA) with State Probation Administration for Monitoring Claims for Substance Abuse Assessment and Treatment Services. This MOA was intended to monitor the provision of and payment for approved substance abuse (SA) assessment and treatment services for persons referred to and receiving such services under the SA voucher program. The Division is working with State Probation Administration to review and update this agreement.
- The Nebraska Supreme Court has adopted rules to implement the Standardized Model. The Standardized Model for the Delivery of Substance Abuse Services was created by Nebraska Supreme Court Rule regarding referrals for substance abuse services for adult offenders and juvenile. It provides a meaningful opportunity for offender rehabilitation through a standardized performance structure in an effort to reduce recidivism, promote good citizenship and enhance public safety. It consists of a standardized screening, assessment and treatment of offenders/juveniles. It ensures communication between Probation Officers and Providers. It requires substance abuse providers to:
 1. Register their services through the Office of Probation Administration and meet the approved criteria.
 2. Have a clear understanding of the connection between substance abuse and criminal offending and attend ongoing training on the treatment of offenders/juveniles.
 3. Provide consistent evaluations, recommendations, and treatment via standardized format and defined terms.

For more information on the Standardized Model see <http://www.supremecourt.ne.gov/probation/community-correctional/standardized%20model.shtml>
- As part of the Standardized Model, the Division endorsed providing Addiction Severity Index (ASI) and Comprehensive Adolescent Severity Inventory (CASI) training and continuing education to NE's substance abuse workforce. As reported under Goal #11: Intended Use - Continuing Education. The contract with the Lincoln Medical Education Partnership (LMEP) Training for Addiction Professionals (TAP) is part of the Division of Behavioral Health's on-going support of the Standards of Practice.
- Justice Behavioral Health Committee (JBHC) is authorized under the Community Corrections Council. The Division of Behavioral Health is an active member of the JBHC. The JBHC developed the "Provisional Criminal Justice Substance Use Disorders Standards of Practice."

GOAL # 13. Progress - Assessment of Need for Treatment & Prevention | Sept 27, 2010 | pg 3

- The JBHC asked the State Advisory Committee on Substance Abuse Services to review and comment on these Standards of Practice. The review was completed on April 14, 2009 and July 14, 2009. The State Advisory Committee on Substance Abuse Services made the following motion at the end of the discussion on July 14, 2009:

“The SACSAS embraces these principles with interest but we have concerns over their use, implementation and potential to create unnecessary regulation. We ask to be kept involved in the active dialogue on this evolving topic prior to full endorsement.”
- Criminal Justice Electronic Data Transfer Interagency Agreement – the Nebraska Department of Health and Human Services - Division Of Behavioral Health (DHHS), the Nebraska Department of Correctional Services (DCS) and the Nebraska Commission on Law Enforcement and Criminal Justice (Crime Commission) signed Electronic Data Transfer Interagency Agreements on June 9, 2009. These agreements have these three state agencies transferring their data to the Division of Epidemiology, College of Public Health at the University of Nebraska Medical Center in Omaha, NE for the purpose of analysis, compilation and reporting for the mutual benefit of the parties. The initial data covers the time period from January 1, 2005 to December 31, 2008. Before public release, the Report(s) produced under these agreements must be acceptable to the DHHS, DCS and the Crime Commission. The Report(s) remain in draft status until these three code level agencies approve the document. This requirement is due to the sensitive nature of the content of the report(s) using these data. The results from this analysis are intended to be used, in part, for future needs assessment.

Alcohol is the primary drug of choice in substance abuse treatment admissions

- In 2006, alcohol was listed as the primary drug of choice during 7 in every 10 substance abuse treatment admissions (70.9%) in Nebraska, followed by methamphetamine (12.5%), marijuana (9.1%), and cocaine (4.7%).

NOTE: The Division of Behavioral Health contracts with the six Regional Behavioral Health Authorities for community substance abuse treatment services. Regional budget plan guidelines will be developed by the Division. These guidelines will direct Regional Behavioral Health Authorities in their efforts to develop and maintain a continuum of care which addresses the needs of Nebraska. Statewide goals and objectives will be based on strategic planning sessions and target variables which will impact the efficacy and effectiveness of alcohol treatment in Nebraska.

Substance Use in Nebraska*Substance use is common in Nebraska with alcohol being the substance of choice*

- In 2005, more than 2 in every 5 Nebraska high school students (42.9%) drank alcohol during the past month, about 1 in every 5 smoked cigarettes (21.8%), and approximately 1 in every 6 used marijuana (17.5%).
- During the combined years of 2004 and 2005, more than half of all persons 12 and older in Nebraska drank alcohol in the past month (55.6%) while more than one-quarter of all persons binge drank (27.2%). In addition, about one-quarter (24.5%) smoked cigarettes and approximately 1 in every 15 used illicit drugs (6.5%).

Compared to the U.S., alcohol use in Nebraska is high while smoking and most drug use is similar

[GOAL # 13. Progress - Assessment of Need for Treatment & Prevention | Sept 27, 2010 | pg 4](#)

- Binge drinking among Nebraska residents was higher than residents nationally across the three data sources presented in this report that contained information on self-reported binge drinking, (although the difference for high school students was non-significant).
- Cigarette smoking among Nebraska residents was nearly identical to residents nationally while drug use tended to be slightly lower (although the differences were generally non-significant); however, past year methamphetamine use was higher among Nebraska residents 12 and older.

Substance use among youth has changed both positively and negatively over the past 15 years

- Alcohol use (including binge drinking) and cigarette smoking among Nebraska high school students declined since the early 1990s, but remained stable among adults during the same time period.
- Marijuana use among Nebraska high school students increased since the early 1990s; however, more recent estimates of use among all persons 12 and older, between 2002 and 2005, were stable and may have begun to decline (although the decline was non-significant).
- Overall, non-marijuana illicit drug use among all persons 12 and older in Nebraska remained virtually unchanged between 2002 and 2005.

Demographic Differences in Nebraska

Differences by age

- Residents in their late teens and early 20's were the most likely age group to binge drink as well as use tobacco and illicit drugs. In addition, they were also more likely than other age groups to drive after drinking, to die or be injured in an alcohol-involved crash, to be arrested for alcohol or drug related offenses, and to be admitted into substance abuse treatment.

Differences by gender

- Among Nebraska high school students, males and females reported similar percentages for alcohol use, cigarette smoking, and illicit drug use. However, among adults, men were more likely than women to binge drink, to drive after drinking, to use smokeless tobacco products, to experience legal consequences from alcohol and drug use, and to be admitted into substance abuse treatment.

Differences by urban/rural

- Residents of the most rural Nebraska counties reported the highest percentage for alcohol impaired driving and smokeless tobacco use; however, alcohol use and cigarette smoking were relatively similar across urban/rural counties while differences for illicit drug use were largely unavailable.

Differences by race/ethnicity

- Among Nebraska adults, Native Americans reported the highest percentage for binge drinking and cigarette smoking (although the binge drinking percentage was not significantly higher than Whites) as well as had the highest death rates for chronic liver disease and alcohol-related death overall. Racial and ethnic differences for illicit drug use were largely unavailable.

Substance abuse prevention efforts occur at both the state and community levels within Nebraska.

GOAL # 13. Progress - Assessment of Need for Treatment & Prevention | Sept 27, 2010 | pg 5

State level: As part of the SPF SIG efforts, Nebraska's external evaluator, Research Triangle Institute (RTI) is conducting annual data collection at the state level using the SAMHSA developed Grantee Level Instrument (GLI) as well as the Systems Integration Interview (SII) tool that was developed by RTI. The SII is designed to measure how well the DHHS Divisions of Public Health and Behavioral Health collaborate on SA prevention as well as how both divisions interact with the Behavioral Health Regional Prevention staff.

Community level: Under the SPF SIG, each community has hired an external evaluator to assist them with data collection and reporting. Coalition staff and local evaluators work together to develop evaluation plans for the community as well as collect and report evaluation related data to the coalition and to the state and RTI. A Community Level Instrument is used as part of this process. As part of the broader evaluation, the SPF SIG and Block Grant programs have been collaborating to assess the policies, programs, and practices currently being used within Nebraska in an effort to ensure that prevention and evaluation are coordinated to the best extent possible across the state. To help accomplish this, both divisions are currently working on improving the www.npirs.org website, the online reporting site for block grant and eventually SPF SIG recipients.

The initial administration of the GLI and SII occurred in May of 2009 with a second and final administration occurring near the end of the SPF SIG, which is targeted for spring or summer of 2012. Year 1 Local Evaluation Plans were prepared by local evaluators and reviewed/approved by RTI in Fall of 2009. RTI continues to collect data, has required that the Coalition Capacity Assessment is completed annually with the CLI every 6 months. The use of NOM surveys and implementing fidelity measures is an ongoing effort.

The Nebraska Substance Abuse Epidemiology Workgroup (NSAEW), formed in March 2007, is a workgroup of administrators, epidemiologists, and key decision makers who collaborate to make decisions regarding the collection and reporting of data related to substance abuse, consequences of substance abuse, and factors that contribute to substance abuse in the State of Nebraska. Work completed by the NSAEW has and will continue to guide decision making around substance abuse prevention in the state, including decisions made by the Nebraska Partners in Prevention (NePiP), the Governor's Advisory Council for substance abuse prevention.

The initial tasks of the NSAEW included creating an epidemiological profile report on substance abuse in Nebraska and establishing a set of criteria to facilitate the selection of the SPF SIG substance abuse prevention priorities. This information served as the foundation for the development of the Nebraska Substance Abuse Strategic Plan.

To complete this work, the NSAEW completed the following steps. First, substance abuse data sources within Nebraska were identified by completing an inventory of available data. Second, data constructs were identified and used to organize data sources and data reporting. The constructs were separated by consequences (e.g., mortality, medical care, motor vehicle crashes, legal consequences, etc.) and consumption (e.g., lifetime use, current use, excessive use, etc.). Lastly, data indicators were selected through group discussion and NSAEW member supplemental online indicator scoring. The following items were considered as part of the indicator selection process: data quality, state level data availability, national comparison, trend availability, future collection plans, and sample size or number of cases.

GOAL # 13. Progress - Assessment of Need for Treatment & Prevention | Sept 27, 2010 | pg 6

The NSAEW continues to discuss data sources and gaps and their relation to ongoing data planning and reporting. As part of this process, the NSAEW will be updating the content of the epidemiology profile report within the next year and will continue to pursue opportunities to collect and report both state and community level data. The SHARP, Student Health and Risk Prevention Survey, is a Prevention Needs Assessment approach which was implemented in the fall of 2010. The Nebraska Department of Education (NDE) and DHHS coordinates the administration of the Youth Risk Behavior Survey (YRBS), Youth Tobacco Survey (YTS), and Nebraska Risk and Protective Factor Student Survey (NRPFS) which make up the Student Health And Risk Prevention (SHARP) survey. The YRBS, YTS, and NRPFS were previously administered separately. Now, all three surveys are administered in the fall of even calendar years. The Bureau of Sociological Research (BOSR) will manage these surveys on behalf of NDE and DHHS. The goal of SHARP is to minimize interruption of school schedules and improve overall school participation in all three surveys.

Additionally, for communities within Nebraska, the State SPF SIG Program, Division of Behavioral Health, and Regional Prevention Coordinators from the six Behavioral Health Regions collaborated to prepare a community assessment toolkit. This toolkit allows communities to conduct a thorough assessment of substance abuse in their communities through examining the structure and functioning of their community, assessing their coalition capacity, measuring community readiness, conducting a detailed needs assessment, and examining the programs, policies, and practices available within their community. This document remains available for all communities within Nebraska.

Based on the Form 6a Prevention Strategy Report (as of 9/2/2009) the risk populations include but are not limited to, Children of Substance Abusers, Pregnant Women/Teens, Violent and Delinquent Behavior, Mental Health Problems, Economically Disadvantaged, Physically Disabled, People Already Using Substances, Homeless and/or Run away Youth, Business and Industry, Civic Groups/Coalitions, College Students, Older Adults, Elementary School Students, Health Professionals, High School Students, Middle/Junior High School Students, Parents/Families, Preschool Students, Prevention/Treatment Professionals, Religious Groups, Teachers/Administrators/Counselors, Youth/Minors, and Law Enforcement/Military. See Form 6a Prevention Strategy Report for more details.

Primary Prevention Activities

As noted on the Form 11ab (Primary Prevention Expenditure Checklist), a sixty seven percent (67%) of the SAPTBG prevention funds are used within the Community Based Process (34%) and the Environmental (34%). A summary of Form 11ab is below.

Form 11ab – Primary Prevention Planned Expenditure Checklist

Block Grant FY 2010		
Information Dissemination	\$58,576	4%
Education	\$153,926	10%
Alternatives	\$83,902	5%
Problem Identification & Referral	\$146,843	9%
Community Based Process	\$529,350	34%
Environmental	\$529,706	34%
other		
Section 1926 - Tobacco	\$76,283	5%
Total	\$1,578,586	100%

GOAL # 13. Progress - Assessment of Need for Treatment & Prevention | Sept 27, 2010 | pg 7

In addition to these efforts, Nebraska facilitates a number of other strategies as noted on Form 6a Prevention Strategy Report (as of 9/2/2009), primary prevention activities include Disseminate A/V Material, Printed Material, Curricula, Newsletters and related content; Accessing services and funding; use of clearinghouse/information resources centers; community and volunteer training (such as neighborhood action training, impactor training, staff/officials training); Community drop-in centers, Community service activities, Community team-building; education programs for those who were driving while under the influence and/or driving while intoxicated; drug free dances and parties; education programs for youth groups; employee Assistance Programs; guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use; health fairs and other health promotion, e.g., conferences, meetings, seminars; Information lines/Hot lines; media campaigns; ongoing classroom and/or small group sessions; parenting and family management; Peer leader/helper programs; Preventing Underage Sales of Tobacco and Tobacco Products per the Synar Amendment; Prevention Assessment and Referral Attendees; Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools; Recreation activities; Resources directories; Speaking engagements; Student Assistance Programs; Systematic planning; Technical Assistance Services; tobacco, and drug use policies in schools; Youth/adult leadership activities; and related activities.

SUBSTANCE ABUSE NEEDS ASSESSMENT ON TREATMENT SERVICES:

The Nebraska Behavioral Health Services Act (Neb. Rev. Stat. §§ 71-801 to 71-830) defines the term "Behavioral health disorder" as mental illness or alcoholism, drug abuse, problem gambling, or other addictive disorder [Neb. Rev. Stat. §71-804(1)].

Nationally, the number of persons with substance dependence or abuse was stable between 2002 and 2007 (22.0 million in 2002, 21.6 million in 2003, 22.5 million in 2004, 22.2 million in 2005, 22.6 million in 2006, and 22.3 million in 2007).

Source: Figure 7.1 Substance Dependence or Abuse in the Past Year among Persons Aged 12 or Older: 2002-2007 Substance Abuse and Mental Health Services Administration, Office of Applied Studies (2008). *Results from the 2007 National Survey on Drug Use and Health: National Findings* (NSDUH Series H-34, DHHS Publication No. SMA 08-4343). Rockville, MD.

<http://www.oas.samhsa.gov/NSDUH/2k7NSDUH/2k7results.cfm#1.2> g Persons Aged 12 or Older: 2002-2007

The Division of Behavioral Health limited the needs assessment work completed for FY2010 application for the Substance Abuse Prevention and Treatment Block Grant to updating Form 8 (Treatment Needs Assessment Summary Matrix), Form 9 (Treatment Needs by Age, Sex and Race/Ethnicity) and How your State determined the estimates for Form 8 and Form 9. Under Form 8 (Treatment Needs Assessment Summary Matrix), the Division of Behavioral Health shows the incidence and prevalence in the State of drug abuse, alcohol abuse and alcoholism. This is summarized below under the column 3. Total Population In Need.

Form 8

Region	1. Substate planning area	2. Total population Census data (estimated 2008)	3. Total Population In Need	
			A. Needing treatment services	B. That would seek treatment
1	Panhandle	85,813	7,723	494
2	Southwest	99,148	8,923	571

GOAL # 13. Progress - Assessment of Need for Treatment & Prevention | Sept 27, 2010 | pg 8

3	South Central	223,379	20,104	1,287
4	North East	204,799	18,432	1,180
5	South East	436,512	39,286	2,514
6	Omaha Metro	733,781	66,040	4,227
	State Total	1,783,432	160,509	10,273

The Gamblers Assistance Program (GAP) during January 2008 through June 2009 preliminary data shows a high proportion of clients with gambling addictions and substance abuse problems. Current findings showed that 36.8% (n = 134 of 364) of GAP consumers treated reported problems related to substance use. The most frequent substance used by GAP clients is alcohol (53.7%), followed by marijuana/hashish/pot (17.2%) and Methamphetamine (14.2%). Reported data warrants further development and research of co-occurring disorders among those experience problem gambling and substance abuse.

Treatment Utilization

Form 7A - Levels of Care (Treatment Utilization Matrix)

Substance Abuse Services Funded by the Division of Behavioral Health

For treatment services provided with an initial admission to an episode of care during the 12-month State Expenditure Period of FY2008

Level of Care	A. Number of Admissions	B. Number of Persons Served
Detoxification (24-Hour Care)		
1. Hospital Inpatient	0	0
2. Free-Standing Residential	6,429	4,363
Rehabilitation/Residential		
3. Hospital Inpatient	259	149
4. Short-term (up to 30 days)	1,590	999
5. Long-term (over 30 days)	1,156	328
Ambulatory (Outpatient)		
6. Outpatient	13,872	9,951
7. Intensive Outpatient	1,851	1,287
8. Detoxification	0	0
9. Opioid Replacement Therapy	300	280

Source: Division of Behavioral Health (September 2009)

Opioid Replacement Therapy - Identifies whether or not the use of methadone or buprenorphine is part of the client’s treatment plan for opioid addiction. In Nebraska, the term Medication Assisted Treatment is beginning to be used for service “Opioid Replacement Therapy”.

Form 7b Number of persons served for alcohol and other drug use in state funded services Unduplicated Count of Persons Served in State Expenditure Period of FY2008 in Substance Abuse Programs Funded by the Division of Behavioral Health (N=21,935)

NOTE: This includes clients who received only substance abuse services and clients who received mental health and substance abuse services.

Form 7b

	Total
17 Years & Under	606

GOAL # 13. Progress - Assessment of Need for Treatment & Prevention | Sept 27, 2010 | pg 9

18 to 24 Years	5,140
25 to 44 Years	11,405
45 to 64 Years	4,616
65 + Years	168
Total	21,935
Pregnant Women	199

Footnote for Form 7a and 7b: In January 2009, the Division of Behavioral Health cleaned its data system by administratively discharging nearly 18,000 records of admission to program prior to November 2003 and of which had no activity in the last year. This reduced the number of active cases in the system. To obtain unduplicated count of persons served, the Division used social security numbers and dates of birth to identify unique clients in the data system.

Treatment Capacity.

Details of treatment capacity are reported on Form 6 - Substance Abuse Entity Inventory. This report includes the Entity Number, I-SATS ID, the Area Served, the State Funds allocated, the SAPT Block Grant Funds for Substance Abuse Prevention and Treatment Services allocated, a specific report of the SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children, funds for the SAPT Block Grant Funds for Primary Prevention. There are no funds allocated from the SAPT Block Grant Funds for Early Intervention Services for HIV.

When

This work is continuously being addressed. For the purposes of this document, Goal 13 Intended Use time period covers from July 1, 2009 to September 30, 2010. That includes both the Federal Fiscal Year of October 1, 2009 to September 30, 2010 and the State fiscal year (starting July 1, 2009). Almost everything the NE Division of Behavioral Health does is organized around the State Fiscal Year (July 1 to June 30), so that becomes the natural reporting cycle. If the reporting time frame is done consistently over time, then everything needed falls into place and is fully addressed.

How

The Intended Use of the funds relating to prevention and treatment are reported on Form 11 as the Intended Use Plan for FY2010

Activity	FY10 SAPTBG	Medicaid	State Funds
Substance Abuse Prev & Treatment (non primary prev)	\$5,926,439	\$1,457,583	\$23,039,179
Primary Prevention	1,578,586	-	183,730
Tuberculosis Services	-	-	-
HIV Early Intervention Services	-	-	-
Administration (excluding program/provider level)	387,903	-	-
Totals	\$7,892,928	\$1,457,583	\$23,222,909

The Division of Behavioral Health contracts most of the funds to the six Regional Behavioral Health Authorities. For the FY2010 SAPTBG, Nebraska received a total of \$7,892,928. These funds were allocated \$5,926,439 (75%) for Substance Abuse Treatment, \$1,578,586 (20%) for

GOAL # 13. Progress - Assessment of Need for Treatment & Prevention | Sept 27, 2010 | pg 10

Primary Prevention, and 387,903 (5%) Administration (excluding program/provider level). No SAPTBG funds are used in either Tuberculosis Services or HIV Early Intervention Services.

NEED FOR TECHNICAL ASSISTANCE

NE is considering Technical Assistance in the following areas:

- Technical Assistance on Strategic Planning. The Division of Behavioral Health completed Behavioral Health Reform by downsizing state psychiatric hospitals and moving the funds into the community. Substance Abuse was included in the effort; however, the primary emphasis was on the mental health system. This should include exploring the further use of telemedicine and related communications technology to expand the reach of substance abuse treatment. This should also include improvement in the use of data for program development and improvement.
- Co-Occurring Mental Health / Substance Abuse issues – the Unduplicated Count of Persons Receiving Services Funded by the Division of Behavioral Health in SFY2009, all clients served in mental health and/or substance abuse services was 37,669. Of this number, 19,949 (53%) were Substance Abuse ONLY Clients or Co-occurring Clients. Only 5,095 (14%) were reported as "Substance Abuse ONLY Clients". This suggests the Division of Behavioral Health needs to improve upon the services available for this population.
- Rate Setting Methods for Community Substance Abuse Services – the Division of Behavioral Health needs assistance on updating the rate setting methods used for purchasing substance abuse services in Nebraska. This rate setting method needs to take into account the issues involved in providing proper services to people with Co-occurring substance abuse and mental health problems.
- Recovery Oriented Systems of Care (ROSC) – part of Behavioral Health Reform included a focus on consumers of Behavioral Health services, including substance abuse. The Division of Behavioral Health would like to enhance/expand our subject area expertise in ROSC. This needs to include help to plan and implement systems using the ROSC approach, a community level focus on recovery oriented systems of care, peer support and other related areas now being developed under the leadership of the Office of Consumer Affairs (in the Division of Behavioral Health) as well as the Consumer Specialists within the six Regional Behavioral Health Authorities. The technical assistance would be used to generate a dialogue on ways to move from acute care models to using recovery as a driving force for service design.
- Development of a Data Strategy – the Division of Behavioral Health needs to develop a long term data strategy in order to work with the rate setting mechanism as well as a sustainable method for collecting the data needed for the National Outcome Measures. This needs to include improving the infrastructure for collecting, storage, analysis and reporting of the data to be used in program development as well as quality improvement.

Goals and Objectives

Goal: Improve ability to make data driven decisions as part of the Division of Behavioral Health's Quality Improvement work:

1. Development of a National Outcome Measures (NOMs) report for the Regions and providers. The Division of Behavioral Health is committed to improving the quality of substance abuse services. This needs to include providing a feedback loop to the Regional Behavioral Health Authorities and the providers. This focus will also support the efforts to improvement the needs assessment both by locality and by the State in general.

GOAL # 13. Progress - Assessment of Need for Treatment & Prevention | Sept 27, 2010 | pg 11

2. Co-occurring Mental Illness and Substance Use Disorders – as reported above, the Unduplicated Count of Persons Receiving Services Funded by the Division of Behavioral Health in SFY2009, only 5,095 (14%) were "Substance Abuse ONLY Clients". This suggests the Division of Behavioral Health needs to improve the service capacity including development of effective policies related to co-occurring populations.
3. Consumer survey – the Division of Behavioral Health needs to review and update methods used to collect and report the consumer survey. The Division of Behavioral Health has received reports from various sources about the number of different consumer surveys completed annually. Each provider needs to complete a form of consumer survey. The Division of Medicaid and Long Term Care uses the Magellan Health Services, the Administrative Services Only Managed Care provider, to do a consumer survey. The Division of Behavioral Health completes an annual survey, which includes substance abuse clients, for the Federal Community Mental Health Services Block Grant. The Division of Behavioral Health intends to review these surveys and explore the possibility of streamlining the survey process. The improved survey method should then produce data that can be used at the local, Regional and State levels for quality improvement. It should also provide a feedback loop to the Nebraska Behavioral Health System.
4. Improved Needs Assessment – In preparing the FY2010 application for the Substance Abuse Prevention and Treatment Block Grant, the Division of Behavioral Health updated Form 8 (Treatment Needs Assessment Summary Matrix), Form 9 (Treatment Needs by Age, Sex and Race/Ethnicity) and How your State determined the estimates for Form 8 and Form 9. In FY2010, the Division will improve upon this work. The starting point will involve working with the following data
 - Using Magellan Behavioral Health data, prepare an analysis of Substance Category [alcohol and/or Illicit Drugs (Marijuana, Cocaine, Methamphetamine, Prescription drug use, Opioids, and Other Compounds)] by How Drug is Administered (snorted, swallowed, absorbed through mouth tissue, smoked, injected, Inhaled) at admission.
 - Capacity and Waiting Lists data by Region and Statewide for the new system implemented October 5, 2009.
 - Compare this to the findings from the most recent Nebraska data available under the National Survey on Drug Use and Health from the Office of Applied Studies under the Substance Abuse and Mental Health Services Administration.

A special focus will be placed on

- priority populations:
 1. Pregnant Injecting Drug Users
 2. Pregnant Substance Abusers
 3. Injecting Drug Users
 4. Women with Dependent Children
- Form 8 categories:
 3. Total Population in need (A. Needing treatment services, B. That would seek treatment)
 4. Number of IVDUs in need (A. Needing treatment services, B. That would seek treatment)
 5. Number of women in need (A. Needing treatment services, B. That would seek treatment)
 6. Prevalence of substance-related criminal activity (A. Number of DWI arrests, B. Number of drug-related arrests, C. Other-Liquor Laws)

GOAL # 13. Progress - Assessment of Need for Treatment & Prevention | Sept 27, 2010 | pg 12

The Nebraska data available under the National Survey on Drug Use and Health will provide a measure of the number of persons needing treatment services. Magellan data in conjunction with the Division's Capacity Management Data/Waiting List data will provide a measure of the number of persons who are actually being served in the Division of Behavioral Health funded substance abuse programs "Did Seek Treatment." The "Seek Treatment" will include both those who voluntarily requested service plus those who received some external motivation (such as a court order). An improved understanding of these relationships will provide a better assessment of need for substance abuse treatment services in Nebraska. The improved understanding will be reflected on Form 8, Form 9, "How the Forms Were Prepared" plus Goal 13. The work will be coordinated with the Nebraska Substance Abuse Epidemiology Workgroup (NSAEW) and the State Advisory Committee on Substance Abuse Services.

Goal: The Division of Behavioral Health received Technical Assistance (TA) in May 2009 on Standards of Care. This TA recommended the Division consider enhancing our Standards of Care by developing a document that would include the "expectations that treatment at higher levels of care would typically be followed by treatment at lower levels of care." In addition, the Division would then introduce a widely used associated measure to support this standard of care i.e. percent of clients completing a higher level of care who are admitted to lower level of care within a specified period. Applying this measure could identify bottlenecks along the continuum of care. Depending on the situation, this could assist the RBHA's and providers when considering resource allocation, efficient and individualized lengths of stay to expand access; barriers such as requirements for duplicate assessments and intake sessions at the next level of care; and processes to improve access. These types of measures would also communicate the expectation that addiction treatment should continue beyond the initial level of care.

Prevention Goals

1. Prevent the onset and reduce the progression of substance abuse, including underage drinking;
2. Reduce substance abuse related problems in communities; and
3. Build prevention capacities and infrastructure at the state/tribal and community levels;

The Division of Behavioral Health is committed to meeting the requirements of the Substance Abuse Prevention and Treatment Block Grant (SAPTBG). Areas of deficiency noted in the 2007 Core Technical Review will be resolved, promoting improved services and efficiency.

1. The array of substance abuse services will be based on a documented needs assessment and corresponding strategic planning.
2. The Nebraska Behavioral Health System will collect and utilize data in the planning and monitoring of substance abuse services.
3. Regional staff and providers will demonstrate knowledge of SAPTBG requirements concerning interim services. Waitlist management will occur, and interim services will be provided to priority populations. This will be documented and made easily accessible.
4. Regions will encourage and assist providers offering services to pregnant women and women with dependent children to:
 - a. Become qualified as defined by federal regulation, and
 - b. Demonstrate continuity of care in the consumer's written record.

Capacity and Waiting Lists

The Division of Behavioral Health is implementing an improved method for collecting and managing the capacity monitoring and waiting list. This new approach is being implemented

GOAL # 13. Progress - Assessment of Need for Treatment & Prevention | Sept 27, 2010 | pg 13

starting on October 5, 2009. The first data reports will be received October 12, 2009. As a result, for the intended use time period, there are no data for a summary of such information for admissions / discharges or to indicate areas availability of prevention and treatment activities of insufficient capacity to meet the need. As these reports become available, there will be special attention should be provided to the following priority populations:

1. Pregnant Injecting Drug Users
2. Pregnant Substance Abusers
3. Injecting Drug Users
4. Women with Dependent Children

This is a description of the State's management information system pertaining to capacity and waiting lists. Under Attachment G: Capacity Management and Waiting List Systems, there is the description of how the Division of Behavioral Health is implementing the new methods. As the system is implemented, there will be documentation on when services are insufficient to meet the need and a summary of such information capacity and waiting lists. The official start of this new waiting list system is October 5, 2009. The first data will be reported to the Division of Behavioral Health on October 12, 2009. Once the data reporting starts, it will be review on the weekly conference call with the six Regional Behavioral Health Authorities. Also, there will be monthly data reports to summarize the trends prepared by the Division of Behavioral Health.

This is part of the plan of correction efforts. In April 2009, the Division of Behavioral Health worked with the Regional Behavioral Health Authorities (RBHA) to amend the annual contract. The RBHA also amended their provider subcontracts. Contracts contained additional interim service language. Outreach activities continued to be spelled out in the contract. The contracts stated that IV-drug abusing clients shall be admitted within 14 days of request for treatment, or if no services are available, must be provided with interim services within 48 hours and admitted to treatment with 120 days. Interim services were now defined in the contract.

The RBHA and subcontractors were required to report to DBH whenever full (90%) capacity is reached and/or if an IV-drug abusing client is unable to be admitted to service.

In August 2009, a Waitlist/Capacity Management procedures and forms were approved. Training was completed for RBHA's and providers on September 25, 2009. Implementation of the new Waitlist/Capacity Management system will be October 5, 2009.

The procedures and forms specify that the individuals from the priority populations who have requested treatment, but who have not had a substance abuse assessment completed within the last 6 months, must have an appointment for a substance abuse assessment within 48 hours from time of request, and must receive the actual assessment within 7 business days of the appointment. The waitlist clock starts when a client completes the assessment process and a recommendation for treatment is made. This will ensure that individuals from the priority populations receive timely access to assessment and treatment services.

When individuals from the priority populations cannot immediately receive treatment as documented in the recommendations of the substance abuse assessment, and as outlined in the ASAM (American Society of Addiction Medicine) Patient Placement Criteria; the individual must receive Interim Services and be placed on waitlist for treatment.

The weekly SA Capacity Report and weekly SA Priority Waitlist/Interim Services Report will be completed and updated by the Behavioral Health Network Providers and be submitted to the

GOAL # 13. Progress - Assessment of Need for Treatment & Prevention | Sept 27, 2010 | pg 14

Regional Behavioral Health Authority each week on the date established by the region. The Regional Behavioral Health Authorities will collect, analyze, and aggregate this data. Every Tuesday, the RBHA will provide the aggregated report to the Division of Behavioral Health’s designated staff via email. The Division will analyze and aggregate this data in order to report on the available capacity (purchased and unpurchased) for substance abuse treatment services. The reports serve as notification to the DBH when programs reach 90 percent of its capacity and DBH will receive such reports within 7 days of reaching 90 percent capacity.

The Division will hold a weekly phone conference to direct both providers and Regional Behavioral Health Authorities to agencies across NE who has available capacity, should a specific level of care not be available in one area of the state.

Information will also be monitored via the Weekly SA Capacity Report and Weekly SA Priority Waitlist/Interim Services Report that indicate when individuals are placed on the Waitlist and when individuals are able to be removed from the Waitlist.

Regional Behavioral Health Authorities will monitor this information in order to track data regarding “length of time” individuals are waiting to access services. This data will assist our system during our annual budget planning process. The Capacity Reports will also track to ensure that all individuals who are on the Waitlist are also receiving the required Interim Services.

Note: All information provided on the Weekly SA Reports will be done so in a manner that does not identify the individual. A unique consumer identifier containing the first four characters of the last name + date of birth (YYYYMMDD) + the last four numbers of the social security number. The unique identifier should help DBH sort out individuals who may be duplicated among waiting lists.

Providers must maintain contact with individuals on the waitlist a minimum of every 7 days from the initial screening.

Summary Reports from the Wait List and Capacity Management Systems

As demonstrated in the table below the State of Nebraska’s capacity and wait list information system is documenting the continued need for additional treatment expansion and that agencies are maintaining wait lists. Each of the Regions is experiencing wait lists with Region 5 and 6 having the largest proportion of persons waiting for services. The table below is a demonstration for selected months in the compliance and progress years showing a combination of Residential and Non-residential wait list size. Residential capacity has been steady over the time period with the distribution of additional funds from LB 1083 and emphasis by the state on the priority populations.

RESIDENTIAL

REGION	OCTOBER 06	JANUARY 07	APRIL 07	JUNE 07	JULY 07	OCTOBER 07	JANUARY 08
1	21	19	26	18	35	34	9
2	10	7	7	12	11	9	10
3	86	75	66	84	107	78	53
4		47		0	62	58	29
5	158	162	201	172	179	182	162
6	118	93	83	74	69	45	42
TOTALS	393	403	383	360	463	406	305

NON-RESIDENTIAL

REGION	OCTOBER 06	JANUARY 07	APRIL 07	JUNE 07	JULY 07	OCTOBER 07	JANUARY 08
1	5	5	5	0	0	0	0
2	0	0	0	0	0	0	0
3	73	56	55	80	38	42	41
4		66		0	21	22	31
5	209	236	261	209	210	191	173
6	176	128	213	211	204	434	349
TOTALS	463	491	534	500	473	689	594

RESIDENTIAL & NON-RESIDENTIAL COMBINED

REGION	OCTOBER 06	JANUARY 07	APRIL 07	JUNE 07	JULY 07	OCTOBER 07	JANUARY 08
1	26	24	31	18	35	34	9
2	10	7	7	12	11	9	10
3	159	131	121	164	145	120	94
4	0	113	0	0	83	80	60
5	367	398	462	381	389	373	335
6	294	221	296	285	273	479	391
TOTALS	856	894	917	860	936	1095	899

As demonstrated in the tables above the State of Nebraska continues to experience capacity issues as reflected in nearly 900 persons waiting to access the treatment system in January 2008. This continues to demonstrate the need for additional coordination of activities among treatment providers and the relative capabilities of the providers to address priority populations. Special emphasis has been given to priority populations, but with wait lists as extensive as those presented, last minute admissions have been the norm rather than the exception.

List Of The Entities That Provide The Services With Description Of The Services Provided.

Nebraska Substance Abuse Treatment and Prevention Providers Approved by the Regional Behavioral Health Authority and Funded by Division of Behavioral Health
As of September 30, 2009

Region	Provider (ISATS NUMBER)	SA Approved Service
1	Region 1 Behavioral Health Authority (NE300205) 4110 Avenue 'D' Scottsbluff, NE 69361 (308) 635-3171	Emergency Community Support -- MH or SA House Related Service -- SA Crisis Response Peer Support -- MH or SA Regional Prevention Coordination - SA
1	Behavioral Health Specialists (NE301302) 600 S. 13th Norfolk, NE 68701 (402) 370-3140	Short Term Residential - SA

GOAL # 13. Progress - Assessment of Need for Treatment & Prevention | Sept 27, 2010 | pg 16

Region	Provider (ISATS NUMBER)	SA Approved Service
1	Human Services, Inc.(NE900699) 419 West 25th Street Alliance, NE 69301 (308) 762-7177	24 Hour Crisis Phone Crisis Assessment/Evaluation - SA (LADC) Social Detoxification Community Support - SA Short Term Residential - SA Intensive Outpatient - SA Outpatient Therapy - SA
1	North East Panhandle Substance Abuse Center (NE100605) 305 Foch St. P.O. Box 428 Gordon, NE 69343 (308) 282-1101	Social Detoxification Short Term Residential - SA Intensive Outpatient - SA Outpatient Therapy - SA Community Support - SA
1	Panhandle Mental Health Center (NE100596) 212 Box Butte Ave. Alliance, NE 69301 (308) 635-3171	Outpatient Therapy - SA
1	Panhandle Mental Health Center (NE300205) 4110 Avenue 'D' Scottsbluff, NE 69361 (308) 635-3171	24 Hour Crisis Phone Crisis Assessment/Evaluation - SA Community Support - SA Intensive Outpatient - SA Outpatient Therapy - SA Youth Outpatient Therapy - SA
1	Panhandle Mental Health Center (NE100408) 2246 Jackson Avenue Sidney, NE 69162 (308) 635-3171	Outpatient Therapy - SA Intensive Outpatient - SA
1	Panhandle Substance Abuse Council (NE900863) 1517 Broadway, Suite 124 Scottsbluff, NE 69361 (308) 632-3044	Regional Prevention Coordination - SA Community Prevention - Panhandle
1	Regional West Medical Center (NE101215) 4021 Avenue 'B' Scottsbluff, NE 69361 (308) 630-1500	Dual Residential (SPMI & CD)
2	Region II Human Services (NE900525) 307 E. 5th Lexington, NE 68850 (308) 324-6754	Regional Prevention Coordination - SA Crisis Assessment/Evaluation - SA (LADC) Urgent Assessment/Evaluation - MH or SA Urgent Outpatient Therapy - MH or SA (LADC) Emergency Community Support - MH or SA Community Support - SA Assessment/Evaluation - SA Outpatient Therapy - SA Outpatient Therapy Dual (SPMI & CD)

GOAL # 13. Progress - Assessment of Need for Treatment & Prevention | Sept 27, 2010 | pg 17

Region	Provider (ISATS NUMBER)	SA Approved Service
		SA Approved Service Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA Youth Outpatient Therapy Dual (SED & CD)
2	Region II Human Services (NE900392) 1012 W. 3rd McCook, NE 69001 (308) 345-2770	Prevention Services Crisis Assessment/Evaluation - SA (LADC) Urgent Assessment/Evaluation - MH or SA Urgent Outpatient Therapy - MH or SA (LADC) Emergency Community Support - MH or SA Community Support - SA Day Rehabilitation Assessment/Evaluation - SA Outpatient Therapy - SA Outpatient Therapy Dual (SPMI & CD) Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA Youth Outpatient Therapy Dual (SED & CD)
2	Region II Human Services (NE900566) 110 N. Bailey Street North Platte, NE 69103 (308) 534-0440	Prevention Services Crisis Assessment/Evaluation - SA (LADC) Urgent Assessment/Evaluation - MH or SA Urgent Outpatient Therapy - MH or SA (LADC) Emergency Community Support - MH or SA Community Support - SA Assessment/Evaluation - SA Outpatient Therapy - SA Outpatient Therapy Dual (SPMI & CD) Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA Youth Outpatient Therapy Dual (SED & CD)
2	Region II Human Services (NE900574) 401 W. 1st Ogallala, NE 69153 (308) 284-6767	Prevention Services Crisis Assessment/Evaluation - SA (LADC) Urgent Assessment/Evaluation - MH or SA Urgent Outpatient Therapy - MH or SA (LADC) Emergency Community Support - MH or SA Community Support - SA Assessment/Evaluation - SA Outpatient Therapy - SA Outpatient Therapy Dual (SPMI & CD) Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA Youth Outpatient Therapy Dual (SED & CD)
2	CenterPointe (NE301401) 2633 'P' Street Lincoln, NE 68503 (402) 475-8717	Dual Residential (SPMI & CD)
2	Great Plains Regional Medical Center (NE100213) 601 W. Leota St.	Crisis Assessment/Evaluation - SA (LADC)

GOAL # 13. Progress - Assessment of Need for Treatment & Prevention | Sept 27, 2010 | pg 18

Region	Provider (ISATS NUMBER)	SA Approved Service
	North Platte, NE 69101 (308) 696-8000	
2	Regional West (NE101215) 4021 Ave. 'B' Scottsbluff, NE 69361 (308) 630-1500	Crisis Assessment/Evaluation - SA (LADC)
2	Richard Young Hospital (NE100118) 4600 17th Avenue Kearney, NE 68848 (308) 865-2202	Crisis Assessment/Evaluation - SA (LADC)
2	St Monica's Behavioral Health (NE101645) 120 Wedgewood Dr Lincoln, NE 68510 (402) 441-3767	Short Term Residential - SA Therapeutic Community - SA
2	Touchstone (NE000081) 1100 Military Road Lincoln, NE 68508 (402) 435-3165	Short Term Residential - SA
2	Goodwill Industries of Greater NE (NE100279) 1804 S. Eddy Grand Island NE 68801 (308) 384-7896	Emergency Community Support - MH/SA Community Support - SA
2	Houses of Hope (NE901242) 601 Cotner Blvd Lincoln, NE 68502 (402) 435-3165	Halfway House - SA
3	Region 3 Behavioral Services (NE100803) 4009 6th Avenue, Suite 65 Kearney, NE 68845 (308) 237-5113	Emergency Community Support - MH or SA Regional Prevention Coordination - SA
3	Behavioral Health Specialists/SOS (NE900707) 4432 Sunrise Place Columbus, NE 68601 (402) 564-9994	Social Detoxification Short Term Residential - SA
3	Buffalo County Community Partners Positive Pressure (NE100801) PO Box 1466 Kearney, NE 68848 (308) 865-2283	Prevention Services
3	Catholic Charities (NE100126) 3020 18th Street Columbus, NE 68601	Dual Residential (SPMI & CD)

GOAL # 13. Progress - Assessment of Need for Treatment & Prevention | Sept 27, 2010 | pg 19

Region	Provider (ISATS NUMBER) (402) 829-9301	SA Approved Service
3	Central Nebraska Council on Alcoholism (NE750144) 219 W. 2nd Street Grand Island, NE 68801 (308) 385-5520	Prevention Services
3	Friendship House/Milne Detox (NE750151) 406 W. Koenig Street Grand Island, NE 68801 (308) 382-0422 / (308) 382-9451	Social Detoxification Halfway House - SA
3	Grand Island Substance Abuse Prevention Coalition (NE750144) 219 West 2nd St. Grand Island, NE 68801 (308) 385-5520	Prevention Services
3	Mary Lanning Memorial Hospital (NE100100) 715 N. St. Joseph Ave. Hastings, NE 68901 (402) 463-5973	Crisis Assessment/Evaluation - SA (LADC) Emergency Community Support - MH or SA
3	Mid-Plains Center for Behavioral Healthcare Services (NE301500) 914 Baumann Dr. Grand Island, NE 68801 (308) 385-5250	Outpatient Therapy Dual (SPMI & CD)
3	South Central Behavioral Services, Inc. (NE901192) 121 15th Ave. Franklin, NE 68939 (308) 237-5951	Assessment/Evaluation - SA Outpatient Therapy - SA Youth Outpatient Therapy - SA Youth Assessment/Evaluation - SA
3	South Central Behavioral Services, Inc. (NE750946) 616 W. 5th St. Hastings, NE 68901 (402) 463-5684	Intensive Outpatient - SA Assessment/Evaluation - SA Outpatient Therapy - SA Youth Intensive Outpatient - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
3	South Central Behavioral Services, Inc. (NE900517) 701 4th Ave., Suite 7 Holdrege, NE 68949 (308) 995-6597	Assessment/Evaluation - SA Outpatient Therapy - SA Youth Outpatient Therapy - SA Youth Assessment/Evaluation - SA
3	Goodwill Industries of Greater NE (NE100279) 1804 S. Eddy Grand Island NE 68801 (308) 384-7896	Emergency Community Support - MH/SA Community Support - SA

GOAL # 13. Progress - Assessment of Need for Treatment & Prevention | Sept 27, 2010 | pg 20

Region	Provider (ISATS NUMBER)	SA Approved Service
3	Garfield-Wheeler-Loop (GLW) Children's Council (NE100804) PO Box 638 455 Grand Avenue Burwell NE 68823 (308) 346-4284	SA Community Coalition
3	Mid Plains Center - Dual Program Box 34 Mason City NE 68855 (308) 385-5250	Dual Outpatient - MH/SA
3	South Central Behavioral Services, Inc. (NE301708) 3810 Central Avenue Kearney, NE 68847 (308) 237-5951	Community Support - SA Intensive Outpatient - SA Assessment/ Evaluation - SA Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Intensive Outpatient - SA Youth Outpatient Therapy - SA
3	South Central Behavioral Services, Inc. (NE900632) 510 East 10th St. Superior, NE 68978 (402) 463-5684	Assessment/Evaluation - SA Outpatient Therapy - SA Youth Outpatient Therapy - SA Youth Assessment/Evaluation - SA
3	South Central Substance Abuse Prevention Coalition (NE900921) 835 South Burlington, Suite 114 Hastings, NE 68901 (402) 463-0524	Prevention Services
3	St. Francis Alcohol Drug Treatment Center (NE100216) 314 S. 14th St. Ord, NE 68862 (308) 728-3678	Assessment/Evaluation - SA Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
3	St. Francis Alcohol and Drug Treatment Center (NE100144) 315 S. 8th Broken Bow, NE 68822 (308) 872-6449	Assessment/Evaluation - SA Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
3	St. Francis Alcohol and Drug Treatment Center (NE900731) 2620 W. Faidley Ave Grand Island, NE 68801 (308) 398-5427	Short Term Residential - SA Intensive Outpatient - SA Assessment/Evaluation - SA Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA

GOAL # 13. Progress - Assessment of Need for Treatment & Prevention | Sept 27, 2010 | pg 21

Region	Provider (ISATS NUMBER)	SA Approved Service
3	St. Francis Alcohol and Drug Treatment Center (NE100118) 4600 17th Avenue Kearney, NE 68847 (308) 865-2000	Assessment/Evaluation - SA Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
3	The Bridge (NE900335) 922 N. Denver St. Hastings, NE 68901 (402) 462-4677	Therapeutic Community - SA
4	Region IV Behavioral Health System (NE100811) 206 Monroe Ave. Norfolk, NE 68701 (402) 370-3100	Emergency Community Support - MH or SA Regional Prevention Coordination - SA
4	Behavioral Health Specialists, Inc. (NE301302) 600 S. 13th Street Norfolk, NE 68701 (402) 370-3140	Community Support - SA Intensive Outpatient - SA Outpatient Therapy - SA Youth Community Support - SA Youth Outpatient Therapy - SA
4	S.O.S. Place (NE900707) 4432 Sunrise Place Columbus, NE 68601 (402) 564-9994	Social Detoxification Short Term Residential - SA
4	Catholic Charities (NE100126) 3020 18th Street, Suite 17 Columbus, NE 68601 (402) 563-3833	Urgent Assessment/Evaluation - MH or SA Community Support - SA Dual Residential (SPMI & CD) Intensive Outpatient - SA Outpatient Therapy - SA Youth Intensive Outpatient - SA Youth Assessment/ Evaluation - SA Youth Outpatient Therapy - SA
4	Heartland Counseling Services, Inc.(NE900491) 917 W. 21st St. South Sioux City, NE 68776 (402) 494-3337	Community Support - SA Intensive Outpatient - SA Outpatient Therapy - SA Youth Intensive Outpatient - SA Youth Assessment/ Evaluation - SA Youth Outpatient Therapy - SA
4	Heartland Solutions (NE100614) 318 E. Highway 20 P.O. Box 246 O'Neill, NE 68763 (402) 336-2800	Urgent Assessment/Evaluation - MH or SA Emergency Community Support - MH or SA Community Support - SA Day Rehabilitation Outpatient Therapy - SA Youth Outpatient Therapy - SA
4	North East Panhandle Substance Abuse Center (NE100605) 305 Foch St.	Social Detoxification

GOAL # 13. Progress - Assessment of Need for Treatment & Prevention | Sept 27, 2010 | pg 22

Region	Provider (ISATS NUMBER)	SA Approved Service
	P.O. Box 428 Gordon, NE 69343 (308) 282-1101	Short Term Residential - SA
4	The Link (NE900418) 1001 Norfolk Avenue Norfolk, NE 68701 (402) 371-5310	Halfway House - SA
4	Women's Empowering Life Line (NE100622) 305 North 9th Street Norfolk, NE 68701 (402) 844-4710	Dual Residential (SPMI & CD) Halfway House - SA
5	Blue Valley Behavioral Health (NE750953) 1123 S. 9th St. Beatrice, NE 68310 (402) 228-3386	Intensive Outpatient - SA Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA 24 Hour Crisis Phone
5	Blue Valley Behavioral Health (NE750045) 820 Central Ave. Auburn, NE 68305 (402) 274-4373	Intensive Outpatient - SA Outpatient Therapy - SA Youth Outpatient Therapy - SA Youth Assessment/ Evaluation - SA
5	Blue Valley Behavioral Health (901184) 225 East 9th, Suite 1 Crete, NE 68333 (402) 826-2000	Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
5	Blue Valley Behavioral Health (750102) 367 'E' Street David City, NE 68632 (402) 367-4216	Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
5	Blue Valley Behavioral Health (NE750110) 521 'E' Street Fairbury, NE 68352 (402) 729-2272	Outpatient Therapy - SA Youth Outpatient Therapy - SA
5	Blue Valley Behavioral Health (NE750128) 116 W. 19th Street Falls City, NE 68355 (402) 245-4458	Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
5	Blue Valley Behavioral Health (NE900913) 831 'F' Street Geneva, NE 68361 (402) 759-4761	Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
5	Blue Valley Behavioral Health (NE750201) 141 N. 4TH Hebron, NE 68370	Outpatient Therapy - SA Youth Outpatient Therapy - SA

GOAL # 13. Progress - Assessment of Need for Treatment & Prevention | Sept 27, 2010 | pg 23

Region	Provider (ISATS NUMBER) (402) 759-4761	SA Approved Service
5	Blue Valley Behavioral Health (NE750409) 1903 4th Corso Nebraska City, NE 68410 (402) 873-5505	Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
5	Blue Valley Behavioral Health (NE750581) 531 Beebe Osceola, NE 68561 (402) 362-6128	Outpatient Therapy - SA Youth Outpatient Therapy - SA
5	Blue Valley Behavioral Health (NE750599) 600 "I" Street Pawnee City, NE 68420 (402) 245-4458	Outpatient Therapy - SA Youth Outpatient Therapy - SA
5	Blue Valley Behavioral Health (750631) 459 S. 6th St. Seward, NE 68434 (402) 643-3343	Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
5	Blue Valley Behavioral Health (NE750409) Johnson County Hospital 202 High Street Tecumseh, NE 68450 (402) 228-3386	Outpatient Therapy - SA Youth Outpatient Therapy - SA
5	Blue Valley Behavioral Health (NE750672) 543 N. Linden Street Wahoo, NE 68066 (402) 443-4414	Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
5	Blue Valley Behavioral Health (NE901382) 722 S. Lincoln Ave, Suite 1 York, NE 68467 (402) 362-6128	Intensive Outpatient - SA Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
5	CenterPointe (NE301401) 1000 South 13th Street Lincoln, NE 68508 (402) 475-5161	Community Support - SA Day Rehabilitation Outpatient Therapy - SA Youth Outpatient Therapy - SA Recovery Support - SA
5	CenterPointe (NE100436) 2220 S. 10th St. Lincoln, NE 68502 (402) 475-5161	Youth Therapeutic Community - SA
5	CenterPointe (NE302219) 2633 'P' St. Lincoln, NE 68503 (402) 475-8748	Dual Residential (SPMI & CD)

GOAL # 13. Progress - Assessment of Need for Treatment & Prevention | Sept 27, 2010 | pg 24

Region	Provider (ISATS NUMBER)	SA Approved Service
5	CFSTAR 2900 'O' Street, Suite 200 Lincoln, NE 68510 (402) 435-2910	Outpatient Therapy - SA
5	Child Guidance Center (NE100563) 2444 'O' Street Lincoln, NE 68510 (402) 475-7666	Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA Therapeutic Consultation - SA
5	Community Mental Health Center (NE750938) 2201 S. 17th St. Lincoln, NE 68502 (402) 441-7940	Crisis Assessment/Evaluation - SA (LADC) 24 Hour Crisis Phone
5	Cornhusker Place (NE750250) 721 'K' Street Lincoln, NE 68508 (402) 477-3951	Social Detoxification CPC Services (Involuntary) Intermediate Residential - SA Short Term Residential - SA Recovery Support - SA
5	Houses of Hope (NE901242) 601 Cotner Blvd Lincoln, NE 68502 (402) 435-3165	Halfway House - SA
5	Lincoln Medical Education Partnership (NE100415) 4600 Valley Road Lincoln, NE 68510 (402) 483-4581	Prevention Services Outpatient Therapy - SA
5	Lutheran Family Services (NE900962) 2900 'O' Street, Suite 200 Lincoln, NE 68510 (402) 435-2910	Intensive Outpatient - SA Outpatient Therapy - SA
5	St. Monica's Behavioral Health Services for Women (NE101464) 120 Wedgewood Dr. Lincoln, NE 68510 (402) 441-3768	Community Support - SA Intensive Outpatient - SA Outpatient Therapy - SA Short Term Residential - SA
5	St. Monica's Behavioral Health Services for Women (NE900038) Project Mother Child 219 S 24 Lincoln, NE 68510 (402) 441-3755	Therapeutic Community - SA
5	St. Monica's Behavioral Health Services for Women (NE100556) 4555 S. 25th St.	Therapeutic Community - SA

GOAL # 13. Progress - Assessment of Need for Treatment & Prevention | Sept 27, 2010 | pg 25

Region	Provider (ISATS NUMBER)	SA Approved Service
	Lincoln, NE 68510 (402) 434-8475	
5	Touchstone (NE000081) 1100 Military Rd. Lincoln, NE 68508 (402) 474-4343	Short Term Residential - SA
5	Lincoln Council of Alcoholism and Drugs (NE900350) 914 L Street Lincoln NE 68510 (402) 475-2694	Assessment Evaluation - SA
6	Region 6 (NE100837) 3801 Harney Street Omaha, NE 68131 (402) 444-6534	Regional Prevention Center
6	Alegent Health, Inc. (NE750904) 6901 N. 72nd St. Omaha, NE 68122 (402) 572-2936	Assessment/Evaluation - SA Outpatient Therapy - SA
6	Alegent Health, Inc. (NE101827) 1309 Harlen Drive Bellevue, NE 68005 (402) 572-2936	Assessment/Evaluation - SA Outpatient Therapy - SA
6	ARCH (NE750441) 604 S. 37th St. Omaha, NE 68105 (402) 346-8898	Halfway House - SA
6	ARCH (NE100496) 1502 N. 58th St. Omaha, NE 68114 (402) 346-8898	Halfway House - SA
6	BAART (NE100781) 1941 Center, Suite 210 Omaha, NE 68105 341-6220	Methadone Maintenance - SA
6	Catholic Charities (NE100431) 1490 N. 16th St. Omaha, NE 68102 (402) 554-0520	Crisis Assessment/Evaluation - SA (LADC) Social Detoxification CPC Services (Involuntary) Community Support - SA Short Term Residential - SA Dual Residential (SPMI & CD) Intensive Outpatient - SA

GOAL # 13. Progress - Assessment of Need for Treatment & Prevention | Sept 27, 2010 | pg 26

Region	Provider (ISATS NUMBER)	SA Approved Service
6	Catholic Charities (NE900665) 3300 N. 60th St. Omaha, NE 68104 (402) 554-0520	Assessment/Evaluation - SA Outpatient Therapy - SA
6	Catholic Charities (NE901333) 4430 S. 33rd St. Omaha, NE 68107 (402) 554-0520	Intermediate Residential - SA
6	Douglas County Community MH Center (NE100810) 4102 Woolworth Ave Omaha NE 68105 (402) 444-7698	CPC Services - Assessment Evaluation - SA Outpatient - SA
6	Heartland Family Services (NE100624) 116 E. Mission Ave. Bellevue, NE 68005 (402) 552-7445	Assessment/Evaluation - SA Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
6	Heartland Family Services (NE100103) 2101 S. 42nd St. Omaha, NE 68105 (402) 552-7445	Assessment/Evaluation - SA Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
6	Heartland Family Services (NE100317) 11212 Davenport St. Omaha, NE 68154 (402) 552-7445	Assessment/Evaluation - SA Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
6	Heartland Family Services (NE100625) 1246 Golden Gate Dr. Papillion, NE 68046 (402) 552-7445	Assessment/Evaluation - SA Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
6	Heartland Family Services (NE100799) 1016 Park Ave., #221 Omaha, NE 68105 (402) 552-7445	Therapeutic Community - SA
6	Latino Center of the Midlands (NE901051) 4821 S. 24th St Omaha, NE 68107 (402) 733-2720	Outpatient Therapy - SA
6	Lutheran Family Services (NE100332) 730 N. Fort Crook Road Bellevue, NE 68005 (402) 978-5621	Assessment/Evaluation - SA Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
6	Lutheran Family Services (NE100220) 403 S. 16th St.	Assessment/Evaluation - SA Outpatient Therapy - SA

GOAL # 13. Progress - Assessment of Need for Treatment & Prevention | Sept 27, 2010 | pg 27

Region	Provider (ISATS NUMBER)	SA Approved Service
	Blair, NE 68008 (402) 978-5621	Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
6	Lutheran Family Services (NE101686) 510 'D' St. Fremont, NE 68025 (402) 978-5621	Assessment/Evaluation - SA Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
6	Lutheran Family Services (NE101763) 124 S. 24th, Suite 100 Omaha, NE 68102 (402) 978-5621	Crisis Assessment/Evaluation - SA (LADC) Urgent Assessment/Evaluation - MH or SA Urgent Outpatient Therapy - MH or SA (LADC) Assessment/Evaluation - SA Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
6	Lutheran Family Services (NE100163) 2505 N. 24th Omaha, NE 68110 (402) 978-5621	Intensive Outpatient - SA Assessment/Evaluation - SA Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
6	Lutheran Family Services (NE100688) 415 South 25 Avenue Omaha, NE 68131 (402) 978-5621	Assessment/Evaluation - SA Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
6	Lutheran Family Services (NE100688) 401 E. Gold Coast Rd. Papillion, NE 68046 (402) 978-5621	Assessment/Evaluation - SA Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
6	Lutheran Family Services (NE100340) 546 Avenue A Plattsmouth, NE 68048 (402) 978-5621	Assessment/Evaluation - SA Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
6	Nebraska Urban Indian Health (NE101298) 2240 Landon Court Omaha, NE 68108 (402) 346-0902	Assessment/Evaluation - SA Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
6	NOVA Therapeutic Community (NE101405) 1915 S. 38th St. Omaha, NE 68105 (402) 455-8303	Youth Intensive Outpatient - SA
6	NOVA Therapeutic Community (NE300072) 3483 Larimore Ave. Omaha, NE 68111 (402) 455-8303	Short Term Residential - SA Therapeutic Community - SA Youth Therapeutic Community - SA
6	Salvation Army (NE750532)	Emergency Community Support - MH or SA

GOAL # 13. Progress - Assessment of Need for Treatment & Prevention | Sept 27, 2010 | pg 28

Region	Provider (ISATS NUMBER)	SA Approved Service
	3612 Cuming St. Omaha, NE 68131 (402) 898-5940	Intensive Case Management - MH or SA
6	Santa Monica (NE750540) 130 N. 39th St. Omaha, NE 68131 (402) 558-7088	Intermediate Residential - SA Halfway House - SA
Tribal Programs Funded Direct By Division		
4	**Omaha Tribe of Nebraska (NE100381) PO Box 368 Macy NE 68039	Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA Halfway House - SA Assessment/Evaluation - SA Outpatient Therapy - SA
4	**Ponca Tribe Of Nebraska (NE100121) 201 Miller Avenue Norfolk NE 68701	Assessment/Evaluation - SA Outpatient Therapy - SA
4	**Santee Sioux Tribe of Nebraska (NE750607) 425 Fraser Avenue No Suite 2 RR 2 Niobrara NE 68760	Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA Assessment/Evaluation - SA Outpatient Therapy - SA
4	**Winnebago Tribe of Nebraska (NE750706) PO Box 687 Winnebago NE 68071	Assessment/Evaluation - SA Outpatient Therapy (Adult)

Goal #14: Hypodermic Needle Program

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

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Prohibitions written into provider contracts; Compliance site visits; Peer reviews; Training/TA.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

Goal #14: Intended Use - Hypodermic Needle Program / September 24, 2010 / Page 1

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

FY 2011- FY 2013 (Intended Use/Plan):

(1) Who – Intravenous Drug Users (IVDU) in need of treatment services are individuals who use hypodermic needles or syringes to take illegal drugs such as heroin, cocaine, or other substances. A person is defined as being in need of services if the individual has a diagnosable substance use disorder with the usual route of admission through needles intravenously and leading to significant functional impairment.

Based on Magellan Health Services data, the Division of Behavioral Health estimates in FY2010, a total of 603 consumers reported for their primary, secondary or tertiary route for substance use as IV injection. Here are the numbers of IV drug users in the Magellan database for SFY2010 by region:

Route – IV injection for FY2010

Primary route="IV" or secondary route="IV" or tertiary route="IV" by region

Region	IV Users	
	Number	Percent
Region 1	35	6%
Region 2	27	4%
Region 3	105	17%
Region 4	85	14%
Region 5	198	33%
Region 6	153	25%
total	603	100%

1. Selected only those records that are getting a substance abuse service or the Duals.
2. SSN and Date of birth were used to unduplicate the cases, and last record was selected.
3. Selected those records that have primary route or secondary route or tertiary route="IV".
4. All the records that have primary route of IV injection or second route of IV injection or tertiary route of IV injection by region.

Source: Division of Behavioral Health

(2) What – no program funded through the Federal Substance Abuse Prevention and Treatment Block Grant (SAPTBG) will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs

(3) When - continuously being implemented

(4) Where in the State (geographic area) - The activities/services are undertaken in each of the six Behavioral Health Regions in Nebraska. The Nebraska Behavioral Health Services Act established the Regional Behavioral Health Authority (RBHA). Under §71-807, the Act assigns all 93 counties to one of six Behavioral Health Regions. Each RBHA is governed by a Regional Governing Board consisting of one county board member (locally elected official) from each county in the region. The administrator of the RBHA is appointed by the Regional Governing Board.

Goal #14: Intended Use - Hypodermic Needle Program / September 24, 2010 / Page 2

Region	Substate Planning Area (SPA)	Regional Office	Counties	Total Census data (estimated 2008)	% of population
1	Panhandle	Scottsbluff	11	85,813	4.80%
2	West Central	North Platte	17	99,148	5.60%
3	South Central	Kearney	22	223,379	12.50%
4	Northeast & North Central	Norfolk	22	204,799	11.50%
5	Southeast	Lincoln	16	436,512	24.50%
6	Eastern	Omaha	5	733,781	41.10%
Totals			93	1,783,432	100%

The Division of Behavioral Health contracts with the six Regional Behavioral Health Authorities for community substance abuse services. Each county in a behavioral health region provides funding as match against state general funds for the operation of the behavioral health authority and for the provision of behavioral health services in the region. The Act prohibits the regions from directly providing services except under very limited circumstances. §71-809 (2) does provide exceptions. One exception is a Regional Behavioral Health Authority may continue to directly provide services it operated on July 1, 2004.

(5) How – The contract between the Division of Behavioral Health and the six Regional Behavioral Health Authorities addresses these requirements under ATTACHMENT F - Federal Block Grant Requirements:

III. K. STERILE NEEDLE DISBURSEMENT AND HIV/AIDS

1. The Contractor will ensure that SAPTBG funded programs will not distribute sterile needles for hypodermic injection of illegal drugs or distribute bleach for the purpose of cleansing needles for the purposes of injection.
2. The Contractor will ensure that SAPTBG funded programs will not perform testing for the etiologic agent for Acquired Immune Deficiency Syndrome unless such testing is accompanied by appropriate pre-test and post-test counseling.

To see the full text of Attachment F, see Addendum - Additional Supporting Documents (Optional).

The Division of Behavioral Health monitors the six Regional Behavioral Health Authorities for compliance with contract provisions. The Regions contract with local qualified substance abuse providers for services. Each provider is specifically reviewed for compliance by the Region annually.

- a. Include restrictions on the use of funds for this purpose in all Regional and Direct contracts.
- b. Work with contract work group, fiscal managers and audit work teams to include appropriate policies and monitoring guidelines for network managers to check program compliance with restriction.
- c. Check program compliance with this restriction during monitoring visits of programs by regions and state staff.
- d. Check program compliance with this restriction during yearly agency monitoring conducted by the Regional Behavioral Health Authorities.
- e. Division Quality Improvement Team reviews Regional Behavioral Health Authorities reports of agency monitoring visits and document actions resulting.

Goal #14: Compliance - Hypodermic Needle Program | September 24, 2010 | Page 1

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

FY 2008 (Annual Report/Compliance):

(1) Who – individuals who use with hypodermic needles or syringes to take illegal drugs
Based on Magellan Health Services data, the Division of Behavioral Health estimates in FY2009, a total of 335 consumers reported their for their primary substance use, the primary route of IV injection. Here are the numbers of IV drug users in the Magellan database for FY2009 by Region:

Region 1	10
Region 2	20
Region 3	88
Region 4	59
Region 5	67
Region 6	88
Out of State	3
Total	335

(Note: As part of a quality initiative regarding data (January 2009), the Division of Behavioral Health administratively discharged nearly 18,000 admissions from our data system. These admission records had no activity in the last year. The DBH worked closely with providers, the six Regional Behavioral Health Authorities (RBHA), and the DBH Administrative Services Only (ASO)/Managed Care Company throughout this process in an attempt to update our data system and ensure the most accurate data possible.)

Here are the numbers of IV drug users in the Magellan database for FY2008 by Region:

Region 1	10
Region 2	19
Region 3	112
Region 4	72
Region 5	126
Region 6	108
Out of State	11
Total	458

Source: Division of Behavioral Health (July 2009)

(2) What – no program funded through the Federal Substance Abuse Prevention and Treatment Block Grant (SAPTBG) will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs

(3) When - continuously being implemented

(4) Where in the State (geographic area) - The activities/services are undertaken in each of the six Behavioral Health Regions in Nebraska. The Nebraska Behavioral Health Services Act established the Regional Behavioral Health Authority (RBHA). Under §71-807, the Act assigns all 93 counties to one of six Behavioral Health Regions. Each RBHA is governed by a Regional Governing Board

Goal #14: Compliance - Hypodermic Needle Program | September 24, 2010 | Page 2

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

Region	Substate Planning Area (SPA)	Regional Office	Counties	Total population Census data (estimated 2008)	% of population
1	Panhandle	Scottsbluff	11	85,813	4.80%
2	West Central	North Platte	17	99,148	5.60%
3	South Central	Kearney	22	223,379	12.50%
4	Northeast & North Central	Norfolk	22	204,799	11.50%
5	Southeast	Lincoln	16	436,512	24.50%
6	Eastern	Omaha	5	733,781	41.10%
Totals			93	1,783,432	100%

The Division of Behavioral Health contracts with the six Regional Behavioral Health Authorities for community substance abuse services. Each county in a behavioral health region provides funding as match against state general funds for the operation of the Behavioral Health Authority and for the provision of behavioral health services in the region. The Act prohibits the regions from directly providing services except under very limited circumstances. §71-809 (2) does provide exceptions. One exception is a Regional Behavioral Health Authority may continue to directly provide services it operated on July 1, 2004.

(5) How – The contract between the Division of Behavioral Health and the six Regional Behavioral Health Authorities includes the following:

K. STERILE NEEDLE DISBURSEMENT AND HIV/AIDS

1. The Contractor will ensure that SAPTBG funded programs will not distribute sterile needles for hypodermic injection of illegal drugs or distribute bleach for the purpose of cleansing needles for the purposes of injection.

The Division of Behavioral Health monitors the six Regional Behavioral Health Authorities for compliance with contract provisions. The Regions contract with local qualified substance abuse providers for services. Each provider is specifically reviewed for compliance by the Region annually.

- a. Include restrictions on the use of funds for this purpose in all Regional and Direct contracts.
- b. Work with contract work group, fiscal managers and audit work teams to include appropriate policies and monitoring guidelines for network managers to check program compliance with restriction.
- c. Check program compliance with this restriction during monitoring visits of programs by regions and state staff.
- d. Check program compliance with this restriction during yearly agency monitoring conducted by the Regional Behavioral Health Authorities.

Goal #14: Progress - Hypodermic Needle Program | September 24, 2010 | Page 1

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

FY 2010 (Progress)

(1) Who – Intravenous Drug Users (IVDU) in need of treatment services are individuals who use hypodermic needles or syringes to take illegal drugs such as heroin, cocaine, or other substances. A person is defined as being in need of services if the individual has a diagnosable substance use disorder with the usual route of admission through needles intravenously and leading to significant functional impairment.

Based on Magellan Health Services data, the Division of Behavioral Health estimates in FY2010, a total of 603 consumers reported for their primary, secondary or tertiary route for substance use as IV injection. Here are the numbers of IV drug users in the Magellan database for SFY2010 by region:

Route – IV injection for FY2010

Primary route="IV" or secondary route="IV" or tertiary route="IV" by region

Region	IV Users	
	Number	Percent
Region 1	35	6%
Region 2	27	4%
Region 3	105	17%
Region 4	85	14%
Region 5	198	33%
Region 6	153	25%
Total	603	100%

1. Selected only those records that are getting a substance abuse service or the Duals.
2. SSN and Date of birth were used to unduplicate the cases, and last record was selected.
3. Selected those records that have primary route or secondary route or tertiary route="IV".
4. All the records that have primary route of IV injection or second route of IV injection or tertiary route of IV injection by region.

Source: Division of Behavioral Health

(2) What – no program funded through the Federal Substance Abuse Prevention and Treatment Block Grant (SAPTBG) will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs

(3) When - continuously being implemented

(4) Where in the State (geographic area) - The activities/services are undertaken in each of the six Behavioral Health Regions in Nebraska. The Nebraska Behavioral Health Services Act established the Regional Behavioral Health Authority (RBHA). Under §71-807, the Act assigns all 93 counties to one of six Behavioral Health Regions. Each RBHA is governed by a Regional Governing Board consisting of one county board member (locally elected official) from each county in the region. The administrator of the RBHA is appointed by the Regional Governing Board.

Goal #14: Progress - Hypodermic Needle Program | September 24, 2010 | Page 2

Region	Substate Planning Area (SPA)	Regional Office	Counties	Total population Census data (estimated 2008)	% of population
1	Panhandle	Scottsbluff	11	85,813	4.80%
2	West Central	North Platte	17	99,148	5.60%
3	South Central	Kearney	22	223,379	12.50%
4	Northeast & North Central	Norfolk	22	204,799	11.50%
5	Southeast	Lincoln	16	436,512	24.50%
6	Eastern	Omaha	5	733,781	41.10%
Totals			93	1,783,432	100%

The Division of Behavioral Health contracts with the six Regional Behavioral Health Authorities for community substance abuse services. Each county in a behavioral health region provides funding as match against state general funds for the operation of the Behavioral Health Authority and for the provision of behavioral health services in the region. The Act prohibits the regions from directly providing services except under very limited circumstances. §71-809 (2) does provide exceptions. One exception is a Regional Behavioral Health Authority may continue to directly provide services it operated on July 1, 2004.

(5) How – The contract between the Division of Behavioral Health and the six Regional Behavioral Health Authorities includes the following:

K. STERILE NEEDLE DISBURSEMENT AND HIV/AIDS

1. The Contractor will ensure that SAPTBG funded programs will not distribute sterile needles for hypodermic injection of illegal drugs or distribute bleach for the purpose of cleansing needles for the purposes of injection.

The Division of Behavioral Health monitors the six Regional Behavioral Health Authorities for compliance with contract provisions. The Regions contract with local qualified substance abuse providers for services. Each provider is specifically reviewed for compliance by the Region annually.

- a. Include restrictions on the use of funds for this purpose in all Regional and Direct contracts.
- b. Work with contract work group, fiscal managers and audit work teams to include appropriate policies and monitoring guidelines for network managers to check program compliance with restriction.
- c. Check program compliance with this restriction during monitoring visits of programs by regions and state staff.
- d. Check program compliance with this restriction during yearly agency monitoring conducted by the Regional Behavioral Health Authorities.
- e. Beginning July 2009, work with the Division Quality Improvement Team, review Regional Behavioral Health Authorities reports of agency monitoring visits and document actions resulting.

Goal #15: Independent Peer Review

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

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Peer review process and/or protocols; Quality control/quality improvement activities; Review of treatment planning reviews; Review of assessment process; Review of admission process; Review of discharge process; achieving CARF/JCAHO/(etc) accreditation.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

Goal #15: Intended Use - Independent Peer Review / August 31, 2010 / Page 1

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

FY2011 – FY2013 (Intended Use/Plan)

The Division of Behavioral Health ensures an Independent Peer Review process to assess the quality, appropriateness, and efficacy of substance abuse treatment services. The Independent Peer Review requires that at least five percent (5%) of the entities providing substance abuse treatment services in the State are reviewed for quality, appropriateness. The Division of Behavioral Health will contract with an organization to carry out the Independent Peer Reviews of identified programs across the State. The programs reviewed are representative of the total population of such entities. Independent Peer Reviewers are individuals with expertise in the field of alcohol and drug abuse treatment.

The reviews will examine the following elements:

- Admission criteria/intake process
- Assessments
- Treatment planning, including appropriate referral, e.g. prenatal care and TB and HIV services
- Documentation of implementation of treatment services
- Discharge and continuing care planning
- Indications of treatment outcomes

The Division of Behavioral Health ensures that the Independent Peer Review does not involve practitioners/providers reviewing their own programs, or programs in which they have administrative oversight, and that there is a separation of peer review personnel from funding decision makers. Independent peer reviews are not conducted as part of the licensing/certification process.

The Division of Behavioral Health includes the Independent Peer Review requirement in the contract with the Regional Behavioral Health Authorities (RBHA). The RBHA's also include the Independent Peer Review requirement in their contracts with treatment providers (subcontractors).

The Division has been contracting for the Independent Peer Review since FY2001 with the same vendor. The Division is examining the current contract deliverables, and at this time has identified enhancements/changes to the future contract which will include:

- The current survey instrument will be revised to address specific programmatic standards for Mental Health and Substance Abuse Services.
- Peer Review processes and activities will be compiled and shared with all service providers across the State with the intent of improving the State's behavioral health service delivery system.
- Each site reviewed will be identified by the type of program (SA, MH, or Dual) in the Annual Report, which will enhance data reporting.
- Each provider will receive a detailed, individualized report in addition to an aggregate report of all agencies reviewed. This will help providers make

Goal #15: Intended Use - Independent Peer Review / August 31, 2010 / Page 2

specific service adjustments to better serve their clientele, as well as to gain a better understanding of other providers in their respective Region. The RBHA administration will also receive both reports to assist them in providing technical assistance to their providers.

In addition to enhancing reporting activities, the Division of Behavioral Health and the Contractor will work to cooperatively to address the following strategies:

- Improve the current process for conducting Peer Reviews to ensure trauma-informed treatment standards are addressed
- Gather consumer opinions in the Peer Review process, including the utilization of consumers and families in the process
- Involve the State Advisory Committee on Substance Abuse Services in Peer Review reporting and service recommendations
- Greater utilization of Peer Review data by the Division Quality Improvement Team

In the past, the providers expressed frustration with the duplication of accreditation reviews and the peer reviews required under the SAPTBG. In FY2010, the issue was resolved in that accreditation reviews may be considered a peer review if the SAPTBG requirements are met.

A total of \$24,500 was allocated for Independent Peer Review services in the FY2010 contract. (NOTE: The current contract is in effect until September 30, 2010. A new contract has not been developed as of this reporting.)

Goal #15: Compliance - Independent Peer Review / September 24, 2010 / Page 1

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

Overview

The Department of Health and Human Services—Division of Behavioral Health—Community-Based Services (DHHS-DBH-CBS) provides for independent peer reviews to assess the quality, appropriateness, and efficacy of treatment services provided in Nebraska to individuals under the program involved, and ensures that at least five percent (5%) of the entities providing services in the State under such program are reviewed. DHHS-DBH-CBS contracted with the Nebraska Association of Behavioral Health Organizations (NABHO) to carry out the Peer Reviews of the selected programs across the State in FY2009. The programs reviewed are representative of the total population of such entities. Independent peer reviewers are individuals with expertise in the field of alcohol and drug abuse treatment. As a part of the independent peer review, the reviewers review a representative sample of patient/client records to determine quality and appropriateness of treatment services while adhering to all Federal and State confidentiality requirements, including 42 CFR Part 2. The reviews examine the following:

- Admission criteria/intake process
- Assessments
- Treatment planning, including appropriate referral, e.g. prenatal care and TB and HIV services
- Documentation of implementation of treatment services
- Discharge and continuing care planning
- Indications of treatment outcomes

DHHS-DBH-CBS ensures that the independent peer review does not involve practitioners/providers reviewing their own programs, or programs in which they have administrative oversight, and that there is a separation of peer review personnel from funding decision makers. Independent peer reviews are not conducted as part of the licensing/certification process.

The Behavioral Health and Network Services Contract between DHHS-DBH-CBS and the Regional Behavioral Health Authority (RBHA) provide for the independent peer review requirement by requiring the Contractor to monitor compliance of providers in meeting requirements regarding other Federal requirements, including cooperation with, and participation in, independent peer reviews.

FY2009 (Compliance)

In compliance with the FY2009 Peer Review contract between the Division of Behavioral Health and the Nebraska Association of Behavioral Health Organizations (NABHO), six peer reviews were conducted of both mental health and substance abuse programs. The agencies selected for review were obtained from a list of eligible programs provided by

Goal #15: Compliance - Independent Peer Review / September 24, 2010 / Page 2

the Nebraska Department of Health and Human Services, and based on representation of a geographical and categorical cross section of the service programs.

Programs selected for the Peer Reviews process are contacted by the Peer Review Committee Chair and mailed a Peer Review Assessment packet. Reviewers are identified and a review date is selected. Peer Review is considered an open process, and the following materials were provided to the agency in advance of the actual review:

- Site Notification Letter
- Peer Review Manual (which clearly outlines: Needed Review Demographic Information; Program/Clinical Standards; Administrative Standards; Standards Worksheets
- Site Scheduling Form

At the conclusion of the agency review, reviewers return their completed standards packets to the Peer Review Committee and the results are compiled. Following are the results of the reviews:

Demographic Information for Nebraska’s 2008-2009 Peer Review

Percent Ethnic/Racial Groups Served Composite

	% Breakout by Program						TOTAL
	A	B	C	D	E	F	
Caucasian	85	78	95	88	62	91	83.17
African American	0	1	0	3	24	3.2	5.2
Hispanic	2.5	12	2.5	4	1.6	4.8	4.57
Native American/ Alaskan	2.5	5	0	1	2.4	1	1.98
Asian/Pacific Islander	0	.2	0	1	0.0	0.0	0.2
Other	0	4	2.5	3	10	0.0	3.25

Percent Gender Served Composite

	% Breakout by Program						TOTAL
	A	B	C	D	E	F	
Female	100	42	44	55	45	48.3	55.72
Male	0	58	56	45	55	51.7	44.28

Percent Ages Served Composite

	% Breakout by Program						TOTAL
	A	B	C	D	E	F	
Adolescent	0	24	30	16	100	12.6	30.43
Elderly	0	16	6	2	0	5.0	4.83
Adult	100	60	64	88	0	82.4	65.73

Scoring for Nebraska's 2008-2009 Peer Review

This represents the aggregate scoring for the six programs participating in the 2008-2009 NABHO Peer Review process

A	B	C	D	E	F
<i>Program/Clinical Standards</i>					
Client Rights					
22/28	27/28	24/28	20/28	28/28	28/28
Program Structure					
18/24	23/24	18/24	13/24	24/24	22/24
Assessment					
24/32	28/32	24/32	28/32	30/32	30/32
Service Planning					
24/32	29/32	24/32	28/32	32/32	29/32
Continuing Care Planning					
11/16	5/16	12/16	14/16	16/16	15/16
Documentation					
24/32	32/32	24/32	26/32	31/32	28/32
Program Evaluation					
6/8	8/8	6/8	7/8	8/8	6/8
<i>Program/Clinical Subtotal</i>					
<i>129/172</i>	<i>162/172</i>	<i>132/172</i>	<i>136/172</i>	<i>169/172</i>	<i>158/175</i>
<i>Administrative Standards</i>					
Organizational Leadership					
25/32	25/32	21/32	28/31	25/32	31/32
Fiscal Administration					
16/16	11/16	12/16	16/16	14/16	16/16
Strategic Planning					
9/12	8/12	9/12	10/12	12/12	12/12
Health and Safety					
27/36	29/36	27/36	35/36	28/36	35/36

Goal #15: Compliance - Independent Peer Review / September 24, 2010 / Page 4

Information Management

10/20 14/20 15/20 18/20 20/20 19/20

Human Resources Mgmt

19/24 22/24 18/24 22/24 20/24 24/24

Quality Improvement

18/24 17/24 18/24 19/24 20/24 24/24

Administrative Subtotal

120/164 126/164 117/164 148/164 139/164 161/164

TOTAL SCORE

249/336 288/336 249/336 284/336 308/336 319/336

Overall Outcome: All six sites received an accumulative score above 243, which puts them in the “commendation” category.

In addition to the demographic information, for each Agency reviewed Best Practices are identified, Major Strengths are documented, and Suggested Improvements are noted.

In an effort to increase Peer participation and input in the Review process, in FY2009 NABHO utilized Peer Recovery Specialists to conduct consumer input groups at two (2) Behavioral Health Treatment facilities in Lincoln, NE. Following are the questions asked of the consumer groups. The responses were compiled for each agency and summarized in NABHO’s Annual Report to the Division of Behavioral Health.

- 1. Comment on your physical surroundings, how safe and comfortable are you?**
- 2. Do you understand your rights as a client? If yes, how were you informed/educated about those rights?**
- 3. How have you been involved in your own treatment?**
- 4. Do you feel your strengths/needs and abilities were considered in your treatment? Can you recall specific times you felt your needs and/or abilities were talked about in terms of your treatment plan or treatment success?**
- 5. Did you feel you were treated with respect by staff at all levels of the organization?**

A total of \$9,500.00 (\$5,588.53 Federal funds; \$3,911.47 State funds) was expended for Peer Review activities during FY2009.

Goal #15: Progress - Independent Peer Review / September 24, 2010 / Page 1

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

FY2010 (Progress)

The Division of Behavioral Health ensures an Independent Peer Review process to assess the quality, appropriateness, and efficacy of substance abuse treatment services. The Independent Peer Review requires that at least five percent (5%) of the entities providing substance abuse treatment services in the State are reviewed for quality, appropriateness. The Division of Behavioral Health will contract with an organization to carry out the Independent Peer Reviews of identified programs across the State. The programs reviewed are representative of the total population of such entities. Independent Peer Reviewers are individuals with expertise in the field of alcohol and drug abuse treatment.

The reviews will examine the following elements:

- Admission criteria/intake process
- Assessments
- Treatment planning, including appropriate referral, e.g. prenatal care and TB and HIV services
- Documentation of implementation of treatment services
- Discharge and continuing care planning
- Indications of treatment outcomes

The Division of Behavioral Health ensures that the Independent Peer Review does not involve practitioners/providers reviewing their own programs, or programs in which they have administrative oversight, and that there is a separation of peer review personnel from funding decision makers. Independent peer reviews are not conducted as part of the licensing/certification process.

The Division of Behavioral Health includes the Independent Peer Review requirement in the contract with the RBHA's. The RBHA's also include the Independent Peer Review requirement in their contracts with treatment providers (subcontractors).

The Division has been contracting for the Independent Peer Review since FY2001 with the same vendor. The Division examined the current contract deliverables, and identified enhancements/changes to future contracts which include:

- The current survey instrument was revised to address specific programmatic standards for Mental Health and Substance Abuse Services.
- Peer Review processes and activities are compiled and shared with all service providers across the State with the intent of improving the State's behavioral health service delivery system.
- Each site reviewed is identified by the type of program (SA, MH, or Dual) in the Annual Report, which enhances data reporting.
- Each provider receives a detailed, individualized report in addition to an aggregate report of all agencies reviewed. This helps providers make specific service adjustments to better serve their clientele, as well as gain a better

Goal #15: Progress - Independent Peer Review / September 24, 2010 / Page 2

understanding of other providers in their respective Region. The RBHA administration also receives both reports to assist them in providing technical assistance to their providers.

In addition to enhancing reporting activities, the Division of Behavioral Health and the Contractor worked cooperatively to address the following strategies:

- Improve the current process for conducting Peer Reviews to ensure trauma-informed treatment standards are addressed
- Gather consumer opinions in the Peer Review process, including the utilization of consumers and families in the process
- Involve the State Advisory Committee on Substance Abuse Services in Peer Review reporting and service recommendations
- Greater utilization of Peer Review data by the Division Quality Improvement Team

The FY2010 Peer Review Report has not been received as of this writing. The Contractor has until the end of the current contract ends, September 30, 2010 to submit the report to the Division of Behavioral Health.

A total of \$24,500 was allocated for Independent Peer Review services in the FY2010 contract. (NOTE: The current contract is in effect until September 30, 2010. A new contract has not been developed as of this reporting, but it is anticipated \$20,000 will be allocated for the FY2011 contract for Independent Peer Review services.)

Independent Peer Review (formerly Attachment H)

(See 45 C.F.R. §96.122(f)(3)(v))

In **up to three pages** provide a description of the State's procedures and activities undertaken to comply with the requirement to conduct independent peer review during FY 2009 (See 42 U.S.C. §300x-53(a)(1) and 45 C.F.R. §96.136).

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

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

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

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

(See 45 C.F.R. §96.122(f)(3)(v))

Provide a description of the State's procedures and activities undertaken to comply with the requirement to conduct independent peer review during FY2009 (See 42 U.S.C. §300x-53(a)(1) and 45 C.F.R. §96.136).

Examples of **programs** include:

- the role of the Single State Agency (SSA) for substance abuse prevention activities and treatment services in the development of operational procedures implementing independent peer review:

As reported under Goal #15: Independent Peer Review, the Nebraska Department of Health and Human Services—Division of Behavioral Health—Community-Based Services (DHHS-DBH-CBS) contracted with the Nebraska Association of Behavioral Health Organizations (NABHO) to carry out the peer reviews of the selected programs across the State. DHHS staff monitors the review process and reports, and provide technical assistance to NABHO as the Review Agency.

- the role of the State Medical Director for Substance Abuse Services in the development of such procedures:

The State Medical Director for Substance Abuse Services provides oversight to the DHHS staff who monitor the review process and reports. The Medical Director keeps the staff and contractor up to date on new information in the field that needs to be included in the reviews.

- the role of the independent peer reviewers:

Independent peer reviewers are selected by and contract with NABHO to conduct peer reviews. The reviewers are individuals with expertise in the field of alcohol and drug abuse treatment. As a part of the independent peer review, the reviewers review a representative sample of patient/client records to determine quality and appropriateness of treatment services while adhering to all Federal and State confidentiality requirements.

DHHS-DBH-CBS ensures that the independent peer review does not involve practitioners/providers reviewing their own programs, or programs in which they have administrative oversight, and that there is a separation of peer review personnel from funding decision makers. Independent peer reviews are not conducted as part of the licensing/certification process.

- the role of the entity(ies) reviewed:

Independent peer reviews are conducted to assess the quality, appropriateness, and efficacy of treatment services provided in Nebraska to individuals served by the program involved, and ensures that at least five percent (5%) of the entities

providing services in the State under such program are reviewed. The involvement of the entities includes assisting in the selection of records/activities to be reviewed, assisting the reviewers in providing information during the review, and providing an efficient work environment to conduct the reviews.

Examples of **activities** include:

The reviews examine the following:

- Admission criteria/intake process
- Assessments
- Treatment planning, including appropriate referral, e.g. prenatal care and TB and HIV services
- Documentation of implementation of treatment services
- Discharge and continuing care planning
- Indications of treatment outcomes

- The number of entities reviewed during the applicable fiscal year:

DHHS ensures that at least five percent (5%) of the entities providing services in the State are reviewed. The programs reviewed are representative of the total population of such entities.

- Technical assistance made available to the entity(ies) reviewed:

Programs selected for the peer reviews process are contacted by the Peer Review Committee Chair and mailed a Peer Review Assessment packet to assist in preparing for the review. The Independent Peer Review is considered an open process, and the following materials are provided to the agency in advance of the actual review:

- Site Notification Letter
- Peer Review Manual (which clearly outlines: Needed Review Demographic Information; Program/Clinical Standards; Administrative Standards; Standards Worksheets
- Site Scheduling Form

- Technical assistance made available to the reviewers, if applicable.

The reviewers are invited to attend an annual all-day training conducted by experts in the mental health and substance abuse field, as well as employees of the review agency. The training covers clinical and program review protocol, and any new procedures and/or initiatives being introduced. Peer reviewers are also available to each other for technical assistance.

Goal #16: Disclosure of Patient Records

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

Note: In addressing this narrative the State may want to discuss activities or initiatives related to the provision of: *Confidentiality training/TA; Compliance visits/inspections; Licensure requirements/reviews; Corrective action plans; Peer reviews.*

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

Goal #16: Intended Use - Disclosure of Patient Records / September 24, 2010 \ Page 1

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

Overview

The Department of Health and Human Services-Division of Behavioral Health-Community-Based Services (DHHS-DBH-CBS) is required to have in effect a system to protect from inappropriate disclosure of patient records maintained by the State in connection with an activity funded under the program involved or by any entity which is receiving funds from the grant. This system must be in compliance with all applicable State and Federal laws and regulations, and shall include provisions for employee education on the confidentiality requirements as well as the fact that disciplinary action may occur upon inappropriate disclosures. If an inappropriate disclosure of the data becomes apparent to DHHS, it is the responsibility of DHHS under the law to correct the violation or terminate the Agreement. DHHS is accountable for the protection of the health information it collects and maintains. DHHS must safeguard and establish practices and processes that are compliant with the HIPAA standards for Privacy and the safeguarding of Protected Health Information.

DHHS signed a contract with the Centers for Medicare and Medicaid Services in 2003, as a single covered entity. All DHHS divisions and business units are part of the covered entity and therefore required to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules. As a covered entity, DHHS was required to write policies and procedures to comply with the HIPAA Privacy and Security Rules and to train all workforce members on the policies and procedures. These federal standards are audited and enforced by the Office for Civil Rights for the Privacy Rule and the Centers for Medicare and Medicaid Services for the Security Rule.

The Health Insurance Portability and Accountability Act (HIPAA) was enacted on August 21, 1996. The legislation was intended to improve the portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, to improve access to long-term care services and coverage, and to simplify the administration of health insurance.

The DHHS-DBH-CBS/ Regional Behavioral Health Authority (RBHA) Behavioral Health and Network Services Contract requires that providers comply with federal and state required standards of confidentiality, as well as collaborate as a member of the regional provider network to develop regional confidentiality protocols to ensure continuity of care with all providers in the Network.

Goal #16: Intended Use - Disclosure of Patient Records / September 24, 2010 \ Page 2

“Business Associates” are persons or organizations that perform functions or activities on behalf of DHHS and create or receive Protected Health Information for or from DHHS. Examples of Business Associate functions or activities include: claims processing, claims administration, data analysis, data processing, data administration, utilization, review, benefit management, practice management, and clinical services.

When DHHS enters into a Business Associate arrangement, a formal written contract is required by the Privacy Rule that delineates the obligations of the Business Associate to take reasonable steps to safeguard the Protected Health Information of individuals that is disclosed and used by the Business Associate.

- The Business Associate will not use or disclose the Protected Health Information other than as permitted by the Agreement
- The Business Associate will use safeguards to protect the information's confidentiality
- The Business Associate will report to DHHS any misuse of the information
- Any agents, sub-grantees, or sub-contractors of the Business Associate will provide the same assurances to the Business Associate
- The Business Associate will return or destroy the Protected Health Information once the contract is terminated, and instructed by DHHS to do so

The HIPAA Privacy Standards regulate the types of uses and disclosures that are permitted without an individual's signed Authorization, as well as a Notice of Information Privacy Practices, individual privacy rights, and Administrative Regulations, and enforcement mechanisms. The Privacy Standards inform health care consumers of how their health information is used and gives health care consumers access to information about themselves. The Privacy Standards require specific written Authorization for use and disclosure of the information for all other purposes.

The Privacy Rule requires that DHHS impose standards of performance for the safeguarding, use, and disclosure of Protected Health Information on the third parties with whom it contracts. If the contractor performs a function or activity involving the use or disclosure of Protected Health Information, a Business Associate relationship exists. Examples of functions or activities include:

- Billing, claims processing or administration
- Data analysis, utilization reviews, quality assurance
- Benefit or practice management
- Clinical services
- Direct client services

Protected Health Information is Individually Identifiable Health Information.

Examples of an individual's Protected Health Information:

- Name
- Mailing Address

Goal #16: Intended Use - Disclosure of Patient Records / September 24, 2010 \ Page 3

- Phone Number
- Birth Date
- Social Security Number
- Photograph
- Admission Date
- History and Physical
- Medical Records/Medical Transcription
- Psychotherapy Notes
- Nurse Notes
- Prescription
- Discharge Summaries
- Deceased Date
- Computer List of Regional Center Patients
- Facility Admission Face Sheet

FY2011- 2013 Intended Use

DHHS-DBH intends to follow current HIPAA rules in the FY2011 Network contracts with the Regional Behavioral Health Authorities. Under ATTACHMENT F - Federal Block Grant Requirements, there is the following:

III. C. 3. Ensure that SAPTBG funded subcontractors offer on-going training to their workforce specific to Federal Confidentiality (42 CFR part 2), including the penalties for non-compliance, and that the Subcontractor have Federal Confidentiality procedures in place.

To see the full text of Attachment F, see Addendum - Additional Supporting Documents (Optional).

Compliance with Nebraska Law

- In the performance of its responsibilities pursuant to the Regional Contracts, the Contractor shall adhere to all Nebraska statutory and regulatory requirements, and any subsequent revisions or additions thereto and all regulations for behavioral health. The Contractor agrees to amend the Contract as necessary to bring it into conformity with federal law or regulation changes.

Compliance with Federal Law

- In the performance of its responsibilities pursuant to the Regional Contracts, the Contractor shall adhere to all Federal statutory and regulatory requirements, and any subsequent revisions or enactments including: (1) the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) as amended by the Alcohol Abuse, Drug Abuse, Mental Health Amendment of 1984 (P.L. 98-509), (2) the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-205) (hereafter referred to as OBRA), (3) the Anti-Drug Abuse act of 1988 (P.L. 100-690), (4) the Drug Abuse Technical Corrections Act of 1989 (P.L. 101-93), (5) the Alcohol, Drug Abuse, and

Goal #16: Intended Use - Disclosure of Patient Records / September 24, 2010 \ Page 4

Mental Health Reorganization Act (42 USC 201) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA; P.L. 104-191). The Contractor agrees to amend the Contract as necessary to bring it into conformity with federal law or regulation changes.

- Providers shall comply with federal and state required standards of confidentiality and shall collaborate as a member of the regional provider network to develop regional confidentiality protocols to ensure continuity of care with all providers in the Network.
- The Protocols shall include, at a minimum, a standard regional release form for each client which allows the Division, or its agent, or the Regional Network Administrator to receive confidential client information to make a determination if care shall be authorized.
- The signed release of information shall be included in each client's record where service will be paid by state and/or federal funds.

Consumer Access to Records

- The HIPAA Privacy Rules guarantees individuals the right to review and obtain a copy of their Protected Health Information contained in the DHHS "Designated Record Set". DHHS may also deny individuals access to information that DHHS obtained under a promise of confidentiality from a source other than a Health Care Provider, such as a Business Associate, if granting the individual access could reveal the source.
- DHHS may deny individuals access to information based on a review by a licensed health care professional and the DHHS Privacy Board if it is determined it is reasonably likely to endanger the life or safety of the individual or another. The individual is entitled to have the denial reviewed by a health care professional who did not participate in the original denial decision and who the covered entity designates to act as a reviewing official.
- A denial of access must be in writing stating the reasons and explaining any review Rights including how to lodge a complaint with DHHS. It must inform the individual where the requested information is located and make available any of the information requested to which access is not being denied.

In addition to following the HIPAA Privacy Standards, DHHS-DBH has established Rules and Regulations related to the Confidentiality of Alcohol and Drug Abuse Patient Records. Following are portions of the current DHHS Regulations pertaining to these records. A complete set of these Regulations may be found at the following website:

http://www.access.gpo.gov/nara/cfr/waisidx_06/42cfr2_06.html

TITLE 42--PUBLIC HEALTH SERVICE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

CHAPTER I—

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

(a) Disclosure authorization

Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any drug abuse prevention function conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall be confidential and be disclosed only for the purposes and under the circumstances expressly authorized under section (b).

(b) Purposes and circumstances of disclosure affecting consenting patient and patient regardless of consent

(1) The content of any record may be disclosed in accordance with the prior written consent of the patient with respect to whom such record is maintained,

(2) Whether or not the patient, with respect to whom any given record is maintained, gives his or her written consent, the content of such record may be disclosed as follows:

(A) To medical personnel to the extent necessary to meet a bona fide medical emergency.

(B) To qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation, but such personnel may not identify, directly or indirectly, any individual patient in any report of such research, audit, or evaluation, or otherwise disclose patient identities in any manner.

(c) Prohibition against use of record in making criminal charges or investigation of patient

The prohibitions of this section continue to apply to records concerning any individual who has been a patient, irrespective of whether or when he or she ceases to be a patient.

The prohibitions of this section do not apply to any interchange of records--

(1) within the Armed Forces or within those components of the Veterans' Administration furnishing health care to veterans, or

(2) between such components and the Armed Forces.

Goal #16: Intended Use - Disclosure of Patient Records / September 24, 2010 \ Page 6

The prohibitions of this section do not apply to the reporting under State law of incidents of suspected child abuse and neglect to the appropriate State or local authorities.

(d) Purpose and effect.

(1) These regulations are not intended to direct the manner in which substantive functions such as research, treatment, and evaluation are carried out. They are intended to insure that an alcohol or drug abuse patient in a federally assisted alcohol or drug abuse program is not made more vulnerable by reason of the availability of his or her patient record than an individual who has an alcohol or drug problem and who does not seek treatment.

(e) Definitions.

For purposes of these regulations:

(1) Alcohol abuse means the use of an alcoholic beverage which impairs the physical, mental, emotional, or social well-being of the user.

(2) Drug abuse means the use of a psychoactive substance for other than medicinal purposes which impairs the physical, mental, emotional, or social well-being of the user.

(3) Diagnosis means any reference to an individual's alcohol or drug abuse or to a condition which is identified as having been caused by that abuse which is made for the purpose of treatment or referral for treatment.

(4) Disclose or disclosure means a communication of patient identifying information, the affirmative verification of another person's communication of patient identifying information, or the communication of any information from the record of a patient who has been identified.

(5) Informant means an individual:

(A) Who is a patient or employee of a program or who becomes a patient or employee of a program at the request of a law enforcement agency or official; and

(B) Who at the request of a law enforcement agency or official observes one or more patients or employees of the program for the purpose of reporting the information obtained to the law enforcement agency or official.

Goal #16: Intended Use - Disclosure of Patient Records / September 24, 2010 \ Page 7

- (6) Patient means any individual who has applied for or been given a diagnosis or treatment for alcohol or drug abuse at a federally assisted program and includes any individual who, after arrest on a criminal charge, is identified as an alcohol or drug abuser in order to determine that individual's eligibility to participate in a program.
- (7) Patient identifying information means the name, address, social security number, fingerprints, photograph, or similar information by which the identity of a patient can be determined with reasonable accuracy and speed either directly or by reference to other publicly available information. The term does not include a number assigned to a patient by a program, if that number does not consist of, or contain numbers (such as a social security, or driver's license number) which could be used to identify a patient with reasonable accuracy and speed from sources external to the program.
- (8) Person means an individual, partnership, corporation, Federal, State or local government agency, or any other legal entity.
- (9) Program means:
 - (A) An individual or entity (other than a general medical care facility) who holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment; or
 - (B) An identified unit within a general medical facility which holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment; or
 - (C) Medical personnel or other staff in a general medical care facility whose primary function is the provision of alcohol or drug abuse diagnosis, treatment or referral for treatment and who are identified as such providers.
- (10) Records means any information, whether recorded or not, relating to a patient received or acquired by a federally assisted alcohol or drug program.
- (11) Third party payer means a person who pays, or agrees to pay, for diagnosis or treatment furnished to a patient on the basis of a contractual relationship with the patient or a member of his family or on the basis of the patient's eligibility for Federal, State, or local governmental benefits.
- (12) Treatment means the management and care of a patient suffering from alcohol or drug abuse, a condition which is identified as having

Goal #16: Intended Use - Disclosure of Patient Records / September 24, 2010 \ Page 8

been caused by that abuse, or both, in order to reduce or eliminate the adverse effects upon the patient.

- (13) Undercover agent means an officer of any Federal, State, or local law enforcement agency who enrolls in or becomes an employee of a program for the purpose of investigating a suspected violation of law or who pursues that purpose after enrolling or becoming employed for other purposes.

(f) Security for written records.

(1) Written records which are subject to these regulations must be maintained in a secure room, locked file cabinet, safe or other similar container when not in use; and

(2) Each program shall adopt in writing procedures which regulate and control access to and use of written records which are subject to these regulations.

(g) Disposition of records by discontinued programs.

(1) General. If a program discontinues operations or is taken over or acquired by another program, it must purge patient identifying information from its records or destroy the records unless—

(A) The patient who is the subject of the records gives written consent to a transfer of the records to the acquiring program or to any other program designated in the consent (the manner of obtaining this consent must minimize the likelihood of a disclosure of patient identifying information to a third party); or

(B) There is a legal requirement that the records be kept for a period specified by law which does not expire until after the discontinuation or acquisition of the program.

(h) Procedure where retention period required by law.

Records must be:

- (1) Sealed in envelopes or other containers labeled as follows:

(A) ``Records of [insert name of program] required to be maintained under [insert citation to statute, regulation, court order or other legal authority requiring that records be kept] until a date not later than [insert appropriate date]"; and

Goal #16: Intended Use - Disclosure of Patient Records / September 24, 2010 \ Page 9

(B) Held under the restrictions of these regulations by a responsible person who must, as soon as practicable after the end of the retention period specified on the label, destroy the records.

(i) Patient access and restrictions on use.

(1) Patient access not prohibited. These regulations do not prohibit a program from giving a patient access to his or her own records, including the opportunity to inspect and copy any records that the program maintains about the patient. The program is not required to obtain a patient's written consent or other authorization under these regulations in order to provide such access to the patient.

(2) Restriction on use of information. Information obtained by patient access to his or her patient record is subject to the restriction on use of his or her information to initiate or substantiate any criminal charges against the patient or to conduct any criminal investigation of the patient.

(j) Disclosures permitted with written consent.

If a patient consents to a disclosure of his or her records, a program may disclose those records in accordance with that consent to any individual or organization named in the consent, except that disclosures to central registries and in connection with criminal justice referrals must meet the requirements of sections (k), (l), and (m), respectively.

(k) Disclosures to prevent multiple enrollments in detoxification and maintenance treatment programs.

For purposes of this section:

(A) Central registry means an organization which obtains from two or more member programs patient identifying information about individuals applying for maintenance treatment or detoxification treatment for the purpose of avoiding an individual's concurrent enrollment in more than one program.

(B) Detoxification treatment means the dispensing of a narcotic drug in decreasing doses to an individual in order to reduce or eliminate adverse physiological or psychological effects incident to withdrawal from the sustained use of a narcotic drug.

(C) Maintenance treatment means the dispensing of a narcotic drug in the treatment of an individual for dependence upon heroin or other morphine-like drugs.

(D) Member program means a detoxification treatment or maintenance treatment program which reports patient identifying information to a central registry and which is in the same State as that central registry or is not more than 125 miles from any border of the State in which the central registry is located.

(I) Restrictions on disclosure. A program may disclose patient records to a central registry or to any detoxification or maintenance treatment program not more than 200 miles away for the purpose of preventing the multiple enrollment of a patient only if:

(1) The disclosure is made when:

- (A) The patient is accepted for treatment;
- (B) The type or dosage of the drug is changed; or
- (C) The treatment is interrupted, resumed or terminated.

(2) The disclosure is limited to:

- (A) Patient identifying information;
- (B) Type and dosage of the drug; and
- (C) Relevant dates.

(3) The disclosure is made with the patient's written consent, and

- (A) The consent must list the name and address of each central registry and each known detoxification or maintenance treatment program to which a disclosure will be made; and
- (B) The consent may authorize a disclosure to any detoxification or maintenance treatment program established within 200 miles of the program after the consent is given without naming any such program.

(4) Use of information limited to prevention of multiple enrollments.

(A) A central registry and any detoxification or maintenance treatment program to which information is disclosed to prevent multiple enrollments may not re-disclose or use patient identifying information for any purpose other than the prevention of multiple enrollments unless authorized by a court order under.

(5) Permitted disclosure by a central registry to prevent a multiple enrollment.

When a member program asks a central registry if an identified patient is enrolled in another member program and the registry determines that the patient is so enrolled, the registry may disclose:

Goal #16: Intended Use - Disclosure of Patient Records / September 24, 2010 \ Page 11

(A) The name, address, and telephone number of the member program(s) in which the patient is already enrolled to the inquiring member program; and

(B) The name, address, and telephone number of the inquiring member program to the member program(s) in which the patient is already enrolled. The member programs may communicate as necessary to verify that no error has been made and to prevent or eliminate any multiple enrollment.

(6) Permitted disclosure by a detoxification or maintenance treatment program to prevent a multiple enrollment. A detoxification or maintenance treatment program which has received a disclosure under this section and has determined that the patient is already enrolled may communicate as necessary with the program making the disclosure to verify that no error has been made and to prevent or eliminate any multiple enrollment.

(7) Disclosures to elements of the criminal justice system which have referred patients.

(A) A program may disclose information about a patient to those persons within the criminal justice system which have made participation in the program a condition of the disposition of any criminal proceedings against the patient or of the patient's parole or other release from custody if:

(B) The disclosure is made only to those individuals within the criminal justice system who have a need for the information in connection with their duty to monitor the patient's progress; and

(C) The patient has signed a written consent.

(8) Duration of consent.

The written consent must state the period during which it remains in effect. This period must be reasonable, taking into account:

(A) The anticipated length of the treatment;

(B) The type of criminal proceeding involved, the need for the information in connection with the final disposition of that proceeding, and when the final disposition will occur; and

(C) Such other factors as the program, the patient, and the person(s) who will receive the disclosure consider pertinent.

(9) Revocation of consent.

The written consent must state that it is revocable upon the passage of a specified amount of time or the occurrence of a specified, ascertainable event. The time or occurrence upon which consent becomes revocable may be no later than the final disposition of the conditional release or other action in connection with which consent was given.

(10) Restrictions on re-disclosure and use.

A person who receives patient information under this section may re-disclose and use it only to carry out that person's official duties with regard to the patient's conditional release or other action in connection with which the consent was given.

(m) Medical emergencies.

(1) Patient identifying information may be disclosed to medical personnel who have a need for information about a patient for the purpose of treating a condition which poses an immediate threat to the health of any individual and which requires immediate medical intervention.

(2) Patient identifying information may be disclosed to medical personnel of the Food and Drug Administration (FDA) who assert a reason to believe that the health of any individual may be threatened by an error in the manufacture, labeling, or sale of a product under FDA jurisdiction, and that the information will be used for the exclusive purpose of notifying patients or their physicians of potential dangers.

(3) Immediately following disclosure, the program shall document the disclosure in the patient's records, setting forth in writing:

(A) The name of the medical personnel to whom disclosure was made and their affiliation with any health care facility;

(B) The name of the individual making the disclosure;

(C) The date and time of the disclosure; and

(D) The nature of the emergency (or error, if the report was to FDA).

(m) Audit and evaluation activities.

If patient records are not copied or removed, patient identifying information may be disclosed in the course of a review of records on program

premises to any person who agrees in writing to comply with the limitations on re-disclosure, and who:

(1) Performs the audit or evaluation activity on behalf of:

(A) Any Federal, State, or local governmental agency which provides financial assistance to the program or is authorized by law to regulate its activities; or

(B) Any private person which provides financial assistance to the program, which is a third party payer covering patients in the program, or which is a quality improvement organization performing a utilization or quality control review; or

(2) Is determined by the program director to be qualified to conduct the audit or evaluation activities.

(n) Copying or removal of records.

Records containing patient identifying information may be copied or removed from program premises by any person who:

(1) Agrees in writing to:

(A) Maintain the patient identifying information in accordance with the security requirements provided in these regulations (or more stringent requirements);

(B) Destroy all the patient identifying information upon completion of the audit or evaluation; and

(C) Comply with the limitations on disclosure; and

(D) Performs the audit or evaluation activity on behalf of:

(i) Any Federal, State, or local governmental agency which provides financial assistance to the program or is authorized by law to regulate its activities; or

(ii) Any private person which provides financial assistance to the program, which is a third part payer covering patients in the program, or which is a quality improvement organization performing a utilization or quality control review.

(o) Confidential communications.

Goal #16: Intended Use - Disclosure of Patient Records / September 24, 2010 \ Page 14

A court order under these regulations may authorize disclosure of confidential communications made by a patient to a program in the course of diagnosis, treatment, or referral for treatment only if:

- (1) The disclosure is necessary to protect against an existing threat to life or of serious bodily injury, including circumstances which constitute suspected child abuse and neglect and verbal threats against third parties;
- (2) The disclosure is necessary in connection with investigation or prosecution of an extremely serious crime, such as one which directly threatens loss of life or serious bodily injury, including homicide, rape, kidnapping, armed robbery, assault with a deadly weapon, or child abuse and neglect; or
- (3) The disclosure is in connection with litigation or an administrative proceeding in which the patient offers testimony or other evidence pertaining to the content of the confidential communications.

Goal #16: Compliance - Disclosure of Patient Records / September 24, 2010 / Page 1

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

Overview

The Department of Health and Human Services-Division of Behavioral Health-Community-Based Services (DHHS-DBH-CBS) is required to have in effect a system to protect from inappropriate disclosure of patient records maintained by the State in connection with an activity funded under the program involved or by any entity which is receiving funds from the grant. This system must be in compliance with all applicable State and Federal laws and regulations, and shall include provisions for employee education on the confidentiality requirements as well as the fact that disciplinary action may occur upon inappropriate disclosures.

If an inappropriate disclosure of the data becomes apparent to DHHS, it is the responsibility of DHHS under the law to correct the violation or terminate the Agreement. DHHS is accountable for the protection of the health information it collects and maintains. DHHS must safeguard and establish practices and processes that are compliant with the HIPAA standards for Privacy and the safeguarding of Protected Health Information.

DHHS signed a contract with the Centers for Medicare and Medicaid Services in 2003, as a single covered entity. All DHHS divisions and business units are part of the covered entity and therefore required to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules. As a covered entity, DHHS was required to write policies and procedures to comply with the HIPAA Privacy and Security Rules and to train all workforce members on the policies and procedures. These federal standards are audited and enforced by the Office for Civil Rights for the Privacy Rule and the Centers for Medicare and Medicaid Services for the Security Rule.

The Health Insurance Portability and Accountability Act (HIPAA) was enacted on August 21, 1996. The legislation was intended to improve the portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, to improve access to long-term care services and coverage, and to simplify the administration of health insurance.

The DHHS-DBH-CBS/ Regional Behavioral Health Authority (RBHA) Behavioral Health and Network Services Contract requires that providers comply with federal and state required standards of confidentiality, as well as collaborate as a member of the regional provider network to develop regional confidentiality protocols to ensure continuity of care with all providers in the Network.

“Business Associates” are persons or organizations that perform functions or activities on behalf of DHHS and create or receive Protected Health Information for or from DHHS.

Goal #16: Compliance - Disclosure of Patient Records / September 24, 2010 / Page 2

Examples of Business Associate functions or activities include: claims processing, claims administration, data analysis, data processing, data administration, utilization, review, benefit management, practice management, and clinical services.

When DHHS enters into a Business Associate arrangement, a formal written contract is required by the Privacy Rule that delineates the obligations of the Business Associate to take reasonable steps to safeguard the Protected Health Information of individuals that is disclosed and used by the Business Associate.

- The Business Associate will not use or disclose the Protected Health Information other than as permitted by the Agreement
- The Business Associate will use safeguards to protect the information's confidentiality
- The Business Associate will report to DHHS any misuse of the information
- Any agents, sub-grantees, or sub-contractors of the Business Associate will provide the same assurances to the Business Associate
- The Business Associate will return or destroy the Protected Health Information once the contract is terminated, and instructed by DHHS to do so

The HIPAA Privacy Standards regulate the types of uses and disclosures that are permitted without an individual's signed Authorization, as well as a Notice of Information Privacy Practices, individual privacy rights, and Administrative Regulations, and enforcement mechanisms. The Privacy Standards inform health care consumers of how their health information is used and gives health care consumers access to information about themselves. The Privacy Standards require specific written Authorization for use and disclosure of the information for all other purposes.

The Privacy Rule requires that DHHS impose standards of performance for the safeguarding, use, and disclosure of Protected Health Information on the third parties with whom it contracts. If the contractor performs a function or activity involving the use or disclosure of Protected Health Information, a Business Associate relationship exists. Examples of functions or activities include:

- Billing, claims processing or administration
- Data analysis, utilization reviews, quality assurance
- Benefit or practice management
- Clinical services
- Direct client services

Protected Health Information is Individually Identifiable Health Information.

Examples of an individual's Protected Health Information:

- Name
- Mailing Address
- Phone Number
- Birth Date
- Social Security Number
- Photograph

Goal #16: Compliance - Disclosure of Patient Records / September 24, 2010 / Page 3

- Admission Date
- History and Physical
- Medical Records/Medical Transcription
- Psychotherapy Notes
- Nurse Notes
- Prescription
- Discharge Summaries
- Deceased Date
- Computer List of Regional Center Patients
- Facility Admission Face Sheet

Response for FY 2008 (Annual Report/Compliance)

DHHS-DBH has followed current HIPAA rules in the FY2007 Network contracts with the Behavioral Health Regions.

Compliance with Nebraska Law

- In the performance of its responsibilities pursuant to the Regional Contracts, the Contractor adheres to all Nebraska statutory and regulatory requirements, and any subsequent revisions or additions thereto and all regulations for behavioral health.

Compliance with Federal Law

- In the performance of its responsibilities pursuant to the Regional Contracts, the Contractor adheres to all Federal statutory and regulatory requirements, and any subsequent revisions or enactments including: (1) the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) as amended by the Alcohol Abuse, Drug Abuse, Mental Health Amendment of 1984 (P.L. 98-509), (2) the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-205) (hereafter referred to as OBRA), (3) the Anti-Drug Abuse act of 1988 (P.L. 100-690), (4) the Drug Abuse Technical Corrections Act of 1989 (P.L. 101-93), (5) the Alcohol, Drug Abuse, and Mental Health Reorganization Act (42 USC 201) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA; P.L. 104-191).
- Providers comply with federal and state required standards of confidentiality and collaborate as a member of the regional provider network to develop regional confidentiality protocols to ensure continuity of care with all providers in the Network.
- The Protocols include, at a minimum, a standard regional release form for each client which allows the Division, or its agent, or the Regional Network Administrator to receive confidential client information to make a determination if care shall be authorized.
- The signed release of information is included in each client's record where service is paid by state and/or federal funds.

Goal #16: Progress - Disclosure of Patient Records / September 24, 2010/ Pg 1

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

Overview

The Department of Health and Human Services-Division of Behavioral Health-Community-Based Services (DHHS-DBH-CBS) is required to have in effect a system to protect from inappropriate disclosure of patient records maintained by the State in connection with an activity funded under the program involved or by any entity which is receiving funds from the grant. This system must be in compliance with all applicable State and Federal laws and regulations, and shall include provisions for employee education on the confidentiality requirements as well as the fact that disciplinary action may occur upon inappropriate disclosures. If an inappropriate disclosure of the data becomes apparent to DHHS, it is the responsibility of DHHS under the law to correct the violation or terminate the Agreement. DHHS is accountable for the protection of the health information it collects and maintains. DHHS must safeguard and establish practices and processes that are compliant with the HIPAA standards for Privacy and the safeguarding of Protected Health Information.

DHHS signed a contract with the Centers for Medicare and Medicaid Services in 2003, as a single covered entity. All DHHS divisions and business units are part of the covered entity and therefore required to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules. As a covered entity, DHHS was required to write policies and procedures to comply with the HIPAA Privacy and Security Rules and to train all workforce members on the policies and procedures. These federal standards are audited and enforced by the Office for Civil Rights for the Privacy Rule and the Centers for Medicare and Medicaid Services for the Security Rule.

The Health Insurance Portability and Accountability Act (HIPAA) was enacted on August 21, 1996. The legislation was intended to improve the portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, to improve access to long-term care services and coverage, and to simplify the administration of health insurance.

The DHHS-DBH-CBS/ Regional Behavioral Health Authority (RBHA) Behavioral Health and Network Services Contract requires that providers comply with federal and state required standards of confidentiality, as well as collaborate as a member of the regional provider network to develop regional confidentiality protocols to ensure continuity of care with all providers in the Network.

Goal #16: Progress - Disclosure of Patient Records / September 24, 2010/ Pg 2

“Business Associates” are persons or organizations that perform functions or activities on behalf of DHHS and create or receive Protected Health Information for or from DHHS. Examples of Business Associate functions or activities include: claims processing, claims administration, data analysis, data processing, data administration, utilization, review, benefit management, practice management, and clinical services.

When DHHS enters into a Business Associate arrangement, a formal written contract is required by the Privacy Rule that delineates the obligations of the Business Associate to take reasonable steps to safeguard the Protected Health Information of individuals that is disclosed and used by the Business Associate.

- The Business Associate will not use or disclose the Protected Health Information other than as permitted by the Agreement
- The Business Associate will use safeguards to protect the information's confidentiality
- The Business Associate will report to DHHS any misuse of the information
- Any agents, sub-grantees, or sub-contractors of the Business Associate will provide the same assurances to the Business Associate
- The Business Associate will return or destroy the Protected Health Information once the contract is terminated, and instructed by DHHS to do so

The HIPAA Privacy Standards regulate the types of uses and disclosures that are permitted without an individual's signed Authorization, as well as a Notice of Information Privacy Practices, individual privacy rights, and Administrative Regulations, and enforcement mechanisms. The Privacy Standards inform health care consumers of how their health information is used and gives health care consumers access to information about themselves. The Privacy Standards require specific written Authorization for use and disclosure of the information for all other purposes.

The Privacy Rule requires that DHHS impose standards of performance for the safeguarding, use, and disclosure of Protected Health Information on the third parties with whom it contracts. If the contractor performs a function or activity involving the use or disclosure of Protected Health Information, a Business Associate relationship exists. Examples of functions or activities include:

- Billing, claims processing or administration
- Data analysis, utilization reviews, quality assurance
- Benefit or practice management
- Clinical services
- Direct client services

Protected Health Information is Individually Identifiable Health Information.

Examples of an individual's Protected Health Information:

- Name
- Mailing Address

Goal #16: Progress - Disclosure of Patient Records / September 24, 2010/ Pg 3

- Phone Number
- Birth Date
- Social Security Number
- Photograph
- Admission Date
- History and Physical
- Medical Records/Medical Transcription
- Psychotherapy Notes
- Nurse Notes
- Prescription
- Discharge Summaries
- Deceased Date
- Computer List of Regional Center Patients
- Facility Admission Face Sheet

FY 2010 (Progress)

DHHS-DBH has followed current HIPAA rules in the FY2010 Network contracts with the Behavioral Health Regions.

Compliance with Nebraska Law

- In the performance of its responsibilities pursuant to the Regional Contracts, the Contractor adheres to all Nebraska statutory and regulatory requirements, and any subsequent revisions or additions thereto and all regulations for behavioral health.

Compliance with Federal Law

- In the performance of its responsibilities pursuant to the Regional Contracts, the Contractor adheres to all Federal statutory and regulatory requirements, and any subsequent revisions or enactments including: (1) the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) as amended by the Alcohol Abuse, Drug Abuse, Mental Health Amendment of 1984 (P.L. 98-509), (2) the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-205) (hereafter referred to as OBRA), (3) the Anti-Drug Abuse act of 1988 (P.L. 100-690), (4) the Drug Abuse Technical Corrections Act of 1989 (P.L. 101-93), (5) the Alcohol, Drug Abuse, and Mental Health Reorganization Act (42 USC 201) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA; P.L. 104-191).
- Providers comply with federal and state required standards of confidentiality and collaborate as a member of the regional provider network to develop regional confidentiality protocols to ensure continuity of care with all providers in the Network.
- The Protocols include, at a minimum, a standard regional release form for each client which allows the Division, or its agent, or the Regional Network Administrator to receive confidential client information to make a determination if care shall be authorized.

Goal #16: Progress - Disclosure of Patient Records / September 24, 2010/ Pg 4

- The signed release of information is included in each client's record where service is paid by state and/or federal funds.

Goal #17: Charitable Choice

An agreement to ensure that the State has in effect a system to comply with services provided by non-governmental organizations (See 42 U.S.C. §300x-65 and 42 C.F.R. part 54 (See 42 C.F.R. §54.8(b) and §54.8(c)(4), Charitable Choice Provisions; Final Rule (68 FR 189, pp. 56430-56449, September 30, 2003).

Note: In addressing this narrative please specify if this provision was not applicable because State did not fund religious providers. If the State did fund religious providers, it may want to discuss activities or initiatives related to the provision of: Training/TA on regulations; Regulation reviews; Referral system/process; Task force/work groups; Provider surveys; Request for proposals; Administered vouchers to ensure patient choice.

FY 2011- FY 2013 (Intended Use/Plan):

FY 2008 (Annual Report/Compliance):

FY 2010 (Progress):

Goal #17: Intended Use - Charitable Choice / September 3, 2010 / Page 1

Goal # 17: An agreement to ensure that the State has in effect a system to comply with 42 U.S.C. 300x-65 and 42 C.F.R. part 54 (See 42 C.F.R. 54.8(c)(4) and 54.8(b), Charitable Choice Provisions and Regulations.

FY 2011- FY 2013 (Intended Use/Plan):

Who – Actual or potential Service Recipients

What – are notified of their right to alternative service by religious service providers

When – at time of service

Where – at religious organizations that are providers of services

How – Religious organizations that are providers must give notice of a service recipients their right to alternative services. The state will fund alternative services through the Regional Behavioral Health Authorities at alternative providers in which the service recipient has no religious objection. Notification to the state of service recipients “opting out” of services because of religious objections is given through the capacity/waiting list system by indicating number of persons requesting such option. The service provider, who is the subject of the request to opt out, must refer service recipient to another service provider of the same service, or make available services in a suitable alternative environment.

Regional Behavioral Health Authorities monitor the compliance to this regulation in yearly monitoring visits that also include review of clinical records where documentation of persons opting out may be found. The Division of Behavioral Health, through its audit work group has included in the Audit Workbook instructions and forms for monitoring this provision. The State receives copies of all monitoring visits and uses them in the Quality Assurance activities. These provisions are applicable to all services of the system including counseling, transportation, housing, residential treatment facilities, etc.

The contract between the Nebraska Division of Behavioral Health - Community-Based Services Section and each of the six Regional Behavioral Health Authorities includes the following:

L. CHARITABLE CHOICE

DHHS must comply with 42 U.S.C. 300x-65 and 42 C.F.R. part 54. [See 42 C.F.R. 54.8(c)(4) and 54.8(b), Charitable Choice Provision and Regulations.]

1. Contractors will ensure that Subcontracts/Contractor include a requirement that SAPTBG funded faith-based programs cannot use SAPTBG funds for inherently religious activities such as (1) worship, (2) religious instruction, or (3) proselytization, and that the programs may engage in these activities only when they are separate in time or location from SAPTBG funded activities and participation in them is voluntary.
2. Contractor will ensure that Subcontractors/Contractor delivering services, including outreach services programs do not discriminate on the basis of one’s religion, religious belief, refusal to hold a religious belief, or refusal to actively participate in a religious practice
3. Contractor will ensure that Subcontracts/Contractor indicate that when an otherwise eligible client objects to the religious character of a program, that the

Goal #17: Intended Use - Charitable Choice / September 3, 2010 / Page 2

program refers the client to an alternative provider within a reasonable period of time of the objection and in accordance with Charitable Choice provisions.

4. Contractor and/or Subcontractors shall report all occurrences of individuals refusing services under the provision of the Charitable Choice requirements for the SAPTBG.
5. Contractor will ensure that contracts with Subcontractor use generally accepted accounting principles to account for SAPTBG funds segregate those funds from non-federal funds subject to the audits by government and apply Charitable Choice in instances where SAPTBG funds are comingled with state/local funds.

Source: Nebraska Department of Health and Human Services
Division of Behavioral Health - Community-Based Services Section
Contract with each of the six Regional Behavioral Health Authorities
FY2011 - ATTACHMENT F - **Federal Block Grant Requirements**

To see the complete FY2011 Regional Behavioral Health contract ATTACHMENT F - **Federal Block Grant Requirements**, go to <https://bgas.samhsa.gov/2011/> ... Appendix / Addendum - Additional Supporting Documents (Optional)

Goal # 17: Compliance - Charitable Choice / September 24, 2010 / Page 1

Goal # 17: An agreement to ensure that the State has in effect a system to comply with 42 U.S.C. 300x-65 and 42 C.F.R. part 54 (See 42 C.F.R. 54.8(c)(4) and 54.8(b)), Charitable Choice Provisions and Regulations.

FY 2008 (Annual Report/Compliance)

Who – Actual or potential Service Recipients

What – are notified of their right to alternative service by religious service providers

When – at time of service

Where – at religious organizations that are providers of services

How – Religious organizations that are providers must give notice of a service recipients their right to alternative services. The state will fund alternative services through the Regional Behavioral Health Authorities at alternative providers in which the service recipient has no religious objection. Notification to the state of service recipients “opting out” of services because of religious objections is given through the capacity/waiting list system by indicating the number of persons requesting such option. The service provider, who is the subject of the request to opt out, must refer service recipient to another service provider of the same service, or make available services in a suitable alternative environment.

Regional Behavioral Health Authorities monitor the compliance to this regulation in yearly monitoring visits that also include review of clinical records where documentation of persons opting out may be found. The Division of Behavioral Health, through its audit work group has included in the Audit Workbook instructions and forms for monitoring this provision. The State receives copies of all monitoring visits and uses them in the Quality Assurance activities. These provisions are applicable to all services of the system including counseling, transportation, housing, residential treatment facilities, etc.

Direct form attachment I (Brief description of any training for local governments and faith-based and community organizations on these requirements):

Direct service contracts are let through the six Regional Behavioral Health Authorities (Substate planning areas) who have the statutory authority to contract for local service provision. In areas of the state the only provider is a traditional faith-based service provider who can meet the regulatory requirements for service provision as an individual or organization through the Nebraska Division of Public Health's Licensure Unit. The Division of Public Health licenses both Health Care Facilities/Services [such as Substance Abuse Treatment Centers] and Professions/Occupations [such as Licensed Alcohol/Drug Counselor (LADC)].

Nebraska began collecting Charitable Choice “opt out” information from the Regional Behavioral Health Authorities on November 1, 2006 as an additional weekly report added on to the Capacity management wait list information. All Regions were provided direct access to the Charitable Choice regulations on the SAMHSA website: <http://www.samhsa.gov/fbc/charchoice.aspx>. When programs were surveyed about the number of persons who may have opted out for

Goal # 17: Compliance - Charitable Choice / September 24, 2010 / Page 2

the previous year, programs reported none. It is possible that programs are unsure of what constitutes an identifiable event under Charitable Choice.

The Division of Behavioral Health received technical assistance in the form of Block Grant 101 from federal representatives on October 28, 2008. In 2009, training for local governments and faith-based and community organizations was handled in three ways. (1) Overall, it is the duty of the six Regional Behavioral Health Authorities. This was addressed by contract amendments to clarify expectations. (2) Between March and June 2009, Vicki Maca, DHHS Division of Behavioral Health Community Services Administrator provided training to the Regions and service providers. The teaching included the revised language added to the contract with the Regions to clarify the expectations on the Charitable Choice requirements. (3) A new waiting list method was implemented on October 5, 2009.

The following language was included in the Division's contract amendment with the Regional Behavioral Health Authorities.

CHARITABLE CHOICE: The Department (DHHS) must comply with 42 U.S.C. 300x-65 and 42 C.F.R. part 54. [See 42 C.F.R. 54.8(c)(4) and 54.8(b), Charitable Choice Provision and Regulations.]

1. Contractors will ensure that subcontracts/contractor include a requirement that Block Grant funded faith-based programs cannot use SAPTBG funds for inherently religious activities such as (1) worship, (2) religious instruction, or (3) proselytization, and that the programs may engage in these activities only when they are separate in time or location from Block Grant funded activities and participation in them is voluntary.
2. Contractor will ensure that subcontractors/contractor delivering services, including outreach services, program cannot discriminate on the basis of one's religion, religious belief, refusal to hold a religious belief, or refusal to actively participate in a religious practice
3. Contractor will ensure that subcontracts/contractor indicate that when an otherwise eligible client objects to the religious character of a program, that the program refers the client to an alternative provider within a reasonable period of time of the objection and in accordance with Charitable Choice provisions.
4. Contractor and/or subcontractors shall report all occurrences of individuals refusing services under the provision of the Charitable Choice requirements for the SAPTBG.
5. Contractor will ensure that contracts with subcontractor use generally accepted accounting principles to account for SAPTBG funds segregate those funds from non-federal funds subject to the audits by government and apply Charitable Choice in instances where SAPTBG funds are comingled with state/local funds.

Goal # 17: Progress - Charitable Choice / September 3, 2010 / Page 1

Goal # 17: An agreement to ensure that the State has in effect a system to comply with 42 U.S.C. 300x-65 and 42 C.F.R. part 54 (See 42 C.F.R. 54.8(c)(4) and 54.8(b)), Charitable Choice Provisions and Regulations.

FY 2010 (Progress)

Who – Actual or potential Service Recipients

What – are notified of their right to alternative service by religious service providers

When – at time of service

Where – at religious organizations that are providers of services

How –

The Regional Behavioral Health Authorities and the providers are required to report all occurrences of individuals refusing services under the provision of the Charitable Choice requirements for the SAPTBG. Specifically, when an otherwise eligible client objects to the religious character of a program, that program needs to refer the client to an alternative provider within a reasonable period of time of the objection and in accordance with Charitable Choice provisions.

Since October 5, 2009, there were no reported cases of a client objecting to the religious character of a program. There were zero people reported under Charitable Choice under the waiting list data.

Religious organizations that are providers must give notice of a service recipients their right to alternative services. The state will fund alternative services through the Regional Behavioral Health Authorities at alternative providers in which the service recipient has no religious objection. Notification to the state of service recipients “opting out” of services because of religious objections is given through the capacity/waiting list system by indicating the number of persons requesting such option. The service provider, who is the subject of the request to opt out, must refer service recipient to another service provider of the same service, or make available services in a suitable alternative environment.

Regional Behavioral Health Authorities monitor the compliance to this regulation in yearly monitoring visits that also include review of clinical records where documentation of persons opting out may be found. The Division of Behavioral Health, through its audit work group has included in the Audit Workbook instructions and forms for monitoring this provision. The State receives copies of all monitoring visits and uses them in the Quality Assurance activities. These provisions are applicable to all services of the system including counseling, transportation, housing, residential treatment facilities, etc.

Direct form attachment I (Brief description of any training for local governments and faith-based and community organizations on these requirements):

Direct service contracts are let through the six Regional Behavioral Health Authorities (Substate planning areas) who have the statutory authority to contract for local service provision. In areas of the state the only provider is a traditional

Goal # 17: Progress - Charitable Choice / September 3, 2010 / Page 2

faith-based service provider who can meet the regulatory requirements for service provision as an individual or organization through the Nebraska Division of Public Health's Licensure Unit. The Division of Public Health licenses both Health Care Facilities/Services [such as Substance Abuse Treatment Centers] and Professions/Occupations [such as Licensed Alcohol/Drug Counselor (LADC)].

Nebraska began collecting Charitable Choice “opt out” information from the Regional Behavioral Health Authorities on November 1, 2006 as an additional weekly report added on to the Capacity management wait list information. All Regions were provided direct access to the Charitable Choice regulations on the SAMHSA website: <http://www.samhsa.gov/fbci/charchoice.aspx>. When programs were surveyed about the number of persons who may have opted out for the previous year, programs reported none. It is possible that programs are unsure of what constitutes an identifiable event under Charitable Choice.

The Division of Behavioral Health received technical assistance in the form of Block Grant 101 from federal representatives on October 28, 2008. In 2009, training for local governments and faith-based and community organizations was handled in three ways. (1) Overall, it is the duty of the six Regional Behavioral Health Authorities. This was addressed by contract amendments to clarify expectations. (2) Between March and June 2009, Vicki Maca, DHHS Division of Behavioral Health Community Services Administrator provided training to the Regions and service providers. The teaching included the revised language added to the contract with the Regions to clarify the expectations on the Charitable Choice requirements. (3) A new waiting list method is being implemented on October 5, 2009.

The following language was included in the Division’s contract amendment with the Regional Behavioral Health Authorities.

CHARITABLE CHOICE: The Department (DHHS) must comply with 42 U.S.C. 300x-65 and 42 C.F.R. part 54. [See 42 C.F.R. 54.8(c)(4) and 54.8(b), Charitable Choice Provision and Regulations.]

1. Contractors will ensure that subcontracts/contractor include a requirement that Block Grant funded faith-based programs cannot use SAPTBG funds for inherently religious activities such as (1) worship, (2) religious instruction, or (3) proselytization, and that the programs may engage in these activities only when they are separate in time or location from Block Grant funded activities and participation in them is voluntary.
2. Contractor will ensure that subcontractors/contractor delivering services, including outreach services, program cannot discriminate on the basis of one’s religion, religious belief, refusal to hold a religious belief, or refusal to actively participate in a religious practice
3. Contractor will ensure that subcontracts/contractor indicate that when an otherwise eligible client objects to the religious character of a program, that the program refers the client to an alternative provider within a reasonable period of time of the objection and in accordance with Charitable Choice provisions.

Goal # 17: Progress - Charitable Choice / September 3, 2010 / Page 3

4. Contractor and/or subcontractors shall report all occurrences of individuals refusing services under the provision of the Charitable Choice requirements for the SAPTBG.
5. Contractor will ensure that contracts with subcontractor use generally accepted accounting principles to account for SAPTBG funds segregate those funds from non-federal funds subject to the audits by government and apply Charitable Choice in instances where SAPTBG funds are comingled with state/local funds.

Charitable Choice (formerly Attachment I)

Under Charitable Choice, States, local governments, and religious organizations, each as SAMHSA grant recipients, must: (1) ensure that religious organizations that are providers provide notice of their right to alternative services to all potential and actual program beneficiaries (services recipients); (2) ensure that religious organizations that are providers refer program beneficiaries to alternative services; and (3) fund and/or provide alternative services. The term "alternative services" means services determined by the State to be accessible and comparable and provided within a reasonable period of time from another substance abuse provider ("alternative provider") to which the program beneficiary ("services recipient") has no religious objection.

The purpose of Charitable Choice is to document how your State is complying with these provisions.

For the fiscal year prior (FY 2010) to the fiscal year for which the State is applying for funds check the appropriate box(es) that describe the State's procedures and activities undertaken to comply with the provisions.

Notice to Program Beneficiaries -Check all that Apply

- Used model notice provided in final regulations
- Used notice developed by State (Please attach a copy in Appendix A)
- State has disseminated notice to religious organizations that are providers
- State requires these religious organizations to give notice to all potential beneficiaries

Referrals to Alternative Services -Check all that Apply

- State has developed specific referral system for this requirement
- State has incorporated this requirement into existing referral system(s)
- SAMHSA's Treatment Facility Locator is used to help identify providers
- Other networks and information systems are used to help identify providers
- State maintains record of referrals made by religious organizations that are providers
- 1 Enter total number of referrals necessitated by religious objection to other substance abuse providers ("alternative providers"), as defined above, made in previous fiscal year. Provide total only; no information on specific referrals required.

Brief description (one paragraph) of any training for local governments and faith-based and community organizations on these requirements.

Direct service contracts are let through the six Regional Behavioral Health Authorities (Substate planning areas) who have the statutory authority to contract for local service provision. In areas of the state the only provider is a traditional faith based service provider who can meet the regulatory requirements for service provision as an individual or organization through the NE Division of Public Health's Licensure Unit. Division of Public Health licenses both Health Care Facilities/Services [such as Substance Abuse Treatment Centers] and Professions/Occupations [such as Licensed Alcohol/Drug Counselor (LADC)]. Nebraska began collecting Charitable Choice "opt out" information from the Regional Behavioral Health Authorities on November 1, 2006 as an additional weekly report added on to the Capacity management wait list information. All Regions were provided direct access to the Charitable Choice regulations on the SAMHSA web site (<http://www.samhsa.gov/fbci/charchoice.aspx>). When programs were surveyed about the number of persons who may have opted out for the previous year, programs reported none. It is possible that programs are unsure of what constitutes a identifiable event under charitable choice. In 2009, the Division of Behavioral Health provided training for local governments and faith-based and community organizations in three ways. (1) Overall, it is the duty of the six Regional Behavioral Health Authorities. This was addressed by contract to clarify expectations. (2) Between March and June 2009, Vicki Maca, DHHS Division of Behavioral Health Community Services Administrator provided training to the Regions and service providers. The teaching included the revised language added to the contract with the Regions to clarify the expectations on the Charitable Choice requirements. (3) A new waiting list method was implemented on October 5, 2009. On June 8, 2010, via the waiting list, one person was reported under the Charitable Choice. The Region was responsible for making alternative arrangements for another provider.

Waivers (formerly Attachment J)

If your State plans to apply for any of the following waivers, check the appropriate box and submit the request for a waiver at the earliest possible date.

- To expend not less than an amount equal to the amount expended by the State for FY 1994 to establish new programs or expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children (See 42 U.S.C. 300x-22(b)(2) and 45 C.F.R. 96.124(d)).
- Rural area early intervention services HIV requirements (See 42 U.S.C. 300x-24(b)(5)(B) and 45 C.F.R. 96.128(d))
- Improvement of process for appropriate referrals for treatment, continuing education, or coordination of various activities and services (See 42 U.S.C. 300x-28(d) and 45 C.F.R. 96.132(d))
- Statewide maintenance of effort (MOE) expenditure levels (See 42 U.S.C. 300x-30(c) and 45 C.F.R. 96.134(b))
- Construction/rehabilitation (See 42 U.S.C. 300x-31(c) and 45 C.F.R. 96.135(d))

If your State proposes to request a waiver at this time for one or more of the above provisions, include the waiver request as an attachment to the application, if possible. The Interim Final Rule, 45 C.F.R. 96.124(d), 96.128(d), 96.132(d), 96.134(b), and 96.135(d), contains information regarding the criteria for each waiver, respectively. A formal waiver request must be submitted to SAMHSA at some point in time if not included as an attachment to the application.

Waivers

Waivers

If the State proposes to request a waiver at this time for one or more of the provisions, include the waiver request as an attachment to the application, if possible. The Interim Final Rule, 45 C.F.R. §96.124(d), §96.128(d), §96.132(d), §96.134(b), and §96.135(d), contains information regarding the criteria for each waiver, respectively. A formal waiver request must be submitted to the SAMHSA Administrator following the submission of the application if not included as an attachment to the application.

Nebraska is not requesting a waiver at this time.

Form 8 (formerly Form 4)

SUBSTANCE ABUSE STATE AGENCY SPENDING REPORT

Dates of State Expenditure Period: From: 7/1/2008 To: 6/30/2009

Activity	Source of Funds					
	A.SAPT Block Grant FY 2008 Award (Spent)	B.Medicaid (Federal, State and Local)	C.Other Federal Funds (e.g., Medicare, other public welfare)	D.State Funds	E.Local Funds (excluding local Medicaid)	F.Other
Substance Abuse Prevention* and Treatment	\$ 5,456,348	\$ 1,292,815		\$ 20,705,005	\$	\$
Primary Prevention	\$ 2,077,471		\$ 685,469	\$ 254,175	\$	\$
Tuberculosis Services	\$	\$	\$	\$	\$	\$
HIV Early Intervention Services	\$	\$	\$	\$	\$	\$
Administration: Excluding Program/Provider	\$ 331,881		\$	\$	\$	\$
Column Total	\$7,865,700	\$1,292,815	\$685,469	\$20,959,180	\$0	\$0

*Prevention other than Primary Prevention

Other Federal Funds are from CSAP State Infrastructure Grant.

Form 8ab (formerly Form 4ab)

Form 8a. Primary Prevention Expenditures Checklist

Activity	SAPT Block Grant FY 2008	Other Federal	State Funds	Local Funds	Other
Information Dissemination	\$ 33,686	\$	\$ 58	\$	\$
Education	\$ 114,072	\$	\$ 131	\$	\$
Alternatives	\$ 37,125	\$	\$ 229	\$	\$
Problem Identification & Referral	\$ 144,019	\$	\$ 60,523	\$	\$
Community Based Process	\$ 1,251,943	\$	\$ 183,538	\$	\$
Environmental	\$ 418,392	\$	\$ 9,696	\$	\$
Other	\$	\$ 685,469	\$	\$	\$
Section 1926 - Tobacco	\$ 78,234	\$	\$	\$	\$
Column Total	\$2,077,471	\$685,469	\$254,175	\$0	\$0

Form 8b. Primary Prevention Expenditures Checklist

Activity	SAPT Block Grant FY 2008	Other Federal	State Funds	Local Funds	Other
Universal Direct	\$	\$	\$	\$	\$
Universal Indirect	\$	\$	\$	\$	\$
Selective	\$	\$	\$	\$	\$
Indicated	\$	\$	\$	\$	\$
Column Total	\$0	\$0	\$0	\$0	\$0

Other Federal Funds expended were obtained from Nebraska Information System, SFY08 YTD General Ledgers Detail, generated and printed on August 19, 2009 and were State Incentive Grant and Safe & Drug Free Schools 9/06 funds. SPF SIG grant that was awarded to the Division of Behavioral Health. The management of this award was transferred to Division of Public Health prior to SFY08. Funds were utilized by grantees for process development of community based primary prevention activities.

Form 8c (formerly Form 4c)

Resource Development Expenditure Checklist

Did your State fund resource development activities from the FY 2008 SAPT Block Grant?

Yes No

Expenditures on Resource Development Activities are:				
<input checked="" type="radio"/> Actual <input type="radio"/> Estimated				
Activity	Column 1 Treatment	Column 2 Prevention	Column 3 Additional Combined	Total
Planning, Coordination and Needs Assessment	\$	\$	\$	\$ 0
Quality Assurance	\$ 5,589	\$ 21,639	\$	\$ 27,228
Training (post-employment)	\$ 124,243	\$	\$	\$ 124,243
Education (pre-employment)	\$ 40,218	\$	\$	\$ 40,218
Program Development	\$	\$ 72,130	\$	\$ 72,130
Research and Evaluation	\$	\$	\$	\$ 0
Information Systems	\$	\$ 25,000	\$	\$ 25,000
Column Total	\$170,050	\$118,769	\$0	\$288,819

Form 9 (formerly Form 6)

SUBSTANCE ABUSE ENTITY INVENTORY

				FISCAL YEAR 2008			
1. Entity Number	2. I-SATS ID <small>[X] if no I-SATS ID</small>	3. Area Served	4. State Funds <small>(Spent during State expenditure period)</small>	5. SAPT Block Grant Funds for Substance Abuse Prevention and Treatment Services (other than primary prevention)	5a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children	6. SAPT Block Grant Funds for Primary Prevention	7. SAPT Block Grant Funds for Early Intervention Services for HIV <small>(if applicable)</small>
000081	NE000081	Southeast	\$959,798	\$60,578			
100100	NE100100	South Central	\$39,970	\$0	\$0	\$0	\$0
100103	NE100103	Northeast	\$66,138	\$0	\$0	\$256,891	\$0
100126	NE100126	Northeast	\$974,811	\$61,684	\$0	\$0	\$0
100163	NE100163	Omaha Metro	\$222,050				
100279	NE100279	South Central	\$89,974	\$27,646	\$0	\$0	\$0
100381	NE100381	Northeast	\$110,017	\$0	\$0	\$0	\$0
100415	NE100415	Southeast	\$31,335	\$230,689	\$71,852	\$100,298	\$0
100418	NE100418	South Central	\$314,794	\$203,368	\$38,522		
100431	NE100431	Omaha Metro	\$3,280,546	\$414,604	\$0	\$0	\$0
100436	NE100436	Southeast	\$26,188	\$10,909			
100556	NE100556	Statewide (optional)	\$30,121				
100563	NE100563	Southeast	\$95,722	\$57,058	\$0	\$0	\$0
100605	NE100605	Panhandle	\$533,542	\$71,558	\$0	\$0	\$0
100614	NE100614	Northeast	\$20,464	\$17,116			
100622	NE100622	Northeast	\$675,937	\$23,955	\$23,955	\$0	\$0
100624	NE100624	Omaha Metro	\$186,718	\$108,766			
100779	NE100779	Northeast	\$153,969		\$0	\$0	\$0
100781	NE100781	Omaha Metro	\$154,010	\$817,927			

100799	NE100799	Omaha Metro	\$166,468	\$18,510			
100811	NE100811	Northeast	\$72,347	\$0	\$0	\$62,024	\$0
100821	NE100821	Omaha Metro	\$165,923	\$193,126			
100829	NE100829	Southeast	\$125,534	\$0	\$0	\$462,665	\$0
100837	NE100837	Omaha Metro	\$124,335	\$0	\$0	\$218,481	\$0
100866	NE100866	Northeast				\$1,794	
100872	NE100872	South Central	\$1,120			\$23,230	
100913	NE100913	Northeast	\$107			\$38,414	
100914	NE100914	Northeast				\$2,291	
100915	NE100915	Northeast	\$958			\$13,040	
100918	NE100918	Statewide (optional)	\$25,000			\$5,000	
100922	NE100922	Statewide (optional)				\$5,000	
100969	NE100969	Southwest	\$63,557				
101258	NE101258	South Central	\$87,343	\$84,919	\$0	\$0	\$0
101298	NE101298	Omaha Metro	\$72,366	\$21,898	\$0	\$0	\$0
101405	NE101405	Omaha Metro	\$8,953				
101553	NE101553	Southwest	\$21,606				
101793	NE101793	Omaha Metro	\$190,026	\$159,898	\$0	\$0	\$0
300072	NE300072	Omaha Metro	\$679,356	\$82,292	\$0	\$0	\$0
300205	NE300205	Panhandle	\$393,506	\$201,253	\$15,663	\$221,716	\$0
301302	NE301302	Northeast	\$351,505	\$241,754	\$0	\$0	\$0
301401	NE301401	Southeast	\$148,794	\$84,317	\$0	\$0	\$0
301500	NE301500	South Central	\$46,340	\$2,146	\$0	\$0	\$0
301708	NE301708	South Central	\$306,312	\$170,151	\$37,582	\$0	\$0
302219	NE302219	Southeast	\$674,105	\$45,760			
750110	NE750110	Southeast	\$103,490	\$217,919			
750144	NE750144	South Central	\$2,683	\$0	\$0	\$57,493	\$0
750151	NE750151	South Central	\$261,556	\$53,896	\$0	\$0	\$0
750250	NE750250	Southeast	\$1,311,412	\$539,515	\$0	\$0	\$0
750441	NE750441	Omaha Metro	\$284,969	\$32,889	\$0	\$0	\$0

750540	NE750540	Southeast	\$264,386	\$129,602	\$129,602	\$0	\$0
750607	NE750607	Northeast	\$23,790	\$0	\$0	\$0	\$0
750706	NE750706	Northeast	\$159,671				
750904	NE750904	Omaha Metro	\$59,380	\$63,408	\$0	\$0	\$0
750938	NE750938	Southeast	\$138,632				
750946	NE750946	South Central	\$58,297				
750953	NE750953	Southeast	\$88,230	\$0	\$0	\$0	\$0
900038	NE900038	Southeast	\$1,846,145	\$123,113	\$33,249	\$0	\$0
900335	NE900335	South Central	\$404,314	\$98,487	\$83,128	\$0	\$0
900350	NE900350	Southeast	\$115,411	\$0	\$0	\$0	\$0
900418	NE900418	Northeast	\$164,811	\$116,064	\$0	\$0	\$0
900491	NE900491	Northeast	\$97,483	\$53,165	\$0	\$0	\$0
900566	NE900566	Southwest	\$655,651	\$64,976	\$63,810	\$245,586	\$0
900699	NE900699	Panhandle	\$356,155	\$211,661	\$93,501	\$0	\$0
900707	NE900707	Northeast	\$722,154	\$178,279			
900731	NE900731	South Central	\$741,469	\$55,862	\$0	\$0	\$0
900863	NE900863	Panhandle	\$0	\$0	\$0	\$0	\$0
900921	NE900921	South Central	\$2,628	\$0	\$0	\$49,291	\$0
900962	NE900962	Southeast	\$184,006	\$31,063	\$0	\$0	\$0
901051	NE901051	Omaha Metro	\$99,881	\$13,048			
901242	NE901242	Southeast	\$942,316	\$29,723	\$0	\$0	\$0
901333	NE901333	Omaha Metro	\$45,218	\$26,206			
NE000007	NE000007	Statewide (optional)				\$23,810	
NE000086	X	Northeast				\$7,000	
NE000087	X	Northeast				\$6,655	
NE0005	NE000005	Statewide (optional)	\$0	\$0	\$0	\$46,424	\$0
NE100800	NE100800	Statewide (optional)	\$0	\$0	\$0	\$18,550	\$0
NE100801	NE100801	South Central	\$3,067	\$0	\$0	\$53,944	\$0
NE100803	NE100803	South Central	\$116,949	\$0	\$0	\$96,507	\$0
NE100804	NE100804	South Central	\$2,502	\$0	\$0	\$45,742	\$0
NE100805	NE100805	Statewide (optional)	\$3,911	\$5,589			
NE100807	NE100807	Southeast	\$0	\$0	\$0	\$0	\$0

NE100809	NE100809	Statewide (optional)	\$6,947	\$0	\$0	\$0	\$0
x	X	Statewide (optional)	\$0	\$0	\$0	\$15,625	\$0
Totals:			\$20,959,179	\$5,456,347	\$590,864	\$2,077,471	\$0

PROVIDER ADDRESS TABLE

Provider ID	Description	Provider Address
NE000086	Wayne State College (Trust)	Counseling Center 1111 Main St Wayne, NE 68787 402-375-7321
NE000087	North Central Community Care Partnership	422 E Douglas St O'Neill, NE 68762 402-336-2406
x	HHS DIV Public Health	301 Centennial Mall South Lincoln, NE 68526 402 471-7818

Form 9a (formerly Form 6a)

Prevention Strategy Report

Column A (Risks)	Column B(Strategies)	Column C (Providers)
No Risk Category Assigned [-99]	Clearinghouse/information resources centers [1]	2
	Media campaigns [3]	1
	Speaking engagements [6]	2
	Information lines/Hot lines [8]	3
	A/V Material Disseminated,Printed Material Disseminated,Curricula Disseminated,Newsletters Disseminated,Original Printed Material Developed [9]	6
	Parenting and family management [11]	1
	Ongoing classroom and/or small group sessions [12]	2
	Systematic planning [42]	1
	Community team-building [44]	2
	Accessing services and funding [45]	2
	Technical Assistance Services Attendees [46]	1
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	1
Children of Substance Abusers [1]	Clearinghouse/information resources centers [1]	1
	Parenting and family management [11]	1
	Community team-building [44]	2
Pregnant Women/Teens [2]	A/V Material Disseminated,Printed Material Disseminated,Curricula Disseminated,Newsletters Disseminated,Original Printed Material Developed [9]	1
	Ongoing classroom and/or small	2

	group sessions [12]	3
Violent and Delinquent Behavior [4]	Clearinghouse/information resources centers [1]	1
	A/V Material Disseminated,Printed Material Disseminated,Curricula Disseminated,Newsletters Disseminated,Original Printed Material Developed [9]	2
	Parenting and family management [11]	1
	Ongoing classroom and/or small group sessions [12]	2
	Systematic planning [42]	1
	Accessing services and funding [45]	1
Mental Health Problems [5]	Information lines/Hot lines [8]	2
	A/V Material Disseminated,Printed Material Disseminated,Curricula Disseminated,Newsletters Disseminated,Original Printed Material Developed [9]	3
	Ongoing classroom and/or small group sessions [12]	1
	Prevention Assessment and Referral Attendees [34]	1
Economically Disadvantaged [6]	A/V Material Disseminated,Printed Material Disseminated,Curricula Disseminated,Newsletters Disseminated,Original Printed Material Developed [9]	1
	Parenting and family management [11]	1
	Prevention Assessment and Referral Attendees [34]	1
	Systematic planning [42]	1
Physically Disabled [7]	Information lines/Hot lines [8]	2
Already Using Substances [9]	Media campaigns [3]	1
	Information lines/Hot lines [8]	5
	A/V Material Disseminated,Printed Material Disseminated,Curricula	10

	Disseminated, Newsletters Disseminated, Original Printed Material Developed [9]	10
	Parenting and family management [11]	1
	Ongoing classroom and/or small group sessions [12]	4
	Driving while under the influence/driving while intoxicated education programs [33]	4
	Prevention Assessment and Referral Attendees [34]	2
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	1
	Systematic planning [42]	1
	Technical Assistance Services Attendees [46]	1
Homeless and/or Run away Youth [10]	Information lines/Hot lines [8]	1
	Technical Assistance Services Attendees [46]	1
Business and Industry [11]	Clearinghouse/information resources centers [1]	1
	Resources directories [2]	1
	Media campaigns [3]	1
	Speaking engagements [6]	1
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	3
	Information lines/Hot lines [8]	5
	A/V Material Disseminated, Printed Material Disseminated, Curricula Disseminated, Newsletters Disseminated, Original Printed Material Developed [9]	9
	Parenting and family management [11]	1
	Peer leader/helper programs [13]	1

	Employee Assistance Programs [31]	1
	Prevention Assessment and Referral Attendees [34]	1
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	1
	Systematic planning [42]	1
	Community team-building [44]	2
	Accessing services and funding [45]	1
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	4
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	1
	Preventing Underage Sales of Tobacco and Tobacco Products-Synar Amendment [55]	1
Civic Groups/Coalitions [12]	Clearinghouse/information resources centers [1]	1
	Speaking engagements [6]	1
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	1
	Information lines/Hot lines [8]	3
	A/V Material Disseminated, Printed Material Disseminated, Curricula Disseminated, Newsletters Disseminated, Original Printed Material Developed [9]	0
	Youth/adult leadership activities [22]	1
	Community and volunteer training, e.g., neighborhood action training, impactor	2

	training, staff/officials training [41]	
	Systematic planning [42]	8
	Community team-building [44]	8
	Accessing services and funding [45]	6
	Technical Assistance Services Attendees [46]	14
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	5
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	3
	Preventing Underage Sales of Tobacco and Tobacco Products-Synar Amendment [55]	1
College Students [13]	Clearinghouse/information resources centers [1]	1
	Resources directories [2]	1
	Speaking engagements [6]	3
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	1
	Information lines/Hot lines [8]	5
	A/V Material Disseminated, Printed Material Disseminated, Curricula Disseminated, Newsletters Disseminated, Original Printed Material Developed [9]	9
	Parenting and family management [11]	1
	Ongoing classroom and/or small group sessions [12]	3
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	2

	Systematic planning [42]	1
	Community team-building [44]	2
	Technical Assistance Services Attendees [46]	4
Older Adults [14]	Speaking engagements [6]	2
	Information lines/Hot lines [8]	2
	Ongoing classroom and/or small group sessions [12]	1
	Employee Assistance Programs [31]	1
	Prevention Assessment and Referral Attendees [34]	1
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	1
	Community team-building [44]	1
Governmental/Elected Officials [15]	Clearinghouse/information resources centers [1]	1
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	1
	Information lines/Hot lines [8]	1
	A/V Material Disseminated, Printed Material Disseminated, Curricula Disseminated, Newsletters Disseminated, Original Printed Material Developed [9]	3
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	1
	Systematic planning [42]	2
	Community team-building [44]	3
	Accessing services and funding [45]	2
	Technical Assistance Services Attendees [46]	4
	Promoting the establishment of review of alcohol, tobacco, and	1

	drug use policies in schools [51]	+
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	3
	Preventing Underage Sales of Tobacco and Tobacco Products-Synar Amendment [55]	1
Elementary School Students [16]	Clearinghouse/information resources centers [1]	1
	Speaking engagements [6]	2
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	1
	Information lines/Hot lines [8]	3
	Ongoing classroom and/or small group sessions [12]	4
	Peer leader/helper programs [13]	1
	Education programs for youth groups [14]	2
	Drug free dances and parties [21]	2
	Technical Assistance Services Attendees [46]	1
General Population [17]	Clearinghouse/information resources centers [1]	1
	Resources directories [2]	1
	Media campaigns [3]	2
	Speaking engagements [6]	4
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	5
	Information lines/Hot lines [8]	5
	A/V Material Disseminated, Printed Material Disseminated, Curricula Disseminated, Newsletters Disseminated, Original Printed Material Developed [9]	25

	Ongoing classroom and/or small group sessions [12]	3
	Youth/adult leadership activities [22]	1
	Employee Assistance Programs [31]	1
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	1
	Systematic planning [42]	2
	Community team-building [44]	5
	Accessing services and funding [45]	3
	Technical Assistance Services Attendees [46]	4
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	2
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	1
Health Professionals [18]	Clearinghouse/information resources centers [1]	1
	Speaking engagements [6]	2
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	1
	Information lines/Hot lines [8]	3
	A/V Material Disseminated, Printed Material Disseminated, Curricula Disseminated, Newsletters Disseminated, Original Printed Material Developed [9]	10
	Ongoing classroom and/or small group sessions [12]	1
	Community and volunteer training, e.g., neighborhood	

	action training, impactor training, staff/officials training [41]	1
	Systematic planning [42]	2
	Community team-building [44]	1
	Accessing services and funding [45]	1
	Technical Assistance Services Attendees [46]	4
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	1
High School Students [19]	Clearinghouse/information resources centers [1]	1
	Speaking engagements [6]	4
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	3
	Information lines/Hot lines [8]	5
	A/V Material Disseminated, Printed Material Disseminated, Curricula Disseminated, Newsletters Disseminated, Original Printed Material Developed [9]	9
	Ongoing classroom and/or small group sessions [12]	6
	Peer leader/helper programs [13]	2
	Education programs for youth groups [14]	3
	Youth/adult leadership activities [22]	2
	Community service activities [24]	1
	Recreation activities [26]	3
	Driving while under the influence/driving while intoxicated education programs [33]	1
	Community and volunteer training, e.g., neighborhood action training, impactor	1

	training, staff/officials training [41]	
	Systematic planning [42]	2
	Community team-building [44]	2
	Accessing services and funding [45]	1
	Technical Assistance Services Attendees [46]	2
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	2
Middle/Junior High School Students [20]	Clearinghouse/information resources centers [1]	1
	Speaking engagements [6]	2
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	1
	Information lines/Hot lines [8]	1
	A/V Material Disseminated, Printed Material Disseminated, Curricula Disseminated, Newsletters Disseminated, Original Printed Material Developed [9]	6
	Ongoing classroom and/or small group sessions [12]	4
	Education programs for youth groups [14]	3
	Youth/adult leadership activities [22]	1
	Recreation activities [26]	5
	Systematic planning [42]	1
	Community team-building [44]	2
	Accessing services and funding [45]	1
	Technical Assistance Services Attendees [46]	2
Parents/Families [21]	Clearinghouse/information resources centers [1]	3
	Media campaigns [3]	1
	Speaking engagements [6]	4
	Health fairs and other health	

	promotion, e.g., conferences, meetings, seminars [7]	5
	Information lines/Hot lines [8]	5
	A/V Material Disseminated, Printed Material Disseminated, Curricula Disseminated, Newsletters Disseminated, Original Printed Material Developed [9]	13
	Parenting and family management [11]	6
	Ongoing classroom and/or small group sessions [12]	5
	Peer leader/helper programs [13]	1
	Education programs for youth groups [14]	3
	Recreation activities [26]	2
	Employee Assistance Programs [31]	1
	Student Assistance Programs [32]	1
	Driving while under the influence/driving while intoxicated education programs [33]	2
	Prevention Assessment and Referral Attendees [34]	1
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	1
	Systematic planning [42]	2
	Community team-building [44]	8
	Accessing services and funding [45]	2
	Technical Assistance Services Attendees [46]	5
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	1
	Ongoing classroom and/or small	

Preschool Students [22]	Ongoing classroom and/or small group sessions [12]	2
	Recreation activities [26]	1
Prevention/Treatment Professionals [23]	Clearinghouse/information resources centers [1]	1
	Resources directories [2]	1
	Media campaigns [3]	1
	Speaking engagements [6]	3
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	1
	Information lines/Hot lines [8]	3
	A/V Material Disseminated, Printed Material Disseminated, Curricula Disseminated, Newsletters Disseminated, Original Printed Material Developed [9]	13
	Parenting and family management [11]	1
	Ongoing classroom and/or small group sessions [12]	4
	Peer leader/helper programs [13]	1
	Employee Assistance Programs [31]	1
	Prevention Assessment and Referral Attendees [34]	2
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	3
	Systematic planning [42]	5
	Community team-building [44]	9
	Accessing services and funding [45]	7
	Technical Assistance Services Attendees [46]	6
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	3
	Guidance and technical	

	assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	2
	Preventing Underage Sales of Tobacco and Tobacco Products-Synar Amendment [55]	0
Religious Groups [24]	Clearinghouse/information resources centers [1]	1
	Resources directories [2]	1
	Speaking engagements [6]	2
	Information lines/Hot lines [8]	5
	A/V Material Disseminated,Printed Material Disseminated,Curricula Disseminated,Newsletters Disseminated,Original Printed Material Developed [9]	6
	Ongoing classroom and/or small group sessions [12]	1
	Community drop-in centers [23]	1
	Systematic planning [42]	1
	Technical Assistance Services Attendees [46]	1
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	1
Teachers/Administrators/Counselors [25]	Clearinghouse/information resources centers [1]	1
	Resources directories [2]	1
	Speaking engagements [6]	4
	Information lines/Hot lines [8]	6
	A/V Material Disseminated,Printed Material Disseminated,Curricula Disseminated,Newsletters Disseminated,Original Printed Material Developed [9]	17
	Ongoing classroom and/or small group sessions [12]	3
	Student Assistance Programs [32]	2

	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	4
	Systematic planning [42]	2
	Community team-building [44]	3
	Accessing services and funding [45]	3
	Technical Assistance Services Attendees [46]	7
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	3
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	1
Youth/Minors [26]	Clearinghouse/information resources centers [1]	1
	Speaking engagements [6]	1
	Information lines/Hot lines [8]	3
	A/V Material Disseminated, Printed Material Disseminated, Curricula Disseminated, Newsletters Disseminated, Original Printed Material Developed [9]	5
	Ongoing classroom and/or small group sessions [12]	4
	Education programs for youth groups [14]	1
	Youth/adult leadership activities [22]	1
	Community service activities [24]	1
	Driving while under the influence/driving while intoxicated education programs [33]	2
	Community and volunteer	

	training, e.g., neighborhood action training, impactor training, staff/officials training [41]	1
	Systematic planning [42]	1
	Community team-building [44]	1
	Accessing services and funding [45]	2
	Technical Assistance Services Attendees [46]	2
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	1
	Preventing Underage Sales of Tobacco and Tobacco Products-Synar Amendment [55]	1
Law Enforcement/Military [27]	Clearinghouse/information resources centers [1]	1
	Speaking engagements [6]	1
	Information lines/Hot lines [8]	3
	A/V Material Disseminated, Printed Material Disseminated, Curricula Disseminated, Newsletters Disseminated, Original Printed Material Developed [9]	4
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	1
	Systematic planning [42]	1
	Community team-building [44]	1
	Accessing services and funding [45]	1
	Technical Assistance Services Attendees [46]	2
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	1
	Preventing Underage Sales of Tobacco and Tobacco Products-	1

	Synar Amendment [55]	
Gays/Lesbians [28]	Information lines/Hot lines [8]	1

Form 10a (formerly Form 7a)

TREATMENT UTILIZATION MATRIX

Dates of State Expenditure Period: From: 7/1/2008 To: 6/30/2009

Level of Care	Number of Admissions ≥ Number of Persons		Costs per Person		
	A.Number of Admissions	B.Number of Persons	C.Mean Cost of Services	D.Median Cost of Services	E.Standard Deviation of Cost
Detoxification (24-Hour Care)					
Hospital Inpatient	0	0	\$	\$	\$
Free-standing Residential	10586	6128	\$ 1609.94	\$ 1455	\$
Rehabilitation / Residential					
Hospital Inpatient	381	320	\$	\$	\$
Short-term (up to 30 days)	1600	831	\$ 9113.11	\$ 8465.79	\$
Long-term (over 30 days)	1194	665	\$ 22921.36	\$ 16416.17	\$
Ambulatory (Outpatient)					
Outpatient	10711	8011	\$ 12091.78	\$ 832.81	\$
Intensive Outpatient	1530	831	\$ 2608.58	\$ 1975.69	\$
Detoxification	0	0	\$	\$	\$
Opioid Replacement Therapy (ORT)					
Opioid Replacement Therapy	299	279	\$ 3534.32	\$	\$

Footnote:

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

(2) For FY2010, with the community based services (Magellan Health) data, only the persons admitted to a Substance Abuse service or a dual service (consumers who received a specialized program including both mental health and substance abuse services) were counted. In the past, persons served in mental health services with a substance abuse diagnosis or reason for admission field showing "substance abuse" were included.

As a result, the counts in FY2010 will drop. However, the Division of Behavioral Health believes this is a more accurate method for reporting persons served.

(3) To obtain unduplicated count of persons served, the Division used social security numbers and dates of birth to identify unique clients in the data system.

(4) The Division of Behavioral Health does not have in place a claims system to track the costs of services provided at the individual level. For that reason, the standard deviation is not presented and the average, and median of costs is a rough estimate based on comparisons between service provision data from the Magellan system and billing information received directly from the regions at a provider level. The numbers were calculated using provider level of data (e.g., number of clients served and costs billed from each provider) and in some levels of care the two did not always correspond. These numbers and costs do not include Medicaid matched services.

Missing: At this time the Division of Behavioral Health is unable to differentiate between substance abuse and mental health hospital inpatient costs. The median cost for detoxification services cannot be determined because the Division received billing from one provider.

Form 10b (formerly Form 7b)

Number of Persons Served (Unduplicated Count) for alcohol and other drug use in state-funded services by age, sex, and race/ethnicity

Age	A. Total	B. White		C. Black or African American		D. Native Hawaiian / Other Pacific Islander		E. Asian		F. American Indian / Alaska Native		G. More than one race reported		H. Unknown		I. Not Hispanic or Latino		J. Hispanic or Latino	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
1. 17 and under	454	222	142	16	7	2	0	2	1	19	16	1	2	18	6	234	152	46	22
2. 18-24	4,456	2,692	1,170	134	53	32	5	23	10	81	63	0	2	138	53	2,842	1,272	258	84
3. 25-44	8,266	4,162	2,272	545	204	67	8	41	13	257	203	9	6	367	112	4,877	2,651	571	167
4. 45-64	3,444	1,894	773	353	106	22	2	21	2	99	49	6	0	99	18	2,335	923	159	27
5. 65 and over	127	88	23	8	0	0	0	0	0	5	1	0	0	2	0	102	24	1	0
6. Total	16,747	9,058	4,380	1,056	370	123	15	87	26	461	332	16	10	624	189	10,390	5,022	1,035	300
7. Pregnant Women	162		130		12		0		0	10		1		9			20		142

Did the values reported by your State on Forms 7a and 7b come from a client-based system(s) with unique client identifiers? Yes No

Numbers of Persons Served who were admitted in a period prior to the 12 month reporting period.

Numbers of Persons Served outside of the levels of care described in Form 10a.

Footnote:

- (1) In January 2009, the Division of Behavioral Health cleaned its data system by administratively discharging nearly 18,000 records of admission to program prior to November 2003 and of which had no activity in the last year. This reduced the number of active cases in the system.
- (2) For FY2010, with the community based services (Magellan Health) data, only the persons admitted to a Substance Abuse service or a dual service (consumers who received a specialized program including both mental health and substance abuse services) were counted. In the past, persons served in mental health services with a substance abuse diagnosis or reason for admission field showing "substance abuse" were included. As a result, the counts in FY2010 will drop. However, the Division of Behavioral Health believes this is a more accurate method for reporting persons served.
- (3) To obtain unduplicated count of persons served, the Division used social security numbers and dates of birth to identify unique clients in the data system.
- (4) There were 9 cases in which age was missing. These cases were evenly distributed among the four categories capturing ages 18 and older.
- (5) There were 15 cases in which gender was missing. These cases were evenly distributed among the four categories capturing ages 18 and older.
- (6) The race category 'unknown' includes cases in which the race was 'unknown,' or the data was missing ('not available').
- (7) The ethnicity category 'Not Hispanic or Latino' includes cases in which ethnicity was unknown (n=196).

Description of Calculations

Description of Calculations

If revisions or changes are necessary to prior years' description of the following, please provide: a brief narrative describing the amounts and methods used to calculate the following: (a) the base for services to pregnant women and women with dependent children as required by 42 U.S.C. §300x-22(b)(1); and, for 1994 and subsequent fiscal years report the Federal and State expenditures for such services; (b) the base and Maintenance of Effort (MOE) for tuberculosis services as required by 42 U.S.C. §300x-24(d); and, (c) for designated States, the base and MOE for HIV early intervention services as required by 42 U.S.C. §300x-24(d) (See 45 C.F.R. §96.122(f)(5)(ii)(A)(B)(C)).

Description of Calculations

If revisions or changes are necessary to prior years' description of the following, please provide: a brief narrative describing the amounts and methods used to calculate the following: (a) the base for services to pregnant women and women with dependent children as required by 42 U.S.C. 300x-22(b)(1); and, for 1994 and subsequent fiscal years report the Federal and State expenditures for such services; (b) the base and Maintenance of Effort (MOE) for tuberculosis services as required by 42 U.S.C. 300x-24(d); and, (c) for designated States, the base and MOE for HIV early intervention services as required by 42 U.S.C. 300x-24(d) (See 45 C.F.R. 96.122(f)(5)(ii)(A)(B)(C)).

A: base of services for Pregnant Women and Women with Dependent children:

To establish the base for specialized services for pregnant women and women with dependent children in FFY92, Nebraska submitted information to the Center for Substance Abuse Treatment (CSAT) detailing the amount the state had expended (\$274,044) for services to this specialized population. This amount was determined through an analysis of admission data from programs to determine the percentage of admissions of pregnant women and women with children compared to total admissions in these programs. This percent was then applied to total program expenditures to extrapolate an agreed upon base. Subsequent requirements to utilize five percent of SAPT Block Grant funds for two years (totaling \$506,669) brought the continuation base to \$753,713 for FFY04 and subsequent years.

In May, 2009, the state accounting system (Nebraska Information System, hereafter referred to as NIS) was altered to establish a method of tracking expenditures for services provided to pregnant women and women with children purchased by the SSA. Under this new method, expenditures reported each month for these services by the Regional Behavioral Health Authorities are directly coded into NIS. Beginning with this application, expenditures reported on Table IV will come directly from NIS.

To ensure that expenditure amounts reported in the future can be compared to past expenditures, an analysis of previously reported amounts was conducted. It was determined that figures included an estimate of funds used to match Medicaid services for these services. It was impossible however to determine how much of the Medicaid match funds were directly related to services to pregnant women and women with children as Medicaid only provided a total paid to providers. Removing these funds from the past two years revealed that Nebraska was, and continues to be, significantly above the continuation base established.

The chart below shows the change. "Previously Reported" includes the estimated Medicaid funds plus Division of Behavioral Health State Funds. "Revised Expenditures" shows only DBH funds.

	Previously Reported	Revised Expenditures
FY07	3,100,000	2,104,935
FY08	2,751,469	1,993,396

B. Tuberculosis:

In 2009, through a series of Technical Assistance site visits and subsequent discussions with the Technical Assistant providers, Nebraska submitted a request to Center for Substance Abuse Treatment (CSAT) and received permission to revise the method used by the Single State Agency (SSA) to calculate the Maintenance of Effort (MOE) for tuberculosis. Under the revised method, data submitted annually to the Center for Disease Control by the Nebraska Department of Health and Human Services, Division of Public Health, Disease Prevention Section would be utilized to determine a percentage of individuals reporting both tuberculosis and drug use. This percentage would then be applied to the total State General funds used for tuberculosis services for the State fiscal year relevant to the application to calculate the MOE by the Division of Public Health. No Division of Behavioral Health funds are expended for tuberculosis services.

C. HIV

Not applicable as Nebraska is currently not a designated HIV state.

SSA (MOE TABLE I)

Total Single State Agency (SSA) Expenditures for Substance Abuse (Table I)

PERIOD	EXPENDITURES	B1(2007) + B2(2008)
(A)	(B)	----- 2 (C)
SFY 2008 (1)	\$24,023,859	\$22,491,519
SFY 2009 (2)	\$20,959,179	
SFY 2010 (3)	\$ 23,539,822	

Are the expenditure amounts reported in Column B "actual" expenditures for the State fiscal years involved?

FY 2008 Yes No

FY 2009 Yes No

FY 2010 Yes No

If estimated expenditures are provided, please indicate when "actual" expenditure data will be submitted to SAMHSA (mm/dd/yyyy):

The MOE for State fiscal year(SFY) 2010 is met if the amount in Box B3 is greater than or equal to the amount in Box C2 assuming the State complied with MOE Requirements in these previous years.

The State may request an exclusion of certain non-recurring expenditures for a singular purpose from the calculation of the MOE, provided it meets CSAT approval based on review of the following information:

Did the State have any non-recurring expenditures for a specific purpose which were not included in the MOE calculation?

Yes No If yes, specify the amount and the State fiscal year: \$, (SFY)

Did the State include these funds in previous year MOE calculations?

Yes No

When did the State submit an official request to the SAMHSA Administrator to exclude these funds from the MOE calculations?
(Date)

TB (MOE TABLE II)

Statewide Non-Federal Expenditures for Tuberculosis Services to Substance Abusers in Treatment (Table II)

(BASE TABLE)

Period	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment (B)	Total State Funds Spent on Clients who were Substance Abusers in Treatment AX B (C)	Average of Columns C1 and C2 C1 + C2 ----- 2 (D)
SFY 1991 (1)	\$ 26,611	1.21 %	\$ 322	\$ 336
SFY 1992 (2)	\$ 28,910	1.21 %	\$ 350	

(MAINTENANCE TABLE)

Period	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment (B)	Total State Funds Spent on Clients who were Substance Abusers in Treatment AX B (C)
SFY 2010 (3)	\$ 87,772	3 %	\$ 2,633

HIV (MOE TABLE III)

Statewide Non-Federal Expenditures for HIV Early Intervention Services to Substance Abusers in Treatment (Table III)

(BASE TABLE)

Period	Total of All State Funds Spent on Early Intervention Services for HIV (A)	Average of Columns A1 and A2 A1 + A2 ----- 2 (B)
SFY 1993 (1)	\$ 0	\$ 0
SFY 1994 (2)	\$ 0	

(MAINTENANCE TABLE)

Period	Total of All State Funds Spent on Early Intervention Services for HIV* (A)
SFY 2010 (3)	\$

* Provided to substance abusers at the site at which they receive substance abuse treatment

Womens (MOE TABLE IV)

Expenditures for Services to Pregnant Women and Women with Dependent Children (Table IV)

(MAINTENANCE TABLE)

Period	Total Women's Base (A)	Total Expenditures (B)
1994	\$753,713	
2008		\$2,751,469
2009		\$2,550,286
2010		\$ 2,240,382

Enter the amount the State plans to expend in FY 2011 for services for pregnant women and women with dependent children (amount entered must be not less than amount entered in Table IV Maintenance - Box A {1994}): \$ 2,368,265

Form T1

Form T1 was pre-populated with the following Data Source: Discharges in CY 2009

EMPLOYMENT/EDUCATION STATUS (From Admission to Discharge)

Short-term Residential(SR)		
Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge	At Admission (T₁)	At Discharge(T₂)
Number of clients employed (full-time and part-time) or student [numerator]	137	110
Total number of clients with non-missing values on employment\student status [denominator]	818	818
Percent of clients employed (full-time and part-time) or student	16.7%	13.4%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	987
Number of CY 2009 discharges submitted:	844
Number of CY 2009 discharges linked to an admission:	829
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	823
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	818
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Long-term Residential(LR)		
Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge	At Admission (T₁)	At Discharge(T₂)
Number of clients employed (full-time and part-time) or student [numerator]	69	230
Total number of clients with non-missing values on employment\student status [denominator]	486	486
Percent of clients employed (full-time and part-time) or student	14.2%	47.3%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	537
Number of CY 2009 discharges submitted:	545
Number of CY 2009 discharges linked to an admission:	522
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	498
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	486
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Intensive Outpatient (IO)		
Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge	At Admission (T₁)	At Discharge(T₂)
Number of clients employed (full-time and part-time) or student [numerator]	195	244
Total number of clients with non-missing values on employment\student status [denominator]	454	454
Percent of clients employed (full-time and part-time) or student	43.0%	53.7%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	562
Number of CY 2009 discharges submitted:	515
Number of CY 2009 discharges linked to an admission:	485
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	467
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	454
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Outpatient (OP)		
Employment/Education - Clients employed (full-time and part-time) or student at admission vs. discharge	At Admission (T₁)	At Discharge(T₂)
Number of clients employed (full-time and part-time) or student [numerator]	1,434	1,553
Total number of clients with non-missing values on employment\student status [denominator]	2,759	2,759
Percent of clients employed (full-time and part-time) or student	52.0%	56.3%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	5,045
Number of CY 2009 discharges submitted:	3,337
Number of CY 2009 discharges linked to an admission:	2,995
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	2,833
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	2,759
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Form T2

Form T2 was pre-populated with the following Data Source: Discharges in CY 2009

STABLE HOUSING SITUATION (From Admission to Discharge)

Short-term Residential(SR)		
Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge	At Admission (T₁)	At Discharge(T₂)
Number of clients with stable housing [numerator]	683	683
Total number of clients with non-missing values on living arrangements [denominator]	761	761
Percent of clients with stable housing	89.8%	89.8%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	987
Number of CY 2009 discharges submitted:	844
Number of CY 2009 discharges linked to an admission:	829
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	823
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	761
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Long-term Residential(LR)		
Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge	At Admission (T₁)	At Discharge(T₂)
Number of clients with stable housing [numerator]	291	291
Total number of clients with non-missing values on living arrangements [denominator]	355	355
Percent of clients with stable housing	82.0%	82.0%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	537
Number of CY 2009 discharges submitted:	545
Number of CY 2009 discharges linked to an admission:	522
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	498
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	355
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Intensive Outpatient (IO)		
Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge	At Admission (T₁)	At Discharge(T₂)
Number of clients with stable housing [numerator]	443	443
Total number of clients with non-missing values on living arrangements [denominator]	447	447
Percent of clients with stable housing	99.1%	99.1%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	562
Number of CY 2009 discharges submitted:	515
Number of CY 2009 discharges linked to an admission:	485
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	467
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	447
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Outpatient (OP)		
Clients with stable housing (independent or dependent living/not homeless) at admission vs. discharge	At Admission (T₁)	At Discharge(T₂)
Number of clients with stable housing [numerator]	2,481	2,477
Total number of clients with non-missing values on living arrangements [denominator]	2,586	2,586
Percent of clients with stable housing	95.9%	95.8%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	5,045
Number of CY 2009 discharges submitted:	3,337
Number of CY 2009 discharges linked to an admission:	2,995
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	2,833
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	2,586
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Form T3

Form T3 was pre-populated with the following Data Source: Discharges in CY 2009

CRIMINAL JUSTICE INVOLVEMENT - NO ARRESTS (From Admission to Discharge)

Short-term Residential(SR)		
Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge	At Admission (T₁)	At Discharge(T₂)
Number of clients with no arrests [numerator]	672	672
Total number of clients with non-missing values on arrests [denominator]	822	822
Percent of clients with no arrests	81.8%	81.8%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	987
Number of CY 2009 discharges submitted:	844
Number of CY 2009 discharges linked to an admission:	829
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	825
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	822
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Long-term Residential(LR)		
Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge	At Admission (T₁)	At Discharge(T₂)
Number of clients with no arrests [numerator]	388	388
Total number of clients with non-missing values on arrests [denominator]	494	494
Percent of clients with no arrests	78.5%	78.5%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	537
Number of CY 2009 discharges submitted:	545
Number of CY 2009 discharges linked to an admission:	522
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	517
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	494
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Intensive Outpatient (IO)		
Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge	At Admission (T₁)	At Discharge(T₂)
Number of clients with no arrests [numerator]	376	376
Total number of clients with non-missing values on arrests [denominator]	459	459
Percent of clients with no arrests	81.9%	81.9%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	562
Number of CY 2009 discharges submitted:	515
Number of CY 2009 discharges linked to an admission:	485
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	480
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	459
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Outpatient (OP)		
Criminal Justice Involvement – Clients with no arrests (any charge) (prior 30 days) at admission vs. discharge	At Admission (T₁)	At Discharge(T₂)
Number of clients with no arrests [numerator]	1,766	1,768
Total number of clients with non-missing values on arrests [denominator]	2,326	2,326
Percent of clients with no arrests	75.9%	76.0%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	5,045
Number of CY 2009 discharges submitted:	3,337
Number of CY 2009 discharges linked to an admission:	2,995
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	2,901
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	2,326
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Form T4

Form T4 was pre-populated with the following Data Source: Discharges in CY 2009

ALCOHOL ABSTINENCE

Short-term Residential(SR)		
A. ALCOHOL ABSTINENCE AMONG <u>ALL</u> CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)		
Denominator = All clients		
Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)	At Admission (T₁)	At Discharge(T₂)
Number of clients abstinent from alcohol [numerator]	216	257
All clients with non-missing values on at least one substance/frequency of use [denominator]	805	805
Percent of clients abstinent from alcohol	26.8%	31.9%
B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL <u>USERS</u> AT ADMISSION		
Denominator = Clients using at admission		
Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)	At Admission (T₁)	At Discharge(T₂)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		57
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	589	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T ₂ / #T ₁ x 100]		9.7%
C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL <u>ABSTINENT</u> AT ADMISSION		
Denominator = Clients abstinent at admission		
Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)	At Admission (T₁)	At Discharge(T₂)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		200
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	216	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T ₂ / #T ₁ x 100]		92.6%

Notes (for this level of care):

Number of CY 2009 admissions submitted:	987
Number of CY 2009 discharges submitted:	844
Number of CY 2009 discharges linked to an admission:	829

Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	825
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	805
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Long-term Residential(LR)		
A. ALCOHOL ABSTINENCE AMONG <u>ALL</u> CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)		
Denominator = All clients		
Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)	At Admission (T₁)	At Discharge(T₂)
Number of clients abstinent from alcohol [numerator]	329	349
All clients with non-missing values on at least one substance/frequency of use [denominator]	509	509
Percent of clients abstinent from alcohol	64.6%	68.6%
B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL <u>USERS</u> AT ADMISSION		
Denominator = Clients using at admission		
Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)	At Admission (T₁)	At Discharge(T₂)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		24
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	180	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T ₂ / #T ₁ x 100]		13.3%
C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL <u>ABSTINENT</u> AT ADMISSION		
Denominator = Clients abstinent at admission		
Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)	At Admission (T₁)	At Discharge(T₂)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		325
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	329	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T ₂ / #T ₁ x 100]		98.8%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	537
Number of CY 2009 discharges submitted:	545

Number of CY 2009 discharges linked to an admission:	522
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	517
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	509
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Intensive Outpatient (IO)		
A. ALCOHOL ABSTINENCE AMONG <u>ALL</u> CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)		
Denominator = All clients		
Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)	At Admission (T₁)	At Discharge (T₂)
Number of clients abstinent from alcohol [numerator]	232	242
All clients with non-missing values on at least one substance/frequency of use [denominator]	467	467
Percent of clients abstinent from alcohol	49.7%	51.8%
B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL <u>USERS</u> AT ADMISSION		
Denominator = Clients using at admission		
Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)	At Admission (T₁)	At Discharge (T₂)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		15
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	235	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T ₂ / #T ₁ x 100]		6.4%
C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL <u>ABSTINENT</u> AT ADMISSION		
Denominator = Clients abstinent at admission		
Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)	At Admission (T₁)	At Discharge (T₂)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		227
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	232	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T ₂ / #T ₁ x 100]		97.8%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	562

Number of CY 2009 discharges submitted:	515
Number of CY 2009 discharges linked to an admission:	485
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	480
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	467
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Outpatient (OP)		
A. ALCOHOL ABSTINENCE AMONG <u>ALL</u> CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)		
Denominator = All clients		
Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)	At Admission (T₁)	At Discharge (T₂)
Number of clients abstinent from alcohol [numerator]	1,644	1,703
All clients with non-missing values on at least one substance/frequency of use [denominator]	2,635	2,635
Percent of clients abstinent from alcohol	62.4%	64.6%
B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL <u>USERS</u> AT ADMISSION		
Denominator = Clients using at admission		
Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)	At Admission (T₁)	At Discharge (T₂)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		91
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	991	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T ₂ / #T ₁ x 100]		9.2%
C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL <u>ABSTINENT</u> AT ADMISSION		
Denominator = Clients abstinent at admission		
Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)	At Admission (T₁)	At Discharge (T₂)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		1,612
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	1,644	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T ₂ / #T ₁ x 100]		98.1%

Notes (for this level of care):

Number of CY 2009 admissions submitted:	5,045
Number of CY 2009 discharges submitted:	3,337
Number of CY 2009 discharges linked to an admission:	2,995
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	2,901
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	2,635

**Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file
[Records received through 5/6/0010]**

Form T5

Form T5 was pre-populated with the following Data Source: Discharges in CY 2009

DRUG ABSTINENCE

Short-term Residential(SR)		
A. DRUG ABSTINENCE AMONG <u>ALL</u> CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)		
Denominator = All clients		
Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission vs. discharge.	At Admission (T ₁)	At Discharge(T ₂)
Number of clients abstinent from drugs [numerator]	382	395
All clients with non-missing values on at least one substance/frequency of use [denominator]	805	805
Percent of clients abstinent from drugs	47.5%	49.1%
B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG <u>USERS</u> AT ADMISSION		
Denominator = Clients using at admission		
Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem)	At Admission (T ₁)	At Discharge(T ₂)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		14
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	423	
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T ₂ / #T ₁ x 100]		3.3%
C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG <u>ABSTINENT</u> AT ADMISSION		
Denominator = Clients abstinent at admission		
Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem)	At Admission (T ₁)	At Discharge(T ₂)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		381
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	382	
Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T ₂ / #T ₁ x 100]		99.7%

Notes (for this level of care):

Number of CY 2009 admissions submitted:	987
Number of CY 2009 discharges submitted:	844

Number of CY 2009 discharges linked to an admission:	829
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	825
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	805
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Long-term Residential(LR)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Denominator = All clients

Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission vs. discharge.	At Admission (T ₁)	At Discharge(T ₂)
Number of clients abstinent from drugs [numerator]	336	345
All clients with non-missing values on at least one substance/frequency of use [denominator]	509	509
Percent of clients abstinent from drugs	66.0%	67.8%

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION

Denominator = Clients using at admission

Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem)	At Admission (T ₁)	At Discharge(T ₂)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		10
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	173	
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T ₂ / #T ₁ x 100]		5.8%

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION

Denominator = Clients abstinent at admission

Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem)	At Admission (T ₁)	At Discharge(T ₂)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		335
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	336	
Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T ₂ / #T ₁ x 100]		99.7%

Notes (for this level of care):

Number of CY 2009 admissions submitted:	537
Number of CY 2009 discharges submitted:	545
Number of CY 2009 discharges linked to an admission:	522
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	517
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	509
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file	
[Records received through 5/6/0010]	

Intensive Outpatient (IO)		
A. DRUG ABSTINENCE AMONG <u>ALL</u> CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)		
Denominator = All clients		
Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission vs. discharge.	At Admission (T₁)	At Discharge(T₂)
Number of clients abstinent from drugs [numerator]	319	322
All clients with non-missing values on at least one substance/frequency of use [denominator]	467	467
Percent of clients abstinent from drugs	68.3%	69.0%
B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG <u>USERS</u> AT ADMISSION		
Denominator = Clients using at admission		
Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem)	At Admission (T₁)	At Discharge(T₂)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		7
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	148	
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T ₂ / #T ₁ x 100]		4.7%
C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG <u>ABSTINENT</u> AT ADMISSION		
Denominator = Clients abstinent at admission		
Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem)	At Admission (T₁)	At Discharge(T₂)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		315
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	319	
Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T ₂ / #T ₁ x 100]		98.7%

Notes (for this level of care):	
Number of CY 2009 admissions submitted:	562
Number of CY 2009 discharges submitted:	515
Number of CY 2009 discharges linked to an admission:	485
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	480
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	467
Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file [Records received through 5/6/0010]	

Outpatient (OP)		
A. DRUG ABSTINENCE AMONG <u>ALL</u> CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)		
Denominator = All clients		
Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) at admission vs. discharge.	At Admission (T₁)	At Discharge(T₂)
Number of clients abstinent from drugs [numerator]	2,040	2,047
All clients with non-missing values on at least one substance/frequency of use [denominator]	2,635	2,635
Percent of clients abstinent from drugs	77.4%	77.7%
B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG <u>USERS</u> AT ADMISSION		
Denominator = Clients using at admission		
Clients abstinent from drugs at discharge among clients using drugs at admission (regardless of primary problem)	At Admission (T₁)	At Discharge(T₂)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		23
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	595	
Percent of clients abstinent from drugs at discharge among clients using drugs at admission [#T ₂ / #T ₁ x 100]		3.9%
C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG <u>ABSTINENT</u> AT ADMISSION		
Denominator = Clients abstinent at admission		
Clients abstinent from drugs at discharge among clients abstinent from drugs at admission (regardless of primary problem)	At Admission (T₁)	At Discharge(T₂)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		2,024
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	2,040	

Percent of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [#T2 / #T1 x 100]

99.2%

Notes (for this level of care):

Number of CY 2009 admissions submitted:	5,045
Number of CY 2009 discharges submitted:	3,337
Number of CY 2009 discharges linked to an admission:	2,995
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths):	2,901
Number of CY 2009 linked discharges eligible for this calculation (non-missing values):	2,635

Source: SAMHSA/OAS TEDS CY 2009 admissions file and CY 2009 linked discharge file
[Records received through 5/6/0010]

Form T6

Most recent year for which data are available ? From: To:

Social Support of Recovery – Clients participating in self-help groups, support groups (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge	Admission Clients (T ₁)	Discharge Clients (T ₂)
Number of clients with one or more such activities (AA NA meetings attended, etc.) [numerator]	<input type="text" value="2201"/>	<input type="text" value="2445"/>
Total number of Admission and Discharge clients with non-missing values on social support activities [denominator]	<input type="text" value="5129"/>	<input type="text" value="5129"/>
Percent of clients participating in social support activities	42.91%	47.67%

State Description of Social Support of Recovery Data Collection (Form T6)

STATE CONFORMANCE TO INTERIM STANDARD	<p>States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described</p> <p>Data were submitted manually, similar to T1. All clients that were admitted to substance abuse or dual services (excluded those who were admitted to CPC, Social Setting Detox services) were included.</p>
---------------------------------------	--

DATA SOURCE	<p>What is the source of data for table T6? (Select all that apply)</p> <p><input checked="" type="checkbox"/> Client Self Report</p> <p>Client self-report confirmed by another source:</p> <p><input type="checkbox"/> Collateral source</p> <p><input type="checkbox"/> Administrative data source</p> <p><input type="checkbox"/> Other: Specify</p> <input type="text"/>
-------------	--

EPISODE OF CARE	<p>How is the admission/discharge basis defined for table T6? (Select one)</p> <p><input type="radio"/> Admission is on the first date of service, prior to which no service has been received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days</p> <p><input checked="" type="radio"/> Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit</p> <p><input type="radio"/> Other, Specify:</p> <input type="text"/>
-----------------	---

DISCHARGE DATA COLLECTION	<p>How was discharge data collected for table T6? (Select all that apply)</p> <p><input type="checkbox"/> Not applicable, data reported on form is collected at time period other than discharge</p> <p>Specify:</p> <p><input type="radio"/> In-Treatment data <input type="text"/> days post admission</p> <p><input type="radio"/> Follow-up data <input type="text"/> months post <input type="text" value="admission"/></p> <p><input type="radio"/> Other, Specify:</p> <input type="text"/>
	<p><input checked="" type="checkbox"/> Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment</p> <p><input type="checkbox"/> Discharge data is collected for a sample of all clients who were admitted to treatment</p> <p><input type="checkbox"/> Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment</p> <p><input type="checkbox"/> Discharge records are not collected for approximately <input type="text"/> % of clients who were admitted for treatment</p>

<p>RECORD LINKING</p>	<p>Was the admission and discharge data linked for table T6? (Select all that apply)</p> <p><input checked="" type="checkbox"/> Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID) Select type of UCID:</p> <ul style="list-style-type: none"> <input type="radio"/> Master Client Index or Master Patient Index, centrally assigned <input type="radio"/> Social Security Number (SSN) <input type="radio"/> Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.) <input checked="" type="radio"/> Some other Statewide unique ID <input type="radio"/> Provider-entity-specific unique ID <p><input type="checkbox"/> No, State Management Information System does not utilize UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohorts basis) or State relied on other data sources for post admission data</p> <p><input type="checkbox"/> No, admission and discharge records were matched using probabilistic record matching</p>
<p>IF DATA IS UNAVAILABLE</p>	<p>If data is not reported, why is State unable to report? (Select all that apply)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Information is not collected at admission <input type="checkbox"/> Information is not collected at discharge <input type="checkbox"/> Information is not collected by the categories requested <input type="checkbox"/> State collects information on the indicator area but utilizes a different measure.
<p>DATA PLANS IF DATA IS NOT AVAILABLE</p>	<p>State must provide time-framed plans for capturing self-help participation status data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

Form T7

Form T7 was pre-populated with the following Data Source: Discharges in CY 2009

Length of Stay (in Days) of All Discharges

Level of Care	Length of Stay (in Days)			
	Average (Mean)	25th Percentile	50th Percentile (Median)	75th Percentile
Detoxification (24-Hour Care)				
1. Hospital Inpatient				
2. Free-standing Residential	7	1	1	1
Rehabilitation / Residential				
3. Hospital Inpatient				
4. Short-term (up to 30 days)	32	27	31	38
5. Long-term (over 30 days)	105	29	79	147
Ambulatory (Outpatient)				
6. Outpatient	176	32	93	207
7. Intensive Outpatient	89	42	53	77
8. Detoxification				
Opioid Replacement Therapy (ORT)				
9. Opioid Replacement therapy	2	1	1	4
10. ORT Outpatient	235	50	173	352

Notes:		
Level of Care	2009 TEDS discharge record count	
	Discharges submitted	Discharges linked to an admission
Total count, all levels of care	14,579	8,885
1. Hospital Inpatient-Detoxification (24-Hour Care)		
2. Free-standing Residential-Detoxification (24-Hour Care)	9,338	4,040
3. Hospital Inpatient-Rehabilitation / Residential		
4. Short-term (up to 30 days)-Rehabilitation / Residential	844	829
5. Long-term (over 30 days)-Rehabilitation / Residential	545	522
6. Outpatient-Ambulatory (Outpatient)	3,337	2,911
7. Intensive Outpatient-Ambulatory (Outpatient)	515	485

8. Detoxification-Ambulatory (Outpatient)		
9. Opioid Replacement therapy-Opioid Replacement Therapy (ORT)		14
10. ORT Outpatient-Opioid Replacement Therapy (ORT)		84
Source: SAMHSA/OAS TEDS CY 2009 linked discharge file [Records received through 05/06/2010]		

INSERT OVERALL NARRATIVE:

INSERT OVERALL NARRATIVE:

The State should address as many of these questions as possible and may provide other relevant information if so desired. Responses to questions that are already provided in other sections of the application (e.g., planning, needs assessment) should be referenced whenever possible.

State Performance Management and Leadership

Describe the Single State Agency's capacity and capability to make data driven decisions based on performance measures. Describe any potential barriers and necessary changes that would enhance the SSA's leadership role in this capacity.

Describe the types of regular and ad hoc reports generated by the State and identify to whom they are distributed and how.

If the State sets benchmarks, performance targets or quantified objectives, what methods are used by the State in setting these values?

What actions does the State take as a result of analyzing performance management data?

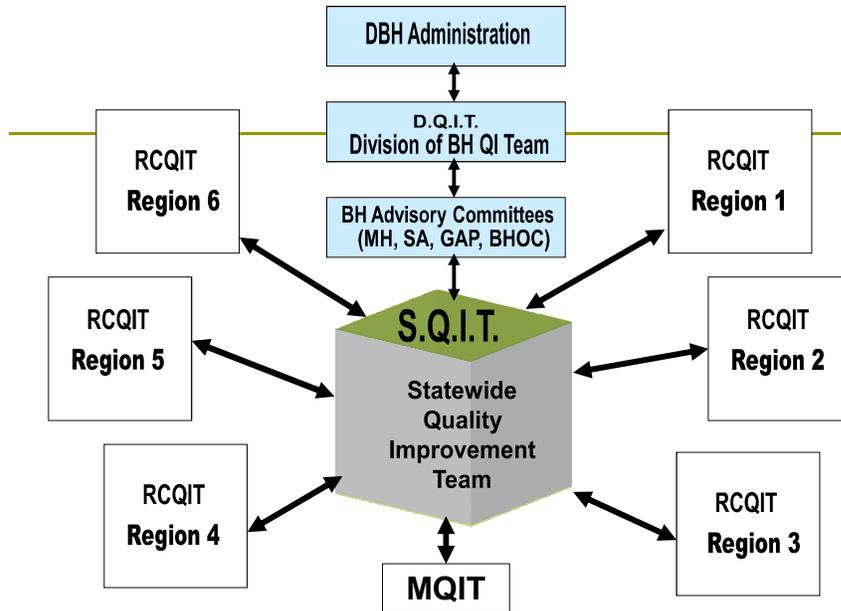
If the SSA has a regular training program for State and provider staff that collect and report client information, describe the training program, its participants and frequency.

Do workforce development plans address NOMs implementation and performance-based management practices?

Does the State require providers to supply information about the intensity or number of services received?

The State should address as many of these questions as possible and may provide other relevant information if so desired. Responses to questions that are already provided in other sections of the application (e.g., planning, needs assessment) should be referenced whenever possible.

State Performance Management and Leadership



RCQIT = Regional Community Quality Improvement Team

Leaders, through a planned and shared communication approach, ensure all stakeholders have knowledge of and participation in ongoing QI activities as a means of continually improving performance. Planned communication methods include posting QI information on the DHHS-DBH public website.

The CQI process must be stakeholder driven. Stakeholders include Consumers and Families, DBH Administration and Staff Consultants, Regional Staff, Service Providers, Advocacy Group and Office of Consumer Affairs Participants, Managed Care Staff, DHHS Partners, etc. Working Relationships are pictured and described below.

- **Division of Behavioral Health Administration** – The DBH Director and Administrator establish and communicate priorities for the annual plan and review feedback from stakeholders in the reporting structure.
- **Division Quality Improvement Team (D.Q.I.T.)** - Provides ongoing operational guidance for continuous quality improvement activities. Meetings are held at least twice monthly.
- **Behavioral Health Advisory Committees (MH, SA and GAP) - Contributes** to the development and implementation of the Annual CQI Plan and activities. The committees meet quarterly.
- **Regional Administrator Meetings - Ensure** that quality improvement processes are operationalized and prioritized at the community team level. Regional Administrators meet regularly with DBH Administration and the R.C.Q.I.T.
- **Statewide Quality Improvement Team (S.Q.I.T.)** - primarily responsible for the identification and prioritization of opportunities for improvement and development of the base plan. Ensures the development and implementation of policies and procedures needed to ensure ongoing improvement and change. Meetings are at least quarterly.

- **Regional Community Quality Improvement Teams (R.C.Q.I.T.)** - Contributes to the development and implementation of local QI activities as it relates to local needs and the DBH CQI Program Plan. Meetings are held on a regular basis.
- **Magellan Quality Improvement Team (M.Q.I.T.)** - Primary responsibilities include:
 - Improving communication and coordination between the Divisions, Regions, Providers and Magellan
 - Developing an understanding of the work flows, systems and processes related to data and making recommendations for improvement
 - Establishing a mechanism for the identification, review and resolution of issues
 - Reviewing reports and recommending content and format improvements to ensure the presentation of meaningful data
 - Meetings are held monthly

Describe the Single State Agency's capacity and capability to make data driven decisions based on performance measures. Describe any potential barriers and necessary changes that would enhance the SSA's leadership role in this capacity.

The Division of Behavioral Health does not have its own data management or claims system at this time. The data system is part of the contract with the Administrative Services Organization (ASO). Under Goal 13 Intended Use, there is a discussion on the need for development of a data strategy. The Division of Behavioral Health is developing a long term data strategy in order to work with the rate setting mechanism as well as a sustainable method for collecting the data needed for the National Outcome Measures and other data for performance measurement and system planning. See GOAL # 13 Assessment of Need for more details.

The current DBH/Magellan Behavioral Health contract began on May 1, 2008 and ends on June 30, 2010. There are optional annual contract renewals for State Fiscal Years 2011, 2012 and 2013. The DBH has exercised the first annual option for SFY 2011 which retains the data management system.

The Magellan Behavioral Health contract includes the following functions for the Nebraska Behavioral Health System:

- Training and Technical Support
- Consumer Eligibility Determination
- Utilization Management
- Information Management
- Data Capture and Transfer Requirements
- Information Reporting
- Claims and Payment Information
- Quality Improvement

The Magellan Behavioral Health contract is monitored by the DBH Managed Care and QI Administrators and is responsible for ensuring the ASO functions purchased are consistent with State of Nebraska requirements.

The Division of Behavioral Health continues to address the data infrastructure in order to improve the capacity for data collection, analysis and reporting. Nebraska uses Magellan Behavioral Health contract as the source used to collect the client data for reporting under the Federal Substance Abuse Prevention and Treatment Block Grant. Magellan collects client data for both community mental health and substance abuse. The data being reported under this

application was collected under the Magellan Behavioral Health ASO services contract covering Nebraska Behavioral Health System (NBHS).

- DBH data management is challenging for a variety of reasons including:
 - Reliance on and limitations of the ASO data system;
 - Multiple data projects/contractors exist and multiple individuals within DBH manage the data related contracts;
 - Integration and coordination of data and reports with other DHHS partners is currently limited to the ASO;
 - DBH limitations prompted regions and providers to develop their own data bases for Professional Partner Program, Housing, Waiting and Capacity Management Lists, Prevention, and other QI related data projects;
- DBH hired a Managed Care and Quality Improvement Manager in July 2008.
 - Implemented Division level QI team (DQIT) to provide a formal structure for reviewing QI information and data reporting and analysis;
 - Implemented Magellan QI Team (MQIT) to improve data quality;
 - Works with ASO contract partners and Magellan on data reports to assist management of the system;
 - Implementing Statewide QI Team (SQIT) and statewide performance measurements for DBH, RBHA's and providers.
- The Division of Behavioral Health (DBH) is working to improve its internal capacity and data infrastructure to do this work. For example, the DBH hired a full time Statistical Analyst in February 2009.
 - MQIT and DBH data team members worked with the ASO and providers to clean up the Magellan system, creating a data dictionary, clarifying data codes and reviewing report processes, educating providers, sending regular provider data communications, resulting in corrective actions and improved processes.
 - Externs are available to assist with specific assigned data projects. The Statistical Analyst is now assigned to monitor the extern tasks daily to determine if additional time is available for data requests/projects.
 - An additional data team member is in place for yearly assignment to assist with both QI processes and data analysis.
- DBH contracted with a vendor to complete a comprehensive needs assessment for the purpose of determining the capacity for developing and maintaining a centralized data system which will track outcomes, measure performance and funding in real time. The data system must meet federal requirements, unify existing databases, fill data gaps and utilize health information exchange efficiency when necessary. Following the assessment the vendor will develop business requirements for the potential data solutions.
- DBH and the ASO data management vendor are collaborating to develop a file exchange format to minimize duplication of data entry from the provider data system and the ASO data system.
- Criminal Justice Electronic Data Transfer Interagency Agreement – the Nebraska Department of Health and Human Services - Division Of Behavioral Health (DHHS), the Nebraska Department of Correctional Services (DCS) and the Nebraska Commission on Law Enforcement and Criminal Justice (Crime Commission) signed Electronic Data Transfer Interagency Agreements on June 9, 2009. These agreements have these three state agencies transferring their data to the Division of Epidemiology, College of Public Health at the University of Nebraska Medical Center in Omaha, NE for the purpose of analysis, compilation and reporting for the mutual benefit of the parties. The initial data covers the

time period from January 1, 2005 to December 31, 2008. Before public release, the Report(s) produced under these agreements must be acceptable to the DHHS, DCS and the Crime Commission. The Report(s) remain in draft status until these three code level agencies approve the document. This requirement is due to the sensitive nature of the content of the report(s) using these data.

Describe the types of regular and ad hoc reports generated by the State and identify to whom they are distributed and how.

Under the Magellan Behavioral Health contract, there are a number of regular and ad hoc reports made available to the state, the six Regional Behavioral Health Authorities, and the providers. Access is via the Magellan web site or reports are sent electronically to the regions for distribution to the providers.

Some examples of the types of reports include, but are not limited to:

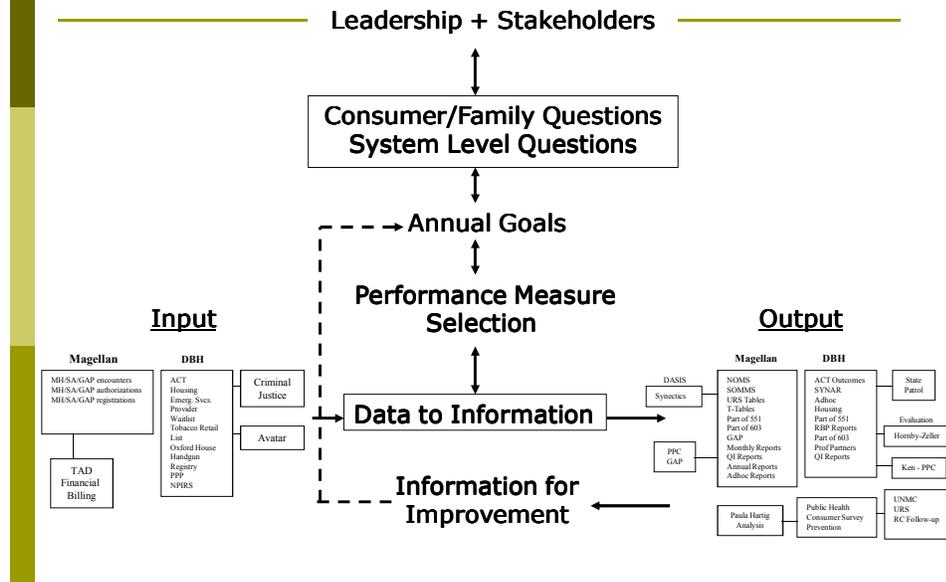
- Turn Around Document (TAD) - A monthly Behavioral Health report that includes, but is not limited to, a count of units authorized or services registered by individual consumer, by service, by provider, and by Region for the current month. These reports are used for billing and payment.
- Duplicate Services Report- Identifies individuals who are receiving services paid by both Medicaid and DBH
- Shifted Authorized/Registered Service Report- Identifies individuals who received a service from either Medicaid, CFS or DBH and there was a shift to another division in the same month
- Average Length of Stay Comparison by service, by region, statewide
- EPC Count and Demographics, Commitment Volume Report
- Discharge Summary
- SED/SPMI Quarterly Summary
- Discharge Compliance Report
- Admission Summary
- Annual Re-Registration Report
- Annual Report
- Utilization – By service, by provider, by region, by service
- DBH Magellan Clinical Review (Appeals Report)
- Quarterly Trauma Report

Ad Hoc Reports are completed as requested. Magellan and DBH have worked on a process for requesting ad hoc reports so regions can receive more timely information.

Additionally, the Annual Consumer Survey and Quarterly SOMMS reports are distributed and discussed.

If the State sets benchmarks, performance targets or quantified objectives, what methods are used by the State in setting these values?

Performance Measurement & Quality Improvement



The Division of Behavioral Health continues to work on establishing benchmarks, performance targets using a quality improvement strategy. The first page of this section describes the QI infrastructure.

The Stateside Quality Improvement Team (SQIT) was developed in 2009 in order to implement statewide quality initiatives that provide strategies aimed at improving the overall behavioral health system. The SQIT is comprised of consumers (50%), Regional Behavioral Health Authority staff, providers, the ASO, and representative from DHHS Division of Medicaid and Long-Term Care.

QI forums were held in all six Behavioral Health regions to share the Division’s CQI plan. Regional staff, providers, consumers and families participated in the forums. The desired outcome of the forums was the identification of suggested performance measures for the FY10 contract. Small group processes were implemented to identify top questions members wanted answered by the DBH. Questions such as, “How long do I have to wait to enter services?” Or “Are the services improving the functioning of individuals served?” The group also identified goals/outcomes for each of the questions and recommended a performance measurement for each question. Participants prioritized their work and selected at one performance measure.

As of September 30, 2009, the Division of Behavioral Health developed the following performance measures and quality initiatives.

Performance measure for SFY2010:

- The SQIT developed performance measure serves to answer the priority question of, “Do consumers perceive the services they receive have improved their quality of life?” This is consistent with the National Outcome Measure “Perception of Services/Care”.
- Goal/Benchmark: 75% of consumers report services received improved their quality of life
- Numerator Number of individuals responding with strongly agree or agree to question on Annual DBH survey

Denominator

Total Number of Individuals Responding to Survey

- Data Source: DBH – Annual Survey for Adults and Youth Contractor is DHHS Public Health/UNMC
- Methodology:
Question will be added to the DBH Annual Consumer Survey for Adults and Consumers. The survey will be administered by the contractor April 1, 2010 through September 2010. A random sample of individuals was selected that utilized a service during FY09 through December 31, 2010. The sample was based on a percentage of utilization for MH/SA, youth/adult and capture for each region.
- Exclusions: Emergency services Not required
- Reporting: Aggregate Summary to DBH analysis team by fall 2010.

Co-Occurring Service Delivery Quality Initiative

The Division of Behavioral Health has a responsibility to meet consumer needs wherever they present in the DBH funded service system to promote recovery in those served. Through a collaborative effort, this quality initiative is intended to improve services to adults with co-occurring mental health and substance abuse disorders and their families.

- Goals/Desired Outcome: The Co-Occurring Disorders Quality Initiative will promote recovery of individuals and families by creating a statewide road map to a statewide, integrated co-occurring service delivery system.
- The Workgroup will produce the following products:
 1. Current strengths of the service delivery system for serving individuals with co-occurring disorders
 2. Current barriers to the service delivery system for serving individuals with co-occurring disorders
 3. Recommended definitions related to co-occurring disorder treatment
 4. Recommended process and tools for identifying dual-capable and dual enhanced status of providers
 5. Recommended work plan for improving infrastructure that supports recovery for individuals with co-occurring disorders including:
 - a. Models to be considered
 - b. Priority populations and service responsibilities
 - c. Identification, welcoming and accessibility
 - d. Standards of Care
 - e. Workforce development, clinical competencies

- f. Clinical Infrastructure for continued improvement and case coordination
- g. Statewide training plan
- h. Funding/Financial reimbursement/processes
- i. Establishing/Monitoring performance improvements

The Chair of the Co-Occurring Disorders Service Delivery Quality Initiative Workgroup is Blaine Shaffer, MD, Chief Clinical Officer for the Division of Behavioral Health. Meetings are held monthly in person when possible with the availability of webinar/videoconferencing and phone conferencing. Subject matter experts are invited to various meetings. The Team Members are invited by DBH to ensure broad representation of stakeholders.

Consumer Survey Process Quality Initiative:

- Goals/Desired Outcome: The Quality Initiative will result in a DBH Consumer and Family Survey process recommendation that ensures that data collection for perception of care and satisfaction is efficient, confidential, respectful, designed through consumer and family involvement; where results are analyzed, reviewed and shared with consumers, families, service providers and others and opportunities for improvement are identified and utilized.
- The Workgroup will produce the following products:
 1. A list of existing consumer and family surveys utilized in DBH funded providers with a comparison of accreditation source requirements.
 2. A list of existing consumer and family surveys utilized in DHHS or other key stakeholder organizations that may include individuals served by DBH.
 3. Strengths of the current survey process to build upon/retain.
 4. Barriers to the current survey process.
 5. Explanation of the DBH current consumer and family survey and Block Grant reporting requirements.
 6. Recommendations for consumer and family surveys including:
 - a. Provider, Region, DBH process (Who is collecting)
 - b. Agreement on information domains in the survey (What is collected) such as:
 1. Satisfaction
 2. Accessibility
 3. Perception of Quality (effective, appropriate, etc.)
 4. Perception of outcomes as a result of receiving services
 5. Perception of participation/involvement in treatment
 6. Recovery
 7. Quality of Life
 8. Domains from other sources (MHBG, Accreditation, etc.)
 - c. Sample selection (Who is surveyed)
 - d. Type of survey (How they are surveyed: electronic, mail, phone)
 - e. Tools/Instruments/Surveys (What and how collected)
 - f. Frequency (When)
 - g. Performance improvement process/communication of survey results, identification of changes for improvement

The Chair of the Consumer Survey Quality Initiative Workgroup is shared with the QI Administrator and the Director of the Office of Consumer Affairs (OCA). Meetings are held at least monthly in person when possible with the availability of webinar/videoconferencing and phone conferencing. Subject matter experts are invited to various meetings. The Team Members are invited by DBH to ensure broad representation of stakeholders.

What actions does the State take as a result of analyzing performance management data?

The Division of Behavioral Health (DBH) reviews analysis of the performance measurement, and other data reports annual consumer survey and the two quality initiatives via the QI structure previously outlined. See beginning diagram of this section.

Network Management Teams, SQIT, and Tuesday data calls are forums where analysis is discussed and action plans developed.

If the SSA has a regular training program for State and provider staff that collect and report client information, describe the training program, its participants and frequency.

Division of Behavioral Health continues to work towards implementing a data-driven approach to managing the service system. This development and implementation process takes collaboration, ongoing communication and perseverance.

Data related training is provided through monthly Magellan Quality Improvement Team (MQIT) and a minimum of quarterly training sessions are held in collaboration with the ASO Vendor. Additionally as changes and enhancements occur, webinars are held with providers.

DBH has completed a user/provider manual and data dictionary in collaboration with the ASO Vendor to ensure consistent instruction for data entry into the information system.

Tuesday Data Calls have been implemented with DBH and the RBHA's to increase education and utilization of data reports and analysis.

Do workforce development plans address NOMs implementation and performance-based management practices?

At this point, the workforce development for NOMs implementation will be handled via the State Quality Improvement Team (S-QIT) and the Magellan Partnership Quality Improvement Team meeting (M-QIT) reported above.

The SOMMS report is shared quarterly with regions and providers. An analysis is provided with the report for areas needing improvement. Data is analyzed at the provider level and shared with the regions to ensure monitoring of specific provider areas for improvement.

NOMS reports are due to DBH in December of 2010. The reports are generated from the data management system by the contracted vendor.

In addition, in the spring of 2009, the Division of Behavioral Health-Community-Based Services (DBH-CBS) Administrator provided training for the Regional Behavioral Health Authorities (RBHA's) and providers in each region. An overview of the grant was provided but the primary focus of the training was on interim services. Here is a summary chart showing the Region, date of the training event, and the number of people attending.

Region	Date	Number Attending
1	March 19, 2009	15
2	March 20, 2009	22
3	May 6, 2009	21

4	April 8, 2009	15
5	June 2, 2009	12
6	May 2, 2009	16
total		101

The training included a discussion on the NOMs and the importance of reporting data to the Magellan Behavioral Health.

Does the State require providers to supply information about the intensity or number of services received?

Yes. Contractually providers must participate in the DBH information management system contracted through our ASO Vendor, Magellan. Client data are reported as requested of the providers through the Administrative Services Organization web site. Client authorizations are given by the ASO. Clients are admitted to a service and terminated from services via the information management system. Clients may be enrolled in several services at the same time from an appropriate array of providers. A monthly Turn Around Document (TAD) Behavioral Health reports a count of units authorized or services registered by individual consumer, by service, by provider, and by Region for the current month. These reports are used for billing and payment.

Under the FY2011 Contract between the Nebraska Department of Health and Human Services - Division of Behavioral Health - Community-Based Services Section and each of the six Regional Behavioral Health Authorities, there are clear requirements covering data reporting.

- ATTACHMENT B - Network Management Responsibilities - Section VIII.

Contractor shall monitor that providers enrolled in the Network (1) comply with the authorization and registration processes and timelines, (2) enter data accurately into the State's information management system managed by the DHHS System Management agent, (3) actively participate in training provided by the DHHS System Management agent, and (4) comply with the terms and requirements of this contract related to data and System Management.

- ATTACHMENT F – Federal Block Grant Requirements, there are requirements to ensure that all programs receiving SAPTBG funding will do a number of things. This include requirements such as Participate in Needs Assessments, Provide updated and accurate information in all SAPTBG reporting requirements, attend SAPTBG training provided, provide the DHHS with the name and contact information of the individual responsible for managing and monitoring the “Waiting List” for all Priority Populations and Provide required data to monitor Priority Populations on a waiting list and receiving interim services.

To see the complete FY2011 Regional Behavioral Health contract ATTACHMENT F - Federal Block Grant Requirements, go to <https://bgas.samhsa.gov/2011/> Appendix / Addendum - Additional Supporting Documents (Optional).

Treatment Corrective Action Plan (submit upon request)

1. Describe the corrective action plan, including critical steps and actions the State and its providers will employ to collect and report the National Outcome Measures data.
2. Discuss the timeframes for the State's corrective action plan detailing the planned milestones and other measures of progress the State has incorporated into its corrective action plan.
3. Describe the State's corrective action plan implementation monitoring activities including interventions or adjustments the State will employ when timeframes or milestones are not achieved.

This narrative response not included because it does not exist or has not yet been submitted.

Form P1

NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use

Measure: 30-Day Use

A. Measure	B. Question/Response	C. Pre- Populated Data	D. Approved Substitute Data
1. 30-day Alcohol Use	<p>Source Survey Item: NSDUH Questionnaire. "Think specifically about the past 30 days, that is, from [DATEFILL] through today. During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?" [Response option: Write in a number between 0 and 30.]</p> <p>Outcome Reported: Percent who reported having used alcohol during the past 30 days.</p>	Ages 18+ - CY 2008	60.80
		Ages 12–17 - CY 2008	15.90
2. 30-day Cigarette Use	<p>Source Survey Item: NSDUH Questionnaire: "During the past 30 days, that is, since [DATEFILL], on how many days did you smoke part or all of a cigarette?" [Response option: Write in a number between 0 and 30.]</p> <p>Outcome Reported: Percent who reported having smoked a cigarette during the past 30 days.</p>	Ages 12–17 - CY 2008	10.10
		Ages 18+ - CY 2008	27.80
3. 30-day Use of Other Tobacco Products	<p>Source Survey Item: NSDUH Questionnaire: "During the past 30 days, that is, since [DATEFILL], on how many days did you use [other tobacco products] † ?" [Response option: Write in a number between 0 and 30.]</p> <p>Outcome Reported: Percent who reported having used a tobacco product other than cigarettes during the past 30 days, calculated by combining responses to questions about individual tobacco products (snuff, chewing tobacco, pipe tobacco).</p>	Ages 18+ - CY 2008	7.30
		Ages 12–17 - CY 2008	7.70
4. 30-day Use of Marijuana	<p>Source Survey Item: NSDUH Questionnaire: "Think specifically about the past 30 days, from [DATEFILL] up to and including today. During the past 30 days, on how many days did you use marijuana or hashish?" [Response option: Write in a number between 0 and 30.]</p> <p>Outcome Reported: Percent who reported having used marijuana or hashish during the past 30 days.</p>	Ages 12–17 - CY 2008	6.60
		Ages 18+ - CY 2008	4.20
5. 30-day Use of Illegal Drugs Other Than Marijuana	<p>Source Survey Item: NSDUH Questionnaire: "Think specifically about the past 30 days, from [DATEFILL] up to and including today. During the past 30 days, on how many days did you use [any other illegal drug] ‡ ?"</p> <p>Outcome Reported: Percent who reported having used illegal drugs other than marijuana or hashish during the past 30 days, calculated by combining responses to questions about individual drugs (heroin, cocaine, stimulants, hallucinogens, inhalants, prescription drugs used without doctors' orders).</p>	Ages 12–17 - CY 2008	4.50
		Ages 18+ - CY 2008	2.40

((s)) Suppressed due to insufficient or non-comparable data

† NSDUH asks separate questions for each tobacco product. The number provided combines responses to all questions about tobacco products other than cigarettes.

‡ NSDUH asks separate questions for each illegal drug. The number provided combines responses to all questions about illegal drugs other than marijuana or hashish.

Form P2

NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use

Measure: Perception of Risk/Harm of Use

A. Measure	B. Question/Response	C. Pre-Populated Data	D. Approved Substitute Data	
1. Perception of Risk From Alcohol	Source Survey Item: NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?" [Response options: No risk, slight risk, moderate risk, great risk] Outcome Reported: Percent reporting moderate or great risk.	Ages 18+ - CY 2008	74.70	
		Ages 12–17 - CY 2008	79	
2. Perception of Risk From Cigarettes	Source Survey Item: NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke one or more packs of cigarettes per day?" [Response options: No risk, slight risk, moderate risk, great risk] Outcome Reported: Percent reporting moderate or great risk.	Ages 12–17 - CY 2008	95	
		Ages 18+ - CY 2008	95.50	
3. Perception of Risk From Marijuana	Source Survey Item: NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke marijuana once or twice a week?" [Response options: No risk, slight risk, moderate risk, great risk] Outcome Reported: Percent reporting moderate or great risk.	Ages 18+ - CY 2008	78.80	
		Ages 12–17 - CY 2008	86.60	

((s)) Suppressed due to insufficient or non-comparable data

Form P3

NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use

Measure: Age of First Use

A. Measure	B. Question/Response	C. Pre-Populated Data	D. Approved Substitute Data
1. Age at First Use of Alcohol	Source Survey Item: NSDUH Questionnaire: "Think about the first time you had a drink of an alcoholic beverage. How old were you the first time you had a drink of an alcoholic beverage? Please do not include any time when you only had a sip or two from a drink." [Response option: Write in age at first use.] Outcome Reported: Average age at first use of alcohol.	Ages 12–17 - CY 2008 12.80	
		Ages 18+ - CY 2008 16.80	
2. Age at First Use of Cigarettes	Source Survey Item: NSDUH Questionnaire: "How old were you the first time you smoked part or all of a cigarette?" [Response option: Write in age at first use.] Outcome Reported: Average age at first use of cigarettes.	Ages 18+ - CY 2008 16	
		Ages 12–17 - CY 2008 12.90	
3. Age at First Use of Tobacco Products Other Than Cigarettes	Source Survey Item: NSDUH Questionnaire: "How old were you the first time you used [any other tobacco product] † ?" [Response option: Write in age at first use.] Outcome Reported: Average age at first use of tobacco products other than cigarettes.	Ages 18+ - CY 2008 18.30	
		Ages 12–17 - CY 2008 13.70	
4. Age at First Use of Marijuana or Hashish	Source Survey Item: NSDUH Questionnaire: "How old were you the first time you used marijuana or hashish?" [Response option: Write in age at first use.] Outcome Reported: Average age at first use of marijuana or hashish.	Ages 12–17 - CY 2008 14	
		Ages 18+ - CY 2008 18.10	
5. Age at First Use of Illegal Drugs Other Than Marijuana or Hashish	Source Survey Item: NSDUH Questionnaire: "How old were you the first time you used [other illegal drugs] ‡ ?" [Response option: Write in age at first use.] Outcome Reported: Average age at first use of other illegal drugs.	Ages 18+ - CY 2008 19.50	
		Ages 12–17 - CY 2008 12.40	

((s)) Suppressed due to insufficient or non-comparable data

† The question was asked about each tobacco product separately, and the youngest age at first use was taken as the measure.
 ‡ The question was asked about each drug in this category separately, and the youngest age at first use was taken as the measure.

Form P4

NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use

Measure: Perception of Disapproval/Attitudes

A. Measure	B. Question/Response	C. Pre- Populated Data	D. Approved Substitute Data
1. Disapproval of Cigarettes	<p>Source Survey Item: NSDUH Questionnaire: “How do you feel about someone your age smoking one or more packs of cigarettes a day?” [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]</p> <p>Outcome Reported: Percent somewhat or strongly disapproving.</p>	Ages 12–17 - CY 2008 91.40	
2. Perception of Peer Disapproval of Cigarettes	<p>Source Survey Item: NSDUH Questionnaire: “How do you think your close friends would feel about you smoking one or more packs of cigarettes a day?” [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]</p> <p>Outcome Reported: Percent reporting that their friends would somewhat or strongly disapprove.</p>	Ages 12–17 - CY 2008 90.90	
3. Disapproval of Using Marijuana Experimentally	<p>Source Survey Item: NSDUH Questionnaire: “How do you feel about someone your age trying marijuana or hashish once or twice?” [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]</p> <p>Outcome Reported: Percent somewhat or strongly disapproving.</p>	Ages 12–17 - CY 2008 86.90	
4. Disapproval of Using Marijuana Regularly	<p>Source Survey Item: NSDUH Questionnaire: “How do you feel about someone your age using marijuana once a month or more?” [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]</p> <p>Outcome Reported: Percent somewhat or strongly disapproving.</p>	Ages 12–17 - CY 2008 87.70	
5. Disapproval of Alcohol	<p>Source Survey Item: NSDUH Questionnaire: “How do you feel about someone your age having one or two drinks of an alcoholic beverage nearly every day?” [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]</p> <p>Outcome Reported: Percent somewhat or strongly disapproving.</p>	Ages 12–17 - CY 2008 88.50	

((s)) Suppressed due to insufficient or non-comparable data

Form P5
NOMs Domain: Employment/Education
Measure: Perception of Workplace Policy

A. Measure	B. Question/Response	C. Pre-Populated Data	D. Approved Substitute Data
Perception of Workplace Policy	<p>Source Survey Item: NSDUH Questionnaire: "Would you be more or less likely to want to work for an employer that tests its employees for drug or alcohol use on a random basis? Would you say more likely, less likely, or would it make no difference to you?" [Response options: More likely, less likely, would make no difference]</p> <p>Outcome Reported: Percent reporting that they would be more likely to work for an employer conducting random drug and alcohol tests.</p>	Ages 18+ - CY 2008 36.70	
		Ages 15-17 - CY 2008 ((s))	

((s)) Suppressed due to insufficient or non-comparable data

Form P6
NOMs Domain: Employment/Education
Measure: ATOD-Related Suspensions and Expulsions

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
In Development	In Progress	In Progress	((s))	

((s)) Suppressed due to insufficient or non-comparable data

Form P7
NOMs Domain: Employment/Education
Measure: Average Daily School Attendance Rate

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Average Daily School Attendance Rate	<p>Source:National Center for Education Statistics, Common Core of Data: The National Public Education Finance Survey available for download at http://nces.ed.gov/ccd/stfis.asp</p> <p>Measure calculation: Average daily attendance (NCES defined) divided by total enrollment and multiplied by 100.</p>	CY 2008	94	

((s)) Suppressed due to insufficient or non-comparable data

Form P8
NOMs Domain: Crime and Criminal Justice
Measure: Alcohol-Related Traffic Fatalities

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Alcohol-Related Traffic Fatalities	<p>Source: National Highway Traffic Safety Administration Fatality Analysis Reporting System</p> <p>Measure calculation: The number of alcohol-related traffic fatalities divided by the total number of traffic fatalities and multiplied by 100.</p>	CY 2008	36.10	

((s)) Suppressed due to insufficient or non-comparable data

Form P9
NOMs Domain: Crime and Criminal Justice
Measure: Alcohol- and Drug-Related Arrests

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Alcohol- and Drug-Related Arrests	Source: Federal Bureau of Investigation Uniform Crime Reports Measure calculation: The number of alcohol- and drug-related arrests divided by the total number of arrests and multiplied by 100.	CY 2008	112.40	

((s)) Suppressed due to insufficient or non-comparable data

Form P10

NOMs Domain: Social Connectedness

Measure: Family Communications Around Drug and Alcohol Use

A. Measure	B. Question/Response	C. Pre-Populated Data	D. Approved Substitute Data
1. Family Communications Around Drug and Alcohol Use (Youth)	<p>Source Survey Item: NSDUH Questionnaire: "Now think about the past 12 months, that is, from [DATEFILL] through today. During the past 12 months, have you talked with at least one of your parents about the dangers of tobacco, alcohol, or drug use? By parents, we mean either your biological parents, adoptive parents, stepparents, or adult guardians, whether or not they live with you." [Response options: Yes, No]</p> <p>Outcome Reported: Percent reporting having talked with a parent.</p>	Ages 12–17 - CY 2008 57.50	
2. Family Communications Around Drug and Alcohol Use (Parents of children aged 12– 17)	<p>Source Survey Item: NSDUH Questionnaire: "During the past 12 months, how many times have you talked with your child about the dangers or problems associated with the use of tobacco, alcohol, or other drugs?" † [Response options: 0 times, 1 to 2 times, a few times, many times]</p> <p>Outcome Reported: Percent of parents reporting that they have talked to their child.</p>	Ages 18+ - CY 2008 ((s))	

((s)) Suppressed due to insufficient or non-comparable data

† NSDUH does not ask this question of all sampled parents. It is a validation question posed to parents of 12- to 17-year-old survey respondents. Therefore, the responses are not representative of the population of parents in a State. The sample sizes are often too small for valid reporting.

Form P11

NOMs Domain: Retention

Measure: Percentage of Youth Seeing, Reading, Watching, or Listening to a Prevention Message

A. Measure	B. Question/Response	C. Pre- Populated Data	D. Approved Substitute Data
Exposure to Prevention Messages	Source Survey Item: NSDUH Questionnaire: "During the past 12 months, do you recall [hearing, reading, or watching an advertisement about the prevention of substance use] † ?" Outcome Reported: Percent reporting having been exposed to prevention message.	Ages 12–17 - CY 2008 92.60	

((s)) Suppressed due to insufficient or non-comparable data

† This is a summary of four separate NSDUH questions each asking about a specific type of prevention message delivered within a specific context.

P-Forms 12a- P-15 – Reporting Period

Reporting Period - Start and End Dates for Information Reported on Forms P12A, P12B, P13, P14 and P15

Forms	A. Reporting Period Start Date	B. Reporting Period End Date
Form P12a Individual-Based Programs and Strategies —Number of Persons Served by Age, Gender, Race, and Ethnicity	7/1/2009	6/30/2010
Form P12b Population-Based Programs and Strategies —Number of Persons Served by Age, Gender, Race, and Ethnicity	7/1/2009	6/30/2010
Form P13 (Optional) Number of Persons Served by Type of Intervention	7/1/2009	6/30/2010
Form P14 Number of Evidence-Based Programs and Strategies by Type of Intervention	7/1/2009	6/30/2010
Form P15 FY 2008 Total Number of Evidence Based Programs and Total SAPT BG Dollars Spent on Evidence-Based Programs/Strategies	7/1/2009	6/30/2010

Source: Nebraska Prevention Information Reporting System (NPIRS)

Form P12a

Individual-Based Programs and Strategies—Number of Persons Served by Age, Gender, Race, and Ethnicity

Question 1: Describe the data collection system you used to collect the NOMs data (e.g., MDS, DbB, KIT Solutions, manual process).

The Nebraska Prevention Information Reporting System (NPIRS) is a web based data reporting system brought on line in November 2008. <http://www.npirs.org>. The system continues to undergo development based on comments received by providers, coalitions, and regional report users. NPIRS reports by funding source the characteristics of the population served by activity.

Question 2: Describe how your State's data collection and reporting processes record a participant's race, specifically for participants who are more than one race.

The Nebraska Prevention Information Reporting System (NPIRS) maintains the race of individuals by single race category. Persons indicating more than one race are reported as "More than one Race" and not duplicated in each of the races indicated.

Category	Description	Total Served
A. Age	1. 0-4	10537
	2. 5-11	17581
	3. 12-14	10388
	4. 15-17	15355
	5. 18-20	3615
	6. 21-24	2585
	7. 25-44	11142
	8. 45-64	8668
	9. 65 And Over	2395
B. Gender	Male	38950
	Female	43316
C. Race	White	68472
	Black or African American	2743
	Native Hawaiian/Other Pacific Islander	221
	Asian	729
	American indian/Alaska Native	961
	More Than One Race (not OMB required)	870
D. Ethnicity	Hispanic or Latino	5436
	Not Hispanic or Latino	76830

Source: Nebraska Prevention Information Reporting System (NPIRS)

Form 12b

Population-Based Programs and Strategies—Number of Persons Served by Age, Gender, Race, and Ethnicity

Category	Description	Total Served
A. Age	1. 0-4	571
	2. 5-11	3738
	3. 12-14	4264
	4. 15-17	5759
	5. 18-20	13240
	6. 21-24	3589
	7.25-44	14977
	8. 45-64	9986
	9. 65 And Over	3044
	10. Age Not Known	
B. Gender	Male	29576
	Female	29592
	Gender Unknown	
C. Race	White	53337
	Black or African American	1410
	Native Hawaiian/Other Pacific Islander	326
	Asian	572
	American indian/Alaska Native	343
	More Than One Race (not OMB required)	1211
	Race Not Known or Other (not OMB required)	
D. Ethnicity	Hispanic or Latino	4040
	Not Hispanic or Latino	55128
	Ethnicity Unknown	

Source: Nebraska Prevention Information Reporting System (NPIRS)

Form P13 (Optional)
Number of Persons Served by Type of Intervention

Intervention Type	Number of Persons Served by Individual- or Population-Based Program or Strategy	
	A. Individual-Based Programs and Strategies	B. Population-Based Programs and Strategies
1. Universal Direct		N/A
2. Universal Indirect	N/A	
3. Selective		N/A
4. Indicated		N/A
5. Total		

Form P14

Number of Evidence-Based Programs and Strategies by Type of Intervention

NOMs Domain: Retention

NOMs Domain: Evidence-Based Programs and Strategies

Measure: Number of Evidence-Based Programs and Strategies

Definition of Evidence-Based Programs and Strategies: The guidance document for the Strategic Prevention Framework State Incentive Grant, Identifying and Selecting Evidence-based Interventions, provides the following definition for evidence-based programs:

- Inclusion in a Federal List or Registry of evidence-based interventions
- Being reported (with positive effects) in a peer-reviewed journal
- Documentation of effectiveness based on the following guidelines:
 - Guideline 1: The intervention is based on a theory of change that is documented in a clear logic or conceptual model; and
 - Guideline 2: The intervention is similar in content and structure to interventions that appear in registries and/or the peer-reviewed literature; and
 - Guideline 3: The intervention is supported by documentation that it has been effectively implemented in the past, and multiple times, in a manner attentive to Identifying and Selecting Evidence-Based Interventions scientific standards of evidence and with results that show a consistent pattern of credible and positive effects; and
 - Guideline 4: The intervention is reviewed and deemed appropriate by a panel of informed prevention experts that includes: well-qualified prevention researchers who are experienced in evaluating prevention interventions similar to those under review; local prevention practitioners; and key community leaders as appropriate, e.g., officials from law enforcement and education sectors or elders within indigenous cultures.

1. Describe the process the State will use to implement the guidelines included in the above definition. Each year coalitions and Regional Behavioral Health Authorities that receive block grant dollars conduct a review of their Strategic Prevention Plans in an effort to determine progress. The Nebraska Prevention Information Reporting System (NPIRS) provides information and data toward that review. Each coalition and Regional Behavioral Health Authority uses evaluative information to adjust their strategic prevention plan. NPIRS provides an array of pre-approved programs/policies/practices from which coalitions might select. Coalitions, through their Regional Behavioral Health Authorities, may also propose additions to the list of approved prevention activities either during the yearly review or during the year by completing an informational sheet designed to assist the coalitions in selecting programs/policies/practices that are a best fit for that community. The State reviews this material with the Regional Prevention Coordinator and consults Federal List or Registries to determine the appropriateness of the activity against the overall community plan. Once a program is approved, it is added into the NPIRS system as an option for selection by the initiating coalition and for the rest of the state. This process helps create progress for Regional Behavioral Health Authorities and Coalitions doing prevention based work for the State of Nebraska.

2. Describe how the State collected data on the number of programs and strategies. What is the source of the data?

Each funded entity is required to submit data on implementation of planned activities through the Nebraska Prevention Information Reporting System. Regional Prevention Coordinators and the State review materials submitted and compare to planned activities.

Number of Evidence-Based Programs and Strategies by Type of Intervention

	A. Universal Direct	B. Universal Indirect	C. Universal Total	D. Selected	E. Indicated	F. Total
1. Number of Evidence-Based Programs and Strategies Funded	733	113	846	245	88	1179
2. Total number of Programs and Strategies Funded	1102	364	1466	336	140	1942
3. Percent of Evidence-Based Programs and Strategies	66.52%	31.04%	57.71%	72.92%	62.86%	60.71%

Source: Nebraska Prevention Information Reporting System (NPIRS)

Form P15 - FY 2008 Total Number of Evidence Based Programs and Total SAPT BG Dollars Spent on Evidence-Based Programs/Strategies

IOM Categories	FY 2008 Total Number of Evidence-Based Programs/Strategies for each IOM category	FY 2008 Total SAPT Block Grant \$Dollars Spent on evidence-based Programs/Strategies
1. Universal Direct	733	\$ 0
2. Universal Indirect	113	\$ 0
3. Selective	245	\$ 0
4. Indicated	88	\$ 0
5. Totals	1179	\$0.00

Note: See definitions for types of interventions in the instructions for P-14 (Universal Direct, Universal Indirect, Selective, and Indicated)

Nebraska Division of Behavioral Health has not collected the funding data in the format or array expressed by this table for the reporting period. No information can be supplied on funding based on the Nebraska Prevention Information Reporting System (NPIRS) or other reporting processes.

Prevention Corrective Action Plan (submit upon request)

1. Describe the corrective action plan, including critical steps and actions the State and its providers will employ to collect and report the National Outcome Measures data.
2. Discuss the timeframes for the State's corrective action plan detailing the planned milestones and other measures of progress the State has incorporated into its corrective action plan.
3. Describe the State's corrective action plan implementation monitoring activities including interventions or adjustments the State will employ when timeframes or milestones are not achieved.

This narrative response not included because it does not exist or has not yet been submitted.

Approved Substitute Data Submission Form

Substitute data has not been submitted for prevention forms.

Prevention Attachment D

FFY 2008 (Optional Worksheet for Form P-15)–Total Number of Evidence-based Programs/Strategies and the Total FFY 2008 SAPT Block Grant Dollars Spent on Substance Abuse Prevention Worksheet . Note: Total EBPs and Total dollars spent on EBPs may be transferred to Form P-15.

Note:The Sub-totals for each IOM category and the Total FFY 2008 SAPT Block Grant Dollars spent on Evidence-based programs/strategies may be transferred to Form P-15.

See:The instructions for Form P-14 for the Definition, Criteria and Guidance for identifying and selecting Evidence-Based Programs and Strategies.

Form P15 Table 1: Program/Strategy Detail for Computing the Total Number of Evidence-based Programs and Strategies, and for Reporting Total FFY 2008 SAPT Block Grant Funds Spent on Evidence-Based Programs and Strategies.

1	2	3	4
FFY2008 Program/Strategy Name Universal Direct	FFY2008 Total Number of Evidence-based Programs and Strategies by Intervention	FFY2008 Total Costs of Evidence based Programs and Strategies for each IOM Category	FFY2008 Total SAPT Block Grant Funds Spent on Evidence-Based Programs/Strategies
1.			
2.			
3.			
4.			
Subtotal			
Universal Indirect Programs and Strategies			
1.			
2.			
3.			
4.			
Subtotal			
Selective Programs and Strategies			
1.			
2.			
3.			
4.			
Subtotal			
Indicated Programs and Strategies			

1.			
2.			
3.			
4.			
Subtotal			
Total Number of (EBPs)/Strategies and cost of these EBPs/Strategies	#	\$	
Total FFY 2008 SAPT Block Grant Dollars \$ Spent on Evidence-Based Programs and Strategies			\$

Description of Supplemental Data

States may also wish to provide additional data related to the NOMs. An approved substitution is not required to provide this supplemental data. The data can be included in the Block Grant appendix. When describing the supplemental data, States should provide any relevant Web addresses (URLs) that provide links to specific State data sources. Provide a brief summary of the supplemental data included in the appendix:

This narrative response not included because it does not exist or has not yet been submitted.

Attachment A, Goal 2: Prevention

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

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

Yes No Unknown

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

Yes No Unknown

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

SAPT
Block
Grant

Yes
 No
 Unknown

Other
State
Funds

Yes
 No
 Unknown

Drug Free
Schools

Yes
 No
 Unknown

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

Yes No Unknown

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

Education Bureau? Yes No Unknown

Dissemination of materials? Yes No Unknown

Media campaigns? Yes No Unknown

Product pricing strategies? Yes No Unknown

Policy to limit access? Yes No Unknown

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

Yes No Unknown

7. Has the State enacted and enforced new policies in the last year to reduce access to alcoholic beverages by minors such as: (HP 26-11c, 12, 23)

- Restrictions at recreational and entertainment events at which youth made up a majority of participants/consumers: Yes No Unknown
- New product pricing: Yes No Unknown
- New taxes on alcoholic beverages: Yes No Unknown
- New laws or enforcement of penalties and license revocation for sale of alcoholic beverages to minors: Yes No Unknown
- Parental responsibility laws for a child's possession and use of alcoholic beverages: Yes No Unknown

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

Yes No Unknown

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

	<u>Age 0 - 5</u>	<u>Age 6 - 11</u>	<u>Age 12 - 14</u>	<u>Age 15 - 18</u>
Cigarettes	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Alcohol	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Marijuana	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>

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

Motor vehicle drivers age 21 and older? 0.08

Motor vehicle drivers under age 21? 0.02

11. How many communities in your State have comprehensive, community-wide coalitions for alcohol and other drug abuse prevention? (HP 26-23)

Communities: 60

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

Yes No Unknown

Appendix A - Additional Supporting Documents (Optional)

Appendix A - Additional Supporting Documents (Optional)

No additional documentation is required to complete your application, besides those referenced in other sections. This area is strictly optional. However, if you wish to add extra documents to support your application, please attach it (them) here. If you have multiple documents, please combine them together in One Word file (or Excel, or other types) and attach here.

Contents

Substance Abuse Capacity and Waiting List Report	1
FY2011 Regional BH contract ATTACHMENT F – Federal Block Grant Requirements	3
Regional Behavioral Health Community Based Providers with ISAT numbers	9
State Epidemiological Outcomes Workgroup (SEOW).....	23

Substance Abuse Capacity and Waiting List Report

ANNUAL SUMMARY as of September 2010

Revised program started October 5, 2009

Substance Abuse Capacity (Summary ending June 30, 2010):

- There were only 9 weeks during the reporting period in the 2nd quarter, while there were 13 weeks during the reporting period in the 3rd and 4th quarter.
- There were fewer people identified as priority populations waiting for substance abuse services in the 4th quarter (n=275) than there were in the 3rd quarter (n=325). In the 2nd quarter, 182 persons identified as priority populations were on the waiting list.
- In the 3rd (44.9%, n=146) and 4th (40.7%, n=112) quarters, the majority of the identified priority populations waiting for substance abuse services were women with dependent children. In the 2nd quarter, most people were waiting for substance abuse services were intravenous drug users (40.7%, n=74).
- In all three quarters, most people identified as priority populations waiting for substance abuse service were waiting for admission into short-term residential services (37.9% (n=74) in the 2nd quarter, 50.7% (n=175) in the 3rd quarter, and 48.1% (n=136) in the 4th quarter, respectively).
- The average length of wait for individuals waiting to enter substance abuse treatment decreased from the 2nd quarter (31.7 days) to the 4th quarter (25.5 days) by 6 days.
- Women with dependent children had the longest average wait in all three quarters, 41 days, 35 days and 32 days, respectively.
- The longest waits for substance abuse services were for outpatient services in the 2nd (55 days) and 3rd (63 days) quarters. The longest waits in the 4th quarter were for therapeutic community services (42 days).

Quarter 2 State Fiscal Year 2010 (starting October 5, 2009)

- There were 182 people who were waiting for services during the nine week reporting period, 12 of which were waiting for more than one type of service or service from multiple providers.
- The majority of people waiting for substance abuse service were intravenous drug users (40.7%, n=74), followed by women with dependent children (36.8%, n=67), mental health board commitments (17.6%, n=32), pregnant women (7.7%, n=14), and pregnant intravenous drug users (1.1%, n=4).
- Most people waiting for substance abuse service were waiting for admission into short-term residential services (37.9%, n=74); followed by therapeutic community services (19.5%, n=38), intensive outpatient services (14.4%, n=28), halfway house services (10.8%, n=21), outpatient services (10.3%, n=20), and dual disorder residential services (3.1%, n=6). Less than 5% of people waiting for service were waiting for intermediate residential (2.6%, n=5) or outpatient dual (1.5%, n=3).
- The average wait for individuals waiting to enter substance abuse treatment is 31.72 days. Pregnant women have the longest average wait at 40.79 days, followed by women with dependent children at 40.61 days, pregnant intravenous drug users at 36.50 days, intravenous drugs users at 27.49 days, and mental health board commitments at 22.71 days.

Appendix / Addendum - Additional Supporting Documents (Optional) / page 2

- On average, the longest waits for substance abuse service are for outpatient services (55.45 days), followed by therapeutic community (45.26), outpatient dual (30.67), intensive outpatient (29.57), dual disorder residential (25.17), short-term residential (23.34), halfway house (23.14), and intermediate residential services (12.00).

Quarter 3 State Fiscal Year 2010 (January 1, 2010 to March 31, 2010)

- There were 325 people identified as priority populations who were waiting for services during the thirteen week reporting period, 21 of which were waiting for more than one type of service or service from multiple providers.
- The majority of the identified priority populations waiting for substance abuse service were women with dependent children (44.9%, n=146), followed by intravenous drug users (37.5%, n=122), mental health board commitments (17.2%, n=56), pregnant women (5.8%, n=19), and pregnant intravenous drug users (0.6%, n=2).
- Most people identified as priority populations waiting for substance abuse service were waiting for admission into short-term residential services (50.7%, n=175); followed by therapeutic community services (21.2%, n=73), dual disorder residential services (9.6%, n=33), outpatient services (7%, n=24), and intensive outpatient services (5.2%, n=18). Less than 5% of people waiting for service were waiting for halfway house (3.2%, n=11), intermediate residential (1.4%, n=5), outpatient dual (0.9%, n=3) or therapeutic community for youth (0.9%, n=3).
- The average wait for persons identified as priority populations waiting to enter substance abuse treatment is 29.82 days. Women with dependent children have the longest average wait at 35.3 days, followed by intravenous drugs users at 26.34 days, pregnant women at 25.47 days, mental health board commitments at 24.21 days, and pregnant intravenous drug users at 10.5 days.
- On average, the longest waits for substance abuse services are for outpatient services (62.58 days), followed by outpatient dual (44.33 days), therapeutic community (37.07 days), halfway house (34.36 days), dual disorder residential (29.8 days), short-term residential (23.36 days), intensive outpatient (18.83 days), intermediate residential (15.2 days), and youth therapeutic community services (10.33 days).

Quarter 4 State Fiscal Year 2010 (April 1, 2010 – June 30, 2010)

- There were 275 people identified as priority populations who were waiting for services during the thirteen week reporting period, 11 of which were waiting for more than one type of service or service from multiple providers.
- The majority of identified priority populations waiting for substance abuse service were women with dependent children (40.7%, n=112), followed by intravenous drug users (37.1%, n=103), mental health board commitments (20.7%, n=57), pregnant women (3.3%, n=9), and pregnant intravenous drug users (1.1%, n=3).
- Most people identified as priority populations were waiting for substance abuse service were waiting for admission into short-term residential services (48.1%, n=136); followed by therapeutic community services (20.8%, n=59), dual disorder residential services (12.0%, n=34), intensive outpatient services (9.9%, n=28), and outpatient services (5.7%, n=16). Less than 5% of people waiting for service were waiting for intermediate residential (1.4%, n=4), halfway house (1.1%, n=3), community support (0.4%, n=1), social setting detox (0.4, n=1), or therapeutic community for youth (0.4%, n=1).
- The average wait for persons identified as priority populations waiting to enter substance abuse treatment is 25.54 days. Women with dependent children have the longest average wait at 31.57 days, followed by mental health board commitments at 23.68 days, intravenous drugs users at 20.5 days, pregnant women at 20.11 days, and pregnant intravenous drug users at 8.67 days.
- On average, the longest waits for substance abuse services are for therapeutic community (41.86 days), followed by dual disorder residential (30.74 days), short-term residential (21.05 days), intensive outpatient (20.44 days), halfway house (14.33 days), therapeutic community for youth (12 days), outpatient (10.5 days), intermediate residential (10 days), social detox setting (8 days), and community support services (1 day).

FY2011 Regional BH contract

ATTACHMENT F – Federal Block Grant Requirements

Nebraska Department of Health and Human Services
Division of Behavioral Health - Community-Based Services Section
FY2011 Contract with each of the six Regional Behavioral Health Authorities

I. GENERAL REQUIREMENTS REGARDING ALL FEDERAL BLOCK GRANT FUNDS

- A. DHHS shall retain all block grant funds not expended under the terms of this Contract.
- B. Influencing Federal Officials
 - 1. The Contractor agrees to disclose when any person or firm has been hired to influence federal officials with regard to federal funding for a specific grant, contract, or project, as set out in federal law.
 - 2. The Contractor agrees to hold DHHS and the State of Nebraska harmless and further agrees that it will not use any state or federal funds to comply with the hold harmless provision.
- C. Publications – When issuing statements, press releases, requests for proposals, bid solicitations, and other documents describing projects or programs, the Contractor and all subcontractors shall clearly state that they are funded in whole, or in part, with State and/or Federal funds. Subcontractors shall use language as specified in the applicable state regulations.
- D. To lobby the Nebraska Legislature or the United States Congress.
- E. To supplant or replace non-federal funds.
- F. To pay the salary of an individual at a rate in excess of Level I of the Executive Schedule, or \$196,700. (5 U.S.C. §5312)(Updated 2010)

II. REQUIREMENTS FOR THE MENTAL HEALTH BLOCK GRANT.

- A. No Mental Health Federal Block Grant funding shall be used in the following ways:
 - 1. To provide inpatient hospital services.
 - 2. To make cash payments to intended recipients of health services.
 - 3. To purchase or improve land, purchase, construct, or permanently improve any building or other facility or purchase major medical equipment.
 - 4. To satisfy any requirement for the expenditure of non-federal funds as a condition of the receipt of Federal funds.
 - 5. To provide financial assistance to any entity other than a public or non-profit private entity.
- B. Contractors receiving Community Mental Health Services Block Grant funds agree to ensure the following services are provided and requirements are met:
 - 1. Community Mental Health Services Block Grant funds are used to establish or expand an organized community-based system for providing mental health services for adults with serious mental illnesses (SMI) and children with serious emotional disturbances (SED).
 - 2. Appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).
 - 3. If a Community Mental Health Center is used, the center shall meet the following criteria:
 - (A) Services principally to individuals residing in a defined geographic area (referred to as a “service area”)
 - (B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
 - (C) 24-hour-a-day emergency care services.
 - (D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
 - (E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

- (F) The Community Mental Health Center services are provided within the limits of the capacities of the center, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.
- (G) The Community Mental Health Center services are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

III. REQUIREMENTS FOR THE SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT. Contractor is responsible for ensuring that a process is in place which provides for continual accountability and monitoring of the following requirements related to deliverables funded with Substance Abuse Prevention and Treatment Block Grant (SAPTBG).

- A. No SAPTBG funding shall be used in the following ways:
 - 1. To provide inpatient hospital services.
 - 2. To make cash payments to intended recipients of health services.
 - 3. To purchase or improve land, purchase, construct, or permanently improve any building or other facility or purchase major medical equipment.
 - 4. To satisfy any requirement for the expenditure of non-federal funds as a condition of the receipt of Federal funds.
 - 5. To provide financial assistance to any entity other than a public or non-profit private entity.
 - 6. To lobby the Nebraska Legislature or the United States Congress.
 - 7. To supplant or replace non-federal funds.
 - 8. To pay the salary of an individual at a rate in excess of Level I of the Executive Schedule, or \$196,700. (5 U.S.C. §5312) (Updated 2010).
 - 9. To provide services in a penal or correctional institution of the state in an amount that exceeds SAPTBG funding that the state used for this purpose in FFY91.

- B. DHHS has established Financial Eligibility Standards for consumers of behavioral health services. DHHS reserves the right to be the Payer of Last Resort for consumers who meet the Clinical Criteria for an identified level of care and who are without the financial resources to pay for care. Refer to Financial Eligibility Policy (revised 11/13/07) which outlines the DHHS policy on Payer of Last Resort.

- C. Contractor will ensure that all programs receiving SAPTBG funding will:
 - 1. Participate in Needs Assessments conducted by the State Behavioral Health Authority or it's Contractor,
 - 2. Participate with Independent Peer Review to assess the quality, appropriateness, and efficacy of treatment services,
 - 3. Ensure that SAPTBG funded subcontractors offer on-going training to their workforce specific to Federal Confidentiality (42 CFR part 2), including the penalties for non-compliance, and that the Subcontractor have Federal Confidentiality procedures in place.
 - 4. Improve the process for referrals of individuals to the treatment modality that is most appropriate for the individuals.
 - 5. Ensure that continuing education is provided to the SAPTBG Prevention and Treatment workforce, and document such training.
 - 6. Provide updated and accurate information in all SAPTBG reporting requirements.
 - 7. As requested by DHHS, attend SAPTBG training provided.
 - 8. The Contractor will provide the DHHS with the name and contact information of the individual responsible for managing and monitoring the "Waiting List" for all Priority Populations.
 - 9. Provide required data to monitor Priority Populations on a waiting list and receiving interim services.
 - 10. Actively publicize within the Contractor's catchment area the availability of services for pregnant women and IV drug users to include the fact that these persons receive such preference and therefore will be given admission priority.

- D. Preference should be given to the following Priority Populations in the order listed below for any programs receiving SAPTBG funding:
 - 1. Pregnant injecting drug users,
 - 2. Other pregnant substance users,
 - 3. Other injecting drug users, and
 - 4. Women with dependent children.

E. CHEMICAL DEPENDENCY EVALUATIONS

1. If an individual identified as a priority has not received a chemical dependency evaluation and is requesting treatment, the individual shall be given an appointment for the evaluation within 48 hours, and receive the evaluation within 7 business days.
2. Upon completion of the evaluation (written report), the individual should immediately receive treatment. In the event that capacity does not exist for the individual to immediately receive treatment, the individual will receive Interim Services within 48 hours (from the time the evaluation report is documented) and will receive Interim Services until treatment is available.

F. INTERIM SERVICES for PRIORITY POPULATIONS The purpose of Interim Services is to reduce the adverse effects of substance abuse, promote health, and reduce the risk of transmission of disease. Interim Substance Abuse Services are services that are provided until an individual is admitted to a treatment program. Contractor will ensure compliance of Subcontractors with the delivery of Interim Services in the following manner:

1. Interim Services should be provided between the time the individual requests treatment and the time they enter treatment. Interim Services must be provided within 48 hours and until the individual can receive the appropriate treatment service, based upon the level of care identified in the substance abuse evaluation. Examples of Interim Services include but are not limited to: a lower level of care with available capacity, community support, traditional outpatient, or other like-services that assist the individual with continued contemplation and preparation for treatment.
2. Interim Services for injecting drug users must include counseling and education about human immunodeficiency virus (HIV), tuberculosis (TB), the risks of needle-sharing, the risks of transmission to sexual partners and infants, and the steps that can be taken to ensure that HIV and TB transmission does not occur, as well as referral for HIV or TB treatment services if necessary.
3. Interim Services for injecting drug abusers must also include education on HIV transmission and the relationship between injecting drugs and communicable diseases.
4. Case management services must also be made available in order to assist client with obtaining HIV and or TB services.
5. All referrals and or follow-up information must be documented and this documentation must be maintained by the program and provided to the Contractor upon the Contractor's request and or the request of DHHS.
6. Interim Services for pregnant women must also include counseling on the effects of alcohol and drug use on the fetus and a referral for prenatal care, counseling and education about HIV and TB, the risks of needle sharing, the risks of transmission to sexual partners and infants, and the steps that can be taken to ensure that HIV and TB transmission does not occur. All referrals and or follow-up information must be documented and made available upon the request of the Contractor and/or DHHS.

G. INTRAVENOUS SUBSTANCE USERS/SPECIAL CONSIDERATIONS

1. Individuals requesting treatment for intravenous drug use shall be admitted to a treatment program no later than 14 days after making the request for admission to such a program; or 120 days after the date of such request, if no such program has the capacity to admit the individual on the date of the request.
2. Interim Services must be provided within 48 hours of the request for treatment. If the individual has not received a substance abuse evaluation and is requesting treatment, the individual shall be given an appointment for the evaluation within 48 hours, and complete the evaluation within 7 business days.
3. Upon completion of the substance abuse evaluation (written report), the individual should receive treatment within 14 days or be provided Interim Services until they are able to enter a treatment program.

H. CAPACITY/WAITLING LIST MANAGEMENT for PRIORITY POPULATIONS

1. The Contractor must provide documentation to the Department within 7 days of reaching 90% of capacity to admit individuals to a treatment program.
2. The Contractor will locate an alternative treatment program with the capacity to serve the individual.
3. If capacity to serve cannot be identified, the Contractor will ensure that Interim Services are made available within 48 hours of the time the individual requested treatment services.
4. Should Interim Services not be made available to an individual within the 48 hour timeframe, the Contractor will immediately contact DHHS. The Contractor and DHHS will then collaboratively problem-solve to immediately resolve the situation.
5. The Contractor will ensure that individuals on the "Waiting List" are tracked utilizing a unique patient identifier.
6. Contractor will ensure that a mechanism is in place that allows for maintaining contact with those individuals on the "Wait List" and document all communication with those on this list.
7. If an individual cannot be located or refuses treatment, the individual's name should be promptly removed from the "Waiting List", but can again be placed on the "Waiting List" should the individual again request. Reasonable efforts should be made to encourage individuals to remain on the "Waiting List".
8. The Contractor will ensure that individuals on the "Waiting List" are provided with the best estimated timeframe for admission to treatment.
9. Contractor will ensure that individuals are placed on the "Waiting List" as many times as they request treatment.
10. Contractor will ensure that individuals on the "Waiting List" are admitted into treatment at the earliest possible time, to the most appropriate level of care, and within a reasonable geographic area that is acceptable to the individual.
11. Should treatment capacity be available outside the Contractor's catchment area, Contractor will ensure that the individual is made aware of the treatment opportunity, and will do so in consultation with the DHHS Capacity Management System.
12. Should the individual chose to receive treatment outside the Contractor's catchment area, the sending and receiving Contractors will collaborate to ensure that treatment occurs, and will do so in consultation with the DHHS Capacity Management System.

I. SAPTBG WOMEN'S SET ASIDE PROGRAMS

A. Providers within the Nebraska Behavioral Health System designated as receiving funding to provide services for women and women with dependent children (Women's Set Aside Programs) are as follows: Panhandle Mental Health Center, Human Services, Inc., St. Monica's, Region II Human Services, The Bridge, South Central Behavioral Services, St. Francis Alcohol & Drug Treatment Center, Women's Empowering Life Line, Lincoln Medical Education Partnership, and other providers that meet the qualifying criteria.

B. The amount set aside for women's services shall be expended on individuals who have no other financial means of obtaining such services as set aside for and as provided in 45 CFR §96.124(e) and §96.137. For women with dependent children in their care and custody or for women who are attempting to regain physical custody of their children, the Contractor will ensure that subcontractors receiving Women's Set Aside funding will serve the family as a unit as evidenced by the provision, facilitation, or arrangement of the following:

1. Admission of women and their children to residential services (when program serves children),
2. Primary medical care for women, including referral for prenatal care while the woman is receiving treatment services,
3. Childcare needs, while the women are receiving services, which facilitate engagement in treatment.
4. Coordinate with the Division of Children and Family Services as appropriate with treatment and discharge planning.
5. Screening (physical and mental development) for infants and children,
6. Primary pediatric health care when appropriate, including immunizations for their children and pediatric treatment for perinatal effects of maternal substance abuse,
7. Based on assessment information, gender-specific therapeutic interventions and or services for women which may address issues of relationships, sexual and physical abuse, and/or parenting,
8. Ensure that the children of drug dependent women are involved in the necessary therapeutic interventions which address developmental needs, issues of sexual and physical abuse/neglect,

9. Provide sufficient case management and transportation to ensure that women and their children have access to services listed above in numbers 1-8,
10. Coordinate discharge planning with family members to include DHHS/Children and Family Services representatives when applicable, and
11. The Contractor is responsible to provide DHHS with documentation which illustrates provision, facilitation or provision of the above listed services and ensure that any changes are reported and on file with DHHS.

J. TUBERCULOSIS (TB) SCREENING AND SERVICES

1. Contractor will ensure that all subcontractors receiving SAPTBG funds shall:
 - a. Report active cases of TB to the DHHS Division of Public Health Tuberculosis Program Manager and adhere to all reporting requirements as set forth including NRS Sec.71-502, 71-1626 and 173 NAC Chapters 1-6, which can be found at www.dhhs.ne.gov/reg/t173.htm.
 - b. Maintain infection control procedures that are consistent with those that are established by the State's infection control office.
 - c. Adhere to State and Federal confidentiality requirements when reporting such cases.
2. The Contractor will ensure that subcontractors of SAPTBG funding will routinely make TB services available to each individual receiving treatment for substance abuse and to monitor such service delivery.
3. The Contractor shall establish procedures that ensure that the following (TB) services are provided, either directly or through arrangements/agreements with other public or non-profit private entities:
 - a. Screening of all admissions for TB,
 - b. Positive screenings shall receive test for TB,
 - c. Counseling related to TB,
 - d. Referral for appropriate medical evaluations or TB treatment,
 - e. Case management for obtaining any TB services,
 - f. Report any active cases of TB to state health officials, and
 - g. Document screening, testing, referrals and/or any necessary follow-up information.
4. The Contractor is responsible to provide DHHS with documentation which illustrates facilitation or provision of the above listed services and ensure that any changes are reported and on file with DHHS.

K. STERILE NEEDLE DISBURSEMENT AND HIV/AIDS

1. The Contractor will ensure that SAPTBG funded programs will not distribute sterile needles for hypodermic injection of illegal drugs or distribute bleach for the purpose of cleansing needles for the purposes of injection.
2. The Contractor will ensure that SAPTBG funded programs will not perform testing for the etiologic agent for Acquired Immune Deficiency Syndrome unless such testing is accompanied by appropriate pre-test and post-test counseling.

L. CHARITABLE CHOICE

DHHS must comply with 42 U.S.C. 300x-65 and 42 C.F.R. part 54. [See 42 C.F.R. 54.8(c)(4) and 54.8(b), Charitable Choice Provision and Regulations.]

1. Contractors will ensure that Subcontracts/Contractor include a requirement that SAPTBG funded faith-based programs cannot use SAPTBG funds for inherently religious activities such as (1) worship, (2) religious instruction, or (3) proselytization, and that the programs may engage in these activities only when they are separate in time or location from SAPTBG funded activities and participation in them is voluntary.
2. Contractor will ensure that Subcontractors/Contractor delivering services, including outreach services programs do not discriminate on the basis of one's religion, religious belief, refusal to hold a religious belief, or refusal to actively participate in a religious practice
3. Contractor will ensure that Subcontracts/Contractor indicate that when an otherwise eligible client objects to the religious character of a program, that the program refers the client to an alternative provider within a reasonable period of time of the objection and in accordance with Charitable Choice provisions.
4. Contractor and/or Subcontractors shall report all occurrences of individuals refusing services under the provision of the Charitable Choice requirements for the SAPTBG.

5. Contractor will ensure that contracts with Subcontractor use generally accepted accounting principles to account for SAPTBG funds segregate those funds from non-federal funds subject to the audits by government and apply Charitable Choice in instances where SAPTBG funds are comingled with state/local funds.

Regional Behavioral Health Community Based Providers with ISAT numbers

1	Region 1 Behavioral Health Authority (NE300205)	Emerg Community Support -- MH or SA
	4110 Avenue 'D'	House Related Service -- SA
	Scottsbluff, NE 69361	Crisis Response
	(308) 635-3171	Peer Support -- MH or SA
		Regional Prevention Coordination - SA
1	Behavioral Health Specialists (NE301302)	Short Term Residential - SA
	600 S. 13th	
	Norfolk, NE 68701	
	(402) 370-3140	
1	Human Services, Inc.(NE900699)	24 Hour Crisis Phone
	419 West 25th Street	Crisis Assessment/Evaluation - SA (LADC)
	Alliance, NE 69301	Social Detoxification
	(308) 762-7177	Community Support - SA
		Short Term Residential - SA
		Intensive Outpatient - SA
		Outpatient Therapy - SA
1	North East Panhandle Substance Abuse Center (NE100605)	Social Detoxification
	305 Foch St.	Short Term Residential - SA
	P.O. Box 428	Intensive Outpatient - SA
	Gordon, NE 69343	Outpatient Therapy - SA
	(308) 282-1101	Community Support - SA
1	Panhandle Mental Health Center (NE100596)	Outpatient Therapy - SA
	212 Box Butte Ave.	
	Alliance, NE 69301	
	(308) 635-3171	
1	Panhandle Mental Health Center (NE300205)	24 Hour Crisis Phone
	4110 Avenue 'D'	Crisis Assessment/Evaluation - SA
	Scottsbluff, NE 69361	Community Support - SA
	(308) 635-3171	Intensive Outpatient - SA
		Outpatient Therapy - SA
		Youth Outpatient Therapy - SA
1	Panhandle Mental Health Center (NE100408)	Outpatient Therapy - SA
	2246 Jackson Avenue	Intensive Outpatient - SA
	Sidney, NE 69162	
	(308) 635-3171	
1	Panhandle Substance Abuse Council (NE900863)	Regional Prevention Coordination - SA
	1517 Broadway, Suite 124	Community Prevnetion - Panhandle
	Scottsbluff, NE 69361	
	(308) 632-3044	

1	Regional West Medical Center (NE101215)	Dual Residential (SPMI & CD)
	4021 Avenue 'B'	
	Scottsbluff, NE 69361	
	(308) 630-1500	
2	Region II Human Services (NE900525)	Regional Prevention Coordination - SA
	307 E. 5th	Crisis Assessment/Evaluation - SA (LADC)
	Lexington, NE 68850	Urgent Assessment/Evaluation - MH or SA
	(308) 324-6754	Urgent Outpatient Therapy - MH or SA (LADC)
		Emergency Community Support - MH or SA
		Community Support - SA
		Assessment/Evaluation - SA
		Outpatient Therapy - SA
		Outpatient Therapy Dual (SPMI & CD)
		Youth Assessment/Evaluation - SA
		Youth Outpatient Therapy - SA
		Youth Outpatient Therapy Dual (SED & CD)
2	Region II Human Services (NE900392)	Prevention Services
	1012 W. 3rd	Crisis Assessment/Evaluation - SA (LADC)
	McCook, NE 69001	Urgent Assessment/Evaluation - MH or SA
	(308) 345-2770	Urgent Outpatient Therapy - MH or SA (LADC)
		Emergency Community Support - MH or SA
		Community Support - SA
		Day Rehabilitation
		Assessment/Evaluation - SA
		Outpatient Therapy - SA
		Outpatient Therapy Dual (SPMI & CD)
		Youth Assessment/Evaluation - SA
		Youth Outpatient Therapy - SA
		Youth Outpatient Therapy Dual (SED & CD)
2	Region II Human Services (NE900566)	Prevention Services
	110 N. Bailey Street	Crisis Assessment/Evaluation - SA (LADC)
	North Platte, NE 69103	Urgent Assessment/Evaluation - MH or SA
	(308) 534-0440	Urgent Outpatient Therapy - MH or SA (LADC)
		Emergency Community Support - MH or SA
		Community Support - SA
		Assessment/Evaluation - SA
		Outpatient Therapy - SA
		Outpatient Therapy Dual (SPMI & CD)
		Youth Assessment/Evaluation - SA
		Youth Outpatient Therapy - SA
		Youth Outpatient Therapy Dual (SED & CD)
2	Region II Human Services (NE900574)	Prevention Services
	401 W. 1st	Crisis Assessment/Evaluation - SA (LADC)
	Ogallala, NE 69153	Urgent Assessment/Evaluation - MH or SA
	(308) 284-6767	Urgent Outpatient Therapy - MH or SA (LADC)

Appendix / Addendum - Additional Supporting Documents (Optional) / page 11

		Emergency Community Support - MH or SA
		Community Support - SA
		Assessment/Evaluation - SA
		Outpatient Therapy - SA
		Outpatient Therapy Dual (SPMI & CD)
		Youth Assessment/Evaluation - SA
		Youth Outpatient Therapy - SA
		Youth Outpatient Therapy Dual (SED & CD)
2	CenterPointe (NE301401)	Dual Residential (SPMI & CD)
	2633 'P' Street	
	Lincoln, NE 68503	
	(402) 475-8717	
2	Great Plains Regional Medical Center (NE100213)	Crisis Assessment/Evaluation - SA (LADC)
	601 W. Leota St.	
	North Platte, NE 69101	
	(308) 696-8000	
2	Regional West (NE101215)	Crisis Assessment/Evaluation - SA (LADC)
	4021 Ave. 'B'	
	Scottsbluff, NE 69361	
	(308) 630-1500	
2	Richard Young Hospital (NE100118)	Crisis Assessment/Evaluation - SA (LADC)
	4600 17th Avenue	
	Kearney, NE 68848	
	(308) 865-2202	
2	St Monica's Behavioral Health (NE101645)	Short Term Residential - SA
	120 Wedgewood Dr	Therapeutic Community - SA
	Lincoln, NE 68510	
	(402) 441-3767	
2	Touchstone (NE000081)	Short Term Residential - SA
	1100 Military Road	
	Lincoln, NE 68508	
	(402) 435-3165	
2	Goodwill Industries of Greater NE (NE100279)	Emergency Community Support - MH/SA
	1804 S. Eddy	Community Support - SA
	Grand Island NE 68801	
	(308) 384-7896	
2	Houses of Hope (NE901242)	Halfway House - SA
	601 Cotner Blvd	
	Lincoln, NE 68502	
	(402) 435-3165	
3	Region 3 Behavioral Services (NE100803)	Emergency Community Support - MH or SA

	4009 6th Avenue, Suite 65 Kearney, NE 68845 (308) 237-5113	Regional Prevention Coordination - SA
3	Behavioral Health Specialists/SOS (NE900707) 4432 Sunrise Place Columbus, NE 68601 (402) 564-9994	Social Detoxification Short Term Residential - SA
3	Buffalo County Community Partners Positive Pressure (NE100801) PO Box 1466 Kearney, NE 68848 (308) 865-2283	Prevention Services
3	Catholic Charities (NE100126) 3020 18th Street Columbus, NE 68601 (402) 829-9301	Dual Residential (SPMI & CD)
3	Central Nebraska Council on Alcoholism (NE750144) 219 W. 2nd Street Grand Island, NE 68801 (308) 385-5520	Prevention Services
3	Friendship House/Milne Detox (NE750151) 406 W. Koenig Street Grand Island, NE 68801 (308) 382-0422 / (308) 382-9451	Social Detoxification Halfway House - SA
3	Grand Island Substance Abuse Prevention Coalition (NE750144) 219 West 2nd St. Grand Island, NE 68801 (308) 385-5520	Prevention Services
3	Mary Lanning Memorial Hospital (NE100100) 715 N. St. Joseph Ave. Hastings, NE 68901 (402) 463-5973	Crisis Assessment/Evaluation - SA (LADC) Emergency Community Support - MH or SA
3	Mid-Plains Center for Behavioral Healthcare Services (NE301500) 914 Baumann Dr. Grand Island, NE 68801 (308) 385-5250	Outpatient Therapy Dual (SPMI & CD)
3	South Central Behavioral Services, Inc. (NE901192) 121 15th Ave. Franklin, NE 68939 (308) 237-5951	Assessment/Evaluation - SA Outpatient Therapy - SA Youth Outpatient Therapy - SA Youth Assessment/Eval - SA

3	South Central Behavioral Services, Inc. (NE750946)	Intensive Outpatient - SA
	616 W. 5th St.	Assessment/Evaluation - SA
	Hastings, NE 68901	Outpatient Therapy - SA
	(402) 463-5684	Youth Intensive Outpatient - SA
		Youth Assessment/Eval - SA
		Youth Outpatient Therapy - SA
3	South Central Behavioral Services, Inc. (NE900517)	Assessment/Evaluation - SA
	701 4th Ave., Suite 7	Outpatient Therapy - SA
	Holdrege, NE 68949	Youth Outpatient Therapy - SA
	(308) 995-6597	Youth Assessment/Eval - SA
3	Goodwill Industries of Greater NE (NE100279)	Emergency Community Support - MH/SA
	1804 S. Eddy	Community Support - SA
	Grand Island NE 68801	
	(308) 384-7896	
3	Garfield-Wheeler-Loop (GLW) Children's Council (NE100804)	SA Community Coalition
	PO Box 638	
	455 Grand Avenue	
	Burwell NE 68823	
	(308) 346-4284	
3	Mid Plains Center - Dual Program	Dual Outpatient - MH/SA
	Box 34	
	Mason City NE 68855	
	(308) 385-5250	
3	South Central Behavioral Services, Inc. (NE301708)	Community Support - SA
	3810 Central Avenue	Intensive Outpatient - SA
	Kearney, NE 68847	Assessment/ Evaluation - SA
	(308) 237-5951	Outpatient Therapy - SA
		Youth Assessment/Eval - SA
		Youth Intensive Outpatient - SA
		Youth Outpatient Therapy - SA
3	South Central Behavioral Services, Inc. (NE900632)	Assessment/Evaluation - SA
	510 East 10th St.	Outpatient Therapy - SA
	Superior, NE 68978	Youth Outpatient Therapy - SA
	(402) 463-5684	Youth Assessment/Eval - SA
3	South Central Substance Abuse Prevention Coalition (NE900921)	Prevention Services
	835 South Burlington, Suite 114	
	Hastings, NE 68901	
	(402) 463-0524	

3	St. Francis Alcohol Drug Treatment Center (NE100216)	Assessment/Evaluation - SA
	314 S. 14th St.	Outpatient Therapy - SA
	Ord, NE 68862	Youth Assessment/Evaluation - SA
	(308) 728-3678	Youth Outpatient Therapy - SA
3	St. Francis Alcohol and Drug Treatment Center (NE100144)	Assessment/Evaluation - SA
	315 S. 8th	Outpatient Therapy - SA
	Broken Bow, NE 68822	Youth Assessment/Evaluation - SA
	(308) 872-6449	Youth Outpatient Therapy - SA
3	St. Francis Alcohol and Drug Treatment Center (NE900731)	Short Term Residential - SA
	2620 W. Faidley Ave	Intensive Outpatient - SA
	Grand Island, NE 68801	Assessment/Evaluation - SA
	(308) 398-5427	Outpatient Therapy - SA
		Youth Assessment/Evaluation - SA
		Youth Outpatient Therapy - SA
3	St. Francis Alcohol and Drug Treatment Center (NE100118)	Assessment/Evaluation - SA
	4600 17th Avenue	Outpatient Therapy - SA
	Kearney, NE 68847	Youth Assessment/Evaluation - SA
	(308) 865-2000	Youth Outpatient Therapy - SA
3	The Bridge (NE900335)	Therapeutic Community - SA
	922 N. Denver St.	
	Hastings, NE 68901	
	(402) 462-4677	
4	Region IV Behavioral Health System (NE100811)	Emergency Community Support - MH or SA
	206 Monroe Ave.	Regional Prevention Coordination - SA
	Norfolk, NE 68701	
	(402) 370-3100	
4	Behavioral Health Specialists, Inc. (NE301302)	Community Support - SA
	600 S. 13th Street	Intensive Outpatient - SA
	Norfolk, NE 68701	Outpatient Therapy - SA
	(402) 370-3140	Youth Community Support - SA
		Youth Outpatient Therapy - SA
4	S.O.S. Place (NE900707)	Social Detoxification
	4432 Sunrise Place	Short Term Residential - SA
	Columbus, NE 68601	
	(402) 564-9994	
4	Catholic Charities (NE100126)	Urgent Assessment/Evaluation - MH or SA
	3020 18th Street, Suite 17	Community Support - SA
	Columbus, NE 68601	Dual Residential (SPMI & CD)
	(402) 563-3833	Intensive Outpatient - SA
		Outpatient Therapy - SA

		Youth Intensive Outpatient - SA
		Youth Assessment/ Evaluation - SA
		Youth Outpatient Therapy - SA
4	Heartland Counseling Services, Inc.(NE900491)	Community Support - SA
	917 W. 21st St.	Intensive Outpatient - SA
	South Sioux City, NE 68776	Outpatient Therapy - SA
	(402) 494-3337	Youth Intensive Outpatient - SA
		Youth Assessment/ Evaluation - SA
		Youth Outpatient Therapy - SA
4	Heartland Solutions (NE100614)	Urgent Assessment/Evaluation - MH or SA
	318 E. Highway 20	Emergency Community Support - MH or SA
	P.O. Box 246	Community Support - SA
	O'Neill, NE 68763	Day Rehabilitation
	(402) 336-2800	Outpatient Therapy - SA
		Youth Outpatient Therapy - SA
4	North East Panhandle Substance Abuse Center (NE100605)	
	305 Foch St.	Social Detoxification
	P.O. Box 428	Short Term Residential - SA
	Gordon, NE 69343	
	(308) 282-1101	
4	The Link (NE900418)	Halfway House - SA
	1001 Norfolk Avenue	
	Norfolk, NE 68701	
	(402) 371-5310	
4	Women's Empowering Life Line (NE100622)	Dual Residential (SPMI & CD)
	305 North 9th Street	Halfway House - SA
	Norfolk, NE 68701	
	(402) 844-4710	
5	Blue Valley Behavioral Health (NE750953)	Intensive Outpatient - SA
	1123 S. 9th St.	Outpatient Therapy - SA
	Beatrice, NE 68310	Youth Assessment/Evaluation - SA
	(402) 228-3386	Youth Outpatient Therapy - SA
		24 Hour Crisis Phone
5	Blue Valley Behavioral Health (NE750045)	Intensive Outpatient - SA
	820 Central Ave.	Outpatient Therapy - SA
	Auburn, NE 68305	Youth Outpatient Therapy - SA
	(402) 274-4373	Youth Assessment/ Evaluation - SA
5	Blue Valley Behavioral Health (901184)	Outpatient Therapy - SA
	225 East 9th, Suite 1	Youth Assessment/Evaluation - SA
	Crete, NE 68333	Youth Outpatient Therapy - SA
	(402) 826-2000	
5	Blue Valley Behavioral Health (750102)	Outpatient Therapy - SA

	367 'E' Street	Youth Assessment/Evaluation - SA
	David City, NE 68632	Youth Outpatient Therapy - SA
	(402) 367-4216	
5	Blue Valley Behavioral Health (NE750110)	Outpatient Therapy - SA
	521 'E' Street	Youth Outpatient Therapy - SA
	Fairbury, NE 68352	
	(402) 729-2272	
5	Blue Valley Behavioral Health (NE750128)	Outpatient Therapy - SA
	116 W. 19th Street	Youth Assessment/Evaluation - SA
	Falls City, NE 68355	Youth Outpatient Therapy - SA
	(402) 245-4458	
5	Blue Valley Behavioral Health (NE900913)	Outpatient Therapy - SA
	831 'F' Street	Youth Assessment/Evaluation - SA
	Geneva, NE 68361	Youth Outpatient Therapy - SA
	(402) 759-4761	
5	Blue Valley Behavioral Health (NE750201)	Outpatient Therapy - SA
	141 N. 4TH	Youth Outpatient Therapy - SA
	Hebron, NE 68370	
	(402) 759-4761	
5	Blue Valley Behavioral Health (NE750409)	Outpatient Therapy - SA
	1903 4th Corso	Youth Assessment/Evaluation - SA
	Nebraska City, NE 68410	Youth Outpatient Therapy - SA
	(402) 873-5505	
5	Blue Valley Behavioral Health (NE750581)	Outpatient Therapy - SA
	531 Beebe	Youth Outpatient Therapy - SA
	Osceola, NE 68561	
	(402) 362-6128	
5	Blue Valley Behavioral Health (NE750599)	Outpatient Therapy - SA
	600 "I" Street	Youth Outpatient Therapy - SA
	Pawnee City, NE 68420	
	(402) 245-4458	
5	Blue Valley Behavioral Health (750631)	Outpatient Therapy - SA
	459 S. 6th St.	Youth Assessment/Evaluation - SA
	Seward, NE 68434	Youth Outpatient Therapy - SA
	(402) 643-3343	
5	Blue Valley Behavioral Health (NE750409)	Outpatient Therapy - SA
	Johnson County Hospital	Youth Outpatient Therapy - SA
	202 High Street	
	Tecumseh, NE 68450	
	(402) 228-3386	
5	Blue Valley Behavioral Health (NE750672)	Outpatient Therapy - SA
	543 N. Linden Street	Youth Assessment/Evaluation - SA

Appendix / Addendum - Additional Supporting Documents (Optional) / page 17

	Wahoo, NE 68066 (402) 443-4414	Youth Outpatient Therapy - SA
5	Blue Valley Behavioral Health (NE901382) 722 S. Lincoln Ave, Suite 1 York, NE 68467 (402) 362-6128	Intensive Outpatient - SA Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
5	CenterPointe (NE301401) 1000 South 13th Street Lincoln, NE 68508 (402) 475-5161	Community Support - SA Day Rehabilitation Outpatient Therapy - SA Youth Outpatient Therapy - SA Recovery Support - SA
5	CenterPointe (NE100436) 2220 S. 10th St. Lincoln, NE 68502 (402) 475-5161	Youth Therapeutic Community - SA
5	CenterPointe (NE302219) 2633 'P' St. Lincoln, NE 68503 (402) 475-8748	Dual Residential (SPMI & CD)
5	CFSTAR 2900 'O' Street, Suite 200 Lincoln, NE 68510 (402) 435-2910	Outpatient Therapy - SA
5	Child Guidance Center (NE100563) 2444 'O' Street Lincoln, NE 68510 (402) 475-7666	Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA Therapeutic Consultation - SA
5	Community Mental Health Center (NE750938) 2201 S. 17th St. Lincoln, NE 68502 (402) 441-7940	Crisis Assessment/Evaluation - SA (LADC) 24 Hour Crisis Phone
5	Cornhusker Place (NE750250) 721 'K' Street Lincoln, NE 68508 (402) 477-3951	Social Detoxification CPC Services (Involuntary) Intermediate Residential - SA Short Term Residential - SA Recovery Support - SA
5	Houses of Hope (NE901242) 601 Cotner Blvd Lincoln, NE 68502 (402) 435-3165	Halfway House - SA
5	Lincoln Medical Education Partnership (NE100415)	Prevention Services

	4600 Valley Road Lincoln, NE 68510 (402) 483-4581	Outpatient Therapy - SA
5	Lutheran Family Services (NE900962) 2900 'O' Street, Suite 200 Lincoln, NE 68510 (402) 435-2910	Intensive Outpatient - SA Outpatient Therapy - SA
5	St. Monica's Behavioral Health Services for Women (NE101464) 120 Wedgewood Dr. Lincoln, NE 68510 (402) 441-3768	Community Support - SA Intensive Outpatient - SA Outpatient Therapy - SA Short Term Residential - SA
5	St. Monica's Behavioral Health Services for Women (NE900038) Project Mother Child 219 S 24 Lincoln, NE 68510 (402) 441-3755	Therapeutic Community - SA
5	St. Monica's Behavioral Health Services for Women (NE100556) 4555 S. 25th St. Lincoln, NE 68510 (402) 434-8475	Therapeutic Community - SA
5	Touchstone (NE000081) 1100 Military Rd. Lincoln, NE 68508 (402) 474-4343	Short Term Residential - SA
5	Lincoln Council of Alcoholism and Drugs (NE900350) 914 L Street Lincoln NE 68510 (402) 475-2694	Assessment Evaluation - SA
6	Region 6 (NE100837) 3801 Harney Street Omaha, NE 68131 (402) 444-6534	Regional Prevention Center
6	Alegent Health, Inc. (NE750904) 6901 N. 72nd St. Omaha, NE 68122 (402) 572-2936	Assessment/Evaluation - SA Outpatient Therapy - SA
6	Alegent Health, Inc. (NE101827) 1309 Harlen Drive Bellevue, NE 68005	Assessment/Evaluation - SA Outpatient Therapy - SA

	(402) 572-2936	
6	ARCH (NE750441) 604 S. 37th St. Omaha, NE 68105 (402) 346-8898	Halfway House - SA
6	ARCH (NE100496) 1502 N. 58th St. Omaha, NE 68114 (402) 346-8898	Halfway House - SA
6	BAART (NE100781) 1941 Center, Suite 210 Omaha, NE 68105 341-6220	Methadone Maintenance - SA
6	Catholic Charities (NE100431) 1490 N. 16th St. Omaha, NE 68102 (402) 554-0520	Crisis Assessment/Evaluation - SA (LADC) Social Detoxification CPC Services (Involuntary) Community Support - SA Short Term Residential - SA Dual Residential (SPMI & CD) Intensive Outpatient - SA
6	Catholic Charities (NE900665) 3300 N. 60th St. Omaha, NE 68104 (402) 554-0520	Assessment/Evaluation - SA Outpatient Therapy - SA
6	Catholic Charities (NE901333) 4430 S. 33rd St. Omaha, NE 68107 (402) 554-0520	Intermediate Residential - SA
6	Douglas County Community MH Center (NE100810) 4102 Woolworth Ave Omaha NE 68105 (402) 444-7698	CPC Services - Assessment Evaluation - SA Outpatient - SA
6	Heartland Family Services (NE100624) 116 E. Mission Ave. Bellevue, NE 68005 (402) 552-7445	Assessment/Evaluation - SA Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
6	Heartland Family Services (NE100103) 2101 S. 42nd St. Omaha, NE 68105 (402) 552-7445	Assessment/Evaluation - SA Outpatient Therapy - SA Youth Assessment/Evaluation - SA Youth Outpatient Therapy - SA
6	Heartland Family Services (NE100317)	Assessment/Evaluation - SA

	11212 Davenport St.	Outpatient Therapy - SA
	Omaha, NE 68154	Youth Assessment/Evaluation - SA
	(402) 552-7445	Youth Outpatient Therapy - SA
6	Heartland Family Services (NE100625)	Assessment/Evaluation - SA
	1246 Golden Gate Dr.	Outpatient Therapy - SA
	Papillion, NE 68046	Youth Assessment/Evaluation - SA
	(402) 552-7445	Youth Outpatient Therapy - SA
6	Heartland Family Services (NE100799)	Therapeutic Community - SA
	1016 Park Ave., #221	
	Omaha, NE 68105	
	(402) 552-7445	
6	Latino Center of the Midlands (NE901051)	Outpatient Therapy - SA
	4821 S. 24th St	
	Omaha, NE 68107	
	(402) 733-2720	
6	Lutheran Family Services (NE100332)	Assessment/Evaluation - SA
	730 N. Fort Crook Road	Outpatient Therapy - SA
	Bellevue, NE 68005	Youth Assessment/Evaluation - SA
	(402) 978-5621	Youth Outpatient Therapy - SA
6	Lutheran Family Services (NE100220)	Assessment/Evaluation - SA
	403 S. 16th St.	Outpatient Therapy - SA
	Blair, NE 68008	Youth Assessment/Evaluation - SA
	(402) 978-5621	Youth Outpatient Therapy - SA
6	Lutheran Family Services (NE101686)	Assessment/Evaluation - SA
	510 'D' St.	Outpatient Therapy - SA
	Fremont, NE 68025	Youth Assessment/Evaluation - SA
	(402) 978-5621	Youth Outpatient Therapy - SA
6	Lutheran Family Services (NE101763)	Crisis Assessment/Evaluation - SA (LADC)
	124 S. 24th, Suite 100	Urgent Assessment/Evaluation - MH or SA
	Omaha, NE 68102	Urgent Outpatient Therapy - MH or SA (LADC)
	(402) 978-5621	Assessment/Evaluation - SA
		Outpatient Therapy - SA
		Youth Assessment/Evaluation - SA
		Youth Outpatient Therapy - SA
6	Lutheran Family Services (NE100163)	Intensive Outpatient - SA
	2505 N. 24th	Assessment/Evaluation - SA
	Omaha, NE 68110	Outpatient Therapy - SA
	(402) 978-5621	Youth Assessment/Evaluation - SA
		Youth Outpatient Therapy - SA
6	Lutheran Family Services (NE100688)	Assessment/Evaluation - SA
	415 South 25 Avenue	Outpatient Therapy - SA
	Omaha, NE 68131	Youth Assessment/Evaluation - SA
	(402) 978-5621	Youth Outpatient Therapy - SA

6	Lutheran Family Services (NE100688)	Assessment/Evaluation - SA
	401 E. Gold Coast Rd.	Outpatient Therapy - SA
	Papillion, NE 68046	Youth Assessment/Evaluation - SA
	(402) 978-5621	Youth Outpatient Therapy - SA
6	Lutheran Family Services (NE100340)	Assessment/Evaluation - SA
	546 Avenue A	Outpatient Therapy - SA
	Plattsmouth, NE 68048	Youth Assessment/Evaluation - SA
	(402) 978-5621	Youth Outpatient Therapy - SA
6	Nebraska Urban Indian Health (NE101298)	Assessment/Evaluation - SA
	2240 Landon Court	Outpatient Therapy - SA
	Omaha, NE 68108	Youth Assessment/Evaluation - SA
	(402) 346-0902	Youth Outpatient Therapy - SA
6	NOVA Therapeutic Community (NE101405)	Youth Intensive Outpatient - SA
	1915 S. 38th St.	
	Omaha, NE 68105	
	(402) 455-8303	
6	NOVA Therapeutic Community (NE300072)	Short Term Residential - SA
	3483 Larimore Ave.	Therapeutic Community - SA
	Omaha, NE 68111	Youth Therapeutic Community - SA
	(402) 455-8303	
6	Salvation Army (NE750532)	Emergency Community Support - MH or SA
	3612 Cuming St.	Intensive Case Management - MH or SA
	Omaha, NE 68131	
	(402) 898-5940	
6	Santa Monica (NE750540)	Intermediate Residential - SA
	130 N. 39th St.	Halfway House - SA
	Omaha, NE 68131	
	(402) 558-7088	
	Tribal Programs Funded Direct By Division	
4	**Omaha Tribe of Nebraska (NE100381)	Youth Assessment/Evaluation - SA
	PO Box 368	Youth Outpatient Therapy - SA
	Macy NE 68039	Halfway House - SA
		Assessment/Evaluation - SA
		Outpatient Therapy - SA
4	**Ponca Tribe Of Nebraska (NE100121)	Assessment/Evaluation - SA
	201 Miller Avenue	Outpatient Therapy - SA
	Norfolk NE 68701	
4	**Santee Sioux Tribe of Nebraska (NE750607)	Youth Assessment/Evaluation - SA
	425 Fraser Avenue No Suite 2 RR 2	Youth Outpatient Therapy - SA
	Niobrara NE 68760	Assessment/Evaluation - SA

		Outpatient Therapy - SA
4	**Winnebago Tribe of Nebraska (NE750706)	Assessment/Evaluation - SA
	PO Box 687	Outpatient Therapy (Adult)
	Winnebago NE 68071	

State Epidemiological Outcomes Workgroup (SEOW)

Nebraska Substance Abuse Epidemiology Workgroup (NSAEW)

Participant List (as of September 27, 2010)

State Participants:

- Debora Barnes-Josiah – Office of Family Health, NDHHS
- Robert Bussard – Division of Behavioral Health, NDHHS
- Orville Cayou – Omaha Nation Community Response Team
- Renee Faber - Division of Behavioral Health, NDHHS
- Crystal Fuller – Region 6 Behavioral Healthcare
- Jim Harvey – Division of Behavioral Health, NDHHS
- Dan Hoyt – University of Nebraska-Lincoln
- Steve King – Department of Corrections
- Linda Major - NU Directions, University of Nebraska-Lincoln
- Lazarous Mbulo – Tobacco Free Nebraska Program, NDHHS
- Sandy Morrissey – Region 5 Prevention System
- Kathy Nordby – Elkhorn Logan Valley Health Department
- Mike Overton – Nebraska Crime Commission
- Michelle Parker – Ho-Chunk Community Development Corp
- Frank Peak – Creighton University Medical Center
- John Penn – Omaha Nation Community Response Team
- Parvathy Pillai – Epidemiology, NDHHS
- Ming Qu – Health Surveillance, NDHHS
- Diane Riibe – Project Extra Mile
- Dean Ross – Omaha Nation Community Response Team
- Tom Safranek – Epidemiology, NDHHS
- Michael Shambaugh-Miller
- Duane Shell – University of Nebraska-Lincoln
- Corey Smith – Northern Plains Tribal Epidemiology Program
- Melissa Tibbits – University of Nebraska Medical Center
- Larry Voegele – Ponca Tribe of Nebraska
- Shinobu Watanabe-Galloway – University of Nebraska Medical Center
- Fred Zwonechek – Nebraska Office of Highway Safety

Federal/Regional Participants:

- Mindy Anderson-Knott – RTI (local RTI evaluator)
- Leslie Ballenger – Southwest RET
- Monique Clinton-Sherrod – RTI
- Kathy Gary – Southwest RET
- Phillip Graham – RTI

Strategic Prevention Framework State Incentive Grant (SPF SIG) Program Staff

NDHHS – Division of Public Health – Community Health & Performance Management

- Jeff Armitage
- Patti DeLancey
- Dianne Harrop
- Jamie Marincic
- Dave Palm

NDHHS = Nebraska Department of Health and Human Services