Nebraska

UNIFORM APPLICATION
FY 2022/2023 Block Grant Application

SUBSTANCE ABUSE PREVENTION AND TREATMENT
and

COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 08/20/2021 4:40.29 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

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

Plan Year
Start Year  2022
End Year  2023

State SAPT DUNS Number
Number  808819957
Expiration Date

I. State Agency to be the SAPT Grantee for the Block Grant
Agency Name  Nebraska Department of Health and Human Services
Organizational Unit  Division of Behavioral Health
Mailing Address  301 Centennial Mall South, Third Floor PO Box 95026
City  Lincoln
Zip Code  68509-5026

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

State CMHS DUNS Number
Number  808819957
Expiration Date

I. State Agency to be the CMHS Grantee for the Block Grant
Agency Name  Nebraska Department of Health and Human Services
Organizational Unit  Division of Behavioral Health
Mailing Address  301 Centennial Mall South, Third Floor PO Box 95026
City  Lincoln
Zip Code  68509-5026

II. Contact Person for the CMHS Grantee of the Block Grant
First Name  Sheri
Last Name  Dawson
Agency Name  NE DHHS Division of Behavioral Health
III. Third Party Administrator of Mental Health Services

Do you have a third party administrator?  
- Yes  
- No

First Name  
Last Name  
Agency Name  
Mailing Address  
City  
Zip Code  
Telephone  
Fax  
Email Address

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

From  
To

V. Date Submitted

Submission Date  
Revision Date

VI. Contact Person Responsible for Application Submission

First Name  John  
Last Name  Trouba  
Telephone  402-471-7824  
Fax  402-471-7859  
Email Address  john.trouba@nebraska.gov

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
### State Information

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

#### Fiscal Year 2022

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

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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.


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 Clean 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).


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.

19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.
LIST of CERTIFICATIONS

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 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

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 2 CFR Part 182 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 work-place 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).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"
The undersigned 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 undersigned 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, subgrants, 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) (31 U.S.C § 3801-3812)

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

**HHS Assurances of Compliance (HHS 690)**


The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.
I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

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

State: ______________________________

Name of Chief Executive Officer (CEO) or Designee: ______________________________

Signature of CEO or Designee: ______________________________

Title: ______________________________ Date Signed: ______________________________

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
State Information

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

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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.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to
State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).


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.

19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.
LIST of CERTIFICATIONS

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 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a “covered transaction” and verify each lower tier participant of a “covered transaction” under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

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 workplace in accordance with 2 CFR Part 182 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. Estimating 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).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. 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.

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 undersigned 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, subgrants, 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) (31 U.S.C § 3801- 3812)

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

**HHS Assurances of Compliance (HHS 690)**


The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

**THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:**

1. **Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.**

2. **Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.**

3. **Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.**

4. **The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.**

5. **Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.**

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.
I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

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

Name of Chief Executive Officer (CEO) or Designee: 

Signature of CEO or Designee\(^1\): 

Title: 

Date Signed: 

\(^{1}\)If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Please upload the states American Rescue Plan funding proposal here in addition to the other documents.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
State Information

Disclosure of Lobbying Activities

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

Name

Title

Organization

Signature:  
Date:

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Narrative Question:
Provide an overview of the state’s M/SUD prevention, early identification, treatment, and recovery support systems of care, including the statutory criteria that must be addressed in the state’s Application. Describe how the public M/SUD system of care is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems of care address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
FFY 2022-2023 Block Grant Application

Instructions for Planning Steps

*Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.*

Provide an overview of the state’s M/SUD prevention, early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state’s Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

**Nebraska’s Behavioral Health System Overview**

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

The DBH provides the four federally recognized tribes state funds, consultation, and technical assistance for both their Mental Health and Substance Use Disorder programs. DBH engages tribal representatives in planning, trainings, and initiatives, as well as supports the culturally appropriate provision of services to tribal members. DBH has customized its Centralized Data System to track the participation of unique services offered to tribal members such as sweat lodge, ceremonies, community responsibilities, and spiritual events.

Additionally, other state and federal agencies (for example, State Probation through the Nebraska Supreme Court, the Nebraska Department of Correctional Services, the Nebraska Department of Education Vocational Rehabilitation, and the Veterans’ Administration) fund or support behavioral health services for specific populations. Partnerships and collaboration among these public and private systems as well as with individuals, families, agencies, and communities are important components in systems of care surrounding each person.

The Nebraska Office of Consumer Affairs (OCA) administers planning, organizing, and development of consumer involvement initiatives to increase consumer involvement at all levels.
of service planning and delivery. The OCA provides education and technical assistance support for consumers and families of substance abuse, and mental health services throughout the state and across DHHS Divisions for the development of programs and services that are recovery focused and consumer and family driven.

**Role of Division of Behavioral Health: SMHA and SSA**

The Nebraska Behavioral Health Services Act designates the DBH as the chief behavioral health authority for the State [§71-806 (1)]. The DBH is both the State Mental Health Authority (SMHA) and the Single State Substance Abuse Authority (SSA). It is important to note that the authority does not extend to MLTC or CFS policy decisions. The DBH administers, oversees, and coordinates the state’s public behavioral health system to address the prevention and treatment of mental health and substance use disorders. The primary goal is to develop a behavioral health system that is co-occurring capable, trauma-informed, recovery-oriented, and person-centered. The DBH is responsible for managing both the Community Mental Health Services Block Grant (CMHSBG) and the Substance Abuse Prevention and Treatment Block Grant (SAPTBG). DBH funds priority treatment and support services for individuals without Medicaid and individuals without insurance or who are underinsured, according to financial eligibility based on a sliding scale on income and family size. The OCA focuses on recovery initiatives, planning, research, and advocacy for behavioral health consumers.

**Strategic Planning**

The DBH is designated by federal and state law as the state’s single authority for mental health and substance use disorders. The DBH’s responsibility is to coordinate public behavioral health care under DHHS. The DBH carries out its responsibilities through leadership and partnership.

**ONE NEBRASKA! ONE PLAN!**

The Division of Behavioral Health Strategic Plan 2017-2020 was a twelve-month endeavor, beginning with a comprehensive needs assessment in 2016 (The complete document *Nebraska Behavioral Health Needs Assessment 2016* can be accessed at URL: [http://dhhs.ne.gov/Behavioral%20Health%20Documents/Needs%20Assessment%20-%202016.pdf](http://dhhs.ne.gov/Behavioral%20Health%20Documents/Needs%20Assessment%20-%202016.pdf) and ending with an inclusive strategic plan that involved a thorough, highly participatory statewide methodology featuring input from consumers, leadership, providers and advisory groups. The development process encompassed four guiding questions:

1) Where are we? (Conduct a needs assessment),
2) What’s important? (Identify priorities),
3) What must be achieved? (Develop plan goals, objectives) and
4) How are we accountable? (Setting metrics).

A similar process was utilized in 2020-21 for a new Strategic Plan FY 2022-2024. As the Division closed out fiscal year 2020, Covid-19 significantly altered new needs assessment and
strategic planning processes requiring revisions to planned activities and adapting to alternate processes and new ways to engage planning partners. DBH engaged OPEN MINDS, a nationally recognized consulting firm, to conduct a Needs Assessment, provide Gap Analysis and facilitate a Strategic Planning process in 2020. The 2017-2020 End of Plan documents, including carry-over strategies and metrics, along with prioritized needs resulting from the new needs and gaps analysis (URL: https://dhhs.ne.gov/Behavioral%20Health%20Documents/2017-2020%20St.Plan%20FINAL%20REPORT.pdf) drove the identification of key objectives and prioritized strategies for the FY 2022-2024 strategic plan. System partners developed a strategic vision “to become a leader for behavioral healthcare quality and health improvement” to guide the work of the behavioral health system through five transformational pillars:

1. Enhance Behavioral Health Influence
2. Implement an Integration Strategy
3. Promote Stakeholder Inclusion
4. Drive Innovation and improve outcomes, and
5. Demonstrate and drive value.

Future work together with system partners is focused on enhancing and expanding collaborations and partnerships across systems of care, agencies and stakeholders across the State.

The goal of the Needs Assessment was to hear directly from individuals, consumers and other stakeholders where and how the system was meeting their needs, not meeting their needs and/or could use improvement. In addition to research, and to ensure all stakeholders in the system were heard, the OPEN MINDS team use three methods to gather information:

1. Visioning Sessions
2. Key Stakeholder Interviews
3. Electronic Surveys in both English and Spanish. The data and information from these sources were synthesized to create a Gap Analysis.

Visioning sessions occurred with Nebraska Department of Health and Human Services (NDHHS) Leadership, Behavioral Health system partners and key community partners. The sessions were centered around the five transformational pillars and to identify goals, needs, gaps and strategies for systemic improvements. The information provided the groundwork for the statewide survey with solicited input from the voices of providers, consumers, families, community partners, advisory members and other system partners.

Key stakeholder interviews were conducted with leaders in Community Behavioral Health, Housing, Justice, Provider Development, Tribal Nations, Minority Needs, Rural Health and Education. Combined with the visioning session findings, the results further informed the survey questions.

The survey, in English and Spanish, was distributed statewide via a variety of State ListServs to behavioral health providers, systems partners, behavioral health authorities, consumers, families and Tribal Nations. The survey was designed to prioritize the needs identified under each of the five transformational pillars. The survey also offered each participant an
Nebraska Uniform Application FY2022/2023 MHBG/SAPTBG Application Planning Step 1 | page 4

opportunity to provide feedback on needs, gaps, and strategies.

The OPEN MINDS team compared data from the Needs Assessment to current services and data to develop the Gap Analysis. While a several months project, the results of this work provided a portrait of “where are we?” and “what’s important?”

The Gap Analysis was then reviewed with NDHHS Leadership and System Partners. This resulted in a list of the top fifteen priorities identified (minimum of three per pillar), as well as drafting initial strategic objectives per priority.

The team then worked with Division staff and partners, including Regional Administrators, to establish key performance indicators, targets, timelines and resources needed to make the plan systemically feasible. Pillars, draft goals and objectives were reviewed with Advisory members. As the plan has considerable systemic change at its core, continued refinement with NeDHHS Leadership resulted in the public facing document located at URL DHHS_DBH_Strategic_Plan_2022-2024-Post.

NeDHHS, DBH leadership is currently scheduling statewide community forums to roll out the plan and solicit further comment. August 2021 has been targeted for final prioritization of strategies and activities feasible per fiscal year along with completion of companion work plan to document “what must be achieved?” and “how will we know / be accountable?”

Objectives and Accountability:
Strategic plan objectives provide the “how” mechanism for achieving the identified goals. They are “SMART” in that they are specific, measurable, attainable, realistic and time-framed. Each objective is examined, analyzed and ultimately incorporated to ensure it adequately addresses the plan goals and domains and, where appropriate, furthers the philosophy and core values of a system of care. DBH identified 30 objectives for 2017-2020 with the results reported on the End of Plan report (URL: https://dhhs.ne.gov/Behavioral%20Health%20Documents/2017-2020%20St.Plan%20FINAL%20REPORT.pdf).

The new Strategic Plan framework, goals, objectives and strategies have been prioritized. A companion workplan with specific measures and timelines is currently in development. The FY2022-2024 Plan is located at URL DHHS_DBH_Strategic_Plan_2022-2024-Post.

The DBH carries out its responsibilities through leadership, partnership, transparency and accountability. The DBH efforts, including those specified in the block grant application, are strategically planned (2017-2020 Strategic Plan, 2022-2024 Strategic Plan), aligned with the Quadruple Aims of Health Care and the Governor’s priorities, recognized and supported by the Governor through the DHHS Dashboard for performance monitoring and the DHHS Business Plan driving performance. The thread of accountability courses throughout these activities.

The DBH holds itself accountable for strategic plan results through Results-Based Accountability (RBA) methodology. RBA is a different way of thinking. It is the framework we use to define, measure, track and describe change within the system. DBH provides
training and technical assistance to build the capacity of DBH and its contracted Regional Behavioral Health Authorities (RBHAs) to use RBA for its Performance Accountability System. Within the RBA framework, the DBH and RBHAs utilize continuous quality improvement processes to establish and measure outcomes for performance metrics.

In cooperation with multiple stakeholders statewide, DBH provides for a system roadmap which has guided the transformation of the current system of care to serve individuals with complex needs. As one example, Nebraska has moved the roadmap forward by offering providers and system partners the opportunity to participate in multiple webinars and onsite trainings with national consultants having expertise in Co-Occurring Disorders. These training opportunities provided technical assistance related to creating a welcoming environment and how to improve integrated treatment by refining organizational procedures and policies. The most recent NeDHHS – DBH Business Plan has focused on improving and expanding workforce competency to serve special populations. Metrics are reported monthly to NeDHHS Leadership and the Governor’s office. Every two years providers have been required to complete self-assessments using the COMPASS EZ to assess their progress in serving individuals with co-occurring/complex needs, and to create plans to improve this ability. Current year self assessments are underway.

DBH has established RBA processes within the Nebraska System of Care (NeSOC) grant, incorporating continuous accountability and quality improvement mechanisms to track, monitor, and manage the achievement of system of care goals and measure outcomes at the system level, practice level, and child and family level. Over the course of the last year, DBH, in partnership with Nebraska Children and Family Foundation, has engaged over 150 stakeholders and youth and family advocates to serve within the System of Care implementation committee structure. These committees have focused on implementation strategies related to policy, funding, service development, quality improvement and cross-system implementation.

Movement forward capitalizes on partner commitment and work completed to date. During the previous year, the Nebraska System of Care (NeSOC) efforts focused on increasing access to services. Through the development of a statewide Youth Mobile Crisis Response program and expansion of intensive case management services and other community based behavioral health services youth and their families experience greater access to needed services and supports. The NeSOC created a common language for care through development of a cross systems glossary of terms and began the process of improving service delivery by eliminating duplication through mapping currently available services and reviewing existing funding streams. This next phase is dedicated to reducing reliance on inpatient and residential services by increasing community- based services. The link to the DBH NeSOC home page is: [http://dhhs.ne.gov/Pages/System-of-Care-Leadership-Board.aspx](http://dhhs.ne.gov/Pages/System-of-Care-Leadership-Board.aspx)

The Division of Behavioral Health Strategic Plans 2017-2020 and 2022-2024, encompass an overall behavioral healthcare system focus by integrating a Substance Abuse Prevention, and Recovery/Supports Statewide Strategic Plan into the documents’ strategies. See URL: [https://dhhs.ne.gov/Behavioral%20Health%20Documents/Strategic%20Plan%202017-](https://dhhs.ne.gov/Behavioral%20Health%20Documents/Strategic%20Plan%202017-)
Public Behavioral Health System Organization: Division of Behavioral Health

State Level Organization
The DBH provides leadership in the administration, integration and coordination of the public behavioral health system and takes primary responsibility for the development, dissemination and implementation of the Division of Behavioral Health Strategic Plan for 2022-2024. Plan implementation is carried out by DBH and includes the Regional Centers, Office of Consumer Affairs (OCA), the six (6) Regional Behavioral Health Authorities (RBHAs) and system partners. Following is an expanded description of each component of the operational structure.

At the state level, the DBH is comprised of three sections: DBH Central, Regional Centers, and Office of Consumer Affairs.

DBH Central

DBH Central is comprised of five operational components:
1. Community-Based Services (CBS): Consists of services and the workforce essential for delivery of statewide, community-based mental health and substance use disorder prevention, treatment, recovery and support services.

2. Data and Quality Improvement (QI): Undertakes systematic and continuous actions that lead to measurable (via data) improvement in divisional operations, health care services and the health status of the consumer.

3. Fiscal: Provides oversight and administration of DBH’s funds from multiple sources including state general funds and block grant funds. It also manages the billing system for services and the development and execution of contracts.

4. Nebraska System of Care (NeSOC): Provides a coordinated framework within which behavioral health care is delivered to adults (ASOC) and youth (YSOC).

5. Prevention: Promotes safe and healthy environments that foster youth, family, and community development through the implementation of early intervention and prevention best practices.

The DBH contracts with the six RBHAs for community based mental health and substance use services. Originally established in 1974 as mental health regions, the Nebraska Behavioral Health Services Act passed in 2004 incorporated substance use disorder services and revised the regional administrative entities into six RBHAs, to mirror designation of the DBH as the state’s chief behavioral health authority. See the Local Level Organization section below for more details on the RBHAs.

In addition to funding mental health and substance use disorder treatment and prevention services
through the RBHAs, the DBH Community Based Services section directly contracts with entities for recovery and support services. Some examples include:

- Trilogy Integrated Services to provide a web portal (Network of Care) for consumers, providers, and the public to access: a comprehensive directory of behavioral health resources in their area, a databank of articles, factsheets and reports about behavioral health conditions, recovery and treatment, and recovery tools for their personal use;
- Father Flanagan’s Boystown to operate the Nebraska Family Helpline (888-866-8660) where families can obtain assistance and provide a single contact point 24 hours a day, seven days a week; to connect callers with family organizations to advocate for families with youth experiencing mental/emotional disorders, support the family voice and offer supportive services such as education, support groups, advocacy and mentoring; and,
- Four federally recognized Native American Tribes in the state, with whom the DBH awards 1.5 million dollars of state funds in contracts, for the provision of culturally specific mental health and substance use disorder treatment services as well as relapse prevention activities.

**Regional Centers**

Regional Centers are the state’s public psychiatric hospitals located in Norfolk and Lincoln.

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

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

- Psychiatric Services: These are services for people with severe and persistent mental illness who have been committed by a mental health board due to mental illness and dangerous behaviors and cannot be served at a community-based hospital facility. The primary mission of the programs is to help individuals stabilize and return to live in the community. Interdisciplinary treatment teams develop individualized treatment plans based upon assessments completed at the time of admission. Discharge planning is part of the treatment plan, and starts when an individual is admitted.
- Forensic Services: Psychiatric Services provide evaluation, assessments, and treatment for individuals as ordered by the Nebraska legal system. The Forensic Program serves individuals who need competency evaluation,
competency restoration, and who are found Not Responsible by Reason of Insanity. The program offers a structured treatment approach which is tailored to the specific needs of the individual patient.

- **Sex Offender Service:** This service provides treatment for individuals with a history of sexually harmful behavior. The population includes convicted sex offenders who have been committed under an inpatient mental health board order for sex offender treatment. Additionally, a residential level transition program works to release the patients with the necessary structure to allow them the opportunity to successfully return to the community.

- **Whitehall Campus:** Whitehall is designated for two distinct residential programs for adolescent males, one for young men who have sexually harmed and one for substance use disorder services. The Juvenile Chemical Dependency Program has relocated from the Hastings Facility to Whitehall, a program licensed and accredited as part of the Lincoln Regional Center. Whitehall provides residential substance use disorder treatment for young men. Most youth are on probation and have been in treatment an average of three times. Whitehall is a Psychiatric Residential Treatment Facility (PRTF) that addresses the treatment needs of male adolescents who have sexually harmed. Each youth has his own room. The program is family-centered and has its own school on the campus. Youth who complete treatment at Whitehall have a low incidence of reoffending sexually based on an independent study that followed the youth over seven years from completion of treatment.

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

### Office of Consumer Affairs

The Office of Consumer Affairs conducts activities to promote consumer involvement in the service system and recovery process. Consumers are defined as persons receiving mental health or substance use services. Activities include:

- Facilitation of community forums for consumers to give feedback on the quality of service and to identify gaps in these services.
- Administration of recovery initiatives, planning, research, and advocacy for behavioral health consumers.
- Administration of peer support training and certification.
- Administration of workforce development for peer support specialists.
- Facilitation of OCA’s People’s Council designed to advise the DBH around consumer involvement in system planning, evaluation and inclusion.
- Administration of family navigator and peer support service provision in NE.
- Regional consumer coordination within the RBHAs
- System Transformation initiatives related to trauma informed care and cultural and linguistic appropriate standards.
- Community Health Worker (CHW) and Peer Support Workforce initiatives
- Administration of Peer Standards and Regulations.
The Office of Consumer Affairs (OCA) provides statewide leadership and resources for the behavioral health system that works to build, promote, and sustain services which incorporate consumer feedback as integral components of the recovery process throughout the system. Activities include planning, organizing, and creating consumer involvement initiatives to increase consumer involvement at all levels of service planning and delivery. Education, technical assistance and support is provided to assist consumer organizations in expanding consumer participation as a priority in state system advocacy initiatives, program development, contract compliance, board development, fiscal management, and recruitment and retention of staff.

The OCA administers the Nebraska Peer Support Services training, testing and certification process. Guidelines for curriculum submission, and the certification process were revised in 2019. See the Consumer Advocacy website:  http://dhhs.ne.gov/Pages/Consumer-Advocacy.aspx

LB 417 was passed during the 105th legislative session. LB 417 added clarifying language to authorize the Division of Behavioral Health to set standards in peer services. Current statute charges the Division with ensuring quality services, including peer support. This bill amended state law to specifically authorize peer support standards for training, credentialing and competencies of a peer recovery workforce. OCA works to raise the bar for the profession and create a culture that widely integrates peers into the workforce and offers support to them as they perform their duties to increase access and quality of care for consumers in Nebraska. In 2019, new training curriculum and certification standards and processes have been implemented and regulations promulgated.

The OCA and the Division of Public Health continue to explore the next steps to incorporate elements of the existing peer support training into the Community Health Worker (CWH) training, and vice versa. This would offer additional training for CHWs who have lived experience with a behavioral health condition and who be able to offer additional support while in the role of a CHW to those they serve. On January 1, 2017 MLTC implemented Heritage Health. Heritage Health is a new health care delivery system that combines Nebraska’s physical health, behavioral health, and pharmacy programs into a single comprehensive and coordinated system for Nebraska’s Medicaid and CHIP clients. CHWs who have additional peer support training will be able to lend their unique insights to the process of personal transformation through improving their health and wellness, living a self-directed life, and striving to reach their full potential. This frontline behavioral and public health worker is a trusted member of and/or has an unusually close understanding of the population/community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. This worker also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, inspiring hope, community/health education, building informal and formal supports, social support, and advocacy. Additional training and certification for the peer and CHW workforce is in alignment with the integrated shift in Nebraska. Integrated care is a pillar of transformation in the 2022-2024 Strategic Plan. Additionally, Medicaid expansion in October 2019 has expanded the population eligible to receive peer support services which is a Medicaid covered service.

The OCA developed and provides oversight of the OCA People’s Council. The People’s Council
is chartered to provide state, regional and local consumer perspective, utilizing personal lived experience, on the DBH/OCA programs and policies affecting consumers and to advocate for systems transformation and a Recovery Oriented System of Care. The council provides recommendations and feedback to the DBH/OCA and serves to support linkage with other stakeholders in efforts to expand consumer involvement in service planning and delivery in Nebraska.

Through the above mentioned functions, the Nebraska OCA People’s Council provides recommendations to guide the DHHS DBH, including the OCA, and related state agency partners on ways to best support adults, children, and their families in the journey of healing, recovery, resiliency, and personal transformation. For more information about the Office of Consumer Affairs, see the DHHS DBH web site at: http://dhhs.ne.gov/Pages/Consumer-Advocacy.aspx

Regional and Local Level Organization

DBH contracts with six RBHAs which authorizes them to purchase services using state general funds, funds received under the Community Mental Health Services block grant and the Substance Abuse Prevention Treatment block grant, and other discretionary federal grants.

![Figure 3 Nebraska Behavioral Health Authorities](image)

By state statute, each RBHHA is responsible for the development and coordination of publicly funded behavioral health services in their region pursuant to rules and regulations of the DHHS. Each RBHHA is governed by a Regional Governing Board consisting of one county board member (locally elected official) from each county in the RBHHA. The administrator of the RBHHA is appointed by the Regional Governing Board.

Table 1 Nebraska Census by Regional Behavioral Health Authority
As part of the RBHA responsibility for the development and coordination of publicly funded behavioral health services in their region, each RBHA is under contract to provide:

- Network management,
- Consumer service coordination,
- Prevention system coordination,
- Emergency system coordination,
- Youth service coordination, and
- Housing coordination.

Each RBHA is under contract to provide Network Management (developing and managing a comprehensive array of mental health and substance use services with sufficient capacity for their designated geographic area based on a comprehensive needs assessment/strategic plan); Prevention System Coordination (promotion of a comprehensive prevention approach, including a mix of evidence-based programs, policies, and/or practices that best address the selected prevention priorities); Emergency System Coordination (to meet the needs of individuals experiencing a behavioral health crisis/emergency situation including coordination of activities and collaboration of community based partners to ensure that individuals receive the least restrictive and most appropriate level of care); Youth System Coordination (collaboration with providers, family advocacy organizations and other youth serving agencies including Division of Children and Family Services and Administrative Office of Probation in the planning for, and development of the system of care infrastructure for youth and their families experiencing behavioral health disorders.); Housing Coordination (leadership, planning activities and system problem solving for regional housing issues for persons with extremely low incomes who have behavioral health disorders, including collaboration with local housing partners) and Consumer Coordination (peers providing leadership in the development of regional planning for recovery-oriented community-based services; promotes and facilitates educational opportunities & other activities that enhance recovery, resiliency, and whole health wellness for consumers and their families.

It is the responsibility of the DBH and each RBHA to monitor, review, and perform
programmatic, administrative, and fiscal accountability and oversight functions on a regular basis with all subcontractors. This includes financial accountability by developing complete and accurate budget plans, compliance with audit procedures, completion of services purchased verifications on all services, ensure timely attainment of financial audits, monitor all funding for compliance with state and federal requirements, compliance with the DBH policy regarding financial eligibility, ensure the DBH funding is used as payment of last resort, monitor all contracts for the purchase of services and related duties.

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

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

**Independent Peer Review**

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

**Prevention System Organization**

The DBH is charged with the development of prevention, treatment and recovery services for the State of Nebraska. DBH strives to maintain a sustainable and effective prevention system by promoting safe and healthy environments that foster youth, family, and community development through best practices in mental health promotion, substance abuse prevention and early intervention. Partnership with the six RBHAs and oversight by DBH’s Prevention System Administrator provides the infrastructure to support a comprehensive prevention system that promotes overall wellness. DBH contracts with the RBHAs for technical assistance, training, and data collection to support local coalitions and community entities. DBH also contracts with the
Nebraska Prevention Collegiate Alliance (NeCPA) to provide similar prevention training and technical assistance to institutions of higher education across the state. The majority of prevention activities purchased by the DBH are carried out by the RBHAs Prevention Coordination system which is designed to operate at the community level, embracing local culture while leading the development of sustainable prevention activities for substance abuse and related societal problems through the life span. Funded primarily by the Substance Abuse Prevention and Treatment Block Grant, and Partnership For Success-Grant, Regional Prevention Coordination staff utilize coexisting prevention efforts such as Strategic Prevention Framework – Partnerships for Success (SPF-PFS) grant, to establish common directives and target populations leading to optimal reach when planning training and technical assistance initiatives.

As a result of DBH’s most recently completed needs assessment, statewide prevention goals have been identified and are included as part of DBH’s overall strategic plan. These data driven priorities will guide prevention programming, decision-making, and policy development at the State, region and community level for the next 3 years. These priorities are also aligned with those of the Substance Abuse Prevention and Treatment Block Grant.

In cooperation and partnership with Regional Prevention System Coordinators, training events are funded throughout the state to introduce, enhance and improve the use of evidence-based, promising and local prevention strategies most appropriate to their local community goals utilizing the Strategic Prevention Framework (SPF) process. Local goals have included the reduction of underage drinking, reduction of driving under the influence, reduction of binge drinking, and preventing prescription drug abuse and marijuana use among youth. 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.

DBH maintains a leadership role among Nebraska’s State Suicide Prevention Coalition (NSSPC) and promotes the goals of the state’s five year strategic plan. The most recent plan ended in 2020 and the new iteration is currently being worked on by the NSSPC. The previous plan can be viewed at: https://www.sprc.org/sites/default/files/NEbraska%20STATE%20SUIC%20PREV%20PLAN%202016-2020.pdf.

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

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

Youth and Adult Services

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

Table 2 List of Funded Services

<table>
<thead>
<tr>
<th>List of funded Mental Health (MH) and Substance Use Disorder (SUD) Services</th>
<th>MH</th>
<th>SUD</th>
</tr>
</thead>
<tbody>
<tr>
<td>(** Shared Medicaid Service) (** pending system update to shared status)</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>Emergency Services &amp; Inpatient Services:</strong></td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>24 Hour Crisis Line</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Crisis Assessment</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Crisis Response</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Crisis Stabilization**</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Emergency Community Support</td>
<td>X</td>
<td></td>
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<tr>
<td>Service Description</td>
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<tr>
<td>----------------------------------------------------------</td>
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</tr>
<tr>
<td>Psych Residential Rehab**</td>
<td>X</td>
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<tr>
<td>Psychological Testing</td>
<td>X</td>
<td></td>
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<tr>
<td>Secure Residential**</td>
<td>X</td>
<td></td>
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<tr>
<td>Short Term Residential**</td>
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<td>X</td>
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<tr>
<td>Therapeutic Community**</td>
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<td>X</td>
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<tr>
<td><strong>Outpatient Services:</strong></td>
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<tr>
<td>Assertive Community Treatment**</td>
<td>X</td>
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<tr>
<td>Assessment**</td>
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<td>X</td>
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<tr>
<td>Benefit Services</td>
<td></td>
<td>X</td>
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<tr>
<td>Client Assistance Program**</td>
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<tr>
<td>Community Support**</td>
<td>X</td>
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<tr>
<td>Day Rehabilitation**</td>
<td></td>
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<tr>
<td>Day Support</td>
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<tr>
<td>Day Treatment**</td>
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<tr>
<td>Family Navigator</td>
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<td>X</td>
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<tr>
<td>Family Peer Support **</td>
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<tr>
<td>Intensive Community Service</td>
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<td>X</td>
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<tr>
<td>Intensive Outpatient - Matrix**</td>
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<td>X</td>
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<tr>
<td>Intensive Outpatient**</td>
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<tr>
<td>Medication Management**</td>
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<tr>
<td>Multisystemic Therapy**</td>
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<tr>
<td>Opioid Treatment Program (OTP)</td>
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<tr>
<td>Outpatient Psychotherapy**</td>
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<td>Peer Support**</td>
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<tr>
<td>Professional Partner</td>
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<td>Recovery Homes (Oxford)</td>
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<td>Recovery Support</td>
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<td>Secure Residential R&amp;B</td>
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<tr>
<td>Substance Abuse Prevention Services</td>
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<tr>
<td>SOAR</td>
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<tr>
<td>Supported Education</td>
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<tr>
<td>Supported Employment</td>
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<td>X</td>
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<tr>
<td>Supported Housing</td>
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<td>X</td>
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<tr>
<td>Therapeutic Consultation</td>
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<td>X</td>
</tr>
<tr>
<td>Warm Hand Off**</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Youth Assessment**</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
Public Behavioral Health System Organization: DHHS Division Partners

Other Division partners within the DHHS agency include the following:

**Division of Medicaid and Long-Term Care**

The Division of Medicaid and Long-Term Care (MLTC) provides funding for an array of services to address mental health and substance use issues of children and adults, including the Medicaid Rehabilitation Option (MRO) services. In addition, Nebraska utilizes the Medicaid 1915(b) Substance Abuse Waiver services, allowing the State to maximize SUD funding across payer sources. The MLTC continues to work with the DBH to standardize service delivery expectations (service definitions) to ensure that Medicaid and non-Medicaid individuals are receiving similar services.

In January 2017, the MLTC Nebraska Medicaid managed care program was redesigned and renamed Heritage Health. Heritage Health is a health care delivery system that combines Nebraska’s physical health, behavioral health, and pharmacy programs into a single comprehensive and coordinated system for Nebraska’s Medicaid and CHIP clients. Heritage Health contracts with three managed care organizations (MCO) who each administer Medicaid’s integrated healthcare delivery system on a statewide basis. Continued cooperation between the DBH and MLTC’s Heritage Health program is a key area of interest and coordination efforts. The DBH has been an active participant in all available Heritage Health implementation meetings. Additionally, DBH has included Heritage Health personnel in ongoing DBH-RBHA meetings to discuss operational efficiency and strategic planning opportunities. There has been active and ongoing coordination between DBH, MLTC and the Heritage Health plans on topics related to implementation of Peer Support as a Medicaid reimbursed service, data collection and sharing opportunities and enhancing the service delivery system. The DBH was a key partner with MLTC and the Heritage Health plans when editing Medicaid service definitions, as well. With Medicaid expansion, which began in October 2019, the opportunities and need for continued and targeted collaboration expand. Review of service definitions is targeted again for later in CY2021.

DBH works closely with MLTC staff on a regular basis; key projects currently include active engagement by MLTC in the implementation of the Nebraska System of Care (NeSOC). State Targeted Response to the Opioid Crisis and State Opioid Response grants and DBH’s involvement in MLTC annual parity reviews of each Heritage Health plan.

The DBH manages the contract for Preadmission Screening and Resident Review (PASRR) to provide screening and evaluations for mental illness/intellectual disabilities for Medicaid persons entering nursing home care. Nebraska has recently RFP’d the service of providing Level I and Level II screening in Nebraska. The new PASRR contractor, KEPRO went live in the state in January 2021. The have created new curriculum, held & recorded new trainings and posted the training on line so every facility and facility administrator has the opportunity to learn the new
system. They have been available 24/7 to providers to problem solve during the transition and the KEPRO team has also started workgroups in our state to ensure key stakeholders have the opportunity to provide input into the new system. DBH and the MLTC staff meet with the KEPRO team on a weekly basis to review the Center for Medicare and Medicaid Services (CMS) requirements and problem-solve other issues relating to screening and evaluation.

DBH and MLTC have Memoranda of Understanding to provide for sharing data and identifying Medicaid eligibility to facilitate DBH’s duties as the chief behavioral health authority for the State of Nebraska and directing the administration and coordination of the public behavioral health system. These include Memoranda of Understanding to provide high level reporting related to eligibility, expenditures and utilization for Medicaid eligible individuals (2015), sharing of Medicaid consumer data for the NeSOC (2017) and the integration with DBH Centralized Data System (2017) to provide a more complete and accurate identification of Medicaid eligibility which has enabled the State to better ensure and utilize the most appropriate funding source for services funded by both MLTC and DBH.

The Division of Public Health

This Division of Public Health (DPH) is responsible for preventive and community health programs and services. It is also responsible for the regulation and licensure of health-related professions and occupations, as well as the regulation and licensure of health care facilities and services. DPH and DBH work collaboratively on mental health and substance use provider agency issues which may impact both quality of care and consumer accessibility in order to promote positive outcomes for consumers and public safety. Specific system issues addressed have included partnering in development of the State Health Improvement Plan for Public Health, developing legislation to align mental health and substance abuse treatment center facility licensure, sharing state priorities and strategies tied to binge drinking and Nebraska health rankings work with the Behavioral Health Education Center of Nebraska, and shared media campaigns including those directed at opioid use disorder. Additionally, the Director of DBH sits on the DPH, Office of Rural Health - Rural Health Commission.

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

DPH partners with the OCA to promote and integrate the use of CLAS standards in the behavioral health system. In August 2016 the Office of Minority Heath at the US DHHS conducted a survey on the awareness, knowledge, adoption, and implementation of CLAS standards at the Nebraska DHHS. The results of the study have helped guide strategic planning efforts. DPH serves as an expert partner consultant to DBH on matters related to strategic planning and CLAS.

The OCA and DPH have continued to explore the next steps to incorporate elements of the existing peer support training into the CHW training, and vice versa. This would offer additional
training for CHWs who have lived experience with a behavioral health condition and who be able to offer additional support while in the role of a CHW to those they serve.

With the addition of Peer Support as a Medicaid reimbursed service, CHWs who have required peer support training will be able to lend their unique insights to the process of personal transformation through improving their health and wellness, living a self-directed life, and striving to reach their full potential. This frontline behavioral and public health worker is a trusted member of and/or has an unusually close understanding of the population/community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. This worker also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, inspiring hope, community/health education, building informal and formal supports, social support, and advocacy.

Staff from the DBH/OCA and Public Health participate in Region VII SAMSHA sponsored focus meetings on integrated services and coordination of peer provided services with respect to standards, training, and certifications. There have been renewed efforts to addressed curriculum as well as CHW standards and certification utilization the peer support framework implemented by the Division. This work is preliminary but ongoing.

Division of Children and Family Services

The Division of Children and Family Services (CFS) is comprised of three sections—the Office of Juvenile Services, Economic Assistance and Protection and Safety. The Director’s leadership team includes Deputy Directors for each section and administrators for Offices: Protection and Safety; Research, Planning and Evaluation; Economic Assistance; Office of Juvenile Services; Prevention Administrator and Divisional Financial Officer. This organizational structure allows CFS to focus attention on and support the priorities identified by the division.

The CFS Office of Juvenile Services (OJS) oversees the operation of two Youth Rehabilitation and Treatment Centers (YRTC). The YRTC’s serve youth between 12 and 18 years that have been adjudicated as a juvenile offender and committed to the Office of Juvenile Services. The CFS Economic Assistance Unit is responsible for the administration of the Supplemental Nutrition Assistance Program (SNAP), Aid to Dependent Children, refugee resettlement, energy assistance, child care subsidies and child support enforcement.

The CFS Protection and Safety Unit, is responsible for Title IV-B Subpart 1 (Child Welfare Services), IV-B Subpart 2 (Promoting Safe and Stable Families), Title IV-E (Foster Care and Adoption Assistance), Child Abuse Prevention and Treatment Act (CAPTA), Chafee Foster Care Independence Program (CFCIP), and Chafee Education and Training Vouchers (ETV). In addition, this section operates the statewide Child/Adult Abuse and Neglect Hotline and is responsible for conducting all initial safety assessments. Services are primarily delivered through the five, state-administered, local Service Areas and through tribal-administered child welfare programs.
Case management functions are state-administered in the Western Service Area (WSA), Central Service Area (CSA), Northern Service Area (NSA) and Southeast Service Area (SESA). CFS contracts for case management and service coordination in the largest service area, the Eastern Service Area (ESA), with Saint Francis Ministries as of January 1, 2020. The Judicial Districts as set forth by the Supreme Court do not conflict with the CFS service area boundaries which as a result allows for greater coordination of service delivery between CFS and the Judicial Branch across the state. The DBH works collaboratively with the CFS Service Areas/caseworkers in accessing services and monitoring waitlists for services for women with dependent children.

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

CFS and DBH OCA have individual contracts with five family organizations in Nebraska for the provision of Family Navigator and Family Peer Support. DBH OCA and CFS jointly manage the contracts to provide consistency in service delivery for families across Nebraska.

A map of the CFS service areas is displayed as Figure 4.

*Figure 4 Division of Children and Family Services Service Areas*

The DBH and CFS work closely together on a variety of important systems issues. CFS is an active participant in the implementation of the System of Care initiative in the state. One primary outcome of the System of Care is to reduce the reliance of out of home placement and treatment, which is a priority initiative for CFS as well. Additionally, CFS currently reports that a high proportion of youth being taken into CFS custody are brought to the attention of the system due to parental substance use; the DBH and CFS are working collaboratively to identify ways to
address this. These are just two examples of the ongoing collaboration between CFS and the DBH at an administrative level. However, there is also critical work that happens “in the field”. Each of the RBHAAs have working relationships with their local CFS offices. It is an expectation that there is ongoing coordination between the RBHA and CFS to keep operations running smoothly across the state.

**The Division of Developmental Disabilities**

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

The DDD is involved in an array of planning and implementation activities to ensure that quality developmental services are provided at the Beatrice State Developmental Center (ICF-ID) and in community based services throughout Nebraska. The DBH, MLTC and the DDD work collaboratively to provide services for individuals who have been determined to meet the eligibility criteria for DDD and experience a behavioral health disorder(s).

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

The Administrative Offices of the Courts and Probation’s (AOC / AOP) reach into the service delivery system has expanded over the past few years. The AOP is committed to delivering a system of seamless services (corrections, juvenile and restorative justice) founded on evidenced-based practices. The community-based programs section has newly created adult and juvenile behavioral health section that works collaboratively with DBH on service development, quality assurance, rates, data systems and data sharing as well as the youth System of Care initiative. DBH staff participate on justice committees including justice reinvestment, Fee for Service Voucher Advisory Committee, and local probation/region/DBH networking meetings.

The DBH staff co-chair the Justice Behavioral Health Committee whose mission is to ensure integration, cooperation, and active communication between the justice system and treatment systems; substance abuse and mental health. The Justice Behavioral Health Committee provides a venue for a collaborative working relationship between justice and treatment providers for the ultimate goal of effective competent client care. Its vision involves educational endeavors, data monitoring, provider competency, legislation and strategic planning.

**Nebraska Department of Correctional Services**

Pursuant to Legislation, Nebraska Department of Correctional (DOC) Services formed a workgroup focused on re-entry into the community for inmates completing their sentences. The DBH participates to ensure timely access to mental health and substance use disorders for
inmates leaving corrections facilities. Recent work includes training on Medication Assisted Treatment and access to medications by the DOC for persons discharging from the facilities. The DOC Reentry Team offer individualized reentry services to all incarcerated people at the beginning of their sentence, throughout incarceration, and after release.

**Addressing the Needs of a Diverse Population**

The DBH is dedicated to providing excellent behavioral health services that are accessible to all members of the community, including racial/ethnic minorities, Native Americans, refugees, and newly-arrived immigrant groups. The DBH functions in accordance with the DHHS Office of Health Disparities & Health Equity (OHDHE), striving for appropriate cultural and linguistic specificity for all recipients of behavioral health services. All RBHAs and their contractors are required to provide services that are culturally and linguistically appropriate. The DBH also contracts directly with the four federally recognized tribes of Nebraska (Ponca, Winnebago, Omaha and Santee Sioux) for behavioral health services and provides staff assistance to the tribes as needed, and works to promote cultural awareness and diversity in the workforce through leadership, training, and direct funding of continuing education classes for providers.

**Table 3 Nebraska 2019 Estimates of Population by Race and Ethnicity**

<table>
<thead>
<tr>
<th>RACE</th>
<th>Number</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian and Alaska Native</td>
<td>18,964</td>
<td>1.0%</td>
</tr>
<tr>
<td>Asian</td>
<td>47,740</td>
<td>2.5%</td>
</tr>
<tr>
<td>Black or African American</td>
<td>94,659</td>
<td>4.9%</td>
</tr>
<tr>
<td>Native Hawaiian and Other Pacific Islander</td>
<td>1,850</td>
<td>0.1%</td>
</tr>
<tr>
<td>Some other race alone</td>
<td>51,049</td>
<td>2.6%</td>
</tr>
<tr>
<td>Two or more races</td>
<td>53,383</td>
<td>2.8%</td>
</tr>
<tr>
<td>White</td>
<td>1,666,763</td>
<td>86.2%</td>
</tr>
<tr>
<td>Total</td>
<td>1,934,408</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ETHNICITY</th>
<th>Number</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>219,645</td>
<td>11.4%</td>
</tr>
<tr>
<td>Non-Hispanic</td>
<td>1,714,763</td>
<td>88.6%</td>
</tr>
<tr>
<td>Total</td>
<td>1,934,408</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

*Source: American Community Survey; Nebraska 2019 Estimates; Tables:B02001 & B03002 accessed 7.21.2021*


Each RBHA is also expected to address the needs of the diverse populations within their designated geographic area based on a comprehensive needs assessment/strategic plan. Each RBHA has an advisory committee consisting of consumers, providers, and other interested parties.

Although Nebraska is often viewed as having a homogenous population, it is becoming increasingly diverse with African American, Hispanic, Native Americans, and immigrants from
the continents of Africa and Asia. This being said, the consumer population remains nearly universal when it comes to language preference. In FY2020, 88.1% of individuals receiving Behavioral Health services funded through the DBH indicated English as their preferred language.

Table 4 Division of Behavioral Health Community Based Services Consumer Race Categories

<table>
<thead>
<tr>
<th>Race of Persons Served</th>
<th>Number</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian and Alaska Native</td>
<td>896</td>
<td>2.8%</td>
</tr>
<tr>
<td>Asian</td>
<td>208</td>
<td>0.7%</td>
</tr>
<tr>
<td>Black or African American</td>
<td>2,764</td>
<td>8.7%</td>
</tr>
<tr>
<td>Native Hawaiian and Other Pacific Islander</td>
<td>113</td>
<td>0.4%</td>
</tr>
<tr>
<td>White</td>
<td>23,419</td>
<td>73.9%</td>
</tr>
<tr>
<td>Two or more races</td>
<td>434</td>
<td>1.4%</td>
</tr>
<tr>
<td>Not Available</td>
<td>3,870</td>
<td>12.2%</td>
</tr>
<tr>
<td>Total</td>
<td>31,704</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>3252</td>
<td>10.3%</td>
</tr>
<tr>
<td>Non-Hispanic</td>
<td>24535</td>
<td>77.4%</td>
</tr>
<tr>
<td>Not Available</td>
<td>3917</td>
<td>12.4%</td>
</tr>
<tr>
<td>Total</td>
<td>31704</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Source: CDS, SFY20 Anchor Dataset; data as of 10.01.2020

The RBHAs provide services to diverse populations as demonstrated by comparing the persons served data from State Fiscal Year 2020 to the U.S. Census 2019 population estimates. The percentages of persons who are other than Asian and White served are proportionally higher among all DBH service recipients, compared to their proportion in the total state population. The current data system does not capture LGBTQ information. The DBH continues to review policy on the collection of data pertaining to gender affiliation and sexual preference.

System Strengths Summary

The Director of the Nebraska Health and Human Services Division of Behavioral Health (DBH) is the designated State Mental Health Authority and Single State Agency. DBH is recognized as the chief authority of the state to administer, oversee and coordinate the state’s public behavioral health system, in collaboration with Regional Behavioral Health Authorities and other partners. While many strengths exist across the state, some of the greatest strengths the DBH has to leverage for continuous improvement include behavioral health consumer involvement at numerous if not all levels of decision making, a wide variety of behavioral health services in state hospitals and community settings, a workforce dedicated to meeting consumers’ complex needs, and engaged system partners who play a vital role in supporting an effective behavioral
health system. Continued training for providers will further develop and maintain a system that is co-occurring capable, trauma-informed, recovery-oriented, and person-centered.

In 2020 and 2021 DBH conducted two core statewide planning activities, the Nebraska NDHHS-DBH Strategic Plan & System Optimization Road Map and the Division of Behavioral Health Strategic Plan 2022-2024. This document draws on these activities to summarize the behavioral health landscape.

Summary of System Strengths:

- Quality Assurance/Performance Improvement (QA/PI) measures that are holistic, particularly the use of the Compass EZ Tool,
- Multiple Continuous Quality Improvement (CQI) processes, ensuring checks and balances,
- Two fully engaged behavioral health advisory committees, State Advisory Committee on Substance Abuse Services and State Advisory Committee on Mental Health Services, whose members have a strong commitment to improving access to care throughout the state,
- Suicide Prevention Plan that is holistic and evidenced-based,
- A valuable and well thought out, data-driven Centralized Data System (CDS) which promotes standards for the delivery of care and offers real time outcome tracking and measurement,
- Development and implementation of the DBH Electronic Billing System (EBS) that provides an in-house system to collect, manage, and report financial information.
- Integration between the DBH CDS and EBS leverages technology platforms to provide comprehensive system planning,
- A Mental Health Court that harnesses peer-support to provide an alternative to incarceration for Serious Mental Illness/Serious Emotional Disturbance (SED/SMI) population,
- A strong consumer group, called the Peoples Council, has the support of the SMHA/SSA, is focused on recovery and advocates for expansion of peer-support and access to services in rural areas,
- DBH funding of core Evidence-Based Practices (EBPs) and the requirement that RBHAs incorporate EBPs into their budgets,
- The development and implementation of behavioral health workforce development model,
- Leadership in promoting a culture of change through a multi-faceted approach to infuse health parity throughout the behavioral health care system,
- Employment of consumer surveys to inform programming and practices by DBH, RBHAs and providers; results also are shared with DBH advisory groups,
• Consumer satisfaction with access to services is higher than the national average,
• Readmission rates for state hospitals, both 30 and 180 days, are below the national average, and
• Consumer employment rates are higher than the national average.

END Plan Step 1
Planning Steps

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

Narrative Question:
This step should identify the unmet service needs and critical gaps in the state’s current M/SUD system of care as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state’s M/SUD system of care. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, SUD prevention, and SUD treatment goals at the state level.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
FFY 2022-2023 Block Grant Application

Instructions for Planning Steps

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

This step should identify the unmet service needs and critical gaps in the state’s current M/SUD system of care as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state’s M/SUD system of care.

States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, SUD prevention, and SUD treatment goals at the state level.

Identifying Unmet Needs and Critical Gaps within Current System

Nebraska understands how important a data driven approach is in order to understand the dynamic needs of our state as well as is necessary to make informed decisions about the services funded for individuals dependent upon the Division of Behavioral Health (DBH) for treatment and recovery. Nebraska has evaluated data from a variety of internal sources on treatment and prevention data collected in addition to external resources that have historically been used to monitor and inform decision making such as the National Survey on Drug Use and Health (NSDUH), the Treatment Episode Data Set (TEDS), and the Uniform Reporting System (URS). The 2020 Behavioral Health Barometer report for Nebraska was also used to identify specific areas of need.

Through review of the aforementioned data sources and reports, the DBH put together an initial needs assessment which was reviewed with the six Regional Behavioral Health Authorities in February 2019 as well as in April 2019 with both of the state Advisory Committees and May 2019 with the State Epidemiological Outcomes Workgroup. These initial reviews provided opportunities for the DBH to receive feedback from valuable stakeholders necessary to help complete the needs assessment and identify Block Grant priority areas and strategies for system improvement. Both committees again were provided information on behavioral health needs in Nebraska during a meeting in August 2019 and again at the Joint Advisory Committee meeting.
in April 2021. These meetings were followed by a posting of the draft Block Grant Application sections which, covered identification of service system gaps and consumer needs. The draft application was also posted on the DBH website for public review and comment. Each of these provided opportunity for feedback and suggestions on which areas of need should be prioritized for FY22/FY23.

State Epidemiological Outcomes Workgroup (SEOW)

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

Currently, the SEOW is composed of Epidemiologists from Behavioral Health and Public Health, administrators from each of the six behavioral health regions and administrators from the DBH and the Division of Public Health. In addition, stakeholders from the public school system, the Office of Highway Safety, the Nebraska Children and Families Foundation, the Nebraska Crime Commission, Ponca Tribe, and the University of Nebraska-Lincoln are also vital members of the group as each provides expertise in their field.

One of the main functions of the SEOW is data review. The SEOW works collectively to identify the availability of data, utilization of data and prioritization of substance abuse data gaps, including missing or incomplete data. In December of 2007, the Substance Abuse and Associated Consequences in Nebraska –An Epidemiological Profile was published. Updates were provided in the summer of 2012 and in 2017 to highlight shared or common risk and protective factors that impact both substance abuse and mental health disorders. Through a formal charter, this work will be accomplished by continuation of the Strategic Planning Framework planning process, working across disciplines and implementing strategies that are specifically designed to create environments that support behavioral health and the ability of individuals to withstand challenges.
One of the many contributions the DBH provides to the workgroup is data from the community based substance abuse treatment information which is collected and tracked within the DBH Centralized Data System (CDS) and the Nebraska Prevention Information Reporting System (NPIRS). The DBH leads the workgroup in its efforts to identify priority substance use disorder issues and problems associated with related mental health disorders to maximize use of resources at the state and community level. In many areas, the state has a wealth of data available from which the SEOW will be able to draw assessment information. For example, the Nebraska Young Adult Alcohol Opinion Survey, the Nebraska Risk and Protective Factor Student Survey and the Youth Risk Behavioral Survey provide excellent data for monitoring underage drinking and other youth substance abuse issues. However, in other areas, such as surveillance systems for monitoring Fetal Alcohol Spectrum Disorders or substance use among older adults, information is minimal. Often, data drives decisions about resources; absence of data impacts the attention directed toward major public health issues. Therefore, ensuring sustainability and ongoing operation of a SEOW is vital to coordinate a public health surveillance system that is capable of providing a comprehensive, focused assessment and analysis.

As part of its work to develop a more inclusive epidemiological profile, the SEOW is continuing to update the Nebraska Statewide Epidemiological Profile of Substance Use and Mental Health to include additional measures of the consequences and effects of substance use and Mental Health conditions. In 2017 the SEOW added information on the number of children removed from households due to parental substance use, economic costs of substance use in Nebraska by business sector, hospitalization due to mental illness, emergency department visit rates for intentional self-harm and prevalence of frequent mental distress in Nebraska.

**Note on Community Behavioral Health Data**

The DBH currently uses its own data management system, the DBH CDS, which was implemented in May 2016. The CDS collects all DBH data related to community behavioral health. The DBH contracts with the six Regional Behavioral Health Authorities (RBHAs) and the RBHAs contract with local providers or, in some cases, directly provide the services. At the service provision level, data are collected and reported directly into the CDS. In this section these notes apply:
1. Data source: Centralized Data System.
   i. Persons Served (unduplicated consumer-level data)
   ii. Service Utilization (encounter-level data)
   iii. Statistics reported do not include number of service utilization or number of persons served at the Regional Centers (state hospitals) unless otherwise noted
2. MH ONLY category means the individual was only served in one or more Mental Health (MH) services funded by the DBH via the six RBHAs.
3. SUD ONLY category means the individual was only served in one or more Substance Use Disorder (SUD) services funded by the DBH via the six RBHAs.
4. DUAL Primary category means the individual was only served in a service category where both Mental Illness and Substance Use Disorder are the primary diagnosis.
5. COMBO means the individual was served in a service category with a combination of both Mental Illness and Substance Use Disorder, where one is listed as the primary diagnosis and the other is listed as a secondary diagnosis.
6. Unless otherwise specified in this report, youth means age 0-17; adult means age 18 and older even though in the State of Nebraska the age of majority is 19.

Overview of Adults and Youth Served for Mental Health and Substance Abuse

In Fiscal Year 2020 (FY20), the DBH funded community-based services for 31,704 individuals. When considering service breakdown, 9,948 received treatment for substance use disorders and 25,241 individuals who received treatment for mental health disorders. As reported in the Uniform Reporting System (URS) tables, there were 13,159 adults served with SMI and 1,680 youth (under 18 years) with SED.

1 Source Annual Report: CDS FY20 Community Based Services Dataset (data as of 10.01.2020)
2 Source Profile and Treatment Data MH: FY2020 URS table 2A 14A
Adults with Serious Mental Illness (SMI)

The DBH, through the six RBHA networks, serves Adults with Serious Mental Illness (SMI). SMI means that:

- The person is 18 years old or older **AND**
- The person has an ICD-10 diagnosis of 
- The person has a GAF score less than 60 **OR**
- The person is served in one of the Nebraska Behavioral Health System (NBHS) funded Community Mental Health Rehabilitation Based Services (Community Support, Assertive Community Treatment, Psychiatric Residential Rehabilitation, Day Treatment, Day Rehabilitation, Day Support, Vocational Support, or related psychiatric rehabilitation services) **OR**
- The service provider has indicated that the person has a functional deficit **OR**
- The person is SSI/SSDI eligible or potentially eligible **OR**
- The service provider indicates that the person meets SMI criteria.

The following data tables are from treatment data entered by providers into the DBH CDS and as reflected in the Nebraska FY2020 Uniform Reporting System (URS).

*Table 1 URS Table 2A for FY20. Profile of Persons Served in Mental Health Services Age 18+*

<table>
<thead>
<tr>
<th>Adults (18+) in Mental Health Services</th>
<th>Total Age 18+</th>
<th>26,884</th>
<th>88.7%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total in MH Services</td>
<td>30,292</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

*Data Source: Table 2A of URS Tables based on SFY20 data from CDS Data as of: 10.01.20*

Of this population reported on URS Table 2A, 43.5% (13,186) were between the ages of 25-44 and 27.0% (8,169) are between the ages of 45-64, while only 3.8% (1,137) were described as 65 years or older. In FY2020 Table 14A, 48.9% of adults 18 years and older (26,884) receiving mental health services were described as having a Serious Mental Illness (SMI). The percentage of adults described as SMI has declined from FY2016 (67.8%) and FY18 (52.3%).
Youth with Serious Emotional Disturbance (SED)

The DBH, through the six RBHA networks, serves Youth with Serious Emotional Disturbance (SED). SED means that:

- The person is between 3 and 17 years old (NE SED definition/URS) **AND**
- The person has and ICD-10 diagnosis of 'F20.0', 'F20.1', 'F20.2', 'F20.3', 'F20.5', 'F20.81', 'F20.89', 'F20.9', 'F22', 'F23', 'F24', 'F25.0', 'F25.1', 'F25.8', 'F25.9', 'F28', 'F29', 'F30.10', 'F30.11', 'F30.12', 'F30.13', 'F30.2', 'F30.3', 'F30.4', 'F30.8', 'F30.9', 'F31.0', 'F31.10', 'F31.11', 'F31.12', 'F31.13', 'F31.2', 'F31.30', 'F31.31', 'F31.32', 'F31.4', 'F31.5', 'F31.60', 'F31.61', 'F31.62', 'F31.63', 'F31.64', 'F31.70', 'F31.71', 'F31.72', 'F31.73', 'F31.74', 'F31.75', 'F31.76', 'F31.77', 'F31.78', 'F31.81', 'F31.89', 'F31.9', 'F32.0', 'F32.1', 'F32.2', 'F32.3', 'F32.4', 'F32.5', 'F32.8', 'F32.9', 'F33.0', 'F33.1', 'F33.2', 'F33.3', 'F33.40', 'F33.41', 'F33.42', 'F33.8', 'F33.9', 'F34.4', 'F34.8', 'F34.9', 'F39', 'F44.89', '300.01', '300.21', '300.3', '301.13', '307.1', '307.23', '307.51', '309.81', '312.34', '314', '314.01', '314.1', '314.2', '314.8', '314.9', 'F40.01', 'F41.0', 'F42', 'F43.10', 'F43.11', 'F43.12', 'F44.89', 'F50.00', 'F50.01', 'F50.02', 'F50.2', 'F63.81', 'F90.0', 'F90.1', 'F90.2', 'F90.8', 'F90.9', 'F95.2' **AND**
- SSI/SSDI eligible or potentially eligible **OR**
- The persons has been admitted to Professional Partner Services, Special Education Services, Day Treatment Mental Health Services, Intensive Outpatient Mental Health Services, Therapeutic Consultation/School Wrap, Respite Care Mental Health Services **OR**
- The service provider indicated that the person meets SED criteria.

The following data tables are also from treatment data entered by providers into the DBH CDS and as reflected in the Nebraska **FY2020** Uniform Reporting System (URS).

**Table 2 URS Table 2A for FY20. Profile of Persons Served, All Programs Age 0-17**

<table>
<thead>
<tr>
<th>Youth (Age 0-17 Years) in Mental Health Services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Youth</td>
<td>3,408</td>
</tr>
<tr>
<td>Total in MH Services</td>
<td>30,292</td>
</tr>
</tbody>
</table>

*Data Source: Table 2A of URS Tables based on SFY20 data from CDS
Data as of: 10.01.20*

In FY2020, 11.3% (3,408) of all individuals receiving mental health services funded by the DBH were youth and of those 49.3% (1,680) were described as having a Serious Emotional Disturbance (SED). The percentage of youth described as SED has declined from FY2016 (57.7%) and FY2018 (48.4%).
Table 3 URS Table 14A for FY20. Profile of Persons with SED served Age 0-17

<table>
<thead>
<tr>
<th>Youth (Age 0-17 Years) with SED</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Youth with SED</td>
<td>1,680</td>
<td>49.3%</td>
</tr>
<tr>
<td>Total Youth in MH Services</td>
<td>3,408</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Data Source: Table 14A of URS Tables based on SFY20 data from CDS
Data as of: 10.01.20

Capacity Management and Waiting List System for Priority Populations

The DBH operates capacity management and waiting list systems for all services, including services for those who are discharging from the state psychiatric hospital, who have a mental health commitment, are intravenous drug users, pregnant women, or women with dependent children. The annual contract between the DBH and the six RBHAs establishes these reporting requirements. DBH moved the waitlist tracking process into the CDS. As a result, individuals are classified according to the highest priority population they qualify for at the time they are seeking service.

Priority populations are determined by federal and state statutes and/or regulations. Persons in these priority populations require priority admission into treatment services. Contracted providers receiving funds must offer priority populations immediate admission into the appropriate recommended treatment or offer priority placement on the waiting list and federal interim services within 48 hours of the request for treatment. Engagement services must be provided until they are admitted into appropriate recommended treatment.
Mental Health Priority Groups

Priority classification for mental health include individuals who had Mental Health Board (MHB) Commitments for inpatient services, outpatient services, or MHB discharged from the Lincoln Regional Center. Mental health service priority populations include:

- Priority Population 1 - Discharged from Regional Center
- Priority Population 2 - Mental Health Board Commitment – Inpatient
- Priority Population 3 - Mental Health Board Commitment - Outpatient

Table 4 MHB Discharged from Lincoln Regional Center (LRC)

<table>
<thead>
<tr>
<th></th>
<th># SERVICE ENCOUNTERS for MHB Discharged from Lincoln Regional Center (LRC)</th>
<th>Average wait time per encounter (days*)</th>
<th>Total # persons served (unduplicated)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MH (only)</td>
<td>DUAL (primary)</td>
<td>COMBO</td>
</tr>
<tr>
<td>FY2017</td>
<td>62</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>FY2018</td>
<td>54</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>FY2020</td>
<td>64</td>
<td>3</td>
<td>5</td>
</tr>
</tbody>
</table>

*Average wait time is based on number of cases for which a value was reported.

Table 5 Table Mental Health Board (In-Patient Commitment)

<table>
<thead>
<tr>
<th></th>
<th># SERVICE ENCOUNTERS for Mental Health Board (Inpatient Commitment)</th>
<th>Average wait time per encounter (days*)</th>
<th>Total # persons served (unduplicated)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MH (only)</td>
<td>DUAL (primary)</td>
<td>COMBO</td>
</tr>
<tr>
<td>FY2017</td>
<td>83</td>
<td>17</td>
<td>32</td>
</tr>
<tr>
<td>FY2018</td>
<td>50</td>
<td>22</td>
<td>16</td>
</tr>
<tr>
<td>FY2020</td>
<td>41</td>
<td>12</td>
<td>7</td>
</tr>
</tbody>
</table>

*Average wait time is based on number of cases for which a value was reported.
Table 6 Table Mental Health Board (Out-Patient Commitment)

<table>
<thead>
<tr>
<th></th>
<th># SERVICE ENCOUNTERS for Mental Health Board (Outpatient Commitment)</th>
<th>Average wait time per encounter (days*)</th>
<th>Total # persons served (unduplicated)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MH (only)</td>
<td>DUAL (primary)</td>
<td>COMBO</td>
</tr>
<tr>
<td>FY2017</td>
<td>696</td>
<td>40</td>
<td>44</td>
</tr>
<tr>
<td>FY2018</td>
<td>779</td>
<td>48</td>
<td>57</td>
</tr>
<tr>
<td>FY2020</td>
<td>823</td>
<td>78</td>
<td>84</td>
</tr>
</tbody>
</table>

*Average wait time is based on number of cases for which a value was reported.

Substance Use Priority Groups

Priority classification for substance use include individuals who are intravenous drug users, pregnant women, or women with dependent children. Substance use priority populations include:

- Priority Population 1 - Pregnant and current intravenous drug using women
- Priority Population 2 - Pregnant substance abusing women
- Priority Population 3 - Current intravenous drug users
- Priority Population 4 - Women with dependent children, including those attempting to regain custody of their children

In FY2018, 11,854 individuals (unduplicated) received some level of services for substance use. Of this population, 57.3% were between the ages of 25-44 (6,787), 20.3% are between the ages of 45-64 (2,405), and 19.9% are between the ages of 18-24 (2,359), while only 1.0% were described as 65 years or older (113). Of those served, 1,198 (10.1%) were persons classified into substance use priority populations. The average wait time for services ranged from 1.82 to 9.59 days for those classified into the various priority populations.

Priority Population 1 - Pregnant and Current Intravenous Drug Using Women

The DBH, through the six RBHA networks, serves youth and adults who are pregnant injecting drug users. The unduplicated counts in Table 7 do not include individuals served through Medicaid and
other funding sources. Generally, this priority group represents only a small percentage of persons served. However, an increasing trend can be observed in Table 7. The percentage of women who were pregnant and using intravenous drugs has changed from FY2017 through FY2020 (0.026%, to 0.038%).

Table 7 Total Services to Pregnant Injecting Drug Users

<table>
<thead>
<tr>
<th></th>
<th># SERVICE ENCOUNTERS for Priority #1 Pregnant Injecting Drug Users</th>
<th>Average wait time per encounter (days*)</th>
<th>Total # persons served (unduplicated)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MH (only)</td>
<td>SUD (only)</td>
<td>DUAL (primary)</td>
</tr>
<tr>
<td>FY2017</td>
<td>0</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>FY2018</td>
<td>0</td>
<td>17</td>
<td>2</td>
</tr>
<tr>
<td>FY2020</td>
<td>2</td>
<td>16</td>
<td>1</td>
</tr>
</tbody>
</table>

*Average wait time is based on number of cases for which a value was reported.

Priority Population 2 - Pregnant Substance Abusing Women

The DBH, through the six RBHA networks, serves youth and adults who are pregnant substance abusing women. The unduplicated counts in Table 8 do not include individuals served through Medicaid and other funding sources. Generally, less than one percent of the persons served are pregnant substance abusing women. Table 8 presents unduplicated data which indicates changes from FY2017 to FY2020 (0.117%, to 0.057%) in the total number of persons served and were classified as pregnant women who were abusing substances.
### Table 8 Services to Pregnant Substance Abusers

<table>
<thead>
<tr>
<th># SERVICE ENCOUNTERS for Priority #2 Pregnant Substance Abusers</th>
<th>Average wait time per encounter (days*)</th>
<th>Total # persons served (unduplicated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH (only)</td>
<td>SUD (only)</td>
<td>DUAL (primary)</td>
</tr>
<tr>
<td>FY2017</td>
<td>0</td>
<td>41</td>
</tr>
<tr>
<td>FY2018</td>
<td>2</td>
<td>36</td>
</tr>
<tr>
<td>FY2020</td>
<td>3</td>
<td>21</td>
</tr>
</tbody>
</table>

*Average wait time is based on number of cases for which a value was reported.

### Priority Population 3 - Persons Who Inject Drugs

The DBH, through the six RBHA networks, serves youth and adults who are injecting drug users. The unduplicated counts in Table 9 do not include individuals served through Medicaid and other funding sources. There is an increasing trend in the number of the persons served who are injecting drug users. Table 9 presents unduplicated data for persons served which indicate an increase in the total number of persons served and were classified as injecting drug users from 2.06% in FY17 to 3.43% in FY2020. Nevertheless, the days waiting for admission has decreased substantially over the same time period.

### Table 9 Services to Injecting Drug Users

<table>
<thead>
<tr>
<th># SERVICE ENCOUNTERS for Priority #3 Injecting Drug Users</th>
<th>Average wait time per encounter (days*)</th>
<th>Total # persons served (unduplicated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH (only)</td>
<td>SUD (only)</td>
<td>DUAL (primary)</td>
</tr>
<tr>
<td>FY2017</td>
<td>7</td>
<td>801</td>
</tr>
<tr>
<td>FY2018</td>
<td>15</td>
<td>1081</td>
</tr>
<tr>
<td>FY2020</td>
<td>39</td>
<td>1,737</td>
</tr>
</tbody>
</table>

*Average wait time is based on number of cases for which a value was reported.
Priority Population 4 - Women with Dependent Children

The DBH, through the six RBHA networks, serves youth and adults who are women with dependent children (WWDC). The unduplicated counts in Table 10 do not include women served through Medicaid and other funding sources. The percentage of women with dependent children served has decreased between FY2017 and FY2020 from 1.66% to 1.52%. There was also a decrease in their wait time for services across each of the years compared.

Table 10 Services to Women with Dependent Children

<table>
<thead>
<tr>
<th># SERVICE ENCOUNTERS for Priority #4 Women with Dependent Children</th>
<th>Average wait time per encounter (days*)</th>
<th>Total # persons served (unduplicated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY2017</td>
<td>MH (only) 19</td>
<td>SUD (only) 643</td>
</tr>
<tr>
<td>FY2018</td>
<td>MH (only) 20</td>
<td>SUD (only) 587</td>
</tr>
<tr>
<td>FY2020</td>
<td>MH (only) 40</td>
<td>SUD (only) 559</td>
</tr>
</tbody>
</table>

*Average wait time is based on number of cases for which a value was reported.

Federal Interim Services for Substance Use

DBH operates a capacity management and waiting list systems for all services. DBH changed the waitlist tracking process when it was activated in the CDS during 2017. As a result individuals are only tracked according to the highest priority population for which they qualify.

Persons in a priority population receive priority admission into treatment services or, if treatment is not immediately available, are offered priority placement on the waiting list and provided interim services within 48 hours of the request for treatment. Engagement services must be provided until they are admitted into appropriate recommended treatment.

In July 2017, CDS added a new data element, “Federal Interim Services Delivered Date,” to enhance collection and monitoring in capacity and waiting list systems. Providers now enter the
date interim services were provided to indicate the date of delivery which allows DBH to track provider compliance to interim service expectations. Contracts with providers require data collection and tracking to maintain this monitoring and reporting capability.

The count of unique persons who received treatment services for substance use disorders in FY2020 was 9,948. Looking specifically at individual encounters where the individual was placed on a waitlist during FY2020 for SUD and Dual type services, there were 1,110 persons of which 257 were indicated to have a priority population status, leaving 853 with “None” or “Unknown” as the priority status indication (Table 11). Federal Interim Service Delivery dates were only recorded for 176\(^3\) of the encounters where a priority population status was recorded. This data indicates work must continue in order to educate providers on the importance of offering Interim Substance Use Disorder Services to priority populations seeking treatment when a provider is not able to admit a pregnant woman within 48 hours or an individual who injects drugs within 14 days after making a request for admission to treatment.

Table 11 Persons Placed on a Waitlist for Admission to SUD or Dual Services in FY20

<table>
<thead>
<tr>
<th>Priority Population by Type</th>
<th>2018</th>
<th>2020*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unknown</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Pregnant and Current Intravenous Drug Using Women</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Pregnant Substance Abusers</td>
<td>27</td>
<td>3</td>
</tr>
<tr>
<td>Injecting Drug Users</td>
<td>275</td>
<td>179</td>
</tr>
<tr>
<td>Women with Dependent Children</td>
<td>167</td>
<td>65</td>
</tr>
<tr>
<td>Mental Health Board Commitment - Inpatient</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Mental Health Board Commitment – Outpatient</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,396</strong></td>
<td><strong>1,110</strong></td>
</tr>
</tbody>
</table>

Data Source: CDS, unduplicated count of persons SFY20
Data as of: 10.01.20
*count includes persons on the waitlist for a day or more

\(^3\) Data Source- Centralized Data System [Interim Service Delivered in FY20; data as of 8.11.2021]
Behavioral Health Services for Individuals in Rural Areas

The DBH provides community based services to individuals with mental health and/or substance use disorders who live in rural areas, which geographically represents much of Nebraska. The U.S. Census Bureau defines an urban areas and urban clusters as relatively “densely developed territory”, [which] encompass residential, commercial, and other non-residential urban land uses (2010 Census Urban and Rural Classification and Urban Area Criteria). Urban areas have populations of 50,000 or more people; urban clusters have populations of at least 2,500 but less than 50,000 people. All areas that are not urban are considered rural.4

As of July 1, 2019, (Table 12) the U.S. Census estimated that Nebraska’s total population was 1,934,408, with approximately 34.1% of persons living in rural counties5. Unduplicated data from FY2017, FY2018 and FY2020 (Table 13) indicated that 34.2%, 33.1% and 38.0%, of the total number of persons served resided in rural areas showed similar trend.

Table 12 references the Statistical Metropolitan6 Areas in accordance with the US Census for Nebraska,7 which includes urban areas and urban clusters. Given the significant infrastructural difference between urban and rural counties in Nebraska, Table 13 indicates the encounter service unit counts by type of service, by age category, and fiscal year for persons residing in rural counties. The overall number of service encounters and persons served in rural counties indicated similar pattern to the state averages in FY17, FY18, and in FY20.

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6 Thirteen (13) counties in Nebraska are designated Metropolitan Areas by the U.S. Office of Management and Budget based on the application of published standards to U.S. Census Bureau data. For the purposes of reporting this measure, the remaining 80 Nebraska Counties are classified as rural.
7 U.S. Census Bureau, Population Division
Table 12 Urban Counties in Nebraska

<table>
<thead>
<tr>
<th>Urban Areas &amp; Urban Clusters</th>
<th>Population 2018</th>
<th>Population 2019*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincoln, NE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lancaster County, NE</td>
<td>317,272</td>
<td>319,090</td>
</tr>
<tr>
<td>Seward County, NE</td>
<td>17,318</td>
<td>17,284</td>
</tr>
<tr>
<td>Omaha-Council Bluffs, NE-IA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cass</td>
<td>26,159</td>
<td>26,248</td>
</tr>
<tr>
<td>Douglas County, NE</td>
<td>566,880</td>
<td>571,327</td>
</tr>
<tr>
<td>Sarpy County, NE</td>
<td>184,459</td>
<td>187,196</td>
</tr>
<tr>
<td>Saunders County, NE</td>
<td>21,303</td>
<td>21,578</td>
</tr>
<tr>
<td>Washington County, NE</td>
<td>20,667</td>
<td>20,729</td>
</tr>
<tr>
<td>Grand Island, NE Area</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hall County, NE</td>
<td>61,607</td>
<td>61,353</td>
</tr>
<tr>
<td>Hamilton County, NE</td>
<td>9,280</td>
<td>9,324</td>
</tr>
<tr>
<td>Howard County, NE</td>
<td>6,468</td>
<td>6,445</td>
</tr>
<tr>
<td>Merrick County, NE</td>
<td>7,733</td>
<td>7,755</td>
</tr>
<tr>
<td>Sioux City, IA-NE-SD Area</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dakota County, NE</td>
<td>20,083</td>
<td>20,026</td>
</tr>
<tr>
<td>Dixon County, NE</td>
<td>5,709</td>
<td>5,636</td>
</tr>
<tr>
<td>Urban (above)</td>
<td>1,264,938</td>
<td>1,273,991</td>
</tr>
<tr>
<td>Rural Total</td>
<td>664,330</td>
<td>660,417</td>
</tr>
<tr>
<td>State of Nebraska Total</td>
<td>1,929,268</td>
<td>1,934,408</td>
</tr>
</tbody>
</table>

Table 13 Behavioral Health services to people living in rural areas

<table>
<thead>
<tr>
<th>Services to people in RURAL AREAS</th>
<th>FY2017</th>
<th>FY2018</th>
<th>FY2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH (only)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youth service encounters</td>
<td>951</td>
<td>1033</td>
<td>1370</td>
</tr>
<tr>
<td># Youths served</td>
<td>833</td>
<td>876</td>
<td>1135</td>
</tr>
<tr>
<td>Adult service encounters</td>
<td>9340</td>
<td>8935</td>
<td>9549</td>
</tr>
<tr>
<td># Adults served</td>
<td>4291</td>
<td>4639</td>
<td>5114</td>
</tr>
<tr>
<td>SUD (only)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youth service encounters</td>
<td>31</td>
<td>21</td>
<td>51</td>
</tr>
<tr>
<td># Youths served</td>
<td>27</td>
<td>16</td>
<td>31</td>
</tr>
<tr>
<td>Adult service encounters</td>
<td>5669</td>
<td>5236</td>
<td>5672</td>
</tr>
<tr>
<td># Adults served</td>
<td>2840</td>
<td>2436</td>
<td>2477</td>
</tr>
<tr>
<td>DUAL (primary)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youth service encounters</td>
<td>14</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td># Youths served</td>
<td>11</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Adult service encounters</td>
<td>1076</td>
<td>993</td>
<td>784</td>
</tr>
<tr>
<td># Adults served</td>
<td>549</td>
<td>490</td>
<td>334</td>
</tr>
<tr>
<td>COMBO</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youth service encounters</td>
<td>14</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td># Youths served</td>
<td>11</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>Adult service encounters</td>
<td>1723</td>
<td>1693</td>
<td>2016</td>
</tr>
<tr>
<td># Adults served</td>
<td>742</td>
<td>704</td>
<td>1016</td>
</tr>
<tr>
<td>RURAL TOTAL* (residents of rural counties)</td>
<td>19,874</td>
<td>21,433</td>
<td>23,120</td>
</tr>
<tr>
<td>Encounters Across All Services</td>
<td>Average Wait Time (days) (based on number of cases for which a value was reported)</td>
<td>2.03</td>
<td>1.19</td>
</tr>
<tr>
<td># Persons served</td>
<td>10,495</td>
<td>10,785</td>
<td>12,046</td>
</tr>
<tr>
<td>Nebraska DHHS-DBH TOTAL**</td>
<td>58,723</td>
<td>63,613</td>
<td>60,891</td>
</tr>
<tr>
<td>Encounters Across All Services</td>
<td>Average Wait Time (days) (based on number of cases for which a value was reported)</td>
<td>2.43</td>
<td>1.58</td>
</tr>
<tr>
<td># Persons served</td>
<td>30,715</td>
<td>32,579</td>
<td>31,704</td>
</tr>
</tbody>
</table>

Data Source: CDS, unduplicated count of encounters and persons served in SFY20
Data as of: 10.01.20
Priority Areas for FY2022/2023

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

1. Prevention of binge drinking among youth and young adults;
2. Increasing the use of Evidence-Based Strategies employed by prevention coalitions to reduce alcohol and substance use;
3. Increasing support for consumers to secure and maintain permanent housing;
4. Increasing support for consumers to sustain and acquire employment;
5. Increasing access to community-based services for priority populations;
6. Increasing the number of persons admitted into treatment for first-episode psychosis;
7. Referral to services for persons with tuberculosis.

Data in support of each focus area are provided below.

Alcohol Use among Youth and Young Adults

According to the United Health Foundation for American's Health Rankings 2018 Nebraska has a very high prevalence of binge drinking. This study indicated that 21.7% of Nebraska adults report binge drinking, which places Nebraska as the 46th out of 50 states. In addition, underage alcohol consumption continues to be a problem among youth in Nebraska. The National Survey of Drug Use and Health (NSDUH) indicates youth alcohol use rates, and binge drinking in particular, are higher in Nebraska compared to national rates. According to 2018-2019 NSDUH results, 29.2% of people aged 12 or older in Nebraska reported binge drinking in the past month compared to the national average of 24.2%.

Additionally, the Behavioral Risk Factor Surveillance System (BRFSS) survey has noted Nebraska binge drinking has been above the U.S. overall rate for the last nine years. In 2019, it found that among Nebraska adults 18 and older, 20.9% reported binge drinking, compared to 16.8% among the U.S. population overall (Figure 1).
BRFSS data from 2011 to 2019 (Figure 2) indicate that the most common ages for binge drinking are from 18 to 34 years old. Binge drinking begins to decrease significantly at age 35 and continues to decrease as individuals get older.
Figure 2 Adult Current Binge Drinking by Age

*Adults 18 and over reporting binge drinking during the 30 days preceding the survey
Source: Behavioral Risk Factor Surveillance Survey (BRFSS)

Individuals in Nebraska identifying as Native American (27.7%), Multiracial (27.6%), and White (21.4%) had the highest age-adjust prevalence of past-30 day binge drinking in 2019 (Figure 3).
Figure 3 Current Binge Drinking (age-adjusted) among Nebraska Adults by Race/Ethnicity

*Adults 18 and over reporting binge drinking during the 30 days preceding the survey
Source: Behavioral Risk Factor Surveillance Survey

Based on the NSDUH data for those 12 and older, clear trends emerged related to concerning alcohol use trends in Nebraska. The trends for alcohol abuse and binge drinking in Nebraska are very similar to the national trends Figure 4. Both Nebraska and the U.S. have seen a decrease in abuse and dependency for alcohol, but the percentage in Nebraska is consistently higher than the overall percentage for the U.S. Young adults (18-25 years) consistently report higher levels of dependency (Figure 5), which reiterates the need to prioritize prevention and other services in this demographic.
Data from NSDUH and BRFSS indicate the need to prioritize prevention efforts targeting alcohol abuse/disorder and to put emphasis on underage and binge drinking among Nebraska youth and young adults. The continued need for alcohol-related services to youth and young adults is further corroborated in the Behavioral Health Barometer\(^8\) (p.12). In Nebraska, the trend for alcohol use disorder among individuals aged 12 and older is consistently higher than the national average at every point of measure.

**Evidence-Based Programs on Alcohol Use and Substance Use**

As indicated in the Behavioral Health Barometer, Volume 6, alcohol appears to be the drug of choice as it is commonly combined with other drugs (Table 14) to make alcohol involved

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\(^8\) Substance Abuse and Mental Health Services Administration. *Behavioral Health Barometer: Nebraska, Volume 6: Indicators as measured through the National Survey on Drug Use and Health, the National Survey of Substance Abuse Treatment Services, and the Uniform Reporting System*. HHS Publication No. SMA-20-Baro-19-States-NE. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020.
treatments account for more than two thirds of Nebraska’s substance use treatments in 2019. This situation, and the distribution of primary substances used as reported at admission to DBH services, Figure 5 further illustrates the need for multifaceted approaches in treatment strategies and processes.

### Table 14 Drug Prevalence among Individuals Enrolled in Substance Use Treatments (Nebraska)

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>2015</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Problem Only</td>
<td>33.0%</td>
<td>29.8%</td>
</tr>
<tr>
<td>Alcohol Problem Only</td>
<td>19.8%</td>
<td>21.3%</td>
</tr>
<tr>
<td>Both Drug and Alcohol Problem</td>
<td>47.2%</td>
<td>48.9%</td>
</tr>
<tr>
<td>Alcohol Involved Treatments</td>
<td>67.0%</td>
<td>70.1%</td>
</tr>
</tbody>
</table>

*Data Source: 2019 Behavioral Health Barometer*


### Figure 5  FY2020 Primary substance of Use reported at admission

Data Source: All persons who received services in FY2020, Centralized Data System (CDS); DAO 10.01.2020
As a requirement of the DBH’s annual Regional Budget Planning process, at least 60% of the Substance Abuse Block Grant (SABG) primary prevention dollars received by community coalitions is firmly allocated for community-based and environmental strategies. Emphasis is placed on using a multi-strategy approach where one or more environmental strategies are designed to impact the community and societal levels (of the social-ecological model) as well as impacting the individuals in their community’s targeted populations. In order to address the availability of substances as well as the community norms around these concerns, sub-recipients are expected to tailor their efforts to areas and strategies to areas highlighted by a local needs assessment and in tandem with community readiness and coalition capacity. Sub-recipients of the SABG are highly encouraged to utilize evidence-based practices and programs to address the identified needs in their catchment areas.

The percentage of Evidence-Based Programs implemented by prevention coalitions to reduce alcohol and substance use among individuals 9 to 20 years old are presented in Figure 7. Prevention data entered into the Nebraska Prevention Information Reporting System (NPIRS) indicate that the percentage of evidence-based strategies reached a historic high in SFY2020 with 33.6% of all programs and strategies classified as such (Figure 6 and 7). The overall goal is to increase the use of Evidence-Based Programs during the upcoming Block Grant period FFY2022-FFY2023.

![Figure 6 Evidence-Based Programs by Intervention Types (2016-2020)](image-url)
Housing: Increase support for consumers to secure and maintain permanent housing.

The lack of safe and affordable housing is a significant barrier to recovery from mental health and/or substance use disorders. (See DBH “Nebraska Supportive Housing Plan” http://dhhs.ne.gov/Reports/DBH-Nebraska%20Supportive%20Housing%20Plan%20--%20August%202016.pdf). Many adults with a serious mental illness live on Supplemental Security Income (SSI), a federal cash benefit program for those either 65 or older, blind, or disabled, and who have limited incomes. SSI provides a limited amount of cash; therefore, persons relying on SSI may have difficulty finding an affordable home.

In Nebraska, Figure 8 shows consumers discharged to stable living situations from community-based behavioral health services over 80% of the time on average. In FY20, from July 2019 through June 2020, of discharges across all services, 83% were discharged to stable living arrangements. For those who were in supported housing services, 92% were discharged to stable living arrangements. Discharges from residential services was 69%. There are observable differences between the average discharge rates to stable living for consumers from all behavioral health services as compared to the discharge rates for those consumers who were in
residential services. As such, it is necessary to focus on the availability of affordable housing options for consumers discharging from the most intensive behavioral health services.

Figure 8 Quarterly Percent of Behavioral Health Consumers in Stable Living Arrangements at Discharge by quarter

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Stable Living - All (SL-ALL)</th>
<th>Residential Services (SL-RES)</th>
<th>Supported Housing (SL-SH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-Jun 19</td>
<td>8,900</td>
<td>804</td>
<td>174</td>
</tr>
<tr>
<td>Jul-Sep 19</td>
<td>10,604</td>
<td>856</td>
<td>198</td>
</tr>
<tr>
<td>Oct-Dec 19</td>
<td>9,269</td>
<td>775</td>
<td>243</td>
</tr>
<tr>
<td>Jan-Mar 20</td>
<td>9,556</td>
<td>786</td>
<td>201</td>
</tr>
<tr>
<td>Apr-Jun 20</td>
<td>8,207</td>
<td>558</td>
<td>131</td>
</tr>
<tr>
<td>Jul-Sep 20</td>
<td>7,562</td>
<td>633</td>
<td>151</td>
</tr>
<tr>
<td>Oct-Dec 20</td>
<td>6,926</td>
<td>560</td>
<td>129</td>
</tr>
<tr>
<td>Jan-Mar 21</td>
<td>6,373</td>
<td>461</td>
<td>107</td>
</tr>
</tbody>
</table>

Data source: DBH Centralized Data System (CDS); Encounters Current / Living Arrangements / Discharge / Service

Service: Stable Living - All (SL-ALL), Residential Services (SL-RES), Supported Housing (SL-SH)

Counts: All=, Res=, SH= are statewide counts that do not include consumers whose status was "not available"

Data as of: 6/21/2021 (note: COVID-19 pandemic as of 1/2020)

Employment: Increase support for consumers to sustain and acquire employment.

Along with housing, consumers have much healthier and sustainable outcomes when they are able to obtain, and sustain, employment. Nebraska, as shown in Table 15 and Table 16, has a significant portion of its consumers who are receiving mental health services and are not in the labor force. Those who are not employed and have not actively sought in the past 30 days have made up over 40% of Nebraska’s consumers for a significant amount of time.
Table 15 Employment Status by Age Group (SAMHSA, 2015)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Employed</th>
<th>Unemployed</th>
<th>Not in Labor Force</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total (Aged 18 or Older)</td>
<td>33.70%</td>
<td>22.60%</td>
<td>43.70%</td>
</tr>
<tr>
<td>18-20</td>
<td>32.60%</td>
<td>23.40%</td>
<td>44.00%</td>
</tr>
<tr>
<td>21-64</td>
<td>34.80%</td>
<td>23.10%</td>
<td>42.10%</td>
</tr>
</tbody>
</table>

Table 16 Employment Status by Age Group (URS Table, FY20)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Employed</th>
<th>Unemployed</th>
<th>Not in Labor Force</th>
<th>Not Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total (Aged 18 or Older)</td>
<td>27.6%</td>
<td>18.40%</td>
<td>35.70%</td>
<td>18.3%</td>
</tr>
<tr>
<td>18-20</td>
<td>28.4%</td>
<td>20.4%</td>
<td>38.3%</td>
<td>12.9%</td>
</tr>
<tr>
<td>21-64</td>
<td>29.1%</td>
<td>19.3%</td>
<td>35.1%</td>
<td>16.5%</td>
</tr>
</tbody>
</table>

Data Source: Table 4 of URS Tables based on SFY20 data from CDS
Data as of: 10.01.20

Even when consumers are able to enter the labor market, those discharging from behavioral health services often struggle to obtain employment by the end of service delivery. Figure 9 shows how discharge rates from mental health and substance use disorder services, with noted exceptions, hover around 50% of consumers in the labor market who are discharging with employment statuses that qualify as employed; these include full and part time employment and full and part time armed forces. These figures highlight employment as a priority area for Nebraska to address moving forward.
Improvements in helping consumers gain employment can be made as demonstrated in Figure 10 which shows two-year quarterly trends for employment outcomes for those discharging from Supported Employment programs.
Increase access to community based services for priority populations

The DBH uses information from multiple sources to consider needs associated with access to mental health and substance abuse services: The Nebraska Annual Social Indicators Survey (NASIS)\(^9\); Behavioral Health Barometer; Behavioral Health in Your Community Survey (BH provider survey) \(^10\); and the National Survey of Substance Abuse Treatment Services (N-SSATS)\(^11\).

The overarching theme in responses from the NASIS 2019 were that respondents were generally aware (60% to 69.5%) of the availability status of treatment for mental health, crisis, and substance use in their community (Figure 11). The substantial number of respondents who indicated that they were not certain about the availability of treatment in their community illustrates a need to increase awareness/visibility and potentially reduce barriers to accessing treatment. Figure 12 presents the likelihood that respondents would use the resources indicated to locate/identify potential services should the need arise for mental health, crisis, and/or substance abuse. This inadvertently indicates need, but more so, it highlights potential modes for communication.

---

\(^9\) NASIS is a multi-focused (inter-organizational) mailed in survey administered to a sample drawn from the general public. The 2019 administration had a historically low response rate (n=377); timing of the distribution was immediately before the catastrophic floods in March.

\(^10\) The Behavioral Health in Your Community Survey sampled 17 local Health Departments of various sizes in Nebraska (n=33).

\(^11\) N-SSATS is a survey directly soliciting feedback from state-approved facilities. In 2013, Nebraska’s response rate was 96.3% (107 respondents).
Figure 11 NASIS 2019: Treatment Availability in Nebraska

![Treatment Availability](image)

**Legend:**
- 0 - Not Certain
- 1 - NO (not Available)
- 2 - NO (but available in a nearby community)
- 3 - NO (but Telehealth option is available)
- 4 - YES (but options are limited / additional services would be required)
- 5 - YES (effective services available, but with some delay)
- 6 - YES (many options / effective service with immediate response available)

- Mental Health
- Crisis
- Substance Use

Figure 12 Potential Resources to Identify/Locate Services

![Perceived Potential Resources for Treatment](image)

**Legend:**
- Mental Health
- Substance Use
As indicated in the Behavioral Health Barometer, mental health consumers in Nebraska and the USA report improved functioning from treatment, which is a positive credit to the effectiveness of services. For children and adolescents (17 and younger) in Nebraska, the percentage is lower than the national percentage by 9.2% (NE 62.4%; USA 71.6%). However, the percentage for adults (18 and older) is higher than the national percentage by 1.3% (NE 73.1%; USA 71.8%).

Additional survey work conducted in early 2019 captures the perspective of the respondents (employees) of local health departments across the state. The most apparent need is to get high quality care for either substance use disorders or mental health concerns across many areas of the state, and particularly in Western Nebraska. Low availability of choices and long wait times were prevalent, even in areas where higher numbers of providers are present. This report aligns with provider data at the county level, and speaks to the need to increase access to services. On the other hand, 69.7% of respondents reported that Behavioral Health is included as a priority in their department’s Community Health Improvement Plan.

Data in the CDS indicate that there is a decreasing trend in the wait times for services both in rural areas and in the state. However, the need persists to increase services to address the increasing number of consumers in priority populations, especially people who inject drugs, and in general.

**Increase access to community based services for priority populations – Need in Short Term Residential**

Nebraska Vital Records 2019 data as compared to data reported in 2018 describes an increase in the number of deaths described as due to drug overdose for several drug types. The highest count of drug overdoses in 2019 were related to various types of opioid use (Table 17). A large portion of drug overdose deaths are due to an unspecified drug listed. The Division of Public Health has been working on a post-mortem toxicology program under the DOJ Comprehensive Opioid Abuse Program (COAP) grant which can run additional labs and testing on suspected drug overdoses. This results in better data collection methods which can identify overdose deaths which would otherwise be listed as unspecified, as a true opioid overdose. So the trend of opioid overdoses could, in fact, be an increase in actual overdoses, an increase in media coverage and
awareness which leads to an increase in reporting, or the increase in better toxicology testing methods.

### Table 17 Number of All Drug Overdose Deaths and Selected Drug Involved Overdose Deaths by Year, Nebraska 2016-2019

<table>
<thead>
<tr>
<th>Drug Type</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>Total 2016-2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Drug-involved Overdose</td>
<td>128</td>
<td>183</td>
<td>154</td>
<td>172</td>
<td>637</td>
</tr>
<tr>
<td>All Opioids (includes heroin, methadone, synthetic) T40.0-T40.4, T40.6</td>
<td>45</td>
<td>63</td>
<td>67</td>
<td>65</td>
<td>240</td>
</tr>
<tr>
<td>Opioid involved (not including heroin) T40.2-T40.4</td>
<td>38</td>
<td>59</td>
<td>60</td>
<td>53</td>
<td>210</td>
</tr>
<tr>
<td>Synthetic opioid involved (includes fentanyl and tramadol) T40.4</td>
<td>11</td>
<td>25</td>
<td>26</td>
<td>24</td>
<td>86</td>
</tr>
<tr>
<td>Methadone involved T40.3</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>6</td>
<td>24</td>
</tr>
<tr>
<td>Benzodiazepine involved T42.4</td>
<td>26</td>
<td>32</td>
<td>40</td>
<td>31</td>
<td>129</td>
</tr>
<tr>
<td>Cocaine involved T40.5</td>
<td>10</td>
<td>*suppressed</td>
<td>*suppressed</td>
<td>*suppressed</td>
<td>10</td>
</tr>
<tr>
<td>Psychostimulants with abuse potential (including methamphetamine) T43.6</td>
<td>19</td>
<td>50</td>
<td>37</td>
<td>52</td>
<td>158</td>
</tr>
<tr>
<td>Unspecified drug listed T50.9</td>
<td>75</td>
<td>96</td>
<td>66</td>
<td>58</td>
<td>295</td>
</tr>
</tbody>
</table>

Note: Categories are not exclusive because some details involve multiple drugs.
* Cells with value less than 5 have been suppressed.

Data Source: Nebraska Vital Record, 2016-2019

Short Term Residential treatment is intended for adults with a primary substance use disorder requiring a more intensive treatment environment to obtain sobriety and engage in treatment. This service is highly structured and provides primary, comprehensive substance use disorder treatment. Each year the DBH funds Short Term Residential treatment for approximately 1,200
to 1,300 individuals. Of those admitted into service in FY2020, the majority presented with a
treatment need related to the use of methamphetamine/speed, alcohol, marijuana/hashish, or
other opiates/synthetics. Table 18 describes the counts of each primary, secondary and tertiary
substance type for those admitted in FY2020.

Table 18 Substances Reported for Individuals Admitting into Short Term Residential Treatment
in FY2020

<table>
<thead>
<tr>
<th>Substance Used</th>
<th>Primary</th>
<th>Secondary</th>
<th>Tertiary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methamphetamine/Speed</td>
<td>540</td>
<td>138</td>
<td>39</td>
</tr>
<tr>
<td>Alcohol</td>
<td>473</td>
<td>156</td>
<td>106</td>
</tr>
<tr>
<td>Marijuana/Hashish</td>
<td>90</td>
<td>370</td>
<td>112</td>
</tr>
<tr>
<td>Other Opiates or Synthetics</td>
<td>26</td>
<td>33</td>
<td>21</td>
</tr>
<tr>
<td>Heroin</td>
<td>17</td>
<td>22</td>
<td>3</td>
</tr>
<tr>
<td>Cocaine</td>
<td>13</td>
<td>26</td>
<td>29</td>
</tr>
<tr>
<td>Amphetamine</td>
<td>36</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td>Alprazolam (Xanax)</td>
<td>0</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Hydrocodone (Vicodin)</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Oxycodone (Oxycontin)</td>
<td>5</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>16</td>
<td>15</td>
</tr>
<tr>
<td>Not Available</td>
<td>0</td>
<td>432</td>
<td>871</td>
</tr>
</tbody>
</table>

**Total = 1,211 persons in SFY2020**

*Data Source:* Centralized Data System (CDS); Persons who received STR treatment in SFY2020;
*Data as of:* 10.01.2020

Consumers across the six behavioral health regions required treatment in Short Term Residential
programs during FY2020. Wait detail of each distinct encounter by the priority populations for
those admitted into Short Term Residential services can be found in Table 19. Distinct encounter
is defined as one episode of care (starting with placement on a waitlist prior to admission) for
one consumer, in one service, to one provider.
Table 19 Access to Short Term Residential Services (STR) for Substance Use Disorder (SUD) for Individuals Placed on Waitlist during FY20

<table>
<thead>
<tr>
<th>Priority SUD Group</th>
<th>Service/Description</th>
<th>Baseline 2018</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant IV Drug User</td>
<td># of STR encounters</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Average wait time</td>
<td></td>
<td>7 days</td>
</tr>
<tr>
<td></td>
<td>Admitted within 14 days*</td>
<td>100%</td>
<td>67%</td>
</tr>
<tr>
<td></td>
<td>Admitted within 30 days*</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>served for Mental Health</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>served for Substance Use</td>
<td>.2%</td>
<td>.3%</td>
</tr>
<tr>
<td>Pregnant Drug User</td>
<td># of STR encounters</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Average wait time</td>
<td>7 days</td>
<td>4 days</td>
</tr>
<tr>
<td></td>
<td>Admitted within 14 days*</td>
<td>86%</td>
<td>75%</td>
</tr>
<tr>
<td></td>
<td>Admitted within 30 days*</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>served for Mental Health</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>served for Substance Use</td>
<td>.3%</td>
<td>.4%</td>
</tr>
<tr>
<td>IV Drug User</td>
<td># of STR encounters</td>
<td>84</td>
<td>244</td>
</tr>
<tr>
<td></td>
<td>Average wait time</td>
<td>13 days</td>
<td>11 days</td>
</tr>
<tr>
<td></td>
<td>Admitted within 14 days*</td>
<td>51%</td>
<td>75%</td>
</tr>
<tr>
<td></td>
<td>Admitted within 30 days*</td>
<td>83%</td>
<td>91%</td>
</tr>
<tr>
<td></td>
<td>served for Mental Health</td>
<td>.2%</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>served for Substance Use</td>
<td>7.9%</td>
<td>24.0%</td>
</tr>
<tr>
<td>Women With Dependent Children</td>
<td># of STR encounters</td>
<td>48</td>
<td>89</td>
</tr>
<tr>
<td></td>
<td>Average wait time</td>
<td>14 days</td>
<td>12 days</td>
</tr>
<tr>
<td></td>
<td>Admitted within 14 days*</td>
<td>38%</td>
<td>71%</td>
</tr>
<tr>
<td></td>
<td>Admitted within 30 days*</td>
<td>79%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>served for Mental Health</td>
<td>.1%</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>served for Substance Use</td>
<td>4%</td>
<td>8.7%</td>
</tr>
<tr>
<td>NEBRASKA DHHS-DBH TOTAL</td>
<td># of STR encounters</td>
<td>1,283</td>
<td>1,018</td>
</tr>
<tr>
<td></td>
<td>total # unduplicated consumers</td>
<td>32,579</td>
<td>31,704</td>
</tr>
<tr>
<td></td>
<td>Average wait time</td>
<td>9 days</td>
<td>9 days</td>
</tr>
<tr>
<td></td>
<td>Admitted within 14 days*</td>
<td>79%</td>
<td>77%</td>
</tr>
<tr>
<td></td>
<td>Admitted within 30 days*</td>
<td>90%</td>
<td>93%</td>
</tr>
</tbody>
</table>

Data Source: Centralized Data System (CDS); Encounter data for persons admitting to STR treatment in SFY2020; Data as of: 10.01.2020

When reviewing FY2020 wait data for those individuals seeking Short Term Residential services, the average wait time was found to be around 9 days and 77% of all consumers were admitted within 14 days. Priority for admission is expected to be granted to those meeting criteria for substance use priority populations; however, the data demonstrates that for Pregnant...
IV Drug Users only 67% of those admitted into service within 14 days and for Women with Dependent Children 71% admitted into service within 14 days.

**Coordinated specialty care for persons with first episode of psychosis**

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

The Nebraska First Episode Psychosis Coordinated Specialty Care (FEP CSC) program is building on the success of the pilot project. Following evaluation and consultation, Nebraska determined that changing from the OnTrackNY model would best meet the needs of providers and individuals served. This change was based in part on the feedback from providers, the rural service delivery, and the desire to expand the program. The teams were trained in the Recovery After an Initial Schizophrenia Episode (RAISE) Navigate model and are implementing the new evidence based practice.

First Episode Psychosis Pilot Program eligibility criteria were changed in 2021 and have been revised as follows:

- Person is 14 to 35 years old
- Person has a diagnosis of: Schizophrenia; Schizotypal Disorder; Schizoaffective Disorder; Delusional Disorder; Brief Psychotic Disorder; and Unspecified Schizophrenia Spectrum and Other Psychotic Disorders
- Symptom Duration of a psychotic disorder for a period lasting more than one (1) week and no more than two (2) years.
- Exclusionary Criteria
  - Diagnosed with an Intellectual Disability
  - Psychotic Disorder Due to a General Medical Condition
  - Substance-Induced Psychotic Disorder (Substance Use Disorder as a secondary diagnosis is not excluded.)
  - Depressive and Bipolar Disorders
The Families of individuals age 18 and younger would have to agree to participate.

A review of recent DBH treatment data for those meeting the age and diagnostic criteria necessary for program eligibility indicates a continuous and even growing need for treatment. As described in Table 20, data from FY2016 to FY2020 shows a fairly consistent count for females and an increase for males between the ages of 14 to 35 who have a psychotic disorder diagnosis. In FY2020 there were 1,001 youth and young adults meeting this criteria amongst those in behavioral health services funded by DBH across the state; 285 were female and 714 were male.

### Table 20 First Episode Psychosis by Gender*, FY2016-2020

<table>
<thead>
<tr>
<th>Gender by Fiscal Year*</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>320</td>
<td>345</td>
<td>342</td>
<td>285</td>
</tr>
<tr>
<td>Male</td>
<td>681</td>
<td>759</td>
<td>767</td>
<td>714</td>
</tr>
<tr>
<td>Not Available</td>
<td>1</td>
<td>2</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>1,002</td>
<td>1,106</td>
<td>1,115</td>
<td>1,001</td>
</tr>
</tbody>
</table>

*Estimates based on those receiving services funded through DBH who meet revised eligibility criteria
Data Source: CDS; unduplicated counts of persons meeting FEP criteria
Data as of 10.01.2020

The FEP CSC Program serves two of the six behavioral health service regions of the state. The two separate, independent FEP CSC Program teams are located in the Omaha metropolitan area and in the RBHA Region 3 Behavioral Health Services in the middle of the state, with a population of 150,000. The two teams are separated by 190 miles. These areas were selected because of an existing concentration of specialty youth services and commitment to serving these families.

Data from FY2016 to FY2020 shows that many of the youth and young adults meeting this criteria across the state (as were described in Table 21) reside in Regions which currently have a FEP Program (Table 22).
Table 21 First Episode Psychosis by FEP Pilot Program Catchment Areas*, FY2016-2020

<table>
<thead>
<tr>
<th>FEP Program Catchment Areas by Fiscal Year*</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regions with FEP Pilot Programs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Region 3</td>
<td>128</td>
<td>151</td>
<td>135</td>
<td>131</td>
</tr>
<tr>
<td>Region 6</td>
<td>448</td>
<td>512</td>
<td>492</td>
<td>372</td>
</tr>
<tr>
<td>Total</td>
<td>576</td>
<td>663</td>
<td>627</td>
<td>503</td>
</tr>
</tbody>
</table>

*Estimates based on those receiving services in Region 3 and Region 6 funded through DBH who meet revised eligibility criteria
Data Source: CDS; unduplicated counts of persons meeting FEP criteria;
Data as of 10.01.2020

While the data indicates a much larger population who may potentially have a need for FEP treatment, admissions have been fairly small while the pilot programs have been getting established, training staff, and learning recruitment strategies. As shown in Table 22, there were 11 new admissions in FY2018 and FY2019, and 7 in FY2020 between the two programs.

Table 22 Statewide Count Total Enrolled FEP Pilot Programs

<table>
<thead>
<tr>
<th>Statewide Count Total Enrolled in FEP Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year</td>
</tr>
<tr>
<td>FY2016</td>
</tr>
<tr>
<td>FY2017</td>
</tr>
<tr>
<td>FY2018</td>
</tr>
<tr>
<td>FY2019</td>
</tr>
<tr>
<td>FY2020</td>
</tr>
</tbody>
</table>

It is important during treatment of psychosis that areas of functioning are addressed. In a 2011 survey, NAMI asked the level of difficulty in managing aspects of daily life for individuals dealing with psychosis. Individuals who experienced psychosis rated social life as very difficult (51.1 percent) followed by work (47.5 percent) romantic relationships (47.4 percent), friendships (42.6 percent) and relationships with parents (39.2 percent).
The teams have been using the Columbia Suicide Severity Rating Scale, the MIRECC-GAF, the OnTrack NY Modified Colorado Symptom Index, the OnTrackNY Quality of Life, and OnTrackNY Experience scales. With the change in models, Nebraska intends to revise outcome reporting and data collection to focus on quality care and evaluate the clinical and organizational changes related to the switch in EBP models. Metrics and tools supported by the NIMH EPINET project have been selected and include the Brief Adherence to Medication Rating Scale and the RAISE Illness and Management Recovery tool.

Use of the Mental Illness Research, Education and Clinical Centers (MIRECC) version of the Global Assessment Functioning (GAF) Expanded scale has allowed providers in the FEP programs to measure and track improvements in functioning for the youth and young adults receiving treatment for first episodes of psychosis. MIRECC GAF Expanded measures individuals in occupational functioning, social functioning, and symptom severity on three subscales, in addition to offering a total functioning score. On average for the program enrollees, scores in each scale and as a whole assessment improved from the initial assessment (taken at the time of admission) to those taken following FEP treatment. The first study offered a baseline average total score difference of 45.75 on the MIRECC GAF between admission and post-treatment. A second study the following year indicated even greater success with an average total score difference of 63.73. Review of pre and post treatment assessment scores have demonstrated improvement in functioning for the enrolled youth and young adults, indicating program success and readiness for enrollment expansion.
Figure 13 MIRECC GAF

MIRECC GAF Expanded Pre- and Post-Treatment Outcome Scores

Additional Considerations

Requirements Regarding Tuberculosis

Under the Substance Abuse Prevention and Treatment Block Grant (§96.127 Requirements Regarding Tuberculosis), the Single State Authority for Substance Abuse Services (SSA) must require programs receiving funds to treat substance abuse to routinely make Tuberculosis (TB) services available to each individual receiving treatment for substance abuse. The DBH is the SSA in Nebraska. While DBH has no specific financial set aside for TB services, partnership exists with the Nebraska Department of Health and Human Services - Division of Public Health which supports TB testing, education and treatment.

In 2020, Nebraska’s Health Departments reported 36 cases of active TB with a case rate of 1.9 per 100,000 (Source: Nebraska Department of Health and Human Services (DHHS) Tuberculosis in Nebraska Annual Report 2020). This represents an increase in the number of cases (17 cases
in 2019). In the United States, a total of 7,163 (provisional) TB cases were reported in 2020 with a case rate of 2.2 cases per 100,000.

Figure 14 Reported Tuberculosis Cases in Nebraska by Year

![Bar chart showing the number of reported TB cases in Nebraska from 2011 to 2020.]

According to the Tuberculosis in Nebraska Annual Report – 2020, Nebraska DHHS Division of Public Health website [https://dhhs.ne.gov/Pages/Tuberculosis.aspx](https://dhhs.ne.gov/Pages/Tuberculosis.aspx), the number of reported persons with TB in Nebraska for the last decade has been highest among racial and ethnic minorities.

Figure 15 Reported Tuberculosis by Ethnicity, Nebraska

![Bar chart showing the number of reported TB cases by ethnicity in Nebraska in 2020.]

According to the Tuberculosis in Nebraska Annual Report – 2020, Nebraska DHHS Division of Public Health website [https://dhhs.ne.gov/Pages/Tuberculosis.aspx](https://dhhs.ne.gov/Pages/Tuberculosis.aspx), the number of reported persons with TB in Nebraska for the last decade has been highest among racial and ethnic minorities.
The DBH contract applicable to each of the six RBHAs requires programs to have working relationships with local health departments and to screen for communicable diseases for all persons requesting substance use disorder treatment services. As such, TB screening is provided
to all persons entering a substance use disorder treatment service. Additional services and/or referrals for services are made available to those individuals whose screening indicates “high risk” for TB. The Tuberculosis Program in the Nebraska Division of Public Health provides the overall coordination for the State of Nebraska. Therefore, the contract between the DBH and the RBHAs addresses the TB Screening and Services requirements. Pertinent language included in the DBH and RBHAs contract includes:

**Tuberculosis (TB) screening and services**

1. The RBHA will ensure that all providers receiving SAPTBG funds shall:
   a. Report active cases of TB to the Division of Public Health Tuberculosis Program Manager and adhere to all reporting requirements as set forth including NRS Sec.71-502, 71-1626 and 173 NAC Chapters 1-6, which can be found at: [http://dhhs.ne.gov/Pages/Title-173.aspx](http://dhhs.ne.gov/Pages/Title-173.aspx)
   b. Maintain infection control procedures that are consistent with those established by the State’s infection control office.
   c. Adhere to State and Federal confidentiality requirements when reporting such cases.

2. The RBHA will ensure that providers receiving SAPTBG funding will routinely make TB services available to each individual receiving treatment for substance abuse and to monitor such service delivery.

3. The RBHA shall establish procedures that ensure that the following (TB) services are provided, either directly or through arrangements/agreements with other public or non-profit private entities:
   a. Screening of all admissions for TB,
   b. Positive screenings shall receive test for TB,
   c. Counseling related to TB,
   d. Referral for appropriate medical evaluations or TB treatment,
   e. Case management for obtaining any TB services,
   f. Report any active cases of TB to state health officials, and
   g. Document screening, testing, referrals and/or any necessary follow-up information.
4. The RBHA is responsible for providing DBH with documentation which illustrates facilitation or provision of the above listed services and ensure that any changes are reported and on file with DBH.

It is expected that continuation of this priority area will help to protect Nebraskans, particularly those in priority populations.

**Services for HIV/AIDS**

In 2018, the rate of cases of acquired immune deficiency syndrome (AIDS) was 5.0 per 100,000 among Nebraska residents.

Nebraska remains a non-designated state and is thereby not required to include HIV/AIDS specific priorities for Block Grant planning purposes.

The term “designated state” means any state whose rate of cases of acquired immune deficiency syndrome (AIDS) is 10 or more such cases per 100,000 individuals (as indicated by the number of such cases reported to and confirmed by the Centers for Disease Control and Prevention (CDC) for the most recent calendar year for which the data are available (See 45 CFR 96.128(b)).

The Nebraska rate of cases of acquired immune deficiency syndrome (AIDS) is less than 10 per 100,000, as reported by SAMSHA in Appendix A for the FY 2022 HIV-designated states in the FFY 2022-2023 Behavioral Health Assessment and Plan Preparation Instructions – Final for SABG 7/9/2021.

**Next Steps in Addressing Unmet Service Needs**

The DBH completed a comprehensive statewide needs assessment in 2020 which provided information on estimating burden of behavioral health in Nebraska, strengths and gaps in the system, the needs of special populations, the status of workforce, and a review of national and
state level initiatives for integrated care. Key findings from the assessment, which included RBHA and other stakeholder input, guided the development of the DBH 2022-2024 Strategic Plan and work plan to address targeted needs. Progress in the work plan is and will be monitored and shared with key stakeholders. An important recommendation, and one that drives ongoing assessment of service need, is DBH optimizing the use of the Nebraska Prevention Information Reporting System (NPIRS) and the Centralized Data System (CDS). The CDS supports service capacity assessment of both residential and outpatient settings, supports longitudinal follow up to assess outcomes and accommodates formal data sharing to coordinate and assess services and outcomes across systems. The DBH works with RBHAs to address unmet needs in a variety of ways. It should be noted that unmet needs may be based on lack of training for providers, lack of funding within the system, or lack of providers in the system with certain expertise.

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

The DBH asks RBHAs to conduct local community needs assessments to better designate regional allocated funding for areas where the unmet needs exist, shifting funding away from areas where needs are adequately met by Medicaid or where funding was unexpended within their contract. The DBH has contracted for consultation in maximizing the use of behavioral health dollars, with consideration going to allocation of funding and other strategies to use dollars efficiently.

The Behavioral Health Education Center of Nebraska (BHECN) provides training and incentives for professionals to practice in areas of provider healthcare shortage, to increase access for consumers in rural and frontier areas, or in professions with a severe shortage within the state (psychiatry). The DBH is also working cooperatively with BHECN and other entities to increase the peer workforce in the system.
Within the Prevention system, the DBH continues to work with RBHAs to support community coalitions in using funding for areas of need for Substance Abuse prevention. Using data from the NPIRS, in addition to a variety of surveys regarding alcohol and drug use, communities are able to evaluate the effectiveness of current prevention efforts and redirect dollars to areas of need when appropriate.

Summary of System Needs and Priorities

Through a comprehensive review of data sources and reports, followed by discussion and review with stakeholder and advisory groups, the DBH has identified seven priority areas. Each identified priority area has been determined as necessary to best address priority and target population needs. Concentration on identified priority areas throughout FY22/FY23 is expected to bring about overall behavioral health system improvements to support the treatment and recovery needs of consumers while working to prevent harmful substance use behaviors. In summary, the DBH has selected the following seven priority areas for FY22/FY23:

1. Prevention of binge drinking among youth and young adults
2. Increase the use of Evidence-Based Strategies employed by prevention coalitions to reduce alcohol and substance use
3. Increase support for consumers to secure and maintain permanent housing
4. Increase support for consumers to sustain and acquire employment
5. Increased access to community-based services for priority populations
6. Increase the number of persons admitted into treatment for first-episode psychosis
7. Referral to services for persons with tuberculosis

#END Plan Step 2.

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1 February 2019. "Behavioral Health in Your Community- A Health Department Review Summary". Survey of Local Health Departments across Nebraska.
# Planning Tables

## Table 1 Priority Areas and Annual Performance Indicators

<table>
<thead>
<tr>
<th>Priority #</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority Area</td>
<td>Alcohol Use among Youth and Young Adults</td>
</tr>
<tr>
<td>Priority Type</td>
<td>SAP</td>
</tr>
<tr>
<td>Population(s)</td>
<td>PP, Other (Adolescents w/SA and/or MH, Students in College, Rural, Children/Youth at Risk for BH Disorder, Underserved Racial and Ethnic Minorities)</td>
</tr>
<tr>
<td>Goal of the priority area</td>
<td>Reduce harmful alcohol use among youth and young adults.</td>
</tr>
<tr>
<td>Strategies to attain the goal</td>
<td>Work with prevention coalitions across the state to continue engaging in partnerships with local schools, colleges and community groups to facilitate trainings and educational activities which aim to enhance awareness of the risks associated with alcohol use, particularly those associated with binge drinking.</td>
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</tbody>
</table>

### Annual Performance Indicators to measure goal success

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>1</th>
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<tbody>
<tr>
<td>Indicator</td>
<td>Prevalence of binge drinking reported by youth and young adults, ages 18 to 24</td>
</tr>
<tr>
<td>Baseline Measurement</td>
<td>31.5%</td>
</tr>
<tr>
<td>First-year target/outcome measurement</td>
<td>31.5%</td>
</tr>
<tr>
<td>Second-year target/outcome measurement</td>
<td>30.0%</td>
</tr>
<tr>
<td>Data Source</td>
<td>Behavioral Risk Factor Surveillance Survey (BRFSS)</td>
</tr>
<tr>
<td>Description of Data</td>
<td>The Behavioral Risk Factor Surveillance System (BRFSS) is a survey which collects state data about residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services. The BRFSS is a cross-sectional survey conducted by states with technical and methodological assistance provided by the Centers for Disease Control and Prevention (CDC). States use a standardized core questionnaire, optional modules, and state-added questions to ask a variety of important health-related topics of which DBH contributes recommendations on question content. It is administered every year and targeted at non-institutionalized adults 18 years of age and older. The Nebraska Department of Health and Human Services (DHHS) Division of Public Health (DPH) contracts with the University of Nebraska-Lincoln, Bureau of Sociological Research (BOSR) to manage BRFSS data collection.</td>
</tr>
<tr>
<td>Data issues/caveats that affect outcome measures</td>
<td>Although this survey has historically been implemented every year, the Division of Behavioral Health does not directly coordinate and is thereby dependent on availability of survey results through coordination with DPH and CDC.</td>
</tr>
</tbody>
</table>

## Priority # 2

<table>
<thead>
<tr>
<th>Priority Area</th>
<th>Increase Use of Evidence-based Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority Type</td>
<td>SAP</td>
</tr>
<tr>
<td>Population(s)</td>
<td>PP, Other (Adolescents w/SA and/or MH, Students in College, Rural, Children/Youth at Risk for BH Disorder, Underserved Racial and Ethnic Minorities)</td>
</tr>
<tr>
<td>Goal of the priority area</td>
<td>Increasing the use of evidence-based strategies supported through Block Grant funding.</td>
</tr>
</tbody>
</table>
Strategies to attain the goal:

Support increased use of evidence-based interventions in prevention practices. Use evidence-based public education and awareness strategies, campaigns, and engagement activities to increase awareness of binge drinking and reduce binge drinking rate. Offer technical assistance to enhance program staff understanding on identification and use of evidence-based strategies in addition to continued training on data collection and entry into the state prevention reporting system related to prevention activities.

Annual Performance Indicators to measure goal success

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>1</th>
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</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>Percentage of Block Grant funded evidence-based strategies.</td>
</tr>
<tr>
<td>Baseline Measurement</td>
<td>33.6%</td>
</tr>
<tr>
<td>First-year target/outcome measurement</td>
<td>36.1%</td>
</tr>
<tr>
<td>Second-year target/outcome measurement</td>
<td>38.6%</td>
</tr>
</tbody>
</table>

Data Source:
Nebraska Prevention Information Reporting System (NPIRS)

Description of Data:
The NPIRS is an internet-based reporting system designed to collect and report prevention activity data in Nebraska. The system collects community, regional, and state level data from recipients of federal and state prevention funds administered by the Division of Behavioral Health. NPIRS provides the reporting capabilities for components of the Federal Block Grant. The reports provide number served by individual-based programs or population-based programs and strategies, numbers served by intervention type, and use of evidence-based programs and strategies.

Data issues/caveats that affect outcome measures:
System users receive numerous training opportunities and work continues to improve consistency and accuracy in reporting into the NPIRS.

Priority #: 3
Priority Area: Consumers in Stable Living Arrangements
Priority Type: SAT, MHS
Population(s): SMI, SED, PWIDC, ESMI, PWID, EIS/HIV, TB, Other (Rural, Homeless)

Goal of the priority area:
Consumers have permanent and stable housing.

Strategies to attain the goal:
Increase system and community-level planning efforts to focus on targeted resources for priority populations. Work with providers and community partners to understand local housing needs and help support response efforts.

Annual Performance Indicators to measure goal success

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>Percentage of consumers in stable living arrangements at discharge from residential services services.</td>
</tr>
<tr>
<td>Baseline Measurement</td>
<td>60%</td>
</tr>
<tr>
<td>First-year target/outcome measurement</td>
<td>65%</td>
</tr>
<tr>
<td>Second-year target/outcome measurement</td>
<td>65%</td>
</tr>
</tbody>
</table>

Data Source:
Nebraska DHHS Division of Behavioral Health Centralized Data System (CDS).
### Description of Data:
Consumer treatment data from CDS. CDS collects consumer-level information to report to the Treatment Episode Date Set (TEDS) of MH and SU Disorders consumers receiving DBH-funded services, either directly or through regional contracts. CDS warehouses all the data entered so that it can be analyzed at any time.

### Data issues/caveats that affect outcome measures:
Information is provided by consumers who may not wish to disclose they are or are at risk of experiencing homelessness. Residential services include: Dual Disorder Residential - MH + SUD, Halfway House - SUD, Intermediate Residential - SUD, Psychiatric Residential Rehabilitation - MH, Secure Residential - MH, Short Term Residential - SUD, Therapeutic Community - SUD, Mental Health Respite - MH + SUD.

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### Priority #: 4
**Priority Area:** Consumer Employment  
**Priority Type:** SAT, MHS  
**Population(s):** SMI, SED, PWWDC, ESMI, PWID, EIS/HIV, TB, Other (Rural, Military Families, Homeless, Underserved Racial and Ethnic Minorities)

**Goal of the priority area:** 
Consumers in the labor market have competitive employment.

**Strategies to attain the goal:** 
Work with providers and community partners to understand local employment opportunities and help support efforts to connect consumers with employers.

### Annual Performance Indicators to measure goal success

| Indicator #: | 1 |
| Indicator: | Percentage of consumers in the labor market who are employed at discharge from any DBH funded service funded service |
| Baseline Measurement: | 55% |
| First-year target/outcome measurement: | 55% |
| Second-year target/outcome measurement: | 58% |

**Data Source:** Nebraska DHHS Division of Behavioral Health Centralized Data System (CDS).

### Description of Data:
Consumer treatment data from CDS. CDS collects consumer-level information to report to the Treatment Episode Date Set (TEDS) of MH and SU Disorders consumers receiving Division-funded services, either directly or through regional contracts. CDS warehouses all the data entered so that it can be analyzed at any time.

### Data issues/caveats that affect outcome measures:
Information is provided by consumers who may not wish to disclose their employment status and thus would be excluded from calculation. The labor market consists of those who are employed [employment status is 'Active/Armed Forces (< 35 Hrs)', 'Active/Armed Forces (35+ Hrs)', 'Employed Full Time (35+ Hrs)', or 'Employed Part Time (< 35 Hrs)'] and those who are unemployed but have been actively looking for employment in the past 30 days.

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### Priority #: 5
**Priority Area:** Access for Priority Populations to Substance Use Disorder Services  
**Priority Type:** SAT  
**Population(s):** PWID, EIS/HIV, TB, Other (Rural, Criminal/Juvenile Justice, Homeless, Underserved Racial and Ethnic Minorities)
Goal of the priority area:
Priority populations are admitting into substance use disorder services in a timely manner.

Strategies to attain the goal:
As required through the contracts with the Regional Behavioral Health Authorities (RBHAs), priority populations are expected to receive priority status according to priority type when waiting to enter a substance abuse treatment service. Educational trainings with RBHAs and providers to ensure priority status is understood and Federal requirements are followed. Monitoring and assessment of Short Term Residential capacity to determine if additional service locations are necessary to meet the needs of all priority populations seeking treatment.

Priority #: 6
Priority Area: First Episode Psychosis (FEP)
Priority Type: MHS
Population(s): SMI, SED, ESMI

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

Strategies to attain the goal:
Continue to develop recovery-oriented services and increase use of evidence-based practices which help individuals stabilize and maintain stabilization in community settings. Support Mental Health trainings to improve early intervention and support, particularly for youth having a first episode of psychosis (FEP). Emphasis will be placed on enhancing recruitment strategies and increasing community awareness on FEP services available.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Percentage of persons reported as injecting drugs who are admitted into Short Term Residential services within 14 days of seeking treatment
Baseline Measurement: 80%
First-year target/outcome measurement: 85%
Second-year target/outcome measurement: 85%

Data Source: Nebraska DHHS Division of Behavioral Health Centralized Data System (CDS).

Description of Data:
Consumer wait and admission data from CDS. CDS collects consumer level information for all consumers placed on a waiting list for MH and SU Disorders receiving DBH funded services, either directly or through regional contracts. CDS warehouses all the data entered so that it can be analyzed at any time.

Data issues/caveats that affect outcome measures:
The CDS access reporting function is monitored for completeness and accuracy on a regular basis.
FEP programs funded by DBH.

**Description of Data:**
FEP programs record admission, service utilization, outcome measures, and discharge data for all FEP participants. This information is available to DBH as requested.

**Data issues/caveats that affect outcome measures:**
DBH is currently dependent on receipt of admission data directly from the FEP programs.

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**Priority #:** 7
**Priority Area:** Tuberculosis
**Priority Type:** SAT
**Population(s):** TB, Other (Homeless, Underserved Racial and Ethnic Minorities)

**Goal of the priority area:**
Tuberculosis screening is provided to all persons entering substance abuse treatment service and meets federal requirements regarding screening for Tuberculosis.

**Strategies to attain the goal:**
Regional Behavioral Health Authorities will comply with contract requirements for Tuberculosis screening to be provided to all persons entering a substance abuse treatment service.

**Annual Performance Indicators to measure goal success**

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicator:</strong></td>
<td>Tuberculosis (TB)</td>
</tr>
</tbody>
</table>

**Baseline Measurement:**
Maintain the contract requirement with the Regional Behavioral Health Authorities for Tuberculosis screening provided to all persons entering a substance abuse treatment service.

**First-year target/outcome measurement:**
The contract requirement will be maintained with the Regional Behavioral Health Authorities for Tuberculosis screening provided to all persons entering a substance abuse treatment service.

**Second-year target/outcome measurement:**
The contract requirement will be maintained with the Regional Behavioral Health Authorities for Tuberculosis screening provided to all persons entering a substance abuse treatment service.

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

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

**Data issues/caveats that affect outcome measures:**
This contract requirement is connected to the Federal requirements under the Substance Abuse Prevention and Treatment Block Grant.

---

**Footnotes:**
### Table 2 State Agency Planned Expenditures [SA]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2022/2023. ONLY include funds expended by the executive branch agency administering the SABG.

<table>
<thead>
<tr>
<th>Activity (See instructions for using Row 1.)</th>
<th>Source of Funds</th>
</tr>
</thead>
</table>
| Source of Funds | A. Substance Abuse Block Grant | B. Mental Health Block Grant | C. Medicaid (Federal, State, and Local) | D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), SAMHSA, etc.) | E. State Funds | F. Local Funds (excluding local Medicaid) | G. Other | H. COVID-19 Relief Funds (MHBG)

#### 1. Substance Abuse Prevention and Treatment

| | $10,495,796.00 | $15,163,378.00 | $7,283,974.00 | $48,338,267.52 | $0.00 | $0.00 | $5,001,647.00 | $1,254,000.00 |

- **a.** Pregnant Women and Women with Dependent Children
  - $1,315,134.00

- **b.** All Other
  - $9,180,662.00

#### 2. Primary Prevention

| | $4,023,942.00 | $0.00 | $2,550,000.00 | $472,726.00 | $0.00 | $0.00 | $1,802,439.20 | $204,554.71 |

- **a.** Substance Abuse Primary Prevention
  - $4,023,942.00

- **b.** Mental Health Primary Prevention

#### 3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)

| | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |

#### 4. Tuberculosis Services

| | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |

#### 5. Early Intervention Services for HIV

| | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |

#### 6. State Hospital

| | $764,196.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $358,109.80 | $96,648.95 |

#### 7. Other 24-Hour Care

| | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |

#### 8. Ambulatory/Community Non-24 Hour Care

| | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |

#### 9. Administration (excluding program/provider level) MHBG and SABG must be reported separately

| | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |

#### 10. Crisis Services (5 percent set-aside)

| | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $7,162,196.00 | $1,555,203.66 |

#### 11. Total

| | $15,283,934.00 | $0.00 | $15,163,378.00 | $9,833,974.00 | $48,810,993.52 | $0.00 | $0.00 | $7,162,196.00 | $1,555,203.66 |

---

4 The 24-month expenditure period for the COVID-19 Relief Supplemental funding is March 15, 2021 – March 14, 2023, which is different from the “standard” SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between July 1, 2021 – March 14, 2023 should be entered in Column I.

5 The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is September 1, 2021 – September 30, 2025, which is different from the expenditure period for the “standard” SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between September 1, 2021 and June 30, 2023 should be entered in Column J.

6 Prevention other than primary prevention

7 The 20 percent set aside funds in the SABG must be used for activities designed to prevent substance misuse.

---

**Footnotes:**

- Providers serving PWWC will be involved in training activities in both the COVID-19 and ARPA activities. It is unclear at this time the amount of funds that will be directed toward benefiting this population.
# Planning Tables

## Table 2 State Agency Planned Expenditures (MH)

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2022/2023. Include public mental health services provided by mental health providers or funded by the state mental health agency by source of funding.

### Planning Period Start Date: 7/1/2021  Planning Period End Date: 6/30/2022

<table>
<thead>
<tr>
<th>Activity</th>
<th>Source of Funds</th>
<th>A. Substance Abuse Block Grant</th>
<th>B. Mental Health Block Grant</th>
<th>C. Medicaid (Federal, State, and Local)</th>
<th>D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), SAMHSA, etc.)</th>
<th>E. State Funds</th>
<th>F. Local Funds (excluding local Medicaid)</th>
<th>G. Other</th>
<th>H. COVID-19 Relief Funds (MHBG)(^a)</th>
<th>I. COVID-19 Relief Funds (SABG)</th>
<th>J. ARP Funds (MHBG)(^b)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Substance Abuse Prevention and Treatment</td>
<td></td>
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<tr>
<td>a. Pregnant Women and Women with Dependent Children</td>
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<td></td>
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<tr>
<td>b. All Other</td>
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<tr>
<td>2. Primary Prevention</td>
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<td>a. Substance Abuse Primary Prevention</td>
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<tr>
<td>b. Mental Health Primary Prevention(^c)</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)(^d)</td>
<td></td>
<td>$330,252.40</td>
<td></td>
<td></td>
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<td></td>
<td>$204,540.00</td>
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<td></td>
</tr>
<tr>
<td>4. Tuberculosis Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Early Intervention Services for HIV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. State Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$70,635,558.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Other 24-Hour Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$4,608,662.00</td>
<td></td>
<td></td>
<td></td>
<td>$10,628,318.92</td>
<td></td>
</tr>
<tr>
<td>8. Ambulatory/Community Non-24 Hour Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$43,954,164.01</td>
<td></td>
<td></td>
<td></td>
<td>$1,650,388.09</td>
<td>$35,700.00</td>
</tr>
<tr>
<td>9. Administration (excluding program/provider level)(^f)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$165,126.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Crisis Services (5 percent set-aside)(^g)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$9,126,690.19</td>
<td></td>
<td></td>
<td></td>
<td>$489,000.00</td>
<td>$75,000.00</td>
</tr>
<tr>
<td>11. Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$2,343,928.09</td>
<td>$0.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^a\) The 24-month expenditure period for the COVID-19 Relief supplemental funding is March 15, 2021 – March 14, 2023, which is different from the expenditure period for the “standard” SABG and MHBG. Per the instructions, the standard SABG expenditures are for the state planned expenditure period of July 1, 2021 – June 30, 2022, for most states.

\(^b\) The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is September 1, 2021 - September 30, 2025, which is different from expenditure period for the “standard” MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A-G are for the state planned expenditure period of July 1, 2021 - June 30, 2022, for most states.

\(^c\) Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside.

\(^d\) While a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

\(^e\) Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.

\(^f\) Row 10 should include Crisis Services programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

---

**Footnotes:**

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022
Table 3 SABG Persons in need/receipt of SUD treatment

<table>
<thead>
<tr>
<th></th>
<th>Aggregate Number Estimated In Need</th>
<th>Aggregate Number In Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pregnant Women</td>
<td>356</td>
<td>36</td>
</tr>
<tr>
<td>2. Women with Dependent Children</td>
<td>10,000</td>
<td>532</td>
</tr>
<tr>
<td>3. Individuals with a co-occurring M/SUD</td>
<td>58,000</td>
<td>4,274</td>
</tr>
<tr>
<td>4. Persons who inject drugs</td>
<td>2,000</td>
<td>1,226</td>
</tr>
<tr>
<td>5. Persons experiencing homelessness</td>
<td>446</td>
<td>350</td>
</tr>
</tbody>
</table>

Please provide an explanation for any data cells for which the state does not have a data source.

- Source Row 1-PW: Estimate obtained by multiplying 2017 ACS estimated count of Nebraska women between ages 15 to 49, 423,817, by 2017 BRFSS estimated percent of pregnant Nebraska women, 1.04, by 2016-2017 NSDUH (table 23) estimated percent 18+ SUD, 8.08.
- Source Row 2-WWDC: SAMHSA/CBHSQ Data Tables in “ASC_AdHoc091-08-18-17” released to SABG Coordinators on August 24, 2017. Table used: “Co-Occurring Need for Treatment at a Specialty Facility for a Substance Use Problem and Characteristic of Interest in the Past Year among Persons Aged 18 or Older, 2012-2014-Women Living with Children”.
- Source Row 3-Individuals with a co-occurring M/SUD: SAMHSA/CBHSQ Data Tables in “ASC_AdHoc091-08-18-17” released to SABG Coordinators on August 24, 2017. Table used: Co-Occurring Need for Treatment at a Specialty Facility for a Substance Use Problem and Characteristic of Interest in the Past Year among Persons Aged 18 or Older, 2012-2014-Any Many Illness in the Past Year”.
- Source Row 4-PWIDs: Data Tables in "ASC_AdHoc091-08-18-17" released to SABG Coordinators on August 24, 2017. Table used: "Co-Occurring Need for Treatment at a Specialty Facility for a Substance Use Problem and Characteristic of Interest in the Past Year among Persons Aged 18 or Older, 2012-2014-Needle Use in Past Year.”
- Source Row 5-Persons experiencing homelessness:* Need estimated based on HUD 2020 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations with a chronic SUD 2020 Point-in-Time Count (PIT). The PIT Count is conducted on a single day across the state and SUD is self-reported. Column C counts of “Aggregate Number In Treatment” Counts reported in Column C are persons served in the DBH Network of Services and do not include individuals served through Medicaid and other funding. • Counts are from FY 2020 anchor dataset (10/01/2020) as reported into the...
Division of Behavioral Health Centralized Data System by treatment providers for individuals in service during FY 2020. • Homeless number in treatment* is a point in time of those experiencing homelessness and in treatment for SUD on 8/20/21.

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Footnotes:
### Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2021       Planning Period End Date: 9/30/2023

<table>
<thead>
<tr>
<th>Expenditure Category</th>
<th>FFY 2022 Grant Award</th>
<th>COVID-19 Award¹</th>
<th>ARP Award²</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Substance Use Disorder Prevention and Treatment³</td>
<td>$5,430,496.65</td>
<td>$5,001,647.00</td>
<td>$1,254,000.00</td>
</tr>
<tr>
<td>2. Primary Substance Use Disorder Prevention</td>
<td>$1,829,372.00</td>
<td>$1,802,439.20</td>
<td>$204,554.70</td>
</tr>
<tr>
<td>3. Early Intervention Services for HIV⁴</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>4. Tuberculosis Services</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>5. Administration (SSA Level Only)</td>
<td>$382,098.35</td>
<td>$358,109.80</td>
<td>$96,648.95</td>
</tr>
<tr>
<td>6. Total</td>
<td>$7,641,967.00</td>
<td>$7,162,196.00</td>
<td>$1,555,203.65</td>
</tr>
</tbody>
</table>

¹The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the “standard” SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in this column.

²The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the “standard” SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in this column.

³Prevention other than Primary Prevention
For the purpose of determining which states and jurisdictions are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant (SABG); Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state's AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

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Footnotes:
### Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2021  Planning Period End Date: 9/30/2023

<table>
<thead>
<tr>
<th>Strategy</th>
<th>IOM Target</th>
<th>A</th>
<th>FFY 2022</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1. Information Dissemination</strong></td>
<td>Universal</td>
<td>$0</td>
<td>$579,970</td>
<td>$95,000</td>
</tr>
<tr>
<td></td>
<td>Selective</td>
<td>$42,185</td>
<td>$220,000</td>
<td>$35,000</td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td>$1,057</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>Universal</td>
<td>$43,242</td>
<td>$799,970</td>
<td>$130,000</td>
</tr>
<tr>
<td></td>
<td>Selective</td>
<td>$86,192</td>
<td>$120,000</td>
<td>$35,000</td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td>$2,100</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>Universal</td>
<td>$488,675</td>
<td>$319,970</td>
<td>$35,000</td>
</tr>
<tr>
<td></td>
<td>Selective</td>
<td>$13,806</td>
<td>$50,000</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td>$3,000</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>Universal</td>
<td>$51,508</td>
<td>$50,000</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>Selective</td>
<td>$14,700</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td>$125,477</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>Universal</td>
<td>$140,177</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

| Universal | $369,710 | $572,499 | $0 |
| Selective  | $14,700 | $0 | $0 |
| Indicated  | $125,477 | $0 | $0 |
| Unspecified| $0 | $0 | $0 |
| **Total** | $369,710 | $572,499 | $0 |

NOT FINAL
| 5. Community-Based Process |  |  |
|----------------------------|---|---|---|
| Selective                  | $0| $0| $39,555 |
| Indicated                  | $0| $0| $0  |
| Unspecified                | $0| $0| $0  |
| **Total**                  | **$369,710**| **$572,499**| **$39,555** |

| 6. Environmental |  |  |
|------------------|---|---|---|
| Universal        | $591,284| $60,000| $0 |
| Selective        | $0| $0| $0  |
| Indicated        | $0| $0| $0  |
| Unspecified      | $0| $0| $0  |
| **Total**        | **$591,284**| **$60,000**| **$0** |

| 7. Section 1926 Tobacco |  |  |
|-------------------------|---|---|---|
| Universal                | $54,354| $0| $0  |
| Selective                | $0| $0| $0  |
| Indicated                | $0| $0| $0  |
| Unspecified              | $0| $0| $0  |
| **Total**                | **$54,354**| **$0**| **$0** |

| 8. Other |  |  |
|----------|---|---|---|
| Universal | $0| $0| $0  |
| Selective | $0| $0| $0  |
| Indicated | $0| $0| $0  |
| Unspecified | $0| $0| $0  |
| **Total** | **$0**| **$0**| **$0** |

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Prevention Expenditures</strong></td>
<td><strong>$1,738,950</strong></td>
<td><strong>$1,802,439</strong></td>
<td><strong>$204,555</strong></td>
</tr>
<tr>
<td><strong>Total SABG Award</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td><strong>$7,641,967</strong></td>
<td><strong>$7,162,196</strong></td>
<td><strong>$1,555,204</strong></td>
</tr>
</tbody>
</table>

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Planned Primary Prevention Percentage</strong></td>
<td>49.02 %</td>
<td>52.30 %</td>
<td>240.87 %</td>
</tr>
</tbody>
</table>

---

1 The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023, for most states.

2 The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023.

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022
Footnotes:
For the FY2022 SA Block Grant, the sum of the total amount reported on Table 5a for SA Block Grant Award - SABG Primary Prevention Planned Expenditures ($1,738,950) plus the total amount of Primary Prevention set-aside funds reported on Table 6 column B. SABG Prevention ($90,422) should equal the amount reported on Table 4, Row 2, FFY 2022 SA Block Grant Award ($1,829,372).
# Planning Tables

## Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2021  Planning Period End Date: 9/30/2023

<table>
<thead>
<tr>
<th>Activity</th>
<th>FFY 2022 SA Block Grant Award</th>
<th>COVID-19 Award¹</th>
<th>ARP Award²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal Direct</td>
<td>$439,085</td>
<td>$199,970</td>
<td>$0</td>
</tr>
<tr>
<td>Universal Indirect</td>
<td>$1,053,533</td>
<td>$1,212,469</td>
<td>$134,555</td>
</tr>
<tr>
<td>Selective</td>
<td>$115,755</td>
<td>$390,000</td>
<td>$70,000</td>
</tr>
<tr>
<td>Indicated</td>
<td>$130,577</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Column Total</strong></td>
<td><strong>$1,738,950</strong></td>
<td><strong>$1,802,439</strong></td>
<td><strong>$204,555</strong></td>
</tr>
<tr>
<td><strong>Total SABG Award³</strong></td>
<td><strong>$7,641,967</strong></td>
<td><strong>$7,162,196</strong></td>
<td><strong>$1,555,204</strong></td>
</tr>
<tr>
<td><strong>Planned Primary Prevention Percentage</strong></td>
<td><strong>22.76 %</strong></td>
<td><strong>25.17 %</strong></td>
<td><strong>13.15 %</strong></td>
</tr>
</tbody>
</table>

¹The 24-month expenditure period for the COVID-19 Relief supplemental funding is March 15, 2021 - March 14, 2023, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023, for most states.

²The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is September 1, 2021 - September 30, 2025, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023.

³Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:
For the FFY2022 SA Block Grant, the sum of the total amount reported on Table 5b for SA Block Grant Award - SABG Primary Prevention Planned Expenditures by IOM Category ($1,738,950) plus the total amount of Primary Prevention set-aside funds reported on Table 6 column B. SABG Prevention ($90,422) should equal the amount reported on Table 4, Row 2, FFY 2022 SA Block Grant Award ($1,829,372).
### Table 5c SABG Planned Primary Prevention Targeted Priorities

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2022 and FFY 2023 SABG awards.

Planning Period Start Date: 10/1/2021       Planning Period End Date: 9/30/2023

<table>
<thead>
<tr>
<th>Substances</th>
<th>SABG Award</th>
<th>COVID-19 Award</th>
<th>ARP Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Tobacco</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Marijuana</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Cocaine</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Heroin</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Inhalants</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Bath salts, Spice, K2)</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Targeted Populations</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Students in College</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Military Families</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>LGBTQ</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>American Indians/Alaska Natives</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>African American</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Hispanic</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Homeless</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Native Hawaiian/Other Pacific Islanders</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Asian</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Rural</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
</tbody>
</table>
Underserved Racial and Ethnic Minorities

1The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the “standard” SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023, for most states.

2The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the “standard” SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023.

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Footnotes:
**Planning Tables**

**Table 6 Non-Direct Services/System Development [SA]**

Planning Period Start Date: 10/1/2021  Planning Period End Date: 9/30/2023

<table>
<thead>
<tr>
<th>Activity</th>
<th>A. SABG Treatment</th>
<th>B. SABG Prevention</th>
<th>C. SABG Integrated(^1)</th>
<th>D. COVID-19(^2)</th>
<th>E. ARP(^3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Information Systems</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$1,984,200.00</td>
<td>$359,000.00</td>
</tr>
<tr>
<td>2. Infrastructure Support</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$454,000.00</td>
<td>$350,000.00</td>
</tr>
<tr>
<td>3. Partnerships, community outreach, and needs assessment</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>4. Planning Council Activities (MHBG required, SABG optional)</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>5. Quality Assurance and Improvement</td>
<td>$0.00</td>
<td>$36,296.00</td>
<td>$0.00</td>
<td>$45,000.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>6. Research and Evaluation</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>7. Training and Education</td>
<td>$277,820.00</td>
<td>$54,126.00</td>
<td>$0.00</td>
<td>$1,273,447.00</td>
<td>$25,000.00</td>
</tr>
<tr>
<td><strong>8. Total</strong></td>
<td><strong>$277,820.00</strong></td>
<td><strong>$90,422.00</strong></td>
<td><strong>$0.00</strong></td>
<td><strong>$3,756,647.00</strong></td>
<td><strong>$734,000.00</strong></td>
</tr>
</tbody>
</table>

\(^1\)Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.

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Printed: 8/20/2021 4:40 PM - Nebraska
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The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in Column D.

The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in Column E.

**Footnotes:**

For the FFY2022 SA Block Grant, the amount of SABG Primary Prevention funds (from Table 4, Row, FFY 2022 SA Block Grant Award) to be used for Non-Direct Services/System Development Activities for SABG Prevention, Column B, and/or SABG Integrated, Column C, = $90,422.00.

For the FFY2022 SA Block Grant, the amount of SABG Administration funds (from Table 4, Row 5) to be used for Non-Direct Services/System Development Activities for SABG Prevention Column B, and/or SABG Integrated, Column C, = $0.
### Planning Tables

#### Table 6 Non-Direct-Services/System Development [MH]

<table>
<thead>
<tr>
<th>Activity</th>
<th>FFY 2022 Block Grant</th>
<th>FFY 2022 COVID Funds</th>
<th>FFY 2022 ARP Funds</th>
<th>FFY 2023 Block Grant</th>
<th>FFY 2023 COVID Funds</th>
<th>FFY 2023 ARP Funds</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Information Systems</td>
<td>$0.00</td>
<td>$318,674.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$23,957.20</td>
<td>$423,674.00</td>
</tr>
<tr>
<td>2. Infrastructure Support</td>
<td>$0.00</td>
<td>$300,000.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$175,000.00</td>
<td>$199,569.00</td>
</tr>
<tr>
<td>3. Partnerships, community outreach, and needs assessment</td>
<td>$0.00</td>
<td>$75,000.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$40,000.00</td>
<td>$40,000.00</td>
</tr>
<tr>
<td>4. Planning Council Activities (MHBG required, SABG optional)</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>5. Quality Assurance and Improvement</td>
<td>$0.00</td>
<td>$80,000.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>6. Research and Evaluation</td>
<td>$0.00</td>
<td>$75,000.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$20,000.00</td>
<td>$75,000.00</td>
</tr>
<tr>
<td>7. Training and Education</td>
<td>$0.00</td>
<td>$250,000.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$777,416.00</td>
<td>$850,000.00</td>
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<tr>
<td><strong>8. Total</strong></td>
<td>$0.00</td>
<td>$1,098,674.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$1,036,373.20</td>
<td>$1,588,243.00</td>
</tr>
</tbody>
</table>

1 The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

2 The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

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Footnotes:
Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions. Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease. It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders. SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity. For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs. Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders. The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care. Use of EHRs in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes and ACOs may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes. SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations. Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.

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

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

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states’ Medicaid authority in ensuring parity within Medicaid programs.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues. Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA’s National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.

SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs. However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.


26 SAMHSA, National All-Payer Inpatient Health Care Cost and Utilization Data, 2011.


Please describe the state's approach to integrating mental health and primary care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community-based mental and substance use disorder settings.

The Nebraska Department of Health and Human Services (DHHS) Division of Behavioral Health is engaged in multiple strategies and activities that have as their core, integration. The Director of the Division of Behavioral Health (DBH) is the designated Single State Authority (SSA) and State Mental Health Authority (SMHA) for the state. As the SSA and SMHA, DBH oversees the SAPTBG and MHBG and provides leadership in funding for substance use disorder programs and mental health programs in the state. DBH provides substance use and mental health disorder services to non-Medicaid eligible consumers using a combination of SAPTBG and MHBG and state funding. DHBS collaborates with other state agencies providing behavioral health services.

Medicaid eligible individuals receive behavioral health services provided by the DHHS Division of Medicaid and Long Term Care (MLTC). These services are coordinated and funded through three MLTC contracted Managed Care plans, many of which utilize providers who are also contracted with DBH. Information about the behavioral health services provided by Medicaid is available at these web sites: https://dhhs.ne.gov/Pages/Medicaid-Behavioral-Health-Definitions.aspx and https://dhhs.ne.gov/Pages/Heritage-Health-Contacts.aspx

MLTC implemented a new integrated managed care program: Heritage Health, with the signing of three contracts in April 2016. Whereas previously behavioral health was a carve out, the three health plans now coordinate a full range of services, including physical health, behavioral health and pharmacy services including services for individuals with co-occurring mental and substance use disorders in primary care settings and community-based mental and substance use disorder treatment settings. The care of behavioral health clients is delivered through a network of providers who contract directly with the plans. This system went live January 2017.

Cross-Agency integration activities include the sharing of a chief behavioral health clinical officer with Medicaid Long Term Care (MLTC) and the participation of key staff on quality improvement, service definition/delivery, waiver activities and administrative processes that support the integration of primary care and behavioral health with the new MLTC / Heritage Health vendors. DHHS and DBH are increasing the use of data sharing and collection to allow for valid comparisons across systems and reporting periods through updated data sharing governance activities. The Extension for Community Healthcare Outcomes (Project ECHO) remains a current strategy that expands access to high quality and effective medical and behavioral health treatment. Project ECHO, considered a revolution in medical education and care delivery, was implemented in Nebraska in 2018 to support provider training in response to the Opioid epidemic. This extension for community healthcare outcomes hub and spoke model increases workforce capacity to provide best practice in specialty care and better equips primary care practitioners in rural areas to better serve the behavioral health population.
System integration through managed care policy and practice includes improved health outcomes based on the social determinants of health, enhanced integration of services and quality of care, care management and preventive services, reduced costly and avoidable care, improved financial sustainability and a quality public system of primary and behavioral health care that is seamless and inclusive of all individuals eligible for services. The MLTC plans are financially and contractually incentivized to invest in prevention case management and care/treatment. At an administrative level, MLTC, the three Heritage Health Managed Care Organizations (MCOs) and DBH meet twice a month.

MLTC expansion went live in October 2019 and offers the opportunity for improved integration efforts and results in all areas, including governance, data sharing, health prevention and promotion, and defining and sharing performance outcomes is expected.

Integration work has required enhanced partnerships with the sister Divisions, including the DBH, to implement a program that is seamless and inclusive of all individuals eligible for service. Key contract features include performance measures specific to population served, establishment of Quality and Integration Committees, early identification of care management needs, inclusion of social determinants of health in health risk assessment and care management strategy and referrals to community resources. Other features include preventive and specialty care, recovery-oriented services and expanded access to primary care. The requirements for the provider network include many shared mental health and substance use disorder treatment providers as well as consistency in service definitions and services packages. At this time there are 55 known Integrated Behavioral Health Clinics with 20 located in rural areas, 33 in urban area and 2 pending. Targeted strategies across Divisions are directed toward setting baselines and increasing the number of primary care practices offering behavioral health services within the practice.

Services are provided by the SSA/SMHA to non-Medicaid eligible consumers in the state and are paid for with a combination of SAPTBG, MHBG and state funding. MLTC contracted plans provide the following services for behavioral health consumers, many of which are also contracted for by SSA/SMHA.
http://dhhs.ne.gov/Pages/Medicaid-Behavioral-Health-Definitions.aspx
http://dhhs.ne.gov/Pages/Heritage-Health-Contacts.aspx

Qualified Health Plans (QHPs) in Nebraska provided through the Federal Marketplace have been reduced however must meet the ten required Essential Health Benefits, including mental and substance use disorders treatment. In addition to covering physical health needs, the plans must cover hospitalization, medication management and outpatient services for behavioral health disorders when they determined to be medically necessary. QHPs do not have to cover services such as case management, housing, peer support or other recovery based services. Payment for rehabilitative behavioral health services such as residential treatment programs is limited and subject to reduced length of stay.

DBH monitors federal parity regulations and has established a Parity System of Care workgroup whose participants include representatives from MLTC, DHHS Division of Public Health (DPH), and the Department of Insurance (DOI). This group provides feedback and guidance on parity legislation and communication for consumers. Qualified Health Plans (QHPs) in Nebraska provided through the Federal Marketplace have been reduced however must meet the ten required Essential Health Benefits, including mental and substance use disorders treatment. In addition to covering physical health needs, the plans must cover hospitalization, medication management and outpatient services for behavioral health disorders when determined to be medically necessary. QHPs do not have to cover services such as case management, housing, peer support or other recovery based services. Payment for rehabilitative behavioral health services such as residential treatment programs is limited and subject to reduced length of stay. The DOI solicits feedback from individuals across the state on an annual basis. Questions for public forums and feedback from same are reviewed by the Parity group. The next statewide review is tentatively planned for the fall of 2021. Legislation related to health plans and the coverage of telehealth and telephonic service delivery for medical and behavioral services occurred in the most recent Legislative session with information shared by members of this group.

The DBH has operated a Centralized Data System (CDS) since May of 2016. The CDS interfaces with provider electronic health records. An electronic billing system (EBS) is also operational and interfaces with the CDS to improve billing practices and enables the Division to access clinical and cost data to support data driven decision making. The CDS is cross checked with Medicaid eligibility data. Providers capture whole health data. The CDS functionality at a base level is accessible by the State Regional Centers which continues the work of bringing the highest level of state psychiatric institutional level of care into the shared information system.

The DBH, in partnership with the Behavioral Health Education Center of Nebraska (BHECN), promotes activities in research and education to improve the quality of services, recruitment and retention of behavioral health professionals and access to programs and services. The DBH and BHECN are engaged in shared workforce strategic planning focusing on access to healthcare data, integration efforts, and reciprocity in relationships, needs assessment, workforce plan and metrics and shared conferences. Last year, BHECN was also contracted to serve as the Region VII Mental Health ATTC. This work will continue to build upon and enhance efforts in integration and workforce development. In October 2020, BHECN was awarded a Health Resources and Services Administration (HRSA) Rural Communities Opioid Response Program grant to connect people and resources in rural Nebraska. The multi-year grant will address barriers to access in rural communities related to substance use disorder, including opioid use disorder. The grant will enable a consortium to build a strategic plan incorporating long-lasting changes to facilitate prevention, treatment and recovery in underserved rural areas.
Through planning efforts and State Targeted Response / State Opioid Response grant funding, the DBH and the University of Nebraska Medical Center (UNMC) have implemented an intensive training and service delivery program approved for UNMC. The program is located within Family Practice medicine which further supports integration initiatives.

The DBH, UNMC, the College of Public Health and BHECN are supporting research projects to expand the utilization of telehealth or telemental health in the State. The UNMC Department of Psychiatry has created a telepsychiatry consultation service to provide psychiatric care to rural communities. Services are provided to underserved areas with the use of HIPPA compliant teleconferencing platforms. E-Psychiatry provides access to an online psychiatrist using telepsychiatry. UNMC's telehealth services help fill the state’s shortage of mental health physicians by having its psychiatric team conduct virtual visits via computer link to nursing homes and some assisted-living facilities and community sites.

Project ECHO, as described earlier, is operational with UNMC. This peer consultation provides condition specific consultation (currently pain management and substance use disorder focused) and case review by treatment experts through the use of telehealth technology. Training and case consultation is provided to general practitioners, which builds competencies and extends the workforce.

Nebraska now has three Certified Community Behavioral Health Clinics whose purpose is to provide integrated care and ensure care coordination with local primary care and hospital partners, and integration with physical health care.

DBH completed a needs and gaps assessment in 2020. A new strategic plan for FY22 is under development and has an integration goal and draft strategies directed to impact mental health and substance use service delivery and practices, workforce development, and increased behavioral health services in primary care settings, including crisis services.

2. Describe how the state provides services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, and payment strategies that foster co-occurring capability.

Funding from the block grant, along with state dollars, pass through from DBH to Regional Behavioral Health Authorities (RBHAs) and are distributed via Sub grants to local providers. The DBH works with the RBHAs and the Nebraska Association of Behavioral Health Organizations (NABHO) to identify needs and develop plans for service delivery. In addition, the DBH has urged RBHAs to work collaboratively with Federally Qualified Health Centers (FQHCs) in their catchment areas to provide integrated opportunities to receive co-occurring behavioral/physical healthcare.

Services are provided by the SSA/SMHA to non-Medicaid eligible consumers in the state and are paid for with a combination of SAPTBG, MHBG and state funding. MLTC contracted health plans provide mental health and substance use disorder services for behavioral health consumers. MLTC and DBH share services and service definitions. Most providers contracted to provide services contract with MLT and the SSA/SMHA.

http://dhhs.ne.gov/Pages/Medicaid-Behavioral-Health-Definitions.aspx
http://dhhs.ne.gov/Pages/Heritage-Health-Contacts.aspx

A collaborative effort to help identify issues early and connect children and teens with services was created by the Nebraska Legislature through passage of legislation creating a pilot children's behavioral health screening and referral program in three primary care clinics. The pilot program provides for a unique combination of primary care, on-site behavioral health, and specialty behavioral health care and education from experts at UNMC. This is achieved via: integration – convenient assessment and treatment for children in their medical home via integrated clinics; screening – early identification of childhood behavioral health problems; and, optimization – consultation, referral, and education from specialty behavioral health providers at UNMC using distance technologies. Children are screened for common behavioral health challenges and referred to behavioral health specialists for treatment. Behavioral health services will be delivered within the primary care practice setting. The program began with three pilot primary care sites in 2013 and expanded to ten pilot sites in 2015. This work is being spearheaded by the Behavioral Health Education Center of Nebraska. See Section 10 for more information.

The DBH supports and encourages local partnerships with FQHCs and other collaborative efforts with primary care and publicly funded systems.

In addition, the Munroe-Meyer Institute is conducting a project to improve access to pediatric mental health services in Nebraska, working as a sub-recipient in a $2.2 million five-year grant awarded to the Nebraska DHHS Title V Maternal and Child Health program. Please see link for more information: https://www.unmc.edu/news.cfm?match=23059

3. a) Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through Qualified Health Plans? [Yes] [No]

b) and Medicaid? [Yes] [No]

4. Who is responsible for monitoring access to M/SUD services provided by the QHP?

The Nebraska Department of Insurance (DOI) is responsible for monitoring access to Mental Health/Substance Use Disorder services by the Qualified Health Plans. The DOI is responsible for evaluating, approving or disapproving life, health, and annuity products marketed to Nebraska residents, as well as reviewing rate filings.
5. Is the SSA/SMHA involved in any coordinated care initiatives in the state?  
   Yes  No

6. Do the M/SUD providers screen and refer for:
   a) Prevention and wellness education  
      Yes  No
   b) Health risks such as
      ii) heart disease  
          Yes  No
      iii) hypertension  
            Yes  No
      iv) high cholesterol  
         Yes  No
      v) diabetes  
         Yes  No
   c) Recovery supports  
      Yes  No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care?  
   Yes  No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services?  
   Yes  No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions? Qualified Health Plans (QHPs) in Nebraska provided through the Federal Marketplace have been reduced in number however must meet the ten required Essential Health Benefits, including mental and substance use disorders treatment. In addition to covering physical health needs, the plans must cover hospitalization, medication management and outpatient services for behavioral health disorders when they determined to be medically necessary. QHPs do not have to cover services such as case management, housing, peer support or other recovery based services. Authorization and payment for rehabilitative behavioral health services such as residential treatment programs is limited and the Parity Team has reviewed parity provisions and identified areas requiring plans of corrections. The Parity Team identified additional issues including challenges to network adequacy for mental health and substance use disorder, lack of resources particularly in rural areas, aging workforce, low reimbursement rates, lack of clarity or standardization in assessment and assessment tools for “parity” and a lack of access to projected claims for comparison analytics. The DOI performs annual focus groups around the state and the workgroup helps to identify questions and interpret feedback received.

10. Does the state have any activities related to this section that you would like to highlight? As a result of the Parity team learning collaboration, the DOI members drafted a Mental Health Parity-related Guidance adopted by the Market Conduct Exam Standards Working Group in December 2018.

    The group has also participated in plan parity review of the Medicaid Heritage Health vendor plans. This group reviewed insurance legislation impacting the behavioral health services via telehealth and telephone in the most recent legislative session. The working relationship allows for ready access to DOI partners and vice versa.

    Please indicate areas of technical assistance needed related to this section
    None at this time.

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Footnotes:
Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS).

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

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

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

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

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

44 https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf
45 http://www.ThinkCulturalHealth.hhs.gov
Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?
   - a) Race
     - Yes ☑ No
   - b) Ethnicity
     - Yes ☑ No
   - c) Gender
     - Yes ☑ No
   - d) Sexual orientation
     - Yes ☑ No
   - e) Gender identity
     - Yes ☑ No
   - f) Age
     - Yes ☑ No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population?
   - Yes ☑ No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers?
   - Yes ☑ No

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations?
   - Yes ☑ No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards?
   - Yes ☑ No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care?
   - Yes ☑ No

7. Does the state have any activities related to this section that you would like to highlight?

The Division of Behavioral Health will release its 2022-2024 Behavioral Health Strategic Plan in the summer of 2021. The simple and shared goal we have for Nebraskans is access to healthcare, our focus is on behavioral healthcare. Together, we must continue to build a more comprehensive array of prevention, treatment, and recovery services that also addresses health equity through cross system engagement. The new plan will address disparities, increase diversity and health equity through cross system engagement, planning and ensuring culturally and linguistically appropriate services (CLAS).

As the chief behavioral health strategist for the state, DBH will serve as a catalyst for responsiveness to the needs of Nebraskans related to prevention, treatment and recovery of mental illness and substance use. For example, as the Latino population in Nebraska has risen, the DBH sought out the services of the Office of Health Equity and Disparity to help design, translate and disseminate a needs assessment survey in Spanish. And, as an identified planning objective moving forward, the 2022-2021 Behavioral Health Strategic Plan establishes a key strategic plan area to increase behavioral health services/access in a variety of settings and address disparities, increase diversity and health equity through cross system engagement, planning and ensuring culturally and linguistically appropriate services (CLAS).

Examples of new collaborations include the DBH and the Office of Health Equity and Disparity collaboration to identify and provide language translation equipment to help support service provision and be able to provide more direct translation services for those who do not prefer English. A second activity is the collaboration and support for the Winnebago Comprehensive Healthcare System, Twelve Clans Unity Hospital and the Winnebago Public Health Department in submitting the Northeast Nebraska Native Alcohol/Substance Abuse Network Planning Project grant. (This is a rural health network development planning grant which received a notice of award in June 2021.)

DBH completed a survey of behavioral health providers during the spring of 2019. Providers were asked about their capacity to meet linguistic and cultural needs of individuals seeking treatment. 75.0% of providers reported consumers have access to translation services or an interpreter if one if required; 73.4% reported they were able to effectively respond to the cultural needs of consumers within their local community; and 54.7% reported they were able to effectively respond and provide high quality care to consumers with disabilities.

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

None at this time.
Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ÷ Cost, \( V = \frac{Q}{C} \)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services.

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

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA’s Evidence Based Practices Resource Center assesses the research evaluating an intervention’s impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA’s Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General, \(^49\) The New Freedom Commission on Mental Health, \(^50\) the IOM, \(^51\) NQF, and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC). \(^52\) The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in “Psychiatry Online.” \(^53\) SAMHSA and other federal partners, the HHS’ Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA’s Treatment Improvement Protocol Series (TIPS) \(^54\) are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA’s Evidence-Based Practice Knowledge Informing Transformation (KIT) \(^55\) was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.
SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers’ decisions regarding M/SUD services.

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


53 [http://psychiatryonline.org/](http://psychiatryonline.org/)

54 [http://store.samhsa.gov](http://store.samhsa.gov)

55 [https://store.samhsa.gov/sites/default/files/d7/priv/ebp-kit-how-to-use-the-ebp-kit-10112019_0.pdf](https://store.samhsa.gov/sites/default/files/d7/priv/ebp-kit-how-to-use-the-ebp-kit-10112019_0.pdf)

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Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions?
   - [ ] Yes
   - [ ] No

2. Which value based purchasing strategies do you use in your state (check all that apply):
   - [ ] a) Leadership support, including investment of human and financial resources.
   - [ ] b) Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
   - [ ] c) Use of financial and non-financial incentives for providers or consumers.
   - [ ] d) Provider involvement in planning value-based purchasing.
   - [ ] e) Use of accurate and reliable measures of quality in payment arrangements.
   - [ ] f) Quality measures focused on consumer outcomes rather than care processes.
   - [ ] g) Involvement in CMS or commercial insurance value based purchasing programs (health homes, accountable care organization, all payer/global payments, pay for performance (P4P)).
   - [ ] h) The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

   The DBH Centralized Data System (CDS) is a DHHS hosted web-based system that utilizes Compass software to collect information from behavioral health providers for service authorization approval for higher levels of care, at admission into service, during the course of treatment and at the time of discharge from behavioral health services. Waitlist and capacity functionality exists in the CDS and is currently being re-evaluated for upgrades in functionality and reporting. Providers enter a variety of demographic, health status and presenting symptoms, trauma history, substance use and treatment progress related data. We believe that this will allow the use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.

   In 2017, the DBH implemented an Electronic Billing System (EBS). The EBS is a DHHS hosted web-based system developed to streamline the billing processes by moving billing for recovery, treatment and prevention efforts from paper to electronic submission. The system provides system-wide consistency in tracking and reporting all DBH Community-Based Services funded mental health and substance abuse services.

   The EBS integrates with the CDS to connect consumer services to funds requested. This provides greater flexibility than rekeyed paper based information to analyze purchased services across providers, areas of the state and by service.

   The EBS and CDS is the primary vehicle used to evaluate service utilization at the State, region and provider level and to make data informed decisions through the DBH's management and quality assurance initiatives. Standard reports for individual providers as well as each RBHA can be used for planning, controlling, and monitoring operations. Statewide reports allow for this oversight on a larger scale and for reports to be aggregated for the state as well as at a very granular level. The result will be more data informed decisions to ensure overall efficiency and cost effectiveness.

   Nebraska continues to explore approaches to design and development of value based reimbursement models with a current focus...
on performance metrics in key areas. Education regarding different types of models and the benefits/challenges of use of each model was presented to DBH senior leadership and sister agency leadership, the MCOs, the Administrative Office of Probation and the Courts and RBHA Partners. Recommendations will drive enhancements to the CDS and EBS systems.

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

None at this time.

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Footnotes:
4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode (RAISE) initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)?
   - Yes
   - No

2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI?
   - Yes
   - No

If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

In addition to the state appropriation for Mental Health First Aid (MHFA), DBH is a key partner on Nebraska’s Project AWARE grant. This grant, awarded to the Nebraska Department of Education, aims to improve prevention, early identification and treatment response for students with or at risk of having behavioral health conditions. As a result, Nebraska has added 31 new certified Youth Mental Health First Aid instructors who trained over 900 individuals during year 2 of Project AWARE.

The Nebraska First Episode Psychosis Coordinated Specialty Care (FEP CSC) program is building on the success of the pilot project. Following evaluation and consultation, Nebraska determined that changing from the OnTrackNY model would best meet the needs of providers and individuals served. This change was based in part on the feedback from providers, the rural service delivery, and the desire to expand the program. The teams were trained in the Recovery After an Initial Schizophrenia Episode (RAISE) Navigate model and are implementing the new evidence based practice.
The goals of the FEP CSC Program continue to be to develop and implement an individualized, person-centered plan that will help the consumer manage symptoms, identify any co-morbid conditions that should be treated, provide for on-going risk assessment, provide education so clients and families can learn to manage the illness and develop coping skills, and focus on consumer goals and recovery. Nebraska uses block grant funds for targeted investments to build core capacities and regional collaborations to develop FEP expertise as the programs reform.

The FEP CSC Program serves two of the six behavioral health service regions of the state. The two separate, independent FEP CSC Program teams are located in the Omaha metropolitan area and in the RBHA Region 3 Behavioral Health Services in the middle of the state, with a population of 150,000. The two teams are separated by 190 miles. These areas were selected because of an existing concentration of specialty youth services and commitment to serving these families.

The FEP CSC program is designed to help consumers navigate the road to recovery from an episode of psychosis, including supporting efforts to function well at home, on the job, at school, and in the social world. This comprehensive program includes four different treatment components that work collaboratively as a team with the consumer. These components include: Medication Management, Supported Employment and Education, Individual Psychotherapy, and Family Psychotherapy/Education.

In 2020, the DBH sponsored training on the evidence based practice of cognitive behavioral therapy for psychosis delivered by Dr. Laura Tulley from the UC Davis Early Psychosis Program. As the training was available across the state, the goal was to support providers treating FEP individuals regardless of their affiliation with an FEP CSC team.

3. How does the state promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

Increasing behavioral health providers in integrated settings is part of the DBH’s current Strategic Plan. DBH is working with the Behavioral Health Education Center of Nebraska (BHECN) and the Division of Public Health (DPH) in reviewing information and revising survey questions to capture responses via the Health Profession Tracking System. This data demonstrates change in professions that are working in integrated (primary care and behavioral health) settings and provides data to inform future training and education of the workforce. There are eight Federally Qualified Health Centers plus the satellite locations in Nebraska that afford opportunities for individuals seeking physical care to access behavioral health care when recommended. DBH, through a Parity team comprised of Medicaid (MLTC), DPH, Legal, Office of Consumer Affairs, and Department of Insurance personnel, works to review and address parity analysis issues within Medicaid and other marketplace plans in Nebraska. Comprehensive, individualized and integrated service delivery is an expectation across public and private systems. The training and best practices described in Question 2 are anticipated to be sustained.

In addition to the Coordinated Specialty Care model currently in operation, other evidence-based practices that are available to consumers with Early Serious Mental Illness (ESMI) include services such as Assertive Community Treatment, Supported Employment, Supported Housing and high fidelity wrap around.

Nebraska has two new Certified Community Behavioral Health Clinics that provide integrated care to people with complex needs. These additions to the integrated care continuum will strengthen the care coordination available to people, including families affected by ESMI.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with ESMI?

5. Does the state collect data specifically related to ESMI?

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI?

7. Please provide an updated description of the state’s chosen EBPs for the 10 percent set-aside for ESMI.

Nebraska’s chosen Evidence-based Practice (EBP) for the 10 percent set aside for ESMI is described above under Question 2, coordination specialty care currently following the RAISE Navigate model.

8. Please describe the planned activities for FFY 2022 and FFY 2023 for your state’s ESMI programs including psychosis?

In addition to training FEP CSC teams in the RAISE Navigate model and implementing the new approach, Nebraska has partnered with a different integrated care provider to host the entire FEP CSC team in one agency. This change in approach is geared towards offering a full continuum of care to FEP CSC families, improved monitoring of service delivery, and a stronger connection to FEP CSC stakeholders and referral sources. As part of building on the initial FEP CSC work, Nebraska has also contracted with TriWest to review the reimbursement structure to best support the teams while ensuring cost efficient care. It is anticipated that a case rate will be applied during the FFY which will more fully compensate teams for the RAISE Navigate model than the previous fee for service structure.

9. Please explain the state’s provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

The Nebraska FEP CSC Programs have been reporting as requested on outcomes measures and fidelity measures to answer key questions around program implementation. Fidelity and outcome information includes CSC components of team structure and functioning, psychopharmacology, individual psychotherapy, family intervention, and supported employment/education.
The teams have been using the Columbia Suicide Severity Rating Scale, the MIRECC-GAF, the OnTrack NY Modified Colorado Symptom Index, the OnTrackNY Quality of Life, and OnTrackNY Experience scales. With the change in models, Nebraska intends to revise outcome reporting and data collection to focus on quality care and evaluate the clinical and organizational changes related to the switch in EBP models. Metrics and tools supported by the NIMH EPINET project have been selected and include the Brief Adherence to Medication Rating Scale and the RAISE Illness and Management Recovery tool.

10. Please list the diagnostic categories identified for your state's ESMI programs.

**Nebraska First Episode Psychosis Coordinate Specialty Care (FEP CSC) Program**

**FEP CSC Program Enrollment Criteria**

a. Age: Male/Female age 14 through 35

b. Diagnostic Criteria Utilizing DSM-5 Diagnoses of Schizophrenia; Schizotypal Disorder; Schizoaffective Disorder; Delusional Disorder; Brief Psychotic Disorder; and Unspecified schizophrenia spectrum and other psychotic disorders

c. Symptom Duration: Symptoms of a psychotic disorder for a period lasting more than one (1) week and no more than two (2) years.

d. Exclusionary Criteria: Diagnosed with an Intellectual Disability; Psychotic Disorder due to a General Medical Condition; Substance-induced Psychotic Disorder; and Depressive and Bipolar Disorders. The families of individuals age 18 and younger would have to agree to participate, but individuals age 19 and older who do not want their families involved could still be enrolled in the program.

e. Anticipated Length of Treatment Minimum of 2 years or an earlier natural point if the individual is stable on medication, non-psychotic, employed/in school, and family is agreeable to discharge.

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

None at this time.

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**Footnotes:**
Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question
States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person’s strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to approach identifies the person’s strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person’s goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person’s needs and desires.

1. Does your state have policies related to person centered planning?  
   - Yes  
   - No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.
   - Not applicable.

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.
   
   The Nebraska Division of Behavioral Health (DBH) supports and promotes the use of person-centered service delivery and participant directed care within the state hospitals, regional and community based provider systems. Nebraska’s public behavioral health system governing regulations “Standards of Care” (NAC 206, Chapter 1 identifies the right of each consumer to receive behavioral health services in the most integrated setting appropriate based on an individualized and person-centered assessment, and actively and directly participate in decisions which incorporate independence, individuality, privacy, and dignity and to make decisions regarding care and treatment. This is evidenced by person-centered planning policies within the state hospitals (e.g. Regional Centers), regional and community based provider program fidelity audits, the work of the Office of Consumers Affairs related to consumer voice and choice, and Consumer Specialist peer-related empowerment activities occurring within the Regional Behavioral Health Authorities (RBHAs). It is the shared vision and expectation to enable individuals and their treatment team to create a plan of care that addresses each person’s needs, strengths, choices and goals, and is sensitive to each person’s experiences, traumas, and cultural background.

   DBH requires via its Network Operations Manual, incorporated into the RBHA contracts by reference, for behavioral health RBHAs and their contracted providers to build a recovery oriented system of care (ROSC). This is defined as a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for persons with behavioral health disorders.

   A ROSC encompasses a menu of individualized, person-centered, and strength-based services within a self-defined network. By design, a ROSC provides individuals and families with more options with which to make informed decisions regarding their care. Services are designed to be accessible, welcoming, and easy to navigate. A fundamental value of a ROSC is the involvement of people in recovery, their families, and the community to continually improve access to and quality of services.

   The DBH has recently ended a 4 year system of care grant through SAMHSA. However, system of care efforts continue throughout the state so that gains realized under the grant are not lost. Under that framework, the service system continues to work on:

1. Ensure that families, other caregivers, young adults and youth are full partners in all aspects of the planning and delivery of their own services and in the policies and procedures that govern care for all children and youth in their community, state, territory, tribe, and nation.

2. Ensure availability and access to a broad, flexible array of effective, community-based services and supports for children and their families that address their emotional, social, educational, and physical needs, including traditional and nontraditional services that build on the family’s natural and informal supports system.

3. Provide individualized services in accordance with the unique potentials and needs of each child and family, guided by a strengths-based, individualized service planning process developed in true partnership with the child, family and/or young adult.

4. Ensure availability of services and supports that are evidence-informed and promising practices, as well as interventions.
supported by practice-based evidence, and monitor the utilization and effectiveness of these services to improve outcomes for children and their families.

5. Ensure the delivery services and supports are available, utilized and accessible within the least restrictive, most normative environments that are clinically appropriate.

6. Ensure that services are integrated at the system level, with linkages between child-serving agencies and programs with mechanisms for administrative and system-level management, in planning, developing and coordinating services and funding boundaries through an integrated care management process.

7. Provide care management, wraparound service planning or similar mechanisms at the practice level to ensure that multiple services are delivered in a coordinated and therapeutic manner and that children, young adults and their families can move through the system of services in accordance with their changing needs.

8. Provide developmentally appropriate behavioral health services and supports that promote protective factors, resiliency, trauma-informed care, and optimal social-emotional outcomes for young children and their families in their homes and community settings.

9. Provide developmentally, socially appropriate and trauma-informed services and supports to facilitate the transition of youth to adulthood and to the adult service system as needed.

10. Incorporate or link with behavioral health promotion, prevention, and early identification and intervention programs and initiatives to improve long-term outcomes, and to identify needs at an earlier stage and ensure behavioral health promotion and prevention activities are directed at all children and adolescents.

11. Incorporate continuous accountability and quality improvement mechanisms to track, monitor, and manage the achievement of system of care goals; fidelity to the system of care philosophy; and quality, effectiveness, and outcomes at the system level, practice level, and child and family level.

12. Protect the rights of children and families and promote and support effective advocacy efforts.

13. Provide services and supports without regard to race, religion, national origin, gender, gender expression, sexual orientation, disability, socioeconomic status, geography, language, immigration status, or other characteristics, and ensure that services are sensitive and responsive to the individual.

The Nebraska System of Care is instituting mechanisms to support person centered planning, through a system of care family liaison who is responsible for working with family-run organizations; working in partnership with DBH staff and system partners in all levels of decision-making, including the development, implementation and evaluation of the Nebraska System of Care (NeSOC) and coordinating feedback regarding involvement of youth and families in all layers of decision making for families receiving services through the System of Care. The liaison coordinates appropriate family and youth support activities with the NeSOC Project Director and Task Lead Coordinator. While youth and family representatives participate in all layers of the governance structure, there are dedicated Youth and Family Advisory Councils operating to ensure youth and families are fully engage in the decision making process.

DBH contracts for the Nebraska Network of Care, an online resource for people with living with behavioral health disorders, their caregivers, and service providers that lets people access information about issues such as treatments, resources and diagnoses, and wellness recovery action plans. Consumers can choose to communicate directly with other participants and to organize and store their own personal health information. This free site, http://networkofcare.ne.gov, offers a single place where information can easily be found about services and supports. Total page visits for FY 20, 125,522 and YTD for FY21, 133,924. Network of Care has been providing a comprehensive web-based platform to research available services and supports to consumers and other stakeholders since 2013.

The Living Well curriculum is available to our Certified Peer Support Specialists to educate consumers on chronic disease self-management. Certified Peer Support Specialists that are trained as facilitators of this curriculum, are providing this education through day programs, county hospitals, shelters, Regional Center programming, jails, churches and community settings. Living Well is a self-directed program for self-management through the Nebraska Chronic Disease Prevention and Control Program in the Division of Public Health. This program enables Nebraska to build additional capacity and increase programming for the chronic disease self-management program. A mental health diagnosis is a chronic condition. Consumers with a mental health diagnosis may also have chronic physical health issues. This curriculum is driven by self-regulation and self-direction and building resiliency.

The state conducts activities to promote consumer involvement in the service system and recovery process. Individual consumers and their families are engaged on a statewide and regional level. The DBH 36-member Joint Advisory Committee (State Advisory Committees on Mental Health and Substance Use Disorder Services) advise, assist, support and advocate for mental health and substance use disorder services. Committee members bring unique skills and knowledge to the table to advise the work of DBH.
4. Describe the person-centered planning process in your state.

Nebraska’s Adult System of Care (ASOC) is a recovery-oriented system of care that is recovery focused, person-centered, strength-based, culturally responsive, individualized, integrated, outcomes-driven, research-based, and adequately and flexibly financed. Nebraska’s ASOC incorporates this framework and associated system of care guiding principles and core values into a spectrum of community-based services and supports that is organized within a coordinated system of care network. It is designed to assist consumers in achieving their optimal level of self-sufficiency and independence by providing mental health and substance use prevention, treatment, recovery, and support services at the right time, in the right amount and in the right place.

The DBH works with consumer specialists (peers) in each of the RBHAs to provide Wellness Recovery Action Planning (WRAP) for consumers of behavioral health services. Individuals who participate in WRAP will create a plan for themselves that includes a wellness toolbox, a daily maintenance plan, identification of triggers and actions to avoid them, a plan for what to do when things break down and an action plan to address crisis, and a post crisis plan. These sessions are available for individuals served in the state hospitals and community based services across the state.

The DBH OCA works collaboratively with the regional consumer specialists to identify regional and statewide opportunities for advocacy, opportunities for growth, identifies gaps in services, provide feedback on policy and service definitions and create opportunities through community events and the use of social media to reduce stigma around behavioral health challenges.

The NeSOC framework incorporates three Core Values: Family driven and youth; Community based; and culturally and linguistically competent. In this framework family driven means families have a primary decision-making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state and tribe. This includes: choosing supports, services, and provider; setting goals; designing and implementing programs; monitoring outcomes; and determining the effectiveness of all efforts to promote the mental health of children and youth. Likewise, youth guided means that youth are included in every level of the system, too, from their own care to policies and procedures. Youth are seen as experts in their own lives and receive training, support and mentoring to better equip them to take on active leadership roles. Family and youth involvement occurs at all levels: Service Delivery as peer mentors and system navigators; Administration involvement with
evaluation, personnel, and training; and Policy involved in work groups and advisory bodies.

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

None at this time.

None at this time.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
Environmental Factors and Plan

6. Program Integrity - Required

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

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: [http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf](http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf). States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

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

   - Yes
   - No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?

   - Yes
   - No

3. Does the state have any activities related to this section that you would like to highlight?

   The state sets a standard for quality prior to accepting providers into the Nebraska Behavioral Health System. The Division of Behavioral Health (DBH) contracts with six Regional Behavioral Health Authorities (RBHAs) to enroll providers in their regional networks. Each RBHA requires providers to meet minimum standards as outlined in the Network Operations Manual developed by the DBH. With rare exception, contracts require providers to be/become Medicaid enrolled, which adds additional quality control and oversight mechanisms. The Centralized Data System further aids providers in determining if clients are enrolled in Medicaid as the system crosschecks against a Medicaid eligibility file. RBHAs, with review and approval of DBH, issue proposals for bidding for new services or capacity needed in the network. RBHA staff, DBH staff, and consumers evaluate proposals for quality based on bid requirements and best practices.

   DBH relays its standards of care through service definitions as well as within regulations. The service definitions detail the basic definition, service expectations, staffing, hours of operations and desired outcomes related to each particular level of care and are an incorporated by reference into the contracts/subawards. The Network Operations manual defines consumer rights, consumer grievances, expectations for trauma informed services, consumer eligibility and payments for services, records content, access, and retention, clinical documentation requirements, discharge planning, and requirements for individualized treatment, rehabilitation, and recovery planning with consumers.
Once in the network, RBHA and DBH staff members provide technical assistance to the providers in the provision of quality recovery oriented services and supports. Annual training and technical assistance, along with Program Fidelity and Unit Audit Reviews, allow providers ample opportunity for improvement in service delivery and to receive technical assistance. The State requires most providers to hold National Accreditation to ensure quality and safety infrastructure within provider organizations. DBH works to ensure that RBHAs are using the Federal Block Grant Program Fidelity Tool during site visits to ensure that SAPTBG requirements are met.

The Division of Behavioral Health also partners with other sister Divisions, such as Medicaid and Long Term Care and Public Health when quality of care concerns are identified.

Please indicate areas of technical assistance needed related to this section

None at this time.

Footnotes:
Environmental Factors and Plan

7. Tribes - Requested

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

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

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure that the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

56 https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20282009%29.pdf

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

   The Division of Behavioral Health (DBH) has met with all four federally recognized tribes in Nebraska in FY21 and will continue to meet and build relationships with them in the future. Technical Assistance is provided to all four tribes throughout the year. DBH and each of the tribes are in regular communication by phone or email. One specific example of coordination and support was evidenced during calendar 2020, given a marked increase in suicide attempts and behavioral health crisis experiences for members within the Omaha Nation tribe. The Omaha Nation reached out to both state and federal partners asking for assistance in responding to this particular crisis. DBH facilitated numerous incident response calls with Omaha Nation elders, behavioral health providers within the Carl T. Curtis center and other invested stakeholders. In particular, DBH was able to set up crisis counseling to tribal members during the day, after hours and on weekends with local therapists in the area until the mental health crisis subsided.

   Every fiscal year each of the tribes provides DBH with their Mental Health/Substance Use Disorder (MH/SUD) program plan. These plans identify the services most beneficial to their respective members and for which DBH funding is requested to support. The MH/SUD program plan demonstrates what services the tribe will provide in the fiscal year. The MH/SUD program plan is then incorporated into the tribe’s contract with DBH. The services performed must meet either standards of the Indian Health Services (IHS) service definitions criteria or the DBH service definitions. Each tribe can select which service provision standards they will utilize. As with all contracts for services from DBH, audits and site visits are conducted to ensure service provision is occurring as planned. If the program is using IHS standards, the IHS review is accepted as the program review. However, auditing to ensure the service is being performed as billed is still completed.

   During these consultations, DBH reviews the tribe’s MH/SUD program plan and verifies that the services are being provided to Nebraska tribal members. Conversations and findings from the review are discussed with tribes’ Program Directors and Clinical
Directors. This is also a further opportunity to meet with tribal representatives about other items needing discussion.

2. What specific concerns were raised during the consultation session(s) noted above?
   The Omaha Nation tribe is struggling with grant awareness, grant application and grant management.

3. Does the state have any activities related to this section that you would like to highlight?
   The State of Nebraska recognizes that the four federally recognized tribes headquartered in Nebraska have a unique status that sets them apart from other groups and interests in Nebraska. The DBH provides state funding directly to those four tribes – the Omaha Tribe of Nebraska, the Ponca Tribe of Nebraska, the Santee Sioux Nation, and the Winnebago Tribe of Nebraska.

   The four federally recognized tribes with whom the DBH allocates $1.6 million of state general funds in contracts, are invited to participate in advisory committees, local and statewide meetings regarding services, trainings on behavioral health topics, and other state activities and initiatives.

   The DBH is in active discussion with other DHHS Divisions such as Division of Medicaid and Long Term care and the three contracted MCOs and with the Division of Children and Family Services, all of whom also have contractual relationships with the Tribes, to understand what, if any, contract management, meeting or other communication efficiencies should be considered to reduce administrative burden on Tribal partners. The DBH will continue its efforts to engage tribal representatives in planning, trainings, and initiatives, as well as support the culturally appropriate provision of services to their tribal members.

   The Northeast Nebraska Native Alcohol/Substance Abuse Network was awarded a HRSA Rural Health Network Development Planning grant in June 2021. The grant targets rural Winnebago and Omaha Reservations. Support partners include DHHS Divisions of Behavioral Health, Public Health Office of Health Disparities and Health Equity and the Nebraska Office of Rural Health.

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

   None at this time.

Footnotes:
Environmental Factors and Plan

8. Primary Prevention - Required SABG

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;

2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;

3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;

4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;

5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and

6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Please respond to the following items

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)?

   - Yes
   - No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply)

   a) (✓) Data on consequences of substance-using behaviors

   b) (✓) Substance-using behaviors

   c) (✓) Intervening variables (including risk and protective factors)

   d) (✓) Other (please list)

   - Adult and Youth perceptions about underage substance use and abuse

3. Does your state collect needs assessment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

   - Children (under age 12)
   - Youth (ages 12-17)
   - Young adults/college age (ages 18-26)
   - Adults (ages 27-54)
   - Older adults (age 55 and above)
   - Cultural/ethnic minorities
   - Sexual/gender minorities
   - Rural communities
   - Others (please list)

4. Does your state use data from the following sources in its Primary prevention needs assessment? (check all that apply)
Archival indicators (Please list)

- National survey on Drug Use and Health (NSDUH)
- Behavioral Risk Factor Surveillance System (BRFSS)
- Youth Risk Behavioral Surveillance System (YRBS)
- Monitoring the Future
- Communities that Care
- State - developed survey instrument
- Others (please list)
  - Nebraska Young Adult Alcohol Opinion Survey (NYAAOS)
  - Nebraska Risk and Protective Factor Student Survey (NRPFSS)
  - Youth Tobacco Survey (YTS)
  - Adult Tobacco Survey (ATS)
  - Nebraska Community Alcohol Opinion Survey (NCAOS)
  - Nebraska Assessment of College Health Behaviors Survey (NACHB)

5. Does your state use needs assessment data to make decisions about the allocation of SABG primary prevention funds?

   - Yes 
   - No

   If yes, (please explain)

   As a requirement of the Division of Behavioral Health’s (DBH) annual Regional Behavioral Health Authority (RBHA) Regional Budget Planning process, at least 60 percent of the SABG Primary Prevention dollars received by community coalitions should be used to fund evidence based strategies. Emphasis is placed on using a multi-strategy approach where one or more environmental strategies are designed to impact the community and societal levels (of the social-ecological model) as well as impacting the individuals in their community’s target populations. In order to address the availability of substances and community norms around these concerns, sub-recipients are expected to familiarize themselves with the wealth of approaches that can be used, and pick those that best fit their assessed needs, as balanced against community readiness and coalition capacity. Beyond this, sub-recipients of the SABG have the flexibility to implement a variety of evidence-based and evidence-informed programs, policies, and substance abuse prevention practices in their community as long as the interventions are supported by a local needs assessment and driven by a planning process using the Strategic Planning Framework.

   If no, (please explain) how SABG funds are allocated:
Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals, families, and communities;

2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;

3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;

4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;

5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and

6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

**Capacity Building**

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce? ☐ Yes ☐ No

   If yes, please describe

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce? ☐ Yes ☐ No

   If yes, please describe mechanism used

   Each of the six RBHAs has a designated Regional Prevention Coordinator (RPC) responsible for the coordination of prevention activities across their region. Through leadership and contractual requirements with DBH, the RPC and their staff comprise the Regional Prevention Coordination System and provide training and technical assistance to area coalitions in implementing data-driven evidence-based policies, programs, and practices. In turn, this system is readily available to develop and deliver training opportunities for community coalitions in response to training and technical assistance (T/TA) needs. RPC’s are knowledgeable in the Strategic Prevention Framework process and use a variety of methods to deliver T/TA, including traditional instructional methods, web-based conference calls, webcasts and coaching. Additionally, submission of an annual work plan and training plan outline from each of the RPCs is reviewed and discussed on a quarterly basis. It is the expectation that RBHA work plans be designed to address the T/TA needs identified in their catchment area and that progress in these areas are monitored on an ongoing basis. RPCs continue to build on existing success by further providing extensive community-based training and technical assistance to assess community readiness, identify outcomes and prioritize the most effective interventions in the development of local sustainability plans.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? ☐ Yes ☐ No

   If yes, please describe mechanism used

   Coalitions have been trained to review existing resources in their community utilizing an asset-based approach to prevention planning, rather than focusing on deficits and gaps. Using this approach allows for careful evaluation of how ready a community is to accept that a substance abuse problem needs to change and take action to change the problem.
SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

**Planning**

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years?  
   - Yes  
   - No

   If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan. Identify DBH web page link to be referenced once the new 2022-2023 Strategic Plan is released.

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan)
   - Yes  
   - No  
   - N/A

3. Does your state’s prevention strategic plan include the following components? (check all that apply):
   a) Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
   b) Timelines
   c) Roles and responsibilities
   d) Process indicators
   e) Outcome indicators
   f) Cultural competence component
   g) Sustainability component
   h) Other (please list):
   i) Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds?  
   - Yes  
   - No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds?  
   - Yes  
   - No

If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based.

State prevention staff, in collaboration with the Prevention Advisory Council (PAC), serve as the prevention evidence-based program (EBP) workgroup for the State of Nebraska. A decision making process has been developed to review and select appropriate programming. This involves completion of an assessment of available evidence of effectiveness, consideration of the overarching state and local level prevention strategy, and an understanding of the local level climate and capacity to implement. Nebraska has a small paid prevention workforce statewide that would overlap substantially with the PAC if an additional committee were to be formed. We have found that the process of reviewing concerns related to evidence-based prevention is best done in conjunction with other advisory efforts. This process has proven to be successful in monitoring the effectiveness of...
evidence-based prevention programs, policies, and strategies selected. Our Nebraska Prevention Information Reporting System (NPIRS) collects data on these strategies and monitors fidelity. For the Nebraska FY20/21 SABG, one of our priority areas focused on increasing the use of evidenced-based strategies supported by block grant funding. With a baseline of 28.0% and a first-year goal of 31.5%, we exceeded that with an outcome of 32.1%. Our second-year goal is set at 34.0% in which preliminary results show an outcome of 41.4%. These outcomes are supported by the work of our PAC and EBP Workgroups.
Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

**Implementation**

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:

   a) SSA staff directly implements primary prevention programs and strategies.
   b) The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
   c) The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
   d) The SSA funds regional entities that provide training and technical assistance.
   e) The SSA funds regional entities to provide prevention services.
   f) The SSA funds county, city, or tribal governments to provide prevention services.
   g) The SSA funds community coalitions to provide prevention services.
   h) The SSA funds individual programs that are not part of a larger community effort.
   i) The SSA directly funds other state agency prevention programs.
   j) Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

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

   b) **Education**:
   DBH funds educational programs and curriculums aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities. State staff, Regional Prevention Coordinators and coalition leaders present to various advisory committees, board groups, schools, youth groups, community and public interest groups upon request. Examples of these primary prevention programs include but are not limited to the following:
   - 3rd Millennium
   - Across Ages
   - Alcohol Literacy Challenge
3. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means?

If yes, please describe

DBH updates and provides annual budgetary guidance for use of SABG dollars through a number of methods. The first has been

If yes, please describe...
to ensure the language within our State to RBHA contract is consistent with the federal register and SABG application instructions. Thus, it is a standard contractual requirement that SABG dollars can only be used to fund primary substance abuse prevention services. These requirements are also outlined in the RBHA Budget Guidelines published each year as part of the community RFP process. Additionally, DBH performs a variety of audits with their providers, including a Programmatic Activity Review for an entity receiving SABG dollars for prevention. The programmatic review is required for all community coalitions funded by the SABG and is conducted annually in partnership with Regional Prevention Coordinators.
SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

### Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years?  
   - Yes  
   - No
   
   If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan.

2. Does your state’s prevention evaluation plan include the following components? (check all that apply):
   - a) Yes  
   - b) Yes
   - c) Yes  
   - d) Yes  
   - e) Yes  
   - f) No  
   - g) No

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:
   - a) Yes  
   - b) Yes  
   - c) No  
   - d) Yes  
   - e) Yes  
   - f) Yes  
   - g) No

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:
   - a) Yes  
   - b) No  
   - c) Yes  
   - d) Yes  
   - e) Yes  
   - f) No
d)  Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

e)  Other (please describe):

Perception of peer use (primarily used for social norming).
Nebraska Substance Abuse Prevention and Treatment Block Grant Evaluation Plan

2021

Prepared for:  
Lindsey Hanlon  
Nebraska Department of Health and Human Services  
Division of Behavioral Health

Prepared by:  
Mindy Anderson-Knott  
Schmeeckle Research

Schmeeckle Research Inc.
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Introduction
The Nebraska Substance Abuse Prevention and Treatment Block Grant (SABG) is funded through federal funding from the Substance Abuse and Mental Health Services Administration (SAMHSA). The Nebraska Department of Health and Human Services Division of Behavioral Health (DBH) administers the grant. Nebraska is divided into six (sub state) Regional Behavioral Health Authorities or “Regions” serving as quasi-governmental agencies with which DBH contracts for community-based treatment and prevention services. DBH sub grants the Prevention SABG funding through the six Regions to allocate their awards in their regions. In 2020, there were a total of 39 coalitions funded with Prevention SABG grants, covering a total of 61 counties across the state.

Schmeeckle Research and the University of Nebraska-Lincoln’s Methodology and Evaluation Research Core Facility were contracted to conduct the evaluation of the Prevention SABG. Mindy Anderson-Knott, a certified evaluator and the current evaluation coordinator for the 2018 Strategic Prevention Framework-Partnerships for Success (SPF-PFS) Grant, is leading the evaluation. While the Nebraska SABG encompasses a variety of prevention, recovery and treatment areas, the focus of this evaluation is on the prevention of harmful alcohol, tobacco, marijuana, and methamphetamine use.

This document provides an outline of the approach to this evaluation, including detailed descriptions of the process and outcome evaluation questions, methods employed for data collection, analysis approaches, reporting plans, and the proposed timeline.

Evaluation Approach
The purpose of the Prevention SABG evaluation is to assess the impacts on state and regional level outcomes, evaluate the effectiveness of different strategies, and to identify and describe strengths and limitations associated with the administration of the grant. The Prevention SABG will be assessed utilizing both process and outcome evaluations. The process evaluation will provide insight into the strengths and limitations associated with administration of the grant and will shed light in explaining variation in outcomes. The overall impact of the Prevention SABG, as well as specific strategy impacts, will be assessed in the outcome evaluation.

Evaluation Questions
To frame the evaluation, a series of evaluation questions were developed to assess the implementation and impact of the Prevention SABG. First, the process evaluation questions are provided, followed by the outcome evaluation questions. Below are the process and outcome questions that frame this evaluation.
Process:
1. How are Prevention SABG subrecipients selecting their target populations and strategies?
2. What aids coalitions in successfully implementing interventions, and what training and technical assistance is needed to improve implementation?
3. To what degree have strategies been implemented to fidelity, and in what ways has the COVID-19 pandemic modified the approaches and interventions used to address alcohol/tobacco/marijuana/methamphetamine use?
4. To what degree is the diversity of Nebraska’s population served by the strategies implemented by the Prevention SABG?
5. To what degree are coalitions successfully implementing their work plans?

Outcome
1. How has the Prevention SABG impacted the implementation of prevention strategies across the state?
2. Has alcohol/tobacco/marijuana/methamphetamine use and the perceptions around them positively changed as a result of the Prevention SABG, and does it vary by region?
3. Have substance use related consequences improved as a result of the Prevention SABG?
4. Which strategies lead to positive changes in alcohol/tobacco/marijuana/methamphetamine use and the perceptions around them?
5. How did substance use related outcomes differ based on the funding source(s) received?

Evaluation Methods
A mixed methods design will be utilized to inform both the process and outcome evaluation questions. Several qualitative methods will be used to explore the Prevention SABG process and provide insight into the facilitators and barriers. Quantitative data will be used to assess impacts on substance use perceptions and behaviors across the state and regionally.

While many strategies were implemented in FY19 and FY20 across the coalitions receiving Prevention SABG funding, many were implemented by only a single coalition. In an effort to focus the evaluation on the most utilized strategies, the evaluation team worked with DBH leadership to select the targeted strategies. The targeted strategies were selected after reviewing planned strategies and NPIRS data using the following criteria:
- there must be a minimum of 10 NPIRS entries across FY19 and FY20
- the strategies must be implemented by at least 4 coalitions
- the strategies must be implemented across more than one region
This resulted in the selection of seven targeted strategies (the number of coalitions implementing each strategy is provided in parentheses following each strategy name):

1. Communities Mobilizing for Change on Alcohol (19)
2. Media (14)
3. Second Step (10)
4. Responsible Beverage Server Training (8)
5. Compliance Checks (8)
6. All Stars (6)
7. Too Good for Drugs & Violence (4)

The following outlines the process and outcome evaluation methods in detail, in timeline order.

**Process Evaluation**
Multiple evaluation methods will be employed to gather process evaluation data. The evaluation will use existing information whenever possible to reduce burden, including NPIRS, quarterly reports and other documentation.

**Regional Prevention Coordinator/DBH Interviews and Focus Group**
Individual interviews will be conducted with each of the Regional Prevention Coordinators (RPCs) and representatives from the Nebraska Department of Health and Human Services responsible for administering the Prevention SABG to better understand the process of administering the Prevention SABG. After completing the interviews, the results will be shared in a focus group setting with all of the RPCs and DBH to further explore the findings and to solicit input on the Prevention SABG evaluation design.

**Workplans and Progress Reports**
There are regional differences in documentation required for the Prevention SABG; however, some coalitions are required to submit monthly or quarterly progress reports to their RPC. These reports, along with Prevention SABG workplans, will be shared with the evaluation team for review. This information will be used to assess adherence to the SPF steps, implementation of selected strategies, training and technical assistance received, and to identify successes and barriers.

**Sub-recipient Interviews**
The evaluator will conduct interviews with stakeholders from each funded community coalition. The interviews will be completed with the coalition coordinator and with other relevant stakeholders associated with the seven strategies being targeted by this evaluation. It is anticipated that approximately 100 interviews will be completed. The interviews will provide insight on SPF adherence, facilitators and barriers, and progress on implementation (including fidelity). In addition, the interviews will inquire about the feasibility of collecting Program Level Instruments (PLIs) in year two.
Nebraska Prevention Information Reporting System (NPIRS)
The Nebraska Prevention Information Reporting System (NPIRS) will be utilized for process data regarding strategy implementation. Regional staff and sub-recipients enter all prevention funded activities into the NPIRS system on a monthly basis to track progress. The system will provide data on the number of participants served/reached, as well as their demographics. In addition, the system will provide fidelity data to describe how the strategy was implemented. The evaluation will obtain NPIRS records for the selected strategies for the previous three years.

Outcome Evaluation
In addition to the measures described above, a variety of other data sources will be used to assess the impact of the Prevention SABG, which are described in detail below. Data sources using sampling techniques designed to allow statewide estimates will be used to evaluate the impact on the state as a whole. In contrast, regional level impacts will be assessed by analyzing data collected from a census or sample drawn with the intent of providing local level estimates.

Evidence-Based Strategy Implementation
While all 93 counties in Nebraska are served by Prevention SABG through the behavioral health regions, preliminary records show strategies are being targeted in all but eight of these counties (Figure 1). The preliminary information presented in Figure 1 will be updated after confirming funding distribution and strategy implementing in each region with the regional prevention coordinators and coalition coordinators.

Figure 1. Counties Receiving Prevention SABG Funding
The strategies implemented across these funded coalitions will be analyzed using NPIRS data to determine how evidence-based strategy implementation has changed over time as a result of the Prevention SABG (and potentially other funding sources) and its priority on increasing the use of evidence-based strategies. The evaluation may also include mapping of strategy implementation and funding sources to further showcase statewide impacts and potential gaps.

**Prevention SABG v. Control Counties and Statewide Impacts**

As Figure 1 shows, 61 counties are being targeted for strategy implementation by Prevention SABG, which leaves 32 counties without targeted implementation efforts from DBH. Therefore, the evaluation will treat these remaining 32 counties as the control group to compare trends over time, starting in 2010. It is anticipated that these counties will likely have lower prevalence rates; however, there is value in measuring changes in trends over time to assess the impacts of these prevention efforts. The evaluation design will analyze data that allows county-level analysis (e.g., NRPFSS, NYAAOS, NACHB) to compare these trends over time, assessing the prevalence of substance use perceptions and behaviors. In addition, the consequences associated with substance use, including emergency room admissions, crashes, and crimes, will be compared across these groups. Finally, all of these data sources, as well as statewide representative data sources (e.g., YRBS, BRFSS, NSDUH, YTS), will be analyzed to assess statewide impacts over time.

**Differences in Impacts**

To evaluate the different impacts between strategies and potential differences in receiving multiple funding sources, data that allows county-level analysis (e.g., NRPFSS, NYAAOS, NACHB) will be analyzed in year one. Counties will be compared by grouping them according to the type of funding sources they receive, and the types of strategies they implement. In year two, additional survey data will be from collected from the selected strategies, which will further inform strategy-specific impacts. It is anticipated that pre-and post-test Program Level Instrument (PLI) surveys will be administered with program participants. To ensure high quality data collection, efforts will be taken in year one with coalitions and program implementers to assess feasibility to determine the best methods for collecting this data.

**Program Level Survey**

Sub-recipients implementing individual level targeted strategies will collect pre- and post-test surveys (or retrospective surveys). The surveys will be administered to all participants receiving the programming. Participants will be matched over time through the use of an identification number generated from multiple survey items that remain stable over time, such as birthdate and gender. The evaluation team will work in tandem with coalition coordinators to administer the surveys, which may be administered online or on paper. If the surveys are administered on paper, they will be returned to the University of Nebraska-Lincoln for data entry.

**Target Population Focus Groups**

The evaluator will conduct focus groups with participants from the target population selected by this evaluation. It is anticipated that approximately 15 focus groups will be
conducted. The focus groups will explore impacts of the selected strategies on the target audience.

**Indicators and Timeline**

Tables 1 and 2 provide a summary of the proposed indicators to assess each of the evaluation questions. For each indicator, the data source, primary lead, and approximate timeline is also provided.
<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Indicator</th>
<th>Data Source</th>
<th>Analysis Lead</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>How are Prevention SABG subrecipients selecting their target populations and strategies?</td>
<td>Type of process used to select target population and strategies (e.g., use of SPF; potentially comparing PFS to non-PFS coalitions)</td>
<td>RPC and DBH Interviews / Focus group Interviews Schmeeckle</td>
<td>January-February 2021</td>
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<td>Type of target population(s) selected by coalition</td>
<td>Work Plans Interviews Schmeeckle</td>
<td>March-June 2021</td>
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<td></td>
<td>Type of strategies selected by coalition</td>
<td>Work Plans Interviews Schmeeckle</td>
<td>March-June 2021</td>
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<td>#/type of facilitators and barriers to implementation</td>
<td>Progress reports Interviews Schmeeckle &amp; UNL</td>
<td>Ongoing</td>
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<td># of implementers available per targeted strategy</td>
<td>Interviews Schmeeckle &amp; UNL</td>
<td>March-June 2021</td>
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<td>Method</td>
<td>Data Source</td>
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<tr>
<td>To what degree have strategies been implemented to fidelity, and in what ways has the COVID-19 pandemic modified the approaches and interventions used to address alcohol/tobacco/marijuana/methamphetamine use?</td>
<td>EBP fidelity scores <em>(comparison by strategy type and region)</em></td>
<td>NPIRS</td>
<td>Schmeeckle Ongoing</td>
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<td>#/type of modifications made to each targeted strategy</td>
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<td>#/type of participants served/reached</td>
<td>Interviews</td>
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<td>Demographics of participants served/reached</td>
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<td>How has the Prevention SABG impacted the implementation of prevention strategies</td>
<td>#/proportion of substance use prevention EBPs implemented over time</td>
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<td>Has alcohol/tobacco/marijuana/methamphetamine use and the perceptions around</td>
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<td>• Risk of harm</td>
<td>BRFSS</td>
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<td>• Disapproval toward use of substances</td>
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<td>Comparison by strategy type and pre/post results (when applicable) for perceptions and behaviors including, but not limited to:</td>
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<td>• 30 day use</td>
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<td>• 30 day binge drinking</td>
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<td>• Risk of harm</td>
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<td>• Disapproval toward use of substances</td>
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<td>Perceived level of impact among participants regarding use and perceptions of substances (comparison by strategy type)</td>
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<td>Schmeeckle</td>
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<td>Have substance use related consequences improved as a result of the Prevention SABG</td>
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<td>Alcohol and drug related crashes</td>
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<td>Alcohol and drug related emergency room visits</td>
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<td>Hospital Discharge Data</td>
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<tr>
<td>How did substance use related outcomes differ based on the funding source(s) received?</td>
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<tr>
<td>#/type of funding sources used to implement substance use prevention strategies</td>
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<td>NPIRS/DBH records/RPC interviews</td>
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<tr>
<td>Perceptions and Behaviors, including, but not limited to:</td>
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<tr>
<td>• 30 day use</td>
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<td>• 30 day binge drinking</td>
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<td>• Risk of harm</td>
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<tr>
<td>• Disapproval toward use of substances</td>
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<td>Alcohol and drug related crashes</td>
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<td>Alcohol and drug related emergency room visits</td>
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<td>Jan- June 2021</td>
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Appendix: Quantitative Data Sources

National Survey on Drug Abuse and Health
The National Survey on Drug Use and Health (NSDUH) is an ongoing in-person household survey directed by SAMHSA and collected by RTI International. The survey, which provides data on substance use and perceptions, is administered to individuals 12 years of age and older. The sample is drawn to provide statewide representative data.

Youth Risk Behavior Survey
The Youth Risk and Behavior Survey (YRBS), a part of the Student Health and Risk Prevention (SHARP) Surveillance System, provides state level data on past and current use of substances. The YRBS instruments have undergone laboratory and field testing on reliability by the Centers for Disease Control and Prevention (CDC), and the data is collected by the Bureau of Sociological Research (BOSR) at UNL from a random sample of high school students in Nebraska in grades 9 through 12. The survey is administered in classrooms through a two-stage cluster design, whereby a random sample of public high schools is drawn by the CDC, then a random sample of classrooms is sampled within the selected and participating schools. The YRBS is conducted biennially by the BOSR in the fall of even years.

Behavioral Risk Factor Surveillance System
The Behavioral Risk Factor Surveillance Systems (BRFSS) is an ongoing telephone survey administered to adults 18 years of age and older. The data is collected by the BOSR, with technical and methodological assistance provided by the CDC. The sample is drawn to ensure representative data from adults in Nebraska. The survey includes a variety of health-related questions, including items related to substance use.

Nebraska Risk & Protective Factor Student Survey
The Nebraska Risk & Protective Factor Student Survey (NRPFSS), also a part of the SHARP Surveillance System, consists of community level data on substance use and perceptions. Similar to the YRBS, the NRPFSS is conducted biennially during even years in-person in Nebraska schools and is collected by the BOSR. The NRPFSS is designed and implemented as a census of students in grades 8, 10, and 12 where every public and non-public school with an eligible grade can choose to participate. Risk and protective factors found in the NRPFSS have been used from the Communities that Care (CTC) survey, the foundation of reliable and valid risk and protective factor information.

Nebraska Young Adult Alcohol Opinion Survey
The Nebraska Young Adult Alcohol Opinion Survey (NYAAOS) is administered by the BOSR to a sample of young adults ages 19 to 25 generated by the Nebraska Department of Motor Vehicles Driver Record Database. In the most recent administration, conducted in 2020, the sample was stratified by county to represent each of the SPF-PFS counties. The multi-modal survey was first administered as a web-push survey through mail contacts. A paper survey option was provided through follow-up contacts. The survey, which also utilized a lottery incentive, provides statewide and regional data on substance use and perceptions.
**Nebraska Assessment of College Health Behaviors**
The Nebraska Assessment of College Health Behaviors (NACHB) is a web-based survey administered to college students between the ages of 18-24 in Nebraska to assess their substance use attitudes and behaviors, among other issues. The survey, fielded by the Methodology and Evaluation Research Core Facility (MERC) at UNL, was first administered in the spring of 2020 at 13 Nebraska Collegiate Consortium (NCC) institutions.

**Nebraska Annual Social Indicators Survey/Nebraska Community Alcohol Opinion Survey**
The Nebraska Annual Social Indicators Survey (NASIS) is an annual omnibus mail survey administered by the BOSR to residents of the state of Nebraska age 19 or over. The sample is a simple random sample drawn from a postal delivery sequence of household addresses to provide a representative statewide sample of Nebraska households. The last birthday method is used to randomly select an adult in the household to complete the survey. Administration will be used to provide statewide baseline estimates. In addition, a brief subsection of the NASIS survey, the Nebraska Community Alcohol Opinion Survey (NCAOS) is used for an oversample in the SPF-PFS targeted counties (using the same random sampling design as NASIS, but after removing NASIS selected households). The two-page NCAOS survey includes demographics and substance use relevant questions only.
Block Grant Evaluation Proposal
2021-2022

April 2021

Prepared for:
Lindsey Hanlon
Nebraska Department of Health and Human Services
Division of Behavioral Health

Prepared by:
Alian Kasabian
University of Nebraska-Lincoln
Social and Behavioral Sciences Research Consortium

Methodology and Evaluation Research Core Facility
Social and Behavioral Science Research Consortium
University of Nebraska-Lincoln

370 Prem S. Paul Research Center at Whittier
School
2200 Vine St.
Lincoln, NE 68583-0866
http://merc.unl.edu
402-472-7218
Project Description
The purpose of this agreement is to provide evaluation services for the Nebraska Substance Abuse Prevention Treatment Block Grant (SAPTBG) Prevention Set-Aside activities.

Project Period
July 1, 2021 – June 30, 2022

Tasks and Deliverables
Perform the statewide evaluation services as outlined below:

<table>
<thead>
<tr>
<th>Administrative</th>
</tr>
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<tbody>
<tr>
<td>1. Communicate regularly with state agency project staff, participate in project-related meetings, and assist with evaluation issues related to the Block Grant project.</td>
</tr>
<tr>
<td>2. Update evaluation plan to assess regional and state-level block grant funding.</td>
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<tr>
<td>3. Create evaluation tools as needed (e.g., pre/post surveys) for local level data collection.</td>
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</table>

<table>
<thead>
<tr>
<th>Data Collection</th>
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<tbody>
<tr>
<td>4. Collect pre/post/follow-up survey data from participants of Second Step, All Stars, TGFDV, and RBST, including providing technical assistance and guidance as needed to ensure effective completion of data collection tasks, and data entry.</td>
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<tr>
<td>5. Conduct interviews with stakeholders implementing targeted strategies.</td>
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<tr>
<td>6. Conduct up to 20 focus groups with participants from Second Step, All Stars, TGFDV, and RBST, and possibly with a comparison group of non-participants.</td>
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<tr>
<td>7. Develop fidelity rubrics and conduct fidelity rubric interviews with program implementers of targeted strategies to get a better grasp of implementation fidelity.</td>
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<tr>
<td>8. Collect coalition capacity data from the non-PFS coalitions.</td>
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<tr>
<th>Analysis/Reporting</th>
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<tbody>
<tr>
<td>10. Develop data briefs for non-PFS coalitions.</td>
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<tr>
<td>11. Focused Conversation with non-PFS coalitions to digest capacity and data briefs.</td>
</tr>
<tr>
<td>12. Review NPIRS data from the Block Grant funded community coalitions.</td>
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<tr>
<td>14. Review workplans provided by each of the Block Grant funded community coalitions.</td>
</tr>
<tr>
<td>15. Review quarterly progress reports provided by each of the Block Grant funded community coalitions where this is available.</td>
</tr>
<tr>
<td>16. Analyze quantitative data (e.g., PLIs, SHARP, NYAAOS, NCAOS).</td>
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<tr>
<td>17. Analyze qualitative interview and focus group data.</td>
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<tr>
<td>18. Using data available, conduct a cost/benefit analysis of the programs of focus.</td>
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<tr>
<td>19. Write statewide and 6 region-level reports summarizing Year 1 results, including infographics.</td>
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</tbody>
</table>
**Proposed Budget:**

<table>
<thead>
<tr>
<th>MERC Service Center</th>
<th>Rate</th>
<th>Hours</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>Senior Project Manager</td>
<td>$78</td>
<td>164</td>
<td>$12,792</td>
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<tr>
<td>Project Manager</td>
<td>$52</td>
<td>780</td>
<td>$40,560</td>
</tr>
<tr>
<td>Project Associate</td>
<td>$26</td>
<td>910</td>
<td>$23,660</td>
</tr>
<tr>
<td>Project Intern</td>
<td>$26</td>
<td>1110</td>
<td>$28,860</td>
</tr>
<tr>
<td>Undergraduate Assistant</td>
<td>$16</td>
<td>240</td>
<td>$3,840</td>
</tr>
<tr>
<td><strong>Total MERC Service Center</strong></td>
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<td><strong>$109,712</strong></td>
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<tr>
<td>Supplies</td>
<td></td>
<td></td>
<td><strong>$880</strong></td>
</tr>
<tr>
<td><strong>Subaward, Schmeeckle Research, Inc.</strong></td>
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<td></td>
<td><strong>$140,055</strong></td>
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<tr>
<td><strong>Total Direct Costs</strong></td>
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<td><strong>$250,647</strong></td>
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<td><strong>Indirect Costs (10% TDC)</strong></td>
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<td><strong>$25,065</strong></td>
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<tr>
<td><strong>Total Proposed Budget</strong></td>
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<td><strong>$275,712</strong></td>
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</table>

*The rates shown here are expected at the time of writing. Work will be billed at the current rate when completed.

**Budget Justification:**

**MERC Service Center**

Service Center rates will be used for all MERC personnel. Senior project manager Alian Kasabian is estimated to commit 164 hours to oversee the work conducted by other Service Center staff and provide guidance on survey development and data analysis. An estimated 780 hours of project manager time will be committed to manage the collection of survey data, conduct interviews and focus groups, analyze data and write reports. An estimated 910 hours of project associate time will be committed to support the evaluation as needed, including conducting interviews and analyzing quantitative and qualitative data. An estimated 1,110 hours of a project intern will be committed to develop capacity briefs, review workplans and progress reports, and analyze quantitative and qualitative data. Undergraduate students are estimated to commit 240 hours to complete data entry and provide transcription support.

**Supplies**

Printing, supplies, and postage is estimated at $880 for the collection of program level instruments.

**Subaward**

Mindy Anderson-Knott of Schmeeckle Research is estimated to commit 649 hours ($110/hour) to the project to oversee the evaluation of the project and be responsible for directing the evaluation tasks. She will be involved in regular communication with the client, updating the evaluation plan, creating evaluation tools, collecting survey and interview data, overseeing the fidelity and capacity projects, and overseeing the analysis and report writing. Liz Gebhart-Morgan of Schmeeckle Research is estimated to commit 463 hours ($75/hour) to the project to assist in the evaluation. She will help with updating the evaluation plan, creating tools, reviewing NPIRS data, analyzing qualitative data and writing the reports. Celeste Illian of Schmeeckle Research is estimated to commit 400 hours ($75/hour) to analyze quantitative data, primarily for the data briefs and cost/benefit analysis. In addition, other Schmeeckle Research Inc. staff may be involved in the project as needed. The
Schmeeckle Subaward also includes travel costs for mileage for 20 visits (average 200 miles roundtrip per visit at $.56/mile), overnight hotel for five nights ($120/night), and meal reimbursements for 20 days ($55/day). These visits are budgeted for travel that may be needed for focused conversation meetings or focus group/interview data collection.

*Facility & Administration Costs*

Indirect costs are included at 10% of Total Direct Costs per sponsor limitations.
Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems
Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

DBH funds a continuum of services for persons with mental illness to live, work and receive treatment and supports in the least restrictive environment to meet their needs. Using SAMHSA's components of recovery, services focus on person centered care that supports individuals to remain in the community of their choice. Rehabilitative services support individuals to strengthen skills to alleviate functional deficits related to an individual's mental illness. Support services, focus on access to safe, affordable housing, employment, and social connection through services such as peer support.

A list of contracted services is reported below. Also, a link to Nebraska Behavioral Health System Service Definitions, known as the Continuum of Care manual, is here: Continuum-of-Care-Manual

List of funded Mental Health (MH) and Substance Use Disorder (SUD) Services
(^^ Shared Medicaid Service) (** pending system update to shared status)

Emergency Services & Inpatient Services: MH SUD
24 Hour Crisis Line YES YES
Crisis Assessment** YES YES
Crisis Response YES YES
Crisis Stabilization** YES YES
Emergency Community Support YES YES
Emergency Protective Custody YES No
Emergency Psychiatric Observation** YES No
Hospital Diversion <24 hrs. YES No
Hospital Diversion >24 hrs. YES No
Acute Hospitalization ** YES No
Sub-Acute Hospitalization** YES No
Mental Health Respite YES No
Clinically Managed Residential Withdrawal Mgmt.** YES No
Dual Residential** YES YES
Halfway House** No YES
Inpatient Post Commitment Treatment ^ ^ YES YES
Intermediate Residential** No YES
Medically Monitored Inpatient Withdrawal Mgmt ** No YES
Psych Residential Rehab** YES No
Psychological Testing** YES No
Secure Residential** YES No
Short Term Residential** No YES
Therapeutic Community** No YES
Outpatient Services: MH SUD
Assertive Community Treatment** YES No
Assessment** YES YES
Benefit Services YES No
Client Assistance Program** YES YES
Community Support** YES YES
Day Rehabilitation** YES No
Day Support YES No
Day Treatment** YES No
Family Navigator YES No
Family Peer Support ** YES No
Intensive Community Service YES YES
Intensive Outpatient - Matrix** YES YES
Intensive Outpatient** YES YES
Medication Management** YES No
Multisystemic Therapy** YES No
Opioid Treatment Program (OTP)** No YES
Outpatient Psychotherapy** YES YES
Peer Support** YES YES
Professional Partner YES No
Recovery Homes (Oxford) No YES
Recovery Support YES YES
Secure Residential R&B No YES
Substance Abuse Prevention Services No YES
SOAR YES YES
Supported Education YES No
Supported Employment YES YES
Supported Housing YES YES
Therapeutic Consultation Yes No
Warm Hand Off YES YES
Youth Assessment ^^ YES YES
Youth Transition Services No YES
#END

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

a) Physical Health
   - Yes
   - No

b) Mental Health
   - Yes
   - No

c) Rehabilitation services
   - Yes
   - No

d) Employment services
   - Yes
   - No

e) Housing services
   - Yes
   - No

f) Educational Services
   - Yes
   - No

g) Substance misuse prevention and SUD treatment services
   - Yes
   - No

h) Medical and dental services
   - Yes
   - No

i) Support services
   - Yes
   - No

j) Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)
   - Yes
   - No

k) Services for persons with co-occurring M/SUDs
   - Yes
   - No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

3. Describe your state’s case management services

Case management services are available to youth, families, and adults through services such as Assertive Community Treatment, Community Support, Youth Transition, Professional Partner Program, Peer Support, and Intensive Community Services. The target is to identify needs that may be contributing to the illness or impacting recovery, and as such, a biopsychosocial evaluation and treatment plan addressing the issues is an expected part of service delivery. Linkage and coordination to resources supporting stable community living is a desired outcome of participation in many of the services. The service definitions delineate the requirement to coordinate care with other treatment providers, in particular, other healthcare providers.


4. Describe activities intended to reduce hospitalizations and hospital stays.

Emergency Protective Custody (EPC) holds are tracked and reviewed on a monthly basis through data provided by treatment services and Emergency Coordinators across the state. The DBH has identified performance measures to drive improved emergency system services and in turn further reduce hospitalization admissions and inpatient length of stay. Continued efforts with community providers and inpatient care providers both (community based and state hospital) to implement process improvement activities and utilize the Centralized Data System are anticipated to provide data to support and/or change practices that will
positively impact lengths of stay and utilization of residential and inpatient care.

The DBH conducts Mental Health Board training with individuals who serve on Mental Health Boards across the state to help with consistent application of clinical criteria used to determine if an individual needs to be committed for outpatient or inpatient care. DBH has worked with Regional Emergency Coordinators to identify individuals with frequent readmissions to service and shorter community tenure. When these individuals are identified, specific coordination with the Regional Behavioral Health Authority (RBHA) and network providers is initiated to assist in establishing appropriate service referrals and crisis planning to support the individual in the community.

The DBH has implemented targeted access measures for specific services; access to medication management service following a discharge from an inpatient setting was one such prioritized service and often presented as a barrier to earlier discharge or was seen as a key factor in readmission to hospitalization. The DBH worked with the Advisory Councils, RHBAs and network hospitals to define the access measure and has built in reporting capability to help track this over time. In FY17, 90.3% of consumers discharging from IP care were able to access medication management within 21 days of discharge; in FY20, this increased to 94.7% of consumers. It is expected that improvement in access to ongoing medication management following discharge from inpatient care will have positive impact on readmission rates.

Additionally, reduction in utilization of inpatient and residential care is a key outcome being monitored through the youth system of care work. This is being done through ongoing expansion of the community based service system, developing workforce competencies in serving youth with complex needs, and continuing to invest in prevention and early intervention programs.
In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state’s M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

<table>
<thead>
<tr>
<th>Target Population (A)</th>
<th>Statewide prevalence (B)</th>
<th>Statewide incidence (C)</th>
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<tbody>
<tr>
<td>1. Adults with SMI</td>
<td>62093</td>
<td>10,993</td>
</tr>
<tr>
<td>2. Children with SED</td>
<td>28,449</td>
<td>1,667</td>
</tr>
</tbody>
</table>

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

Column B Estimates of “Statewide Prevalence”: Source Row 1 – Adults with SMI: Estimate obtained by multiplying the 2017 American Community Survey (ACS) estimate for Nebraskans 18+, 1,444,034, by 2016/2017 NSDUH estimated percent of Nebraskans with SMI, 4.3. – Source Row 2 – Children with SED: “URS Table 1: Number of Children with a Serious Emotional Disturbance, age 9 to 17, by State, 2017” Estimate based on Level of Functioning threshold score of ≤ 60 using upper limit. Column C Estimates of “Statewide Incidence”: Source Row 1 – Adults with SMI: URS Table 16 “Profile of Adults with Serious Mental Illnesses and Children with Serious Emotional Disturbances Receiving Specific Services” – Source Row 2 – Children with SED: Table 16.
## Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?

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<tbody>
<tr>
<td>a)</td>
<td>Social Services</td>
<td>□ Yes □ No</td>
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<td>b)</td>
<td>Educational services, including services provided under IDE</td>
<td>□ Yes □ No</td>
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<td>c)</td>
<td>Juvenile justice services</td>
<td>□ Yes □ No</td>
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<td>d)</td>
<td>Substance misuse prevention and SUD treatment services</td>
<td>□ Yes □ No</td>
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<tr>
<td>e)</td>
<td>Health and mental health services</td>
<td>□ Yes □ No</td>
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<tr>
<td>f)</td>
<td>Establishes defined geographic area for the provision of services of such system</td>
<td>□ Yes □ No</td>
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</tbody>
</table>
Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

**Criterion 4**

a. Describe your state’s targeted services to rural population.

The DBH provides community based services to individuals with mental health and/or substance use disorders who live in rural areas, which geographically represents much of Nebraska. As of July 1, 2018, the U.S. Census estimated that Nebraska’s total population was 1,929,268, with approximately 34.43% of persons living in rural counties.

Nebraska is a geographically large area with 99.3% of its land area classified as rural based on population size in 2010, according to the U.S. Census Bureau. And the National Center for Frontier Communities, using the state office of rural health definition of frontier, classified 39 of the 93 Nebraska counties as frontier based on 2010 census data. In 2017, 88 of Nebraska’s 93 counties were designated as federal mental health professional shortage areas. Individuals across the state can identify and locate behavioral health services nearest to their home through the online resource Network of Care. DBH contracts for the Nebraska Network of Care, an online resource for people with behavioral health needs, their caregivers, and service providers that lets people access information about issues such as treatments, resources and diagnoses, and wellness recovery action plans. Consumers can also choose to communicate directly with other participants and to organize and store their own personal health information.

Behavioral health services funded through the CMHSBG and the SAPTBG are identified above in Criterion 1. These are services available to maintain a continuity of care for individuals who have been served through programs providing outreach and services for rural residents, older adults, and individuals who experience homelessness in frontier, rural and urban areas.

Partnerships and collaborations with public and private systems, as well as with individuals, families, and communities are important components in systems of care surrounding each individual served. For example, other state agencies (e.g., State Probation through the Nebraska Supreme Court, the Nebraska Department of Correctional Services (NDCS), the Nebraska Department of Education Vocational Rehabilitation (NDE-VR), and the Veterans Administration) fund or support behavioral health services for specific populations. The DBH collaborates with the NDCS to ensure those individuals released from correctional facilities are connected with the services they need to meet their rehabilitation needs. The DBH works with NDE-VR in the provision of Supported Employment services to individuals with serious mental illness and substance use disorders.

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

Telehealth has become an increasingly important method of alternative service delivery to rural areas. Although it has been a reimbursable activity previous to the pandemic, the use of telehealth has increased due to pandemic restrictions and provided a tremendous benefit to those who otherwise might need to travel significant distances to access care. DBH began collecting method of service delivery in January 2021. Preliminary data indicates that 62.6% of services were delivered via traditional face to face, 23.1% by telehealth, 9.1% by telephone only and 1% by a combination of telehealth and telephone. DBH will continue to capture the data and trend the information.

b. Describe your state’s targeted services to the homeless population.

Persons who are homeless and have mental illness in Nebraska have specialized needs that may not be met by more traditional service delivery methods. Projects for Assistance in Transition from Homelessness (PATH) works with local area providers in areas with the highest rates of homelessness who work to meet the immediate needs of homeless individuals and at the same time assist consumers in developing self-sufficiency through referral and attainment of services. In addition to the PATH funds that support the RBHAs in serving the population areas with the highest rates of homelessness, the Nebraska Homeless Assistance Program (NHAP) within the DHHS Division of Children and Family Services supports a network of shelter, supportive housing, and service providers. These providers plan for and provide a balance of emergency, transitional, and permanent housing and service resources to address the needs of people who are homeless so they can make the critical transition from homelessness to jobs, independent living, and permanent housing. For more information on NHAP see the DHHS web site at:

http://dhhs.ne.gov/Pages/Homeless-Assistance.aspx

Stable living at discharge from all services is a provider, region and state performance measure reviewed monthly. The DBH, through state funds, provides housing related assistance funds to support transition to safe and affordable permanent housing. DBH also targets support of recovery housing such as Oxford Houses which provide access to housing to persons in recovery who might otherwise be homeless. In FY20, DBH reports 83% of individuals were discharged to stable living arrangements across all
c. Describe your state's targeted services to the older adult population.

The Nebraska Care Management Program was created through a legislative mandate in 1987 and established a statewide system of care management units through the Area Agencies on Aging. Care managers assist older persons with functional disabilities, both physical and mental, and help their families select and obtain a variety of services that allow them to remain in a residence of their choosing. Counseling Services provides information and advice for older individuals in regard to public and private insurance, public benefits, lifestyle changes, legal matters and other appropriate matters. Included in Counseling Services are Legal Assistance, Financial Counseling, Volunteer Placement, Case Management, Employment Program, Ombudsman and Mental Health Counseling. Mental Health Counseling services provide counseling to an individual by a licensed mental health professional which is intended to address a diagnosed mental health condition.

DBH staff work with system partners on training and outreach to nursing facilities and assisted living facilities who serve the older population to better identify and screen and respond to their behavioral health needs. The Pre-Admission Screening and Resident Review (PASRR) functionality resides within DBH to ensure individuals appropriately meet nursing facility level of care and if specialized behavioral health service needs are identified, they are provided.
Criterion 5

Describe your state’s management systems.

Workforce competency is bolstered through several methods. The Behavioral Health Education Center of Nebraska (BHECN) trains students and mental health professionals with a focus on meeting the needs of employers and consumers. Using a regional approach, BHECN delivers training, curriculum development, outcomes research, and funds psychiatric residents who provide service to underserved areas. They partner with community agencies to offer practice based learning to students and professionals. The Workforce Analysis completed by BHECN helps identify knowledge gaps and workforce needs.

The DBH, in collaboration with the University of Nebraska Public Policy Center, hosts regular trainings to strengthen the knowledge base and skill set of providers. The trainings are offered at no cost to providers and are made available via access to recording to those unable to attend so that they can be widely disseminated. Grant funding allows Nebraska mental health providers to access a variety of trainings and materials geared towards serving people with SUD, SMI and SED, which leads to a more skillful, up to date, and successful workforce.

Increasing Nebraska’s behavioral health workforce competencies to serve individuals with complex and co-occurring needs through specific and targeted best practices and to best carry out the plan included the DBH targeting competency trainings as identified in the FY19-20 DHHS Business Plan. Through collaborative relationships, as of June 2021, the cumulative count of providers receiving training for workforce competency enhancement/improvement reached 1,986 trained (July 2019-May 2021). Multiple trainings were postponed or rescheduled as a result of Covid -19 however, training of providers exceeded annual targets.

The Division of Behavioral Health (DBH) ensures block grant funds and state dollars are used in accordance with SAMHSA’s expectations that the FFY2022-2023 block grants funds to be directed toward four purposes:
1. To fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time;
2. To fund those priority treatment and support services not covered by CHIP, Medicaid, Medicare, or private insurance for low-income individuals and that demonstrate success in improving outcomes and/or supporting recovery;
3. For SABG funds, to fund primary prevention: universal, selective, and indicated prevention activities and services for persons not identified as needing SUD treatment; and
4. To collect performance and outcome data to determine the ongoing effectiveness of promotion/SUD prevention, treatment and recovery supports and to plan the implementation of new services.

The DBH contracts with the six RBHAs to enroll providers in their networks. The four purposes related to block grant funding are passed through to RBHAs in the Regional Budget Planning Guidelines.

DBH regulations defines the financial eligibility criteria for consumers seeking care. Within these regulations (NAC 206, Chapter 6.005), it clearly defines that DBH reserves the right to be the payer of last resort and that DBH will not reimburse providers for any Medicaid reimbursable service provided to Medicaid consumers.

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

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

DBH is committed to creating a culture that fosters improvement; a culture where data is collected, reported and used to guide policy and implementation. The DBH administrative oversight includes, but is not limited to, the of use statewide data, including:
• Capacity and Waiting Lists
• Utilization
• DBH Centralized Data System activities
• Annual Consumer Survey
• National Outcome Measures (NOMs)
• Professional Partner Program (PPP)
• Emergency System Report
• Uniform Reporting System (URS)
• Treatment Episode Data Set (TEDS)
The DBH holds itself accountable for strategic plan results through Results-Based Accountability (RBA) methodology. DBH provides training and technical assistance to build the capacity of DBH and its contracted RBHAs to use RBA for its Performance Accountability System. Within the RBA performance dashboard framework, the DBH and RBHAs utilize Continuous Quality Assurance and Improvement processes to measure outcomes for established performance metrics.

RBA methodology provides:
- Consistency in Language
- Identification of State Priorities to Measure
- Framework for Interpreting and Studying Data to Help “Turn the Curve”
- Reporting Successes and Planning for Work that Remains
- Preparation for Performance Contracting

Through the CQI program, DBH links data, knowledge, structures, processes, and outcomes which enables DBH to implement improvements throughout the system. Within the public Nebraska Behavioral Health System, DBH operationalizes the CQI Core Principles, including:
- Customer Focused
- Strength Based
- Recovery Oriented
- Representative Participation and Active Involvement
- Data Informed Practice
- Use of Statistical Tools
- Continuous Quality Improvement Activities

DBH sets clear direction through an annual CQI plan. The DBH CQI program establishes accountability through:
- Data Calls
- Annual Report
- Annual Consumer Survey
- Partnership Survey
- Services provided to consumers and families in the state of Nebraska
- Business Plan and Performance Dashboards
- Strategic Plan and Updates

The DBH has implemented an in-house Centralized Data System (CDS) to monitor and report on treatment and programmatic activities within the Nebraska Behavioral Health System. Functionality within the CDS includes:
- Consumer demographics
- Encounter and waitlist management
- Alert and notifications to the end users
- Authorizations and Appeals
- Business rule engine to hold the logic by which authorization criteria are met
- Utilization Management and Billing – billing to be built in a separate system (the DBH in-house Electronic Billing System), but will have a very close synchronization with the CDS
- Reports and dashboards

The DBH has implemented an in-house Electronic Billing System (EBS) for the purpose of contract management and reporting of various funds to assist Community-Based Consumers. EBS is a billing system, not a claims system. The EBS structure includes five principal layers: Service; Provider; Contract; Payment Methodology, and Spending Authority. Functionality within EBS includes:
- Contract building
- Budgeting
- Payment Processing
- Reallocation of Funds, and
- Reports and dashboards including costs per service and costs per person served

DBH administrative tools, including the annual Region Budget Plan Guidelines and the contracts with the six RBHAs, are the primary mechanisms to support program integrity. Each year, the RBHAs are statutorily required to submit a Regional Budget Plan. The Plan overviews the comprehensive mental health and substance use disorder services with sufficient capacity for designated geographic area that are based on a comprehensive needs assessment/strategic plan as well as pertinent fiscal and utilization data. This budget plan is submitted to the DBH per specific specifications and expectations detailed in Regional Budget Plan Guidelines. Within these guidelines, federal program requirements are listed including the populations to be served with the funding, allowable and unallowable expenditures, and audit requirements, as well as the specific purposes identified by SAMHSA for the block grant. This document, along with their respective plans, are incorporated into the subsequent subaward issued by the DBH. The RBHAs, in turn, pass these same terms and requirements to subsequent recipients of the funds, which is verified in the Network Services Review in which DBH reviews compliance to contractual requirements.

In addition, it is a shared responsibility of the DBH and RBHAs to monitor, review, and perform programmatic, administrative, and
fiscal accountability and oversight functions on a regular basis with all subcontractors. If the RBHA is a direct provider of services, the DBH is responsible for the oversight functions for the services provided directly by the Region.

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

External measures are performed by outside entities and include:
1. Fiscal audit as conducted by a certified public accountant, and
2. Accreditation by a nationally recognized accrediting body.

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

**10. Substance Use Disorder Treatment - Required SABG**

**Narrative Question**

**Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs**

**Criterion 1**

**Improving access to treatment services**

1. Does your state provide:

   a) A full continuum of services

      i) Screening

      ii) Education

      iii) Brief Intervention

      iv) Assessment

      v) Detox (inpatient/social)

      vi) Outpatient

      vii) Intensive Outpatient

      viii) Inpatient/Residential

      ix) Aftercare; Recovery support

   b) Services for special populations:

      Targeted services for veterans?

      Adolescents?

      Other Adults?

      Medication-Assisted Treatment (MAT)?
Criterion 2: Improving Access and Addressing Primary Prevention -See Narrative 8. Primary Prevention-Required SABG.
Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability?  
   - Yes □  No □

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities?  
   - Yes □  No □

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care?  
   - Yes □  No □

4. Does your state have an arrangement for ensuring the provision of required supportive services?  
   - Yes □  No □

5. Has your state identified a need for any of the following:
   a) Open assessment and intake scheduling  
      - Yes □  No □
   b) Establishment of an electronic system to identify available treatment slots  
      - Yes □  No □
   c) Expanded community network for supportive services and healthcare  
      - Yes □  No □
   d) Inclusion of recovery support services  
      - Yes □  No □
   e) Health navigators to assist clients with community linkages  
      - Yes □  No □
   f) Expanded capability for family services, relationship restoration, and custody issues?  
      - Yes □  No □
   g) Providing employment assistance  
      - Yes □  No □
   h) Providing transportation to and from services  
      - Yes □  No □
   i) Educational assistance  
      - Yes □  No □

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Beginning July 2017, the Centralized Data System began tracking the delivery date of (federally defined) interim services for individuals placed on a waiting list (including PWWDC); thus allowing for more precise tracking and monitoring of program compliance. Additionally, an online capacity tracking offers weekly review of capacity over 90% to ensure adequate capacity for services exist in Nebraska. Capacity used percentages over 90% are displayed as an alert for monitoring and follow up as applicable. The Division continues to work with the RBHAs providing guidance on expectations for PWWDC, providing information and annually collecting information on trainings on this topic done by RBHAs.
**Criterion 4, 5 and 6: Persons Who inject Drugs (PWID), Tuberculosis (TB), Human Immunodeficiency Virus (HIV), Hypodermic Needle Prohibition, and Syringe Services Program**

### Criterion 4,5&6

**Persons Who Inject Drugs (PWID)**

1. Does your state fulfill the:
   - a) 90 percent capacity reporting requirement  
     - Yes  
     - No
   - b) 14-120 day performance requirement with provision of interim services  
     - Yes  
     - No
   - c) Outreach activities  
     - Yes  
     - No
   - d) Syringe services programs, if applicable  
     - Yes  
     - No
   - e) Monitoring requirements as outlined in the authorizing statute and implementing regulations  
     - Yes  
     - No

2. Has your state identified a need for any of the following:
   - a) Electronic system with alert when 90 percent capacity is reached  
     - Yes  
     - No
   - b) Automatic reminder system associated with 14-120 day performance requirement  
     - Yes  
     - No
   - c) Use of peer recovery supports to maintain contact and support  
     - Yes  
     - No
   - d) Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)?  
     - Yes  
     - No

3. States are required to monitor program compliance related to activities and services for PWID. Please provide a detailed description of the specifics strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

In the State to RBHA contract for substance use services, RBHAs are required to adhere to the priority populations' admission process in providing substance use treatment. Priority admission requirements apply to all Substance Use Disorder services contracted by DBH receiving State or Federal Dollars, including Dual Diagnosis Services and Supported Housing Services. The RBHA ensures that this priority population list is maintained at the provider level via inclusion in the RBHA to Network Provider contract.

Regional providers of substance use services are required to admit Persons Who Inject Drugs (PWID) into services within 48 hours of initial contact. Admission may be immediate into the appropriate recommended treatment or placement on the waiting list with the provision of interim services within 48 hours, with these interim services continuing until the PWID is admitted into the recommended treatment. Should the provider not have an opening immediately available, the provider works with RBHA personnel to find openings within the RBHA and throughout the state to offer the PWID. Should the PWID choose to wait for an opening with the intake provider, the person’s name is placed on the waitlist, according to his/her priority, and no later than 48 hours following initial contact, is offered interim services. The intake provider contacts the PWID weekly to follow his/her progress and to update her on available openings with the intake provider as well as available openings statewide. The provider maintains this weekly contact with the PWID until admitted into services or substance use treatment services are declined.

Providers of substance use services are required to submit information regarding consumers to the RHBA and DBH through entry into the Centralized Data System. This information includes but is not limited to priority type who are receiving services in addition to information for all consumers according to their priority level who are placed on the provider’s waiting list for specified services. Priority levels include: (1) pregnant injecting drug users; (2) other pregnant substance users; (3) other injecting drug users; (4) women with dependent children; and, (5) all others, including those consumers with Mental Health Board Commitments.

The submitted data by RBHA, the resultant reports, the (Statewide) Weekly Substance Abuse Capacity Report, and, the (Statewide) Weekly Substance Abuse Priority Waiting/Interim Services List for Priority Populations, are compiled and distributed to the RBHAs to monitor and to share with providers.

Through the annual Services Purchased and tri-annual Program Fidelity reviews and audits, the RBHA conducts formal reviews of individual consumer substance use treatment at the provider level. A component of these reviews is the timeliness of admission into interim and recommended substance use treatment. At least once per three-year cycle, and, using a DBH developed Substance Abuse Treatment and Prevention Block Grant tool, providers are assessed for their capability in providing services for PWID.

Tools include a Network Contractual Compliance Checklist which specifically verifies network administration and management systems. This helps to ensure the RBHA provider network has the capacity to provide substance abuse prevention services and substance use treatment for priority populations, including PWID, and the mechanisms the RBHA employs to address waitlist requirements and monitor timeframes. The Network Contractual Compliance Checklist tool identifies the need for corrective actions, plan of corrective status and next steps by the Provider/RBHA.
Should the review result in the need for a Corrective Action Plan (CAP), the plan is due to the RBHA within 30 days of receipt of the audit report. A copy of the CAP will be forwarded to the Division upon receipt by the RBHA with the RBHA’s final report and subsequent follow-up reports sent to the Division upon completion.

The RBHA shall complete a report detailing the results of the review and distribute it to the provider within 45 days of the visit. If the review indicates less than substantive compliance, the report shall require the provider to complete a Corrective Action Plan (CAP) detailing how they intend to correct the components not meeting compliance. CAPs shall be submitted to RBHA/Division within 30 days of the notification that the provider did not meet compliance standards in the review.

Upon receipt of the CAP, the RBHA/DBH may provide technical assistance (TA Plan) to the provider. Another available option is to put the provider on probationary status with re-review of the service(s) within the current year, or, for less severe transgressions, wait until the next fiscal year’s review.

If the provider does not take corrective action, or does not submit needed documentation for corrective action by the due date, the RBHA shall withhold payment from the provider for the identified service(s) until such required documentation is received by the RBHA. If similar or additional sanctions are required in successive program fidelity reviews, or if corrective actions are not made, additional sanctions will be imposed. These sanctions may include, but are not limited to, requiring additional Corrective Action Plans, termination of purchasing the specific service from the provider, or termination of contract with the provider.

In July 2017, the Centralized Data System began tracking the delivery date of (federally defined) interim services for individuals placed on a waiting list (including PWWDC); thus allowing for more precise tracking and monitoring of program compliance. Additionally, an online capacity tracking will offer weekly review of capacity over 90% to ensure adequate capacity for services exist in Nebraska. Capacity used percentages over 90% are displayed as an alert for monitoring and follow up as applicable.

**Tuberculosis (TB)**

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery?  
   - Yes  
   - No

2. Has your state identified a need for any of the following:
   a) Business agreement/MOU with primary healthcare providers  
      - Yes  
      - No
   b) Cooperative agreement/MOU with public health entity for testing and treatment  
      - Yes  
      - No
   c) Established co-located SUD professionals within FQHCs  
      - Yes  
      - No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

   Nebraska’s system monitors data needed to identify compliance issues and the success of corrective action plans for tuberculosis services provided through the block grant. The system includes standardized reporting to the DBH.

   These processes are achieved through the propagation of the annual Regional Budget Plan Guidelines and State to RBHA contract. In the State to RBHA contract for substance use services, the RBHA will ensure that providers receiving State or Federal Dollars will routinely make TB services available to each individual receiving treatment for substance use disorders and to monitor such service delivery. The RBHA ensures that this requirement is maintained at the provider level via inclusion in the RBHA to Network Provider contract.

   Each RBHA has established 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
   g. Document screening, testing, referrals and/or any necessary follow-up information

   Tools include a Network Contractual Compliance Checklist which specifically verifies Network Administration and Management Systems ensure the RBHA provider network has the capacity to provide such substance abuse prevention services and substance use treatment services, and the mechanisms the RBHA employs to address requirements and monitor timeframes. The Network Contractual Compliance Checklist tool identifies the need for corrective actions, plan of corrective status and next steps by the Provider/RBHA.
with SAPTBG requirements (interim services, tuberculosis and HIV requirements, subcontractor compliance and charitable choice) for agencies designated as, and providing services for, specified priority consumer populations (IV drug users, pregnant women, women with dependent children). This fidelity review is conducted a minimum of once every three years for those agencies who receive SAPTBG funds and is conducted at the time of the services purchased review. Please see PWID question #3 above for more detail.

**Early Intervention Services for HIV (for "Designated States" Only)**

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring the service delivery?  
   - Yes  
   - No

2. Has your state identified a need for any of the following:
   
   a) Establishment of EIS-HIV service hubs in rural areas  
   - Yes  
   - No

   b) Establishment or expansion of tele-health and social media support services  
   - Yes  
   - No

   c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS  
   - Yes  
   - No

**Syringe Service Programs**

1. Does your state have in place an agreement to ensure that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes (42 U.S.C. § 300x-31(a)(1))?  
   - Yes  
   - No

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program?  
   - Yes  
   - No

3. Do any of the programs use SABG funds to support elements of a Syringe Services Program?  
   - Yes  
   - No

If yes, please provide a brief description of the elements and the arrangement.
**Criterion 8,9&10**

**Service System Needs**

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state’s approach for improvement?

2. Has your state identified a need for any of the following:
   a) Workforce development efforts to expand service access
   b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services
   c) Establish a peer recovery support network to assist in filling the gaps
   d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, sexual and gender minorities)
   e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations
   f) Explore expansion of services for:
      i) MAT
      ii) Tele-Health
      iii) Social Media Outreach

**Service Coordination**

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care?

2. Has your state identified a need for any of the following:
   a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services
   b) Establish a program to provide trauma-informed care
   c) Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education

**Charitable Choice**

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 ($54.8(b) and $54.8(c)(4)) and 68 FR 56430-56449)?

2. Does your state provide any of the following:
   a) Notice to Program Beneficiaries
   b) An organized referral system to identify alternative providers?
   c) A system to maintain a list of referrals made by religious organizations?

**Referrals**

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs?

2. Has your state identified a need for any of the following:
   a) Review and update of screening and assessment instruments
   b) Review of current levels of care to determine changes or additions
   c) Identify workforce needs to expand service capabilities
d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background

Patient Records
1. Does your state have an agreement to ensure the protection of client records?  
   - Yes  - No
2. Has your state identified a need for any of the following:
   a) Training staff and community partners on confidentiality requirements
      - Yes  - No
   b) Training on responding to requests asking for acknowledgement of the presence of clients
      - Yes  - No
   c) Updating written procedures which regulate and control access to records
      - Yes  - No
   d) Review and update of the procedure by which clients are notified of the confidentiality of their records including the exceptions for disclosure:
      - Yes  - No

Independent Peer Review
1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers?  
   - Yes  - No
2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.
   Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.
   Starting July 1, 2013 the Division of Behavioral Health (DBH) established a new approach consistent with revised SAMHSA program policy on using private accreditation bodies to meet this Independent Peer Review requirement under both the MHBG and SABG. There is an expectation of most SABG and MHBG fund recipients to have National Accreditation through the The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or other nationally recognized accreditation organization(s) approved by the Director (Chapter 5, section 001.3).
   The only exceptions would be for substance abuse prevention funds, when a nationally recognized accreditation organization appropriate to the organization’s services cannot be identified, and/or when there is evidence that, due to the organization’s size and service utilization, accreditation is not fiscally feasible.
3. Has your state identified a need for any of the following:
   a) Development of a quality improvement plan
      - Yes  - No
   b) Establishment of policies and procedures related to independent peer review
      - Yes  - No
   c) Development of long-term planning for service revision and expansion to meet the needs of specific populations
      - Yes  - No
4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds?  
   - Yes  - No
   If Yes, please identify the accreditation organization(s)
   i) Commission on the Accreditation of Rehabilitation Facilities
   ii) The Joint Commission
   iii) Other (please specify)
      Commission on Accreditation
Narrative Question

Criterion 7 and 11: Group Homes for Persons In Recovery and Professional Development

Criterion 7 & 11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program?  
   - Yes  - No

2. Has your state identified a need for any of the following:
   a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service  
      - Yes  - No
   b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing  
      - Yes  - No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state’s substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:
   a) Recent trends in substance use disorders in the state  
      - Yes  - No
   b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services  
      - Yes  - No
   c) Performance-based accountability:  
      - Yes  - No
   d) Data collection and reporting requirements  
      - Yes  - No

2. Has your state identified a need for any of the following:
   a) A comprehensive review of the current training schedule and identification of additional training needs  
      - Yes  - No
   b) Addition of training sessions designed to increase employee understanding of recovery support services  
      - Yes  - No
   c) Collaborative training sessions for employees and community agencies’ staff to coordinate and increase integrated services  
      - Yes  - No
   d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort  
      - Yes  - No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?
   a) Prevention TTC?  
      - Yes  - No
   b) Mental Health TTC?  
      - Yes  - No
   c) Addiction TTC?  
      - Yes  - No
   d) State Targeted Response TTC?  
      - Yes  - No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924, and 1928 (42 U.S.C. 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:
   a) Allocations regarding women  
      - Yes  - No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:
   a) Tuberculosis  
      - Yes  - No
   b) Early Intervention Services Regarding HIV  
      - Yes  - No

3. Additional Agreements
   a) Improvement of Process for Appropriate Referrals for Treatment  
      - Yes  - No
   b) Professional Development  
      - Yes  - No
c) Coordination of Various Activities and Services

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

NDHHS Division of Behavioral Health Rules & Regulations – Title 206 Behavioral Health Services public access via URL:

http://dhhs.ne.gov/Pages/Title-206.aspx
Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

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

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2020-FFY 2021?
   - Yes
   - No

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

None at this time.

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Footnotes:
Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma \(^57\) is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing ?business as usual.? These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA’s guidance for implementing the trauma-informed approach discussed in the Concept of Trauma\(^58\) paper.

\(^{57}\) Definition of Trauma: Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.

\(^{58}\) Ibid

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

1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues?
   - Yes ☑️ No

2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers?
   - Yes ☑️ No

3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care?
   - Yes ☑️ No

4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?
   - Yes ☑️ No

5. Does the state have any activities related to this section that you would like to highlight.

The Division of Behavioral Health (DBH) has a public policy statement to promote the provision of a Trauma-Informed System of Care which describes our commitment to transform publically funded systems by strengthening the understanding of the broad effect of trauma, including safety, on the lives and communities of all Nebraskans. The State of Nebraska is committed to infusing trauma informed awareness, knowledge and skills into the organizational cultures, practices and policies that impact the system of care for children and adults.

DBH has included definitions and language in the regulations to support trauma-informed care and provide clarity in
The DBH believes that all system of care stakeholders and providers:

a) Understand their role and capacity to ensure trauma-informed responses in every interaction with children, adolescents and adults;

b) Are informed about the effects of psychological trauma and ensure agency wide commitment to a trauma-sensitive environment;

c) Ensure staff at every level is equipped with appropriate competencies to effectively address trauma;

d) Ensure that early assessment for trauma occurs utilizing research based strategies;

e) Ensure that all consumer interactions and services are recovery-oriented and trauma-sensitive; and

f) Understand that re-traumatization may occur if safe, effective, responsive services and practices are not available.

Through the DBH Regional Budget Plan (RBP) Guidelines and contracts with the six Regional Behavioral Health Authorities (RBHAs), it is expected that providers are competent in the delivery of trauma informed care. Expectations include that RBHA network development and coordination must develop and implement strategies to ensure that all behavioral health providers are informed about the effects of trauma, consistently screen for trauma symptoms and history of traumatic events, provide ongoing assessment of trauma symptoms and problems related to that trauma, offer services that are recovery oriented and trauma sensitive and are made aware that re-traumatization may occur if safe, effective, responsive services are not available.

DBH directs providers to screen clients for a personal history of trauma. Disclosure of trauma information by consumers takes a trusting relationship and may not be best captured right at the time of admission. Trauma screening information may be available at admission but is not required until discharge, thus allowing for rapport between the consumer and provider to be established. Trauma information can be updated in the DBH Centralized Data System (CDS) at any time the provider identifies new information relevant to the treatment program. Data is constantly available to the RBHAs and providers for review through the CDS. DBH uses the philosophy of trauma screening as a universal precaution. When screenings were initiated, the DBH provided specific instructions to providers about the process of screening which was based on the Harris and Fallot Universal Trauma Screening Guidelines (2001). Key principles include being aware of the individual’s needs, strengths and vulnerabilities prior to the screening, and using the screening as early as possible (and appropriate) in the assessment process.

RBHAs must also annually submit a list of the number of the trauma specific services that providers have available to support consumer choice in selecting trauma services. Over the last few years, the DBH noted a range of services listed as trauma specific. A repository was developed and placed on our Network of Care website.

http://dhhs.ne.gov/Reports/Trauma%20Informed%20Services%20Fiscal%20Year%202015.pdf

The DBH Strategic Plan requires effectiveness and specifies a continuous quality improvement (CQI) process for services funded by the DBH, focusing on a number of factors including trauma. Providers were initially trained on the Harris and Fallot TIC tool and required to complete the self/peer assessment beginning in 2013 and with regular reassessment every other year thereafter.

Reassessment is currently underway in 2021. After the Trauma-Informed Care (TIC) assessment was completed, results were reviewed and strengths for continued growth as well as opportunities for improvement were reviewed. Focus has been aimed at improvement in consideration of trauma across all service components including but not limited to: Program Procedures and Settings; Formal Service Policies; Trauma Screening, Assessment, and Service Planning; Program Procedures and Settings; Administrative Support for Program Wide Trauma-Informed Services; Human Resources Practices; and Staff Trauma Training and Education. Analyses is conducted for continuation of improvement efforts and to identify ongoing training needs. Data submission will continue in the next BG cycle to determine provider and Region progress and needed training for TIC.

DBH promotes Trauma Informed Care through a statewide initiative, Trauma Informed Nebraska (TIN). The purpose of TIN is to promote the development and implementation of a statewide, consumer-driven, recovery-oriented, trauma-informed system that ensures all behavioral health providers are informed about the effects of psychological trauma and are aware of the origin and effects of trauma on survivors. Through TIN, the DBH and the Behavioral Health Education Center of Nebraska (BHECN), multiple trainings called Trauma 101 and Recovery, have been provided to network providers over the last several years. A train the trainer process was established to ensure there is ongoing training throughout the state. Trauma 101 and Recovery includes:

- Introductions/Opening Exercise; Define PTSD and Trauma; Trauma Informed and Trauma Specific; Symptoms of PTSD/Triggers; ACES Study/Survey/Applications; Screening; Healing Neen Video; PTSD and Substance Use Disorder; Memory and Trauma; Creating Safe Environments; Vicarious Trauma – Exercise; Treatment Approaches; Trauma/Addiction/Recovery; Resources. DBH in conjunction with the UNL PPC has sponsored numerous TIC trainings and have training specific for CPSS (Peer Certification) to ensure best practices.

Trauma educational opportunities and resources about trauma specific services are not uncommon. Materials on Seeking Safety, PCIT and TF-CBT are examples. Nebraska has had a number of providers and RBHAs involved in the National Learning Community on trauma. Training material and resources continue to be shared.

DBH places great importance on continuing the strengthening of partnerships to help address trauma needs system wide. A June 2019 National Association of Alcohol and Drug Abuse Counselors training included trauma informed care. The DBH, in collaboration with the Administrative Office of the Courts and Probation, held a Statewide Behavioral Health – Justice Conference.
in October 2019. Presentations include addressing trauma from individual and workforce perspectives.

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

None at this time.

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Footnotes:
Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question
More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.\(^{59}\)

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.\(^{60}\)

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

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\(^{60}\) *http://csgjusticecenter.org/mental-health/

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services? **Yes** **No**

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? **Yes** **No**

3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system? **Yes** **No**

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances? **Yes** **No**

5. Does the state have any activities related to this section that you would like to highlight?

The Justice Behavioral Health Committee (JBHC), formerly known as the Justice Substance Abuse Team, was created in 2003 to help improve communication and collaboration between the criminal justice and treatment systems. JBHC is staffed by the Administrative Office of Probation. This group meets quarterly and consists of 34 members representing the Executive and Judicial branches as well as behavioral health treatment providers and consumers. JBHC has established the Data, Curriculum, Sex Offender, and Provider sub-committees to assist in fulfilling its mission. The Division of Behavioral Health (DBH), in partnership with justice partners, and through the work of the Justice Behavioral Health Committee, established assessment standards and core curriculum rubrics incorporated into justice and behavioral health trainings. Confirmation of the rubrics and associated trainings are reviewed annually with the committee which includes representatives from Corrections, Parole, Probation, Problem Solving Courts, Regional Behavioral Health Authorities (RBHAs) and providers, Licensing Boards, Medicaid, Public Health, Child and Family Services, Public Defense, research and academia.

The committee is currently reassessing committee and subcommittee structure. Areas under consideration include collaboration with the Legislative body, cross system needs assessment and planning, evidenced based service delivery for the justice involved
population and data integration. Both the Division of Behavioral Health and the Administrative Office of Probation have completed needs assessments and are looking for areas of alignment in strategic plans.

The DBH and the Office of Probation Administration held a well received Behavioral Health Justice statewide conference in 2019. With support and guidance from members, JBHC is preliminarily planning for a statewide conference in 2022.

DBH and statewide partners and stakeholders participated in a GAINS Center’s Criminal Justice Learning Collaborative focused on Competency to Stand Trial and Competency Restoration in 2019-2020. Priorities are to reduce the number of persons referred for competency evaluations and reduce the wait time for inpatient competency restoration. Strategies include education, data integration, diversion and screening. Legislation was enacted authorizing the Division to move forward with implementing outpatient competency restoration services in FY22. Program parameters, standards, curriculum, forms and other administrative work is underway with direct involvement from the Administrative Office of Probation, Judiciary and Court Administration.

The Nebraska System of Care (NeSOC) efforts have been previously supported through a SAMSHA SOC Expansion and Sustainability grant. This grant cycle ended in September 2020; however, the Administrative Office of the Courts and Probation (AOC) continue to be directly involved in ongoing system of care efforts across the youth service system.

Crisis Intervention Team: In Omaha, a Crisis Intervention Team (CIT) model was developed and adopted as a cooperative community partnership involving law enforcement agencies, mental health service providers, mental health consumers, family members, and community funders. Through participation in this program, CIT police officers learn to recognize common forms of mental illness and to utilize the most effective means of communicating with people undergoing crisis. The officers are trained to de-escalate the individuals in crisis and allow the consumer to participate in the decision-making regarding their treatment. CIT officers must successfully complete 40 hours of training to become certified. This training has been offered to law enforcement providers in other RBHAs. To learn more about the Heartland Crisis Intervention Team program see their web page https://www.heartlandcit.org.

Behavioral Health Threat Assessment (BETA): RBHA Region V Systems and the Lincoln Police Department provide Behavioral Health Threat Assessment (BETA). a 40-hour advanced training designed to assist Nebraska law enforcement personnel to obtain better outcomes when working on issues involving persons with mental illness. The training is also open to behavioral health professionals. This training includes advanced mental health training (such as how to identify and describe signs and symptoms of mental illness), systems issues, and how to conduct a basic threat assessment. There is heavy involvement in the training by consumers of mental health services, helping students learn to connect at several levels and improve positive outcomes between law enforcement and people who have mental health problems. This training has been offered to law enforcement providers in other RBHAs. BETA training began in 2010 and to date 651 Law Enforcement and partners have been trained. An 8-hour Mini-BETA and a Youth BETA began in 2018 as an adaptation and reach rural partners. To date 88 and 123 law enforcement and partners respectively have been trained in those sessions. Training was cancelled in 2021 due to the pandemic but anticipated to resume in FY22.

Crisis Response Team: This is a statewide service pairing mental health professionals and emergency community support staff providing law enforcement with expert consultation and resources. This is designed to prevent custody relinquishment for behavioral health consumers when less restrictive measures will promote safety and allow access to services. Teams use natural supports and resources to build upon a consumer’s strengths to help resolve an immediate behavioral health crisis in the least restrictive environment by assisting the consumer to develop a plan to resolve the crisis. The service is provided by licensed behavioral health professionals who complete brief mental health status exams and substance use disorder screenings, assess risk, and provide crisis intervention, crisis stabilization, referral linkages, and consultation to hospital emergency room personnel, if necessary. The goal of the service is to avoid an Emergency Protective Custody hold or inpatient psychiatric hospitalization. This service is available in all RBHAs.

The Youth Mobile Crisis Response was launched statewide in 2017 and provides community-based services and support for youth who are at risk for or experiencing a serious emotional disturbance. Accomplishments since the implementation of the NeSOC grant in September 2016 include:

- 2,658 - Number of service encounters (episodes of care) youth received through end of FY2020 under the NeSOC Grant.
- 1,751 - Mobile Crisis Response encounters for youth.
- 74.5% - Youth served through Mobile Crisis Response were successfully served in the community (youth remained in home or with a family friend).
- 13.9 years - Average age of youth served through the NeSOC Grant.

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

None at this time.

Footnotes:

None at this time.
Environmental Factors and Plan

14. Medication Assisted Treatment - Requested (SABG only)

Narrative Question
There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], 49[4], and 63[5].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate.

SAMHSA is asking for input from states to inform SAMHSA's activities.


Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? ☑ Yes ☐ No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women? ☑ Yes ☐ No

3. Does the state purchase any of the following medication with block grant funds? ☑ Yes ☐ No
   a) Methadone
   b) Buprenorphine, Buprenorphine/naloxone
   c) Disulfiram
   d) Acamprosate
   e) Naltrexone (oral, IM)
   f) Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately*? ☑ Yes ☐ No

5. Does the state have any activities related to this section that you would like to highlight?

The Nebraska Division of Behavioral Health (DBH) contracts with the six Regional Behavioral Health Authorities (RBHAs) and includes a provision in these contracts that SUD providers may not refuse to serve individuals receiving Medication Assisted Treatment (MAT). DBH will continue to promote and sponsor training opportunities and disseminate materials to increase provider competence in this area and to educate consumers on how to effectively use these services.

To promote education of providers, the DBH maintains linkages on its website (http://dhhs.ne.gov/Pages/State-Opioid-
Response.aspx) to the Pain and Substance Use Disorder Project ECHO as well as the American College of Academic Addiction Medicine. Once on the DBH site, providers can also access a variety of resources, information and training materials on MAT. DBH partners with a variety of entities to educate providers on the utility of MAT. Discussion continues with systems partners, including the Division of Medicaid and Long Term Care, Department of Corrections, Administrative Office of the Courts and Probation and others, gathering information on current expenditures, utilization and other data to make informed decisions. The DBH continues partnership with the Division of Public Health (DPH) in their opioid overdose prevention activities. The DPH receives a number of grants supporting this work and the DBH collaborates with their efforts. Additionally, the DBH partners with the Nebraska Medical Association (NMA) to coordinate MAT training efforts in an attempt to integrate with primary care physicians. Recent outreach efforts by the NMA also include special populations such as probation, drug-solving courts, and emergency departments.

Additionally, Nebraska is a 2020 recipient of the State Opioid Response grant, which is purposed to mitigate the effects of opioid use disorders, including both prescription opioids and illicit drugs, such as heroin, as well as stimulant use disorder by identifying statewide needs, increasing access to treatment, including medication assisted treatment, and reducing prescription drug overdose deaths through the provision of prevention, treatment and recovery activities.

*Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychosocial treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.

Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.
Environmental Factors and Plan

15. Crisis Services - Required for MHBG

Narrative Question
In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful. SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA’s publication, Practice Guidelines: Core Elements for Responding to Mental Health Crises,

“Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization.”

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.

Please check those that are used in your state:

1. Crisis Prevention and Early Intervention
   a) Wellness Recovery Action Plan (WRAP) Crisis Planning
   b) Psychiatric Advance Directives
   c) Family Engagement
   d) Safety Planning
   e) Peer-Operated Warm Lines
   f) Peer-Run Crisis Respite Programs
   g) Suicide Prevention

2. Crisis Intervention/Stabilization
   a) Assessment/Triage (Living Room Model)
   b) Open Dialogue
   c) Crisis Residential/Respite
   d) Crisis Intervention Team/Law Enforcement
   e) Mobile Crisis Outreach
   f) Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support
   a) Peer Support/Peer Bridgers
   b) Follow-up Outreach and Support
   c) Family-to-Family Engagement
   d) Connection to care coordination and follow-up clinical care for individuals in crisis
   e) Follow-up crisis engagement with families and involved community members


62 http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427
4. Emergency evaluation services

Dependent upon consumer needs, all emergency services provided by network providers focus on outcomes which lead to a referral to the least restrictive, least intensive level of care appropriate to meet the person’s needs, or a rapid return to community living with appropriate supports, as necessary. For people in crisis, services within the Continuum of Care include:

- 24-Hour Crisis Line;
- Crisis Response;
- Crisis Stabilization;
- Emergency Community Support;
- Emergency Psychiatric Observation;
- Hospital Diversion;
- Mental Health Respite;
- Inpatient Treatment;
- Residential Treatment;
- Outpatient Treatment; and
- Support services including recovery support, peer support, community supports.

The DBH manages implementation of the statewide emergency system through ongoing oversight of each of the Regional Emergency System Coordinators (RESC), as a group and individually, to insure an effective continuum of care for crisis services. DBH organizes and conducts a conference call once per month with RESCs and quarterly in person meetings. The DBH and RESCs review complex cases in the community, review system issues and system strengths. DBH also organizes and staffs weekly in person meetings with one of the state’s psychiatric hospitals, the Lincoln Regional Center (LRC). DBH and LRC work together to insure the individuals at LRC are at the least intrusive most appropriate level of care. They review complex cases and work together to develop strategies and solutions for individuals with complex needs. These meetings maintain relevancy with crisis centered activities within each RBHA and at LRC, and to insure that consumers are receiving treatment in accordance with their strengths and needs. They allow opportunities for individual case reviews, brainstorming for solutions to meet the complex needs of consumers, identification of strengths and needs in statewide treatment options, and the sharing of local developments that are occurring with all RBHA/LRC partner networks.

The DBH encourages RESCs to be in ongoing communication with each other and with LRC staff, and to work together to meet consumer needs when those treatment options are not available within a RBHA. DBH also utilizes the statewide mental health and substance use wait list information as a measure in determining capacity for, and access to, treatment for consumers with mental health board commitments.

Regional providers of mental health and substance use services are required to enter consumer information into the Centralized Data System (which is available to the RBHAs and to DBH). This information includes but is not limited priority status, and who are placed on the provider’s wait list for services. Priority levels for admission to services for SUD services include: (1) pregnant injecting drug users; (2) other pregnant substance users; (3) other injecting drug users; (4) women with dependent children; and, (5) all others including those consumers with Mental Health Board Commitments. Priorities for admission to mental health services include persons discharging from Lincoln Regional Center, persons discharging from local hospitals, and persons who are outpatient committed by a mental health board.

State regulations provide service definitions that describe the types of crisis services individuals can receive in different areas of Nebraska. Below is the list of crisis services available along with their definition:

- Emergency Psychiatric Observation: Emergency Psychiatric Observation provides less than 24 hours of care in a secure, medically supervised hospital setting for evaluation and stabilization of acute psychiatric and/or substance use disorder symptoms.

- Crisis Stabilization: Crisis Stabilization is intended to provide immediate, short-term, individualized, crisis-oriented treatment and recovery services needed to stabilize acute symptoms of mental illness, alcohol and/or other drug use, and/or emotional distress. Individuals in need exhibit a psychiatric and/or substance use disorder crisis with a moderate to high risk for harm to self/others
and need short-term, protected, supervised, residential placement. The intent of the service is to treat and support the individual throughout the crisis; provide crisis assessment and interventions; medication management; linkages to needed behavioral health services; and assist in transition back to the individual's typical living situation.

- Emergency Protective Custody/Crisis Stabilization: Crisis Stabilization is designed to provide custody, screening, emergency mental health evaluation, and crisis intervention to individuals placed in emergency protective custody under the auspices of Nebraska Mental Health Commitment Act by law enforcement. Crisis Stabilization services include immediate, short-term, individualized, crisis-oriented treatment and recovery needed to stabilize acute symptoms of mental illness, alcohol and/or other drug abuse, and/or emotional distress. Individuals in need exhibit a psychiatric and/or substance use disorder crisis as defined under the Commitment Act at risk for harm to self/others and need short-term, protected, supervised services. The intent of the service is to treat and support the individual throughout the crisis; provide crisis assessment and interventions; medication management; linkages to needed behavioral health services; and assist in transition back to the individual's typical living situation.

- 24-Hour Crisis Line: The 24-Hour Crisis Line must be answered by a live voice 24 hours a day and 7 days a week and have the ability to link to a licensed behavioral health professional, law enforcement, and other emergency services. The 24-Hour Crisis Line is designed to assist consumers in pre-crisis or crisis situations related to a behavioral health problem. The desired outcome is ensuring the safety of the consumer in a time of distress that has the potential to lead to a life-threatening situation.

- Mental Health Respite: Mental Health Respite is designed to provide shelter and assistance to address immediate needs which may include case management on a 24/7 basis to consumers experiencing a need for transition to another home or residential setting or a break from the current home or residential setting. Mental Health Respite provides a safe, protected, supervised residential environment on a short-term basis. The intent of the service is to support a consumer throughout the transition or break, provide linkages to needed behavioral health services, and assist in transition back into the community.

- Emergency Community Support: Emergency Community Support is designed to assist consumers who can benefit from support due to a behavioral health need and who are either currently residing in a community setting or transitioning from a psychiatric hospital into a community setting. Emergency Community Support services include case management, behavioral health referrals, assistance with daily living skills, and coordination between consumer and/or consumer's support system and behavioral health providers.

- Crisis Response: Crisis Response is designed to use natural supports and resources to build upon a consumer's strengths to help resolve an immediate behavioral health crisis in the least restrictive environment by assisting the consumer to develop a plan to resolve the crisis. The service is provided by licensed behavioral health professionals who complete brief mental health status exams and substance use disorder screenings, assess risk, and provide crisis intervention, crisis stabilization, referral linkages, and consultation to hospital emergency room personnel, if necessary. The goal of the service is to avoid an Emergency Protective Custody hold or inpatient psychiatric hospitalization.

- Hospital Diversion: Hospital Diversion is a peer-operated service designed to assist consumers in decreasing psychiatric distress, which may lead to hospitalization. It is designed to help consumers rethink crisis as an opportunity to change toward a more self-determined independent life. Trained Peer Companions are help other consumers utilize self-help tools. Peer Companions provide contact, support, and/or referral for services, as requested, during and after the stay as well as manning a Warm Line. Hospital Diversion is located in a family/home setting in a residential district that offers at least 4-5 guest bedrooms and is fully furnished for comfort. Participation in the service is voluntary.

Through the efforts of the Nebraska System of Care (NeSOC) work, Nebraska has expanded to include a Youth Mobile Crisis Response service which is designed for youth and adolescents. Mobile Crisis Response, which had only been available in pocketed areas of the state, was expanded statewide on May 1, 2017. Youth Mobile Crisis Response teams provide immediate crisis counseling to those in need in the community. Youth Mobile Crisis Response may partner with law enforcement to assist with risk assessment, provide crisis intervention, crisis stabilization and refer families to health resources in their communities. Depending on location, services are offered face-to-face or via telehealth. Youth Mobile Crisis Response may be accessed through the Nebraska Family Helpline, providing a consistent statewide access point. In addition, consumers eligible for Medicaid benefits have access to other crisis interventions, such as Crisis therapy, under the Medicaid program.

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

None at this time.

Footnotes:
Environmental Factors and Plan

16. Recovery - Required

Narrative Question
The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports); purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual’s mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life to the greatest extent possible, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see SAMHSA’s Working Definition of Recovery from Mental Disorders and Substance Use Disorders.

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:
3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

DBH has promulgated new regulations for the training and certification of peer support (mental health/substance use). Service standards, including peer run services, are within the Title 206 Behavioral Health Services Regulations and Service Definitions. The new regulations went into effect June 27, 2021 upon the Governor’s signature. The next phase includes finalizing and executing a revised service definition document, i.e., a Continuum of Care manual. One example of a service that utilizes a peer-run model is Hospital Diversion. The basic definition is:

Hospital Diversion is a peer-operated service designed to assist consumers in decreasing psychiatric distress, which may lead to hospitalization. It is designed to help consumers rethink crisis as an opportunity to change toward a more self-determined independent life. Meaningful involvement can ensure that consumers lead a self-determined life in the community, rather than remaining dependent on the behavioral health system for a lifetime. Hospital Diversion offers consumers the opportunity to take control of their crisis or potential crisis and develop new skills through a variety of traditional self-help and proactive tools designed to maintain wellness. Trained Peer Companions are the key ingredients in helping other consumers utilize self-help tools. Peer Companions provide contact, support, and/or referral for services, as requested, during and after the stay as well as manning a Warm Line. Hospital Diversion is located in a family/home setting in a residential district that offers at least 4-5 guest bedrooms and is fully furnished for comfort. Participation in the service is voluntary.

The Mental Health Association of Nebraska, a peer run organization, is CARF Accredited and operates Keya House (Hospital Diversion Services). Community Alliance is CARF Accredited and operates Safe Harbor Peer Services.

Nebraska also has:
• Family Peer Support Navigators
• Peer-Run Crisis Diversion Services
• Peer-Run Warmlines- Lincoln, Omaha, and North Platte
• Housing Related Assistance (MH/SU)
• Supported Employment
• Peer Support services (Individual, Family, Youth)
• Recovery Support services
• Recovery/Oxford Houses
• Wellness Recovery Action Planning
• Person Centered Planning
• Self-directed Care

For additional information on service delivery, see the new Continuum of Care Manual, https://dhhs.ne.gov/Behavioral Health Documents/Continuum-of-Care-Manual.pdf, which includes updated service definitions, guidance on telehealth service provision, and prevention information.

Case management facilitates the achievement of individual wellness through advocacy, assessment, planning, linking, communication, education, resource management, and service facilitation. Additionally, block grant funded providers are to be welcoming, engaging and continually improving integrated services to the populations they serve, including those with developmental disabilities who have mental health and substance abuse disorders and all other individuals who have complex needs. Recovery support services are initiated at the onset of the individual’s treatment planning and service delivery process. To the extent possible, the development of a service plan is to be a collaborative process involving the consumer, family members, and other support/service systems. A key component of service coordination is the expectation to develop and sustain strong working relationships with community partners who provide the necessary supports and services which assist individuals with behavioral health disorders. Establishing strong working relations with law enforcement, community hospital(s), housing providers, vocational/employment agencies, educational institutions, child welfare representatives, advocacy organizations, criminal justice representatives, etc., is vital to fully assess the effectiveness of on-going services and to determine if additional services are needed.

DBH has the authority and responsibility to direct and coordinate the public behavioral health system, including integration and coordination of the system; comprehensive statewide planning for the provision of an appropriate array of community-based behavioral health services and continuum of care; development and management of data and information systems; prioritization and approval of all expenditures of funds received and administered by the division; and promotion of activities in research and
education to improve the quality of behavioral health services, recruitment and retention of behavioral health professionals, and access to behavioral health programs and services. DBH works in partnership and contracts with six Regional Behavioral Health Authorities (RBHA) to carry out its charge.

The RBHA have structures and mechanisms to support a coordinated system of care approach to support recovery and resilience of children and youth with behavioral health needs. The RBHA develop local systems of care across the state responsive to local needs and building upon the unique strengths and communities of each region, forging partnerships with youth, families, providers, DHHS divisions of Children and Family Services (CFS) and Medicaid and Long-Term Care (MLTC), county leaders, local system stakeholders, and community leaders and members.

Funding administered through the RBHAs is intended to serve individuals who are not Medicaid eligible or do not have insurance coverage. Each RBHA braids funding from state, federal, and local county sources to develop local networks of providers to ensure an array of non-traditional supports not covered by Medicaid are available, ranging from emergency to resiliency-oriented supports to wraparound. System coordination is central to their purpose, coordinating the local behavioral health system in the region through strategic strengths-based/recovery-focused processes that empower individuals and communities to assure that network providers, system partners and the many stakeholders of the behavioral health system work in a coordinated manner that supports individuals across the life span to promote resiliency and achieve recovery. Each RBHA has established multi-stakeholder collaborative structures to coordinate efforts in formal functional areas for Consumers (including youth) and Family Involvement and Inclusion, Network Management, Emergency Services System, Prevention Services System, and Youth System of Care (YSC). Each RBHA has implemented since 1995 a Professional Partner Program (PPP) using a fidelity-based version of the wraparound care coordination model to support services to families who have children with serious emotional disorders and to ensure that youth and families have a voice and ownership in developing an accessible, comprehensive, individualized family support plan.

In collaboration with system partners, the DBH developed and implemented guidelines, as outlined in the PPP manual, for children and young adults with mental and substance use disorders and their families for individualized care planning. The PPP manual is reviewed at least annually, with updates identified and incorporated as needed based upon quality improvement processes led by DBH. The PPP program evaluation, outcomes, and admission criteria are being re-assessed in order to continue to identify improvements that better assess the impact of PPP on children and youth, better measure family functioning over time, improve quality care, increase access to High Fidelity Wraparound Services, increase involvement of children, youth, and families, and continue in efforts to build strong partnerships across child serving agencies to implement family centered care.

With ten wraparound components at its core, an individualized service plan is developed for each youth/young adult and his/her family, based upon the strengths and concerns of the youth/young adult and his/her family across life domains, including mental health, substance abuse, residential, family, education, vocational, financial, social/recreational, medical, legal, safety, and cultural.

The Professional Partner, youth/young adult and family identifies wraparound team members who will contribute to the development of an Individual Family Service Plan (IFSP) (or Plan of Care - for the purposes of transition aged programs). The IFSP must be a clear, outcome focused plan with time sensitive and measurable goals and objectives that are purposed to support the safety, well-being, recovery and resiliency of the youth. The identified goals and objectives will directly reflect the information reported in the Intake/Interpretative Summary.

The format for the IFSP plan may vary but must include at a minimum:
- Clear demonstration of youth/young adult/family partnership in the plan development
- Youth/young adult and Family Strengths
- Presenting Problems
- Goals and Expected Outcomes/Pre-Discharge Plan
- Objectives/Interventions must be measureable and timely
- Team Members, both formal and informal
- Safety planning

Each RBHA Network includes a Youth Systems coordination function, responsible for the children’s behavioral health system within their respective RBHA. The Youth Systems Coordinator coordinates activities and collaborates with community based partners to ensure that children and youth with behavioral health disorders receive the most appropriate services located within their community, whenever possible. They also collaborate with the RBHA Network providers and other agencies serving youth to engage in activities that address the behavioral health needs of youth transitioning into adulthood. Youth Systems Coordinators promote quality improvement by participating in statewide youth system coordination, enhance Nebraska System of Care (NeSOC) principles, assess RBHA Network providers of youth services for Family Centered Practice models (FCP), and provide technical assistance when needed and as appropriate to increase providers’ ability to incorporate FCP and NeSOC principles into their practices.

The youth systems services infrastructure facilitates the involvement of youth, families, and system partners at the regional and individual family levels. The structures in each RBHA, alongside parallel structures for child welfare through the CFS’s five Service Areas (SAs) are long-standing and provide a key component of the foundation upon which the NeSOC strategic plan implementation efforts are built. While their geographic boundaries are not fully aligned, there is much overlap and each RBHA...
works with assigned SAs. This enhanced regional alignment is key to sustainability, as both RBHAs and SAs have established networks among NeSOC stakeholders in each RBHA.

The population of focus for Nebraska System of Care Strategic Plan is defined, inclusively, as: Children and youth with serious emotional and behavioral health needs and their families across all of Nebraska’s child-serving systems. Our vision, mission and values describe our hopes and intentions for the future, guides our efforts and provides a foundation for a system of care for children, youth and their families.

Vision Simply Said: All Nebraska children, youth and families will reach their full potential by experiencing improved wellness and mental health, exhibiting greater well-being, functioning successfully in the community and realizing greater stability in their living situation.

Mission Simply Said: Nebraska will improve the lives of children, youth and families by working within the partnerships to improve service delivery systems, including the cost and quality of care, as a means of providing meaningful benefits and measureable outcomes to children, youth and families as experienced in the context of everyday living.

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

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

The Division of Behavioral Health Strategic Plan is designed to move the system to improve services for these populations through “person-centered and self-directed” approaches of care in recovery-oriented systems. Within the framework of recovery-oriented systems of care, the person centered approach allows for greater flexibility for cultural adaptations within service delivery.

The peer support service definition, requirements for training and certification are integrated for mental health and substance use. The curriculum is a trauma informed and culturally competent model of peer support and is based upon the SAMHSA domains of peer support. Additional information on the new training and certification process and its implementation is located at DHHS – DBH – Office of Consumer Affairs website https://dhhs.ne.gov/Pages/Consumer-Advocacy.aspx

The DBH offers multiple training opportunities for the professional workforce on recovery principles and recovery oriented practice and systems, including the role of peer providers. Trainings specific to the peer support workforce growth and development have targeted certified peer support specialists as well as behavioral health providers to educate on the value and use of peer support within the behavioral health system. Trainings were also offered on ethical issues and practical strategies designed to protect clients and practitioners. DBH also offered a motivational interviewing training that addressed the fundamental concepts of MI for peer support specialists and identified critical conditions necessary for change to occur. Clinical supervision of nonclinical staff and peer to peer supervision are training breakout sessions planned for the 2019 Behavioral Health – Justice Conference. DBH and the University of Nebraska Medical Center and Behavioral Health Education Center of Nebraska (BHECN) continue to collaborate on peer workforce development, the role of peers, and curriculum improvements. In 2018, BHECN was awarded the MH – ATTC and it is anticipated that the competency of and the role of peers in the workforce will grow. Additionally, though funding support of the State Targeted Response to the Opioid Crisis grant, DBH offered training specific to Medication Assisted Treatment to peer support specialists in the state. Additional training needs are being assessed and will be developed to meet identified needs. Research is currently underway to identify specific peer support training curriculum standards that could be considered to establish a specialized endorsement in SUD peer support. Other potential training endorsements being considered include Youth Peer Support and Family Peer Support.

5. Does the state have any activities that it would like to highlight?

During the month of September of 2020, the DBH Office of Consumer Affairs organized a month of educational and stigma reducing efforts for Recovery month. These included weekly FaceBook lives from individuals in recovery, family members, physicians in recovery and a song artist who spoke specific to her mental health recovery journey through the lyrics of her songs. A virtual candle lighting event was held encouraging individuals affected by mental health and substance use challenges, family members and individuals who had lost a loved one as a result of these challenges to light a virtual candle and share their personal message.

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

None at this time.

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Footnotes:
Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question
The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court’s decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999), provide legal requirements that are consistent with SAMHSA’s mission to reduce the impact of M/SUD on America’s communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court’s Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

Please respond to the following items

1. Does the state’s Olmstead plan include:
   - Housing services provided. [ ] Yes [ ] No
   - Home and community based services. [ ] Yes [ ] No
   - Peer support services. [ ] Yes [ ] No
   - Employment services. [ ] Yes [ ] No

2. Does the state have a plan to transition individuals from hospital to community settings?
   - Please indicate areas of technical assistance needed related to this section.
     None at this time.

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Footnotes:
Environmental Factors and Plan

18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children’s Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.

According to data from the 2015 Report to Congress on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and
• residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

65 The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America’s #1 Public Health Problem.

Please respond to the following items:

1. Does the state utilize a system of care approach to support:
   a) The recovery and resiliency of children and youth with SED?
   b) The recovery and resiliency of children and youth with SUD?

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:
   a) Child welfare?
   b) Juvenile justice?
   c) Education?

3. Does the state monitor its progress and effectiveness, around:
   a) Service utilization?
   b) Costs?
   c) Outcomes for children and youth services?

4. Does the state provide training in evidence-based:
   a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families?
   b) Mental health treatment and recovery services for children/adolescents and their families?

5. Does the state have plans for transitioning children and youth receiving services:
   a) to the adult M/SUD system?
   b) for youth in foster care?

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

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

The RBHA have structures and mechanisms to support a coordinated system of care approach to support recovery and resilience of children and youth with behavioral health needs. The RBHAs develop local systems of care across the state responsive to local needs and building upon the unique strengths and communities of each region, forging partnerships with youth, families, providers, DHHS Divisions of Children and Family Services (CFS) and Medicaid and Long-Term Care (MLTC), Developmental Disabilities (DD), Administrative Office of Probation and the Courts, county leaders, local system stakeholders, and community leaders and members.
Additionally the governance structure of the NeSOC was changed to be more inclusive of the larger child and family.

The NeSOC Leadership Board met to revisit the identified desired outcomes and the governance structure of the NeSOC efforts. In January of 2019, the NeSOC implemented a phased work plan which guides the NeSOC efforts. The work plan had 64 action steps identified over a 3 year period which addressed: NeSOC infrastructure, Service Design and Delivery, Evaluation and COI and Workforce development. Additionally there were performance measures identified for each phase.

The NeSOC also implemented a NeSOC Operational Structure. The operational structure identified an appointed Leadership Board, Implementation Committee, Youth and Family Advisory Councils, five standing statewide work teams and six localized Leadership and Service Delivery Teams. The localized Leadership and Service Delivery Teams are facilitated by the RBHAs. In January of 2019, the NeSOC Leadership Board met to revisit the identified desired outcomes and the governance structure of the NeSOC efforts. The desired outcomes remained relatively unchanged however activities of focus for the next 18 months were identified.
services/supports efforts. To that end, in June 2019, the Leadership Board agreed to both a name change as well as a new charter. The newly created Children's Impact collective (CIC) replaced the previous Leadership Board. Additionally the Leadership Board decided to increase the frequency of meetings from quarterly to monthly. The Leadership Board also eliminated the implementation committee as the meeting were somewhat duplicative as both meetings/groups consisted of similar participant compositions as well as agendas. The Youth Advisory and Family Advisory Councils remained unchanged. Finally the five standing work teams referenced above have moved to ad hoc work teams which will be called upon by the CIC as needed.

Additionally Nebraska completed a financial investment blue print outlining several areas where cost efficiencies may be found in the youth and family serving systems which could be reinvested into the behavioral health system to development of additional evidence based services and supports and work force development.

Since implementation of the NeSOC efforts, Nebraska has added capacity to the Professional Partner Program which serves the state through a contract with the behavioral health authorities to provided centralized case management using the Wraparound approach. Additionally, Nebraska has added a state wide mobile crisis support service accessed through a centralized intake line which will connect families with a licensed clinician either in person or via telehealth within one hour. Other highlighted results of the NeSOC efforts include clinical training (expanded capacity in Child and Parent Psychotherapy, Intensive Outpatient Therapy, Mental health services in schools, Multi-systemic Therapy (MST), Parent Child Interaction Therapy, Parents and Children Together, Therapeutic consultation and youth and family peer support. Competency development has been an area focus for the NeSOC efforts. Clinical endorsement training was provided to increase competency among clinicians serving youth with low cognitive disorders and SED. During summer 2019 and 2020, clinical endorsement training to serve youth with problematic sexual behavior was provided. Through the NeSOC efforts the Lead Family Contact (in coordination with the Family Advisory Council) has developed a Family Leadership Academy. The Academy includes a general training as well as a train the trainer option.

Although the SOC grant ended in September 2020, a no cost extension was approved and related strategies under that NCE continue. The SOC framework developed under the grant also continues to operate today, with ongoing commitment from multiple system partners to operationalize SOC values and principles across the youth service system. The CIC is in the process of identifying priority initiatives to be focused on over the next one-two years. These will be aligned with DBH strategic planning efforts identified through needs assessment activities as well as annual SOC evaluation activities completed during the grant.

7. Does the state have any activities related to this section that you would like to highlight?
   Please see Question 6 response concerning the SCIP program and Mobile Crisis Response service.
   Please indicate areas of technical assistance needed related to this section.
   None at this time.

Footnotes:
Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question
Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state’s suicide prevention plan in the last 2 years?  

2. Describe activities intended to reduce incidents of suicide in your state.

The Division of Behavioral Health (DBH) previously was awarded the Garret Lee Smith Suicide Prevention Grant in 2014 which ended September 2019. Under this grant, DBH and system partners developed and implemented the 2016-2020 Nebraska State Suicide Prevention Plan. The plan provided a framework to help Nebraskans work together to prevent suicide. This plan set out shared strategies for suicide prevention and set the stage for action plans created by communities, agencies and organizations across the state. This plan was intended to promote a reduction in the incidents of suicide in Nebraska and was supported by the DBH and Regional Behavioral Health Authorities (RBHAs). Nebraska’s plan was built on the 2012 National Strategy for Suicide Prevention by embracing an ecological approach to suicide and the organization of goals and objectives in four interconnected strategic directions. Although the plan ended in 2020, the strategies continue to be carried on through system partners. The University of Nebraska Public Policy Center was awarded a Garret Lee Smith grant in October of 2019 which builds upon continuing to decrease suicide rates in Nebraska, particularly in terms of youth suicide. DBH continues to be a partner with the implementation of the grant.

There were eight key activities identified in the plan to ensure suicide prevention became an expected component of service delivery and data collection:

Healthy Empowered Individuals, Families & Communities

Strategy 1: Increase Nebraskans’ knowledge of factors promoting wellness and recovery.

This strategy set the stage for communities and organizations to come together to make suicide prevention a priority by increasing the factors that protect us from suicide risk. Health promotion and enhancement of pro-social activities (i.e., sharing, helping others, providing support) create connections among people, which in turn decrease suicide risk. Wellness and recovery are supported when communities embrace getting help for mental health problems as a sign of strength. This also helps break down the stigma associated with getting mental health treatment.

Strategy 2: Increase the number of Nebraskans who know warning signs and how to help someone who is at risk for suicide.

Promoting widespread awareness of suicide warning signs and how to help will increase the likelihood that a person is identified and connected to help early. This strategy created an understanding that Nebraskans of all ages can make a difference and save a life by knowing what to look for, the questions to ask and resources to help.

Clinical & Community Prevention Services


This strategy creates the expectation that every system in Nebraska (education, healthcare, justice, etc.) have suicide prevention as a part of their service, training and culture. Using proven interventions and data collection to move culturally sensitive strategies into the evidence informed category will ensure that Nebraskans are served well.

Strategy 4: Increase local/regional collaborations addressing health promotion and early prevention.

Nebraskans regularly come together and collaborate. This strategy expands the focus of new and existing collaborations to
include promotion of healthy behaviors and prevention of risk factors for suicide as early as possible. Collaborations are encouraged to embrace the ecological approach by implementing interventions that promote health at all levels (individual, relationships, community, and society). The Nebraska State Suicide Prevention Coalition (NSSPC) serves as a networking hub for local coalitions and collaborative groups specifically addressing suicide.

Treatment & Support Services Strategy

Strategy 5: Increase clinical expertise in assessment and management of suicide risk across the state.

Mental health treatment and support services in Nebraska are not readily available in all areas of the state. This strategy addressed the availability and quality of treatment services in Nebraska by insisting that professionals offering mental health services have the knowledge and skill to appropriately assess and manage suicide risk. Clinical settings (mental health, substance abuse and healthcare) are encouraged to adopt practices that move Nebraska closer to the desired outcome of zero suicides.

Strategy 6: Increase availability of crisis management services across the state.

A critical component of suicide prevention is the availability and accessibility of services when someone is in need of them. Crisis intervention, management and support services are prioritized for development or enhancement as part of this strategy. Postvention services (serving survivors immediately after a suicide death) are critical in the aftermath of suicide and serve a crisis management function for survivors. These services are delivered in communities (e.g., Local Outreach to Survivors of Suicide – LOSS – teams) and in organizations such as schools or universities by crisis response teams.

Surveillance, Research and Evaluation Strategy

Strategy 7: Expand the use of regularly collected data to measure progress toward achievement of suicide prevention goals and action plans at all levels (state, regional, local, organizational).

A variety of data is collected and reported locally, regionally and at the state level. This goal encourages use of this data to assess progress toward achieving goals related to suicide prevention that are set at regional or state levels. Incorporating evaluation and tracking protocols in action plans that minimize the burden of data collection by using existing datasets when possible will be more sustainable over time.

Strategy 8: Increase coordination of data dissemination at all levels.

Data is collected and reported in every system (e.g., education, health, justice, etc.) at every level (state, regional, local, organizational). Coordination and agreement of what to track and how to report it will increase evidence informed decision making and the overall understanding of progress made in the area of suicide prevention. Accessible, easily understood reporting should be the goal of data reporting at every level.

The DBH also collaborates with the Nebraska State Suicide Prevention Coalition (NSSPC) in an advisory capacity to help plan and implement suicide prevention activities across the state. The NSSPC has been tasked with updating the state's Suicide Prevention Strategic Plan. Additionally, the DBH has allocated funding towards a statewide media campaign, "Nebraska Needs You", which addresses suicide prevention messaging to multiple target populations.

The DBH funds and monitors the provision of Mental Health First Aid Training statewide. In FY20, 98.9% of the 1,777 individuals trained reported they would recommend the training to others; 97.5% reported a new ability to recognize the signs of a mental health crisis and 96.7% reported being able to connect someone with community, peer and personal supports.

3. Have you incorporated any strategies supportive of Zero Suicide?

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments?

5. Have you begun any targeted or statewide initiatives since the FFY 2020-FFY 2021 plan was submitted?

If so, please describe the population targeted.

Nebraska’s University of Nebraska Public Policy Center was awarded another GLS Suicide Prevention Grant beginning October 2019. The purpose of Nebraska’s project is to reduce the number of suicides and attempts for youth ages 10-24 with a focus on outreach to 15-24 year olds because their suicide rate is increasing in Nebraska, exceeding the US rate. Prevention activities are concentrated in southeast Nebraska because the youth suicide rate for this area exceeds the state and US rate. The entire state is reached by including suicide prevention in coordinated school health plans for K-12 schools and workforce development for clinicians serving youth in crisis. Nebraska will promote the zero suicide approach for health and behavioral health organizations along with evidence-based strategies and practices to prevent youth suicide. The project has four goals. 1) Decrease the youth suicide rate 80% in Regional Behavioral Health Authority (RBHA) Region V Systems by 2024. 2) 100% of Nebraska public school districts will have policies and protocols in place for suicide prevention, post-suicide intervention, and transition back to school after a suicide crisis by 2024. 3) Twenty (20) Nebraska providers or healthcare systems will implement the zero suicide approach by...
2024. 4) 100% of Nebraska’s child serving systems will adopt evidence-based practices to follow-up with youth after a suicide attempt or hospitalization by 2024. During the course of the grant we will reach 70,000 15 to 24-year-olds in RHBA Region V Systems, and embed suicide prevention practices in 244 school districts reaching 187,000 public school students in grades 5-12 statewide. We will train at least 200 clinicians by introducing 30 organizations to the zero-suicide initiative, embed suicide screening with school psychologist services in 17 educational service units and 12 treatment organizations. We will implement evidence-based follow-up after youth experience a suicide crisis in five child serving systems and two healthcare systems, and implement evidence-based post-suicide intervention practices on five post-secondary campuses impacting lives of 40,000 college age students.

In addition to the above mentioned activities, Nebraska’s Department of Education (NDE) is a recipient of SAMSHA’s Project AWARE grant. As a key partner, the DBH is actively involved in grant management and grant implementation activities. Mental Health prevention, promotion, early identification and suicide prevention are all targeted activities within this grant.

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

None at this time.

Footnotes:
Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question
The success of a state’s MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state’s office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state’s ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period?  Yes  No

2. Has your state identified the need to develop new partnerships that you did not have in place?  Yes  No

If yes, with whom?
DBH provides leadership in the administration, integration and coordination of the public behavioral health system. DBH utilizes a system of care conceptual framework to support cross system activities serving the Nebraska adult and youth systems of care. Services are administered by a variety of different system partners, including the Administrative Office of Probation, DHHS: MLTC, DPH, CFS, DDD and Veterans’ Affairs, Nebraska Association of Behavioral Health Organizations, Nebraska Departments of Correctional Services, Education and Insurance, Nebraska Tribes, Nebraska University System, Regional Behavioral Health Authorities, and treatment, prevention and support service providers.

Cross system partnerships at the state level are facilitated through state agency representative membership on advisory committees, including the DBH Joint Advisory Committee (State Advisory Committees on Mental Health and Substance Use Disorder Services) and DBH Prevention Advisory Committee.

Nebraska’s Adult System of Care incorporates this conceptual framework and the associated system of care guiding principles and core values into a spectrum of effective, community-based services and supports that is organized within a coordinated system of care network.

DBH works through and in partnership with six Regional Behavioral Health Authorities (RBHAs) to carry out its charge to support a coordinated system of care approach to children and youth services. The RBHAs have structures and mechanisms to support a coordinated system of care approach to support recovery and resilience of children and youth with behavioral health needs. The RBHAs develop local systems of care across the state responsive to local needs and building upon the unique strengths and communities of each region, forging partnerships with youth, families, providers, DHHS Divisions of Children and Family Services
System partners include public agencies and private organizations, including state and local governmental agencies, Tribal organizations, private organizations and individuals and families. The Nebraska System of Care (NeSOC) Children’s Impact Collective is led by the Nebraska Department of Health and Human Services (DHHS) Chief Executive Officer.

System partners include:

• NDHHS – Division of Behavioral Health
• NDHHS – Divisions and Office of:
  o Children & Family Services
  o Development Disabilities
  o Medicaid & Long-Term Care
  o Office of Health Disparities
• Nebraska Judicial System - Administrative Office of the Courts
• Nebraska Judicial System - Administrative Office of Probation
• Nebraska Judicial System - Court Improvement Project
• Nebraska Children’s Commission
• Family Organizations
  o Speak Out
  o Families Care
  o Parent to Parent Network
  o Families Inspiring Families
  o Healthy Families Project
  o Nebraska Family Support Network
• Youth Partners
• Family Partners
• Nebraska Children and Families Foundation
• Omaha Tribe of Nebraska
• Ponca Tribe of Nebraska
• Santee Sioux Nation
• Winnebago Tribe of Nebraska
• Tribal Society of Care (Inter-tribal initiative led by Santee Sioux Nation)
• Nebraska Department of Education
• Regional Behavioral Health Authorities
• MCOs – Heritage Health (3)
• Behavioral Health Education Center of Nebraska (BHECN)
• UNL Public Policy Center

The Division of Behavioral Health developed three new Memoranda of Understanding (MOUs) and nine contracts with the following system partners.

MOUs:
State of Nebraska Judicial Branch – Nebraska Probation System
NDHHS Medicaid & Long-Term Care
NDHHS Children & Family Services

Contracts:
University of Nebraska Public Policy Center
Region I Behavioral Health Authority
Region II Behavioral Health Authority
Region III Behavioral Health Services
Region IV Behavioral Health System
Region V Systems
Region VI Behavioral Healthcare
Behavioral Health Education Center of Nebraska
Sharon Darylmple - Family Lead Contact

System of Care in Nebraska has worked towards:
<> Operationalizing the strategies for system coordination across state, regional and local leadership teams and workgroups.
<> Implementing a phased work plan.
<> Developing and implementing a communication plan to educate partners, families and stakeholders.

The DBH and the DHHS Division of Medicaid and Long Term Care (MLTC) comprise the largest funders within the public behavioral health system. Coordination of activities and alignment of priorities across these two divisions is critical to ensuring appropriate resource allocation. The DBH and MLTC have continued to work together on system initiatives including but not limited to:
BHECN offers training programs to introduce high school and college students to mental health and substance use prevention, treatment, and recovery services. These include professionals who address mental health and substance use disorders treatment in order to provide improved access to DBH has created new collaborations with the Behavioral Health Education Center of Nebraska (BHECN) to grow the workforce of quality, safety, and cost of patient care.

Participation in CyncHealth statewide designated health information exchange is promoted by the State of Nebraska under LB411, passed by the legislature and signed by the governor in May 2021. Electronic health information exchange allows providers and increased access and use of the PDMP by medical professionals.

In 2019, the state began exploring interstate data sharing, and looking at expanding capabilities for integration and trying to promote and support interoperability, which is being encouraged at the federal level. Providers will be required to query PDMPs when prescribing controlled substances for Medicaid and Medicare patients starting in 2020.

For more information please see:

DBH has expanded its collaboration with the Nebraska Judicial System – Administrative Office of Probation to begin exploring opportunities for information exchange across data systems to address efficiency in service utilization and funding and avoidance of duplication of services. These discussions include building a data interface with the DBH Centralized Data System. Probation was a key partner in DBH most recent needs assessment and strategic planning work. Probation is currently initiating planning work and meeting regularly with DBH to align key strategies to address service provision to justice involved individuals.

The Nebraska Injury Prevention Program (NIPP) is a Centers for Disease Control and Prevention funded Core Violence and Injury Prevention Program and is working toward a safe and injury-free life for all Nebraskans. The NIPP works cooperatively with the Division of Behavioral Health on a number of initiatives including suicide prevention, prevention efforts related to underage drinking and education efforts related to prescription drug overdose.

DBH continues its collaboration with the CyncHealth, formerly known as Nebraska Health Information Initiative (NeHII), to include participation in broader technology discussions, for example, DBH technology capacity to interact with information exchanges and interfaces. CyncHealth provides a connection point for patient health information throughout the state of Nebraska by working with its vendors to securely connect patient data and allow members to access that data while maintaining the privacy, security, and accuracy of the information being exchanged. CyncHealth complies with HIPAA rules, as do CyncHealth participants. Participation in CyncHealth statewide designated health information exchange is promoted by the State of Nebraska under LB411, passed by the legislature and signed by the governor in May 2021. Electronic health information exchange allows providers and patients to appropriately access and securely share a patient’s vital medical information electronically – improving the speed, quality, safety, and cost of patient care.

DBH has created new collaborations with the Behavioral Health Education Center of Nebraska (BHECN) to grow the workforce of professionals who address mental health and substance use disorders treatment in order to provide improved access to prevention, treatment, and recovery services. These include:

- BHECN offers training programs to introduce high school and college students to mental health and substance use treatment
centers. Graduate students pursuing such careers rotate among rural hospitals in North Platte, Hastings and Kearney.

• The University of Nebraska Medical Center (UNMC) and Creighton School Medicine have adjusted their training of family practice physicians and staff, incorporating behavioral health instruction. Behavioral health care providers are increasingly working in primary care settings across the state, to provide more coordinated care.

• Counseling and psychology interns are working in 24 rural primary care clinics that have behavioral health services integrated into patients’ overall care.

• Project ECHO modules are funded with opioid targeted response grant funds to expand statewide education related to pain management and substance use treatment, including medication assisted treatment.

• BHECN is expanding its footprint in rural Nebraska to support efforts increase retention of behavioral health providers, recruitment and establishing a statewide network of behavioral health providers. In May 2018, BHECN hosted the inaugural Rural Provider Support Network Conference in Scottsbluff, located in the Nebraska Panhandle. In 2015, BHECN opened the BHECN office at the University of Nebraska – Kearney, a rural hub in central Nebraska.

Project AWARE
In September 2018, the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS) awarded the State of Nebraska the Project AWARE (Advancing Wellness and Resilience in Education) - State Education Agency (SEA) grant. This five year program supports the development and implementation of a comprehensive plan of activities, services, and strategies to decrease youth violence and support the healthy development of school-aged youth.

Nebraska’s AWARE-SEA Project is being jointly undertaken by the Nebraska Department of Education (NDE) and Nebraska Department of Health and Human Services – Division of Behavioral Health (DBH) to build and enhance partnerships and collaboration between State and local systems. The project focuses on the high level of mental and behavioral health needs of school-age children in rural schools, including depression, anxiety, suicide ideation, trauma, and substance use. Educators statewide feel unprepared to handle the severity of mental health issues arising daily in schools. Training for school staff to better address students’ mental and behavioral health needs has been identified as a critical priority.

In response, NDE and DBH are partnering at the State level to collaborate with three Local Education Agencies (LEAs) to improve school-based mental health services. The LEAs of Chadron, Hastings, and South Sioux City are demographically and geographically diverse, with varying levels of poverty and scarcity of mental health resources. Two sites have higher free/reduced lunch rates, indicative of poverty and student mobility. Each differs in racial/ethnic composition, with higher proportions of Hispanic and Native American students. All three LEAs have strong, long-standing track records of successful collaborations with State and local partners, including mental health providers, community coalitions, civic organizations, the business and private sector, and stakeholders, including students and families.

This project is intended to build and expand the capacity of the NDE, in partnership with the DBH and the three LEA Site partners, to:

• Prevent the development of mental health and behavioral disorders among students by providing a positive, supportive, and trauma-informed learning environment.

• Increase awareness of mental health issues among school-aged youth and skills fostering resilience and pro-social behaviors through strength-based approaches and social-emotional learning.

• Increase the school-based mental health services available and connect students with mental health issues and their families to the appropriate services.

• Increase schools’ capacity to identify and immediately respond to the mental health needs of students exhibiting behavioral or psychological signs requiring clinical intervention.

• Increase schools’ capacity to identify and intervene in bullying and aggressive or violent behaviors of students that may contribute to school violence.

The strong collaborative relationship already established between NDE and DBH puts Nebraska’s AWARE Project in a unique position to build upon infrastructure created through the NeSOC Initiative. NDE has representatives on NeSOC’s Leadership Board, Implementation Committee and all work teams, ensuring cohesive alignment and coordinated implementation across both SAMHSA-funded initiatives. The AWARE Project Directors also serve on the Governor’s School Safety Task Force, Legislature’s Children Commission, Nebraska Joint Juvenile Justice Coalition / Juvenile Services Committee, Supreme Court Commission on Children in the Courts, ESU Coordinating Council’s School-Mental Health Committee, and NDE’s Facility-Based Schools Community of Practice.

Nebraska Psychiatric Bed Registry Pilot Project with RBHA Region 6 Behavioral Healthcare. Nebraska selected the vendor OpenBeds to run the bed registry project. Open Beds is an Appriss Health company providing technology that identifies, unifies and tracks behavioral health resources to facilitate rapid access to definitive treatment. The pilot project was fully operational in October of 2020. With the OpenBeds behavioral health system in Region 6, Nebraska’s most populous behavioral health region, can become more responsive for the people it serves. Social workers, case managers, and other healthcare professionals will no longer need to spend hours on the phone to try to locate available treatment options for their patients. Instead, these providers can immediately identify treatment services and refer patients to care in a few clicks. Data collected during the pilot will identify capacity challenges and provide data driven opportunities to find solutions.
acute psychiatric emergency wait to admit into inpatient psychiatric beds. The registry funding is a joint project between the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Association of State Mental Health Program Directors (NASMHPD). Nebraska is the only state in the Midwest to have been selected.

Nebraska's registry serves the state's most populous RBHA, Region 6 Behavioral Healthcare, which includes Cass, Dodge, Douglas, Sarpy and Washington counties in eastern Nebraska. Region 6 Behavioral Healthcare has a diverse mix of publicly contracted hospitals and private hospitals that afford the opportunity to capture capacity issues and process variables. Data from the pilot will be used to analyze bed capacity, workforce, and system barriers to access. In addition, the data will be used to inform policy decisions about alternate payment models such as value-based contracting and innovations to payment structures supporting efficient service delivery. Nebraska's registry will have the opportunity to learn from best practices from the other 22 states developing crisis intervention registry projects.

The planning process began in the spring of 2019. The DBH and Region 6 Behavioral Healthcare have developed a workgroup, which will include representatives from the RBHA, DHHS, local emergency departments, public and private hospitals, law enforcement, behavioral health providers, county attorneys, community stakeholders and consumers with lived experience. The workgroup will develop a centralized, real-time system to track inpatient beds and assess capacity for inpatient psychiatric beds in the area.

The pilot project in Region 6 Behavioral Healthcare area was fully operational in October 2020. DBH is working with the current vendor on potential expansion of the bed registry throughout the state.

The Nebraska Division of Behavioral Health Nebraska System of Care (NeSOC) integrates the state educational system as a cornerstone in its work. The NeSOC connects and coordinates the work of State child-serving agencies; nonprofit and local governments, behavioral health care providers, families and patient advocates. It helps children, youth, and families function better at home, in school, in the community, and in life.

In 2013-2014, over 1,000 families, youth, service providers and other stakeholders were involved in the development of a System of Care Strategic Plan. The Nebraska Department of Health and Human Services - Division of Behavioral Health received a grant in 2016 to expand and sustain the System of Care. Partners from across the state are working to implement the elements which were identified through the System of Care strategic plan.

The state-level leadership team actively engages with multiple state agency offices to improve overall state infrastructure in order to globally enhance the state’s capacity to improve access and service provision to children and youth and families. This work includes the representatives of partners serving as members and representatives on the Nebraska State Advisory Committee on Mental Health Services.

The educational system is often the first system families turn to when they have concerns about their children’s social emotional development or behavioral health. Additionally the education system provides strong ongoing support to youth and their families. The NeSOC is building upon existing relationships with the Nebraska Department of Education as well as local school districts and the Educational Service Units. Partners from the education field are embedded throughout the NeSOC governance structure. As stated above, DBH is actively engaged in the implementation and management of the Project AWARE grant in partnership with the Nebraska Department of Education.

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

None at this time.
21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S.C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created Best Practices for State Behavioral Health

Planning Councils: The Road to Planning Council Integration. 69

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.


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

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.

   a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

   The Division of Behavioral Health administers, oversees, and coordinates the state’s public behavioral health system to address the prevention and treatment of mental health and substance use disorders. The Nebraska Behavioral Health Services Act is the enabling legislation which mandates the Division of Behavioral Health (DBH) role as the chief behavioral health authority for the State of Nebraska. This legislation also established the State Advisory Committee on Mental Health Services and the State Advisory Committee on Substance Abuse Services. When meeting in joint session, the two advisory committees serve as a behavioral health advisory council.

   The joint committee continues its active involvement in the state plan guiding the public health behavioral system by providing advice and assistance to the DBH on the ongoing planning efforts that inform and shape planning at State, regional, and local levels. This includes guiding review of behavioral health strategic plan initiatives, needs assessments, consumer surveys, Results-based Accountability, Continuous Quality Improvement and other efforts guiding activities across the systems, and prioritization of state planning activities in the state application.

   November 14, 2019 Joint Advisory Committee (JAC) Meeting

   The JAC agenda included the Director’s Update, review of the December 2019 Block Grant Implementation Report, review of the progress on the DBH 2017-2020 Strategic Plan, a JAC Impact Discussion, and DHHS efforts for integration of data systems, human resources, education to serve individuals holistically, engaging a vendor for a new needs assessment that includes a larger public behavioral health system viewpoint and improve the system to better serve youth and adults that have complex needs, and work to encourage cross system partner organizations to consider training on mental health first aid and suicide prevention.

   The agenda included a report to the JAC which reviewed the progress of the strategic plan which focused on two parts. First, progress on integrated services and delivering quality and effective services:

   • Young adult suicide rate has decreased; Binge drinking among youth and young adults has decreased; Increase in stable living at discharge; Increase in providers reporting practicing integrated health; Reduced out of home replacements; General satisfaction of services has improved; and, Increase diversity of population served in prevention and treatment. Second, items that require additional improvement:

   • Veteran and Native American suicide rate; Employment at discharge from outpatient services; Youth considering suicide; Non-medical use of pain relievers among young adults; Underage drinking; and, Waitlist to Lincoln Regional Center for mental health services and court orders.

   Source: Nebraska Department of Health and Human Services
In December 2020, the Nebraska Governor issued Executive Order No. 20-36 (December 1, 2020) providing limited waiver of certain requirements of the Nebraska Open Meetings Act. The order was scheduled to end on January 31, 2021 but was extended by Executive Order No. 21-02, signed January 11, 2021, which extended the limited waiver to April 30, 2021. The Nebraska legislature passed Legislative Bill 83 in the 2021 legislative session on April 15, 2021, and the Governor approved LB 83 on April 21, 2021, that made changes to public meeting provisions and, in particular, provided for virtual conferencing of no more than half of all meetings in a calendar year under the Nebraska Open Meetings Act.

Throughout 2020 and 2021, DBH continued communications with JAC members through various channels, in addition to regular channels such as posting on the DBH web site, including weekly (and later monthly) DHHS Key Partners Calls, utilizing the DHHS KEYPARTNERS2020 Listserv to regularly share information and virtual conferencing with JAC members for the DBH OPEN MINDS preparatory planning activities and the needs assessment and strategic planning activities.

January 29, 2021 Joint Advisory Committee (JAC) Meeting
The January 29, 2021 JAC meeting was the first ever virtual meeting format for an advisory committee meeting. The JAC agenda included the Director’s Update, DBH Strategic Planning Update, Review of the SAMSHA Block Grants Reporting (December 2020), Grant Update on the Crisis Counseling and Training Program (CCP) & COVID Grant Update, and Report of the SAMSHA State Emergency Grant.

The Director’s Update addressed the COVID-19 pandemic, DBH approval for alternative service delivery via telehealth and/or telephone during the pandemic, and an update on behavioral health-related Legislative Bills introduced in the 2021 session. The Legislative Bills included: LB296 - Access to patient records; LB663 - Mental Health Indicator in criminal justice information systems (Director Dawson testified on behalf of DBH in opposition of this bill); and LB247 - Create the Mental Health Crisis Hotline Task Force (which ties into the 9-8-8 planning grant activity). And, an update on LB1124 - Opioid Settlement Workgroup to identify best practices to split the funds, from the 2020 legislative session.

The DBH Strategic Planning Update included information on the virtual needs assessment and strategic planning process that was initiated in 2020. Open Minds, a national consulting firm, facilitated visioning, interviews and surveys with multiple system leaders, community partners, providers, consumers, families and community members, the following needs were prioritized including, but not limited to:
1. Increase activities to reduce stigma; stigma is seen as the most difficult barrier to overcome for consumers.
2. Integration of physical and behavioral health is a primary need for consumers and their families.
3. Improve interagency and intersystem sharing of data; lack of integration is a barrier to providing seamless, integrated “whole person” care and track outcomes.
4. There is a consistent need to expand the ability to use technology to both provide and receive services across Nebraska, especially in rural and frontier communities.
5. Expand use of evidenced-based practices.
6. Drive innovation and demonstrate outcomes. Developing alternate reimbursement models, such as Value-Based Reimbursement, is needed in the changing marketplace.

7. DHHS and DBH must continue to address cultural diversity and increase health equity throughout the system.

A draft plan was submitted by Open Minds inclusive of needs, priorities, measureable objectives, and key performance indicators for the next three years. The draft plan is under review by the DHHS CEO. Initial work plan activity has begun both internally and in with Regional Behavioral Health Authority Administrators.

A review of the SAMSHA Block Grants Reporting (December 2020) reported on FY20 Block Grant Reporting on Performance Indicators and Priority Areas and Budgets and Expenditures.

An update on the Crisis Counseling and Training Program (CCP) & COVID Grant reported on the FEMA/SAMHSA grant activities. The Range of Crisis Counseling Services includes: Individual crisis counseling, brief educational or supportive contact, group crisis counseling, support and educational groups, self-help groups, assessment, referral and resource linkage, public education, development and distribution of educational materials, media messaging and risk communications. Funded services have been used across the state through the work of all six Regional Behavioral Health Authorities, the Nebraska Rural Response Hotline and the Nebraska Family Helpline.

Report on the SAMSHA State Emergency Grant (SEG) - The SAMSHA State Emergency Grant will provide $2 million for services over the project period of 4/20/2020 to 8/19/2021. The funding is for direct services to the following targeted populations: Those with serious mental illness (SMI), those with substance use disorders (SUDs), or those with co-occurring SMI and SUDs (70%); Healthcare practitioners with mental disorders (less severe than SMI) requiring mental health care as a result of COVID-19 (10%); and all other individuals with mental disorders less severe than SMI (20%). The services currently included are: Assessment, Peer Support, Outpatient Therapy and Medication Management. Committee members were asked for recommendations on ways to market SEG grant funds and/or about other potential providers for SEG services. Committee members recommended approaching the Federally Qualified Health Centers (FQHCs), other sliding fee clinics outside of the Regional Behavioral Health Networks, and potential the Opioid Treatment Centers (OTPs) in the state.

April 8, 2021 Joint Advisory Committee (JAC) Meeting

The April 8, 2021 JAC meeting was a virtual meeting, only the second ever virtual meeting format for the advisory committee meeting.

The JAC agenda included the Director’s Update, Block Grant Priority Areas for FY2022-2023 plan, SAMSHA COVID-19 Supplemental Block Grant Funding, the 988 Planning Grant, a presentation by the Nebraska Office of Vocational Rehabilitation Acquired Brain Injury Program, a Synar Update and 206 Regulation Update.

The Director’s Update addressed current activities, include the following:

- Statewide availability of Outpatient Competency Restoration (OCR) to be implemented July 1, 2021.
- Behavioral Health Disaster work coordinated through Regional Behavioral Health Authorities providing outreach services to individuals and connect them to services through the SAMHSA Crisis Counseling Assistance and Training Program (CCP) grant.
- The Nebraska workgroup formed to develop recommendations for utilization of the $2.1 million in the first round of settlement dollars from opioid settlements will focus on prevention, treatment, and recovery purposes related to the opioid crisis, substance use and co-occurring needs across Nebraska. Director Dawson asked members to consider the needs in their area and submit those ideas to the DBH email.
- The new FY20 Annual Report At A Glance infographic released by DBH.

During the Block Grant Priority Areas FY2022-2023, the JAC was presented a review of and guided discussion on Division planning efforts including but not limited to progress metrics on the 2017-2020 Strategic Plan (which sunset on December 31, 2020), FY20 Annual Report data, 2020-21 Needs Assessment and priority areas identified by stakeholders for the FY2022 -2024 Strategic Plan and progress on FY2020-2021 Block Grant activities. DBH planning is driven by the Governor’s mission: Create opportunity through more effective, more efficient and customer focused state government. DBH developed a needs assessment and FY2022-2024 Strategic Plan framework of Influence, Integration, Inclusion, Innovation and better Outcomes and demonstration of value for behavioral health.

Discussion about community members’ ability to stay engaged with their community during the pandemic and the data trends presented. Interest in more information about the impact of COVID-19 on women that appears to be captured in FY20 substance use disorder service data. Following discussion, the committees entertained a motion to recommend the state continue current targets for FY2022 and review potential change to targets for stable housing and employment. The motion on recommendation was accepted.

The presentation on the new supplemental Block Grant funding which provide additional relief based on impact of COVID-19. The additional Block Grants are one-time funds therefore sustainability has to be considered in the budget planning. The same Block Grant regulations also apply.
The Division was awarded $7,162,196.00 for Substance Abuse Prevention and Treatment Block Grant (SAPTBG). The Community Mental Health Services Block Grant (MHBG) award total is $3,795,400.00. State and federal spending cannot be reduced to utilize either of these funds. The award period for both Block Grants is March 15, 2021 – March 14, 2023. A high overview of proposed activities to bridge the needs and gaps in funding were presented. With the short timeline, it was not possible to determine costs, feasibility or viability of any activity. All items may not be submitted or funded with block grant funds.

Discussion and/or Recommendations by the Committees:

Comments provided during the discussion on utilizing the MHBG COVID and SAPTBG COVID supplemental funds for alternate or additional uses identified areas to consider include:

- Expand out-patient services for residents in long-term facilities.
- Workforce resilience, self-care and well-being.
- Support services within the Youth Rehabilitation and Treatment Centers.
- Improve rural web access to support virtual services.
- Create the Complex Care Collaborative Group consultant and treatment planning.
- Funding to blend with Public Health CDC Health Disparities fund to increase critical incident stress management.
- Provide mental health to EMS/First Responders who have been dealing with trauma related to serving those with COVID-19, especially in rural areas.
- Incorporation of services within the criminal justice system or jail facilities.
- ¾ Way Housing as a step down service and remove barriers encountered by providers with data sharing across state agencies. Explore opportunity to adopt National Alliance for Recovery Residences (NARR) standards.
- Education and training initiatives targeting workforce culture and EBPs such as Medication Assisted Treatment (MAT) and Contingency Management, particularly in rural areas. Additionally, train on various MAT options, include implant option.
- Additional outreach to local governments and schools to provide substance use disorder educational programming – reports of increasing IV drug and meth use among youth.
- Leverage opportunities provided by the Health Resources and Services Administration (HRSA) programs (loan forgiveness) supporting provider training and MAT.
- Enhance social detox ability to accept and serve consumers with Benzodiazepine-class of medications.

The Synar Update reported as of October 2020, retailers are prohibited to sell tobacco products to individuals under the age of 21. The Retailer Violation Rate for 2020 was 1.8% as compared to 9.7% in FY19. This, however, is an anomalous year. Report Samples are down in FY20 from FY19 by 154 inspections due to the inability to conduct inspection during the COVID Pandemic quarantine. Compliance rates goal remains at 20% or less for products sold to minors. With the purchase age being 21 now, there are requirements to increase age for youth inspectors. The groups are ages 18, 19 & 20 or 16, 18 & 20. DBH will need to determine how to modify sample methodology.

August 12, 2021 Joint Advisory Committee (JAC) Meeting

The August 12, 2021 JAC meeting returned to regular order, following expiration of Executive Order 21-02 providing continued limited waiver of public meeting requirements through April 30, 2021. The JAC agenda included the Director’s Update, DBH Strategic Plan 2022-2024 Update, SAMHSA Block Grant Awards and applications and a 988 Grant Update.

The Director's Update addressed current activities, include the following:

- The 988 Mental Health Hotline planning with a draft plan ready in September.
- Cross system planning DHHS to implement its Strategic Plan goals.
- Update on the first round of settlement dollars from opioid settlements - the use of these funds must be sustainable.
- Title 206 Regulations were signed by the Governor in June. As a part of these regulations, some service definitions are being updated and processed.
- Workforce initiative continues with a focus on the integration of mental health and medical care.
- The 2022-2024 Strategic Plan has been a major focus of DBH this summer.

Presentations on the block grant COVID 19 Relief Supplemental Funding and American Rescue Plan Act (ARPA) applications and awards provided updates on activity and funding plans. No comments were received and no formal recommendations were entertained by the committees.

SAMHSA FFY2022-2023 Block Grant application materials reviewed included the planning process, prioritization process, planned expenditures and proposed Priority Areas for the FFY2022-2023 Combined Substance Abuse Prevention and Treatment and Community Mental Health Services Block Grant application. Discussion included review of the Priority Areas for FY2022-2023 which the committee had recommended be retained at the April meeting. No formal recommendations were entertained by the committees at the August meeting.

The DBH web page URL for Joint Advisory Committee meeting agenda and minutes is: http://dhhs.ne.gov/Pages/Advisory-Committees-on-Mental-Health-and-Substance-Abuse.aspx

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?

Yes ☐ No ☑
2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?

   Yes ☐ No ☒

3. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

   Nebraska Revised Statute 71-814 (2) establishes the responsibilities and duties of the State Advisory Committee on Mental Health Services: "The committee shall be responsible to the division and shall (a) serve as the state’s mental health planning council as required by Public Law 102-321, (b) conduct regular meetings, (c) provide advice and assistance to the division relating to the provision of mental health services in the State of Nebraska, including, but not limited to, the development, implementation, provision, and funding of organized peer support services, (d) promote the interests of consumers and their families, including, but not limited to, their inclusion and involvement in all aspects of services design, planning, implementation, provision, education, evaluation, and research, (e) provide reports as requested by the division, and (f) engage in such other activities as directed or authorized by the division."

   Nebraska Revised Statute 71-815 (2) establishes the responsibilities and duties of the State Advisory Committee on Substance Abuse Services: "The committee shall be responsible to the division and shall (a) conduct regular meetings, (b) provide advice and assistance to the division relating to the provision of substance abuse services in the State of Nebraska, (c) promote the interests of consumers and their families, (d) provide reports as requested by the division, and (e) engage in such other activities as directed or authorized by the division."

   Committee meetings include two opportunities (near the beginning and the end of meetings) for public comment regarding discussions and issues that are before the committees. Throughout the day, committee members are engaged in discussion of agenda items and following each topic committee members are asked for recommendations to the DBH regarding actions or next steps for the DBH to consider when moving forward in each respective area. All committee members have equal voice/vote in committee recommendations. Administrative staff from the Community Based Services Section of DBH as well as staff from the Office of Consumer Affairs attend meetings to listen to committee discussion as well as public comment for a better understanding of committee perspective.

   A lunch presentation during each meeting typically revolves around individuals with lived experience sharing successes, barriers and challenges in their individual roads to recovery. This keeps the consumer perspective in front of the committee as well as DBH staff, and allows successes and challenges to have “face” to support the reality of challenges for those we serve.

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

   None at this time.

   Additionally, please complete the Advisory Council Members and Advisory Council Composition by Member Type forms.²⁰

²⁰There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022
Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States **MUST** identify the individuals who are representing these state agencies.

State Education Agency  
State Vocational Rehabilitation Agency  
State Criminal Justice Agency  
State Housing Agency  
State Social Services Agency  
State Health (MH) Agency.

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<th>2022</th>
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<th>2023</th>
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<tr>
<th>Name</th>
<th>Type of Membership</th>
<th>Agency or Organization Represented</th>
<th>Address, Phone, and Fax</th>
<th>Email (if available)</th>
</tr>
</thead>
</table>
| Ashley Berg (SA) | Providers | State Education Agency | 2535 Country Club Avenue Omaha NE, 68104  
PH: 515-298-0214 | aberg@sarpy.com |
| Heather Bird (SA) | Providers | State Vocational Rehabilitation Agency | 7149 North 163 Street Bennington NE, 68007  
PH: 402-552-7461 | hbird@heartlandfamilyservice.org |
| Mary Ann Borgeson (MH) | Others (Advocates who are not State employees or providers) | State Criminal Justice Agency | 12503 Anne Street Omaha NE, 68137  
PH: 402-444-6413 | Maryann.borgeson@douglascounty-ne.gov |
| Kenneth Beau Boryca (SA) | Providers | State Housing Agency | 18923 Omaha NE, 68136  
PH: 402-346-0902 | kboryca@nuihc.com |
| Margaret Damme (MH) | Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services) | State Social Services Agency | 6433 Havelock Avenue Lincoln NE, 68507  
PH: 402-326-1875 | megd@freshstarthome.org |
| To be appointed DHHS DBH Representative (MH) | State Employees | State Health (MH) Agency | 301 Centennial Mall South, 6th Floor Lincoln NE, 68509  
PH: 402-471-3644 | |
| Kris Elmshaeuser (MH) | State Employees | DHHS Div of Behavioral Health - LRC | 301 Centennial Mall South, 6th Floor Lincoln NE, 68509  
PH: 402-471-3644 | kris.elmshaeuser@nebraska.gov |
| Lindy Foley (MH) | State Employees | Dept of Education - Special Education | 301 Centennial Mall South, 6th Floor Lincoln NE, 68509  
PH: 402-471-3644 | lindy.foley@nebraska.gov |
| Victor Gehrig (SA) | Persons in recovery from or providing treatment for or advocating for SUD services | Dept of Education, Office Voc Rehab | 301 Centennial Mall South, 6th Floor Lincoln NE, 68509  
PH: 402-471-3644 | vgehrig@gpcom.net |
| Jill Gregg (SA) | Providers | State Health (MH) Agency | 10310 North Osage Avenue Hastings NE, 68901  
PH: 402-462-4677 | jillgregg@hotmail.com |

Printed: 8/20/2021 4:40 PM - Nebraska - OMB No. 0930-0168  Approved: 04/19/2019  Expires: 04/30/2022

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<table>
<thead>
<tr>
<th>Name</th>
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<th>Organization</th>
<th>Address</th>
<th>Phone</th>
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<tbody>
<tr>
<td>Laura Hart (MH)</td>
<td>State Employees</td>
<td>Dept of Econ Dev - Div Community and Housing</td>
<td>301 Centennial Mall South, 4th Floor Lincoln NE, 68509</td>
<td>308-202-0177</td>
<td><a href="mailto:laura.hart@nebraska.gov">laura.hart@nebraska.gov</a></td>
</tr>
<tr>
<td>Jacob Hausman (MH)</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td></td>
<td>8919 South 67 Street Papillion NE, 68133</td>
<td>402-371-2745</td>
<td><a href="mailto:hausman.jacob@gmail.com">hausman.jacob@gmail.com</a></td>
</tr>
<tr>
<td>Laurie Holman (MH)</td>
<td>State Employees</td>
<td>Nebraska Crime Commission</td>
<td>301 Centennial Mall South, 5th Floor Lincoln NE, 68509</td>
<td>402-471-2259</td>
<td><a href="mailto:laurie.holman@nebraska.gov">laurie.holman@nebraska.gov</a></td>
</tr>
<tr>
<td>Jay Jackson (SA)</td>
<td>Persons in recovery from or providing treatment for or advocating for SUD services</td>
<td></td>
<td>30612 205th Avenue Columbus NE, 68601</td>
<td>402-562-3755</td>
<td><a href="mailto:jayjack@jackson-services.com">jayjack@jackson-services.com</a></td>
</tr>
<tr>
<td>Susan Jensen (MH)</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
<td></td>
<td>15801 Cary Circle Omaha NE, 68136</td>
<td>402-618-7254</td>
<td><a href="mailto:blessed_6@msn.com">blessed_6@msn.com</a></td>
</tr>
<tr>
<td>C.J. Johnson (MH)</td>
<td>Providers</td>
<td></td>
<td>69 Willow Bend Marquette NE, 68854</td>
<td>402-441-4349</td>
<td><a href="mailto:cjj@region5systems.net">cjj@region5systems.net</a></td>
</tr>
<tr>
<td>Wendy Kaiser (MH)</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td></td>
<td>804 Juniper Drive Papillion NE, 68046</td>
<td>402-885-0850</td>
<td><a href="mailto:wendykaiser16@gmail.com">wendykaiser16@gmail.com</a></td>
</tr>
<tr>
<td>Faithe Kroll (SA)</td>
<td>Providers</td>
<td></td>
<td>2 Colonial Lane Holdrege NE, 68949</td>
<td>308-995-6548</td>
<td><a href="mailto:faithe@holdregecounseling.com">faithe@holdregecounseling.com</a></td>
</tr>
<tr>
<td>Kristen Larsen (MH)</td>
<td>State Employees</td>
<td>DHHS Div Public Health</td>
<td>301 Centennial Mall South Lincoln NE, 68509</td>
<td>402-471-0143</td>
<td><a href="mailto:Kristen.Larsen@nebraska.gov">Kristen.Larsen@nebraska.gov</a></td>
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<tr>
<td>Angie Ludemann (MH)</td>
<td>State Employees</td>
<td>DHHS Div Children &amp; Family Services</td>
<td>301 Centennial Mall South, 3rd Floor Lincoln NE, 68509</td>
<td>402-471-9364</td>
<td><a href="mailto:angie.ludemann@nebraska.gov">angie.ludemann@nebraska.gov</a></td>
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<tr>
<td>Diana Meadors (SA)</td>
<td>Providers</td>
<td></td>
<td>24224 Martin Avenue Valley NE, 68064</td>
<td>402-341-6220</td>
<td><a href="mailto:dmeadors@heartprograms.com">dmeadors@heartprograms.com</a></td>
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<tr>
<td>Kelli Means (SA)</td>
<td>Providers</td>
<td></td>
<td>1200 W Eisenhower Avenue Norfolk NE, 68701</td>
<td>402-371-8000</td>
<td><a href="mailto:kmeans@midtownhealthne.org">kmeans@midtownhealthne.org</a></td>
</tr>
<tr>
<td>Ashley Pankonin (MH)</td>
<td>Parents of children with SED/SUD</td>
<td></td>
<td>33060 Road 769 Grant NE, 69140</td>
<td>308-352-6720</td>
<td><a href="mailto:ashleypankonin@gmail.com">ashleypankonin@gmail.com</a></td>
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<tr>
<td>Jennifer Reyna (MH)</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td></td>
<td>1014 Martha Street Omaha NE, 68108</td>
<td>402-905-1073</td>
<td><a href="mailto:jreyna@latinocenter.org">jreyna@latinocenter.org</a></td>
</tr>
<tr>
<td>Jodi Richards (MH)</td>
<td>Parents of children with SED/SUD</td>
<td></td>
<td>1307 8th Avenue Kearney NE, 68845</td>
<td>308-455-7115</td>
<td><a href="mailto:jodilea1975@gmail.com">jodilea1975@gmail.com</a></td>
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<tr>
<td>Daniel Rutt (SA)</td>
<td>Persons in recovery from or providing treatment for or advocating for SUD services</td>
<td>835 South Burlington Street Hastings NE, 68901 PH: 402-462-2066</td>
<td><a href="mailto:dan@reviveinc.org">dan@reviveinc.org</a></td>
<td></td>
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<tr>
<td>Angela Sattler (MH)</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>620 East 7th Street Cozad NE, 69130 PH: 308-537-4021</td>
<td><a href="mailto:acartmill99@gmail.com">acartmill99@gmail.com</a></td>
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<tr>
<td>Carisa Schweitzer Masek (MH)</td>
<td>State Employees</td>
<td>301 Centennial Mall South, 5th Floor Lincoln NE, 68509 PH: 402-471-1920</td>
<td><a href="mailto:Carisa.SchweitzerMasek@nebraska.gov">Carisa.SchweitzerMasek@nebraska.gov</a></td>
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<tr>
<td>Randy See (SA)</td>
<td>Others (Advocates who are not State employees or providers)</td>
<td>Hall County Juvenile Services Grand Island NE, 68801 PH: 308-385-5124</td>
<td><a href="mailto:randy.see@hallcountyne.gov">randy.see@hallcountyne.gov</a></td>
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<tr>
<td>Danielle Smith (MH)</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>6333 Glass Ridge Drive Lincoln NE, 68526 PH: 402-314-9387</td>
<td><a href="mailto:dsmith@winitiative.org">dsmith@winitiative.org</a></td>
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<tr>
<td>Mary Thunker (MH)</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
<td>8911 Decatur Street Omaha NE, 68114 PH: 402-640-8196</td>
<td><a href="mailto:mthunker@gmail.com">mthunker@gmail.com</a></td>
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**Footnotes:**

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022
### Environmental Factors and Plan

#### Advisory Council Composition by Member Type

**Start Year:** 2022       **End Year:** 2023

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<th>Type of Membership</th>
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<td>Vacancies (Individuals and Family Members)</td>
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<td>Representatives from Federally Recognized Tribes</td>
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<td><strong>Total Individuals in Recovery, Family Members &amp; Others</strong></td>
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<td><strong>Total State Employees &amp; Providers</strong></td>
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<td>Youth/adolescent representative (or member from an organization serving young people)</td>
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* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

The Division of Behavioral Health administers, oversees, and coordinates the state's public behavioral health system to address the prevention and treatment of mental health and substance use disorders. The Nebraska Behavioral Health Services Act is the enabling legislation which mandates the Division of Behavioral Health (DBH) role as the chief behavioral health authority for the State of Nebraska. This legislation also established the State Advisory Committee on Mental Health Services and the State Advisory Committee on Substance Abuse Services. When meeting in joint session, the two advisory committees serve as a behavioral health advisory council, aka Planning Council.
The Planning Council continues its active involvement in the state plan guiding the public health behavioral system by providing advice and assistance to the DBH on the ongoing planning efforts that inform and shape planning at State, regional, and local levels. This includes guiding review of behavioral health strategic plan initiatives, needs assessments, consumer surveys, Results-based Accountability, Continuous Quality Improvement and other efforts guiding activities across the systems, and prioritization of state planning activities in the state application.

Planning Council involvement in the block grant applications includes participation in the DBH strategic planning process activities which inform the block grant goals, priority areas and budgets. The planning process includes the preparatory planning, needs assessment and prioritization work to develop the strategic plan.

The Planning Council January 29, 2021 meeting, the first ever virtual meeting format employed by the advisory committee, included the agenda item DBH Strategic Planning Update which included information on the virtual needs assessment and strategic planning process that was initiated in 2020. Open Minds, a national consulting firm, facilitated visioning, interviews and surveys with multiple system leaders, community partners, providers, consumers, families, community members and members of the Planning Council.

The Planning Council April 8, 2021 meeting, also meeting via virtual conferencing, included the agenda item Block Grant Priority Areas FY2022-2023, which involved the Planning Council in a review of and guided discussion on DBH planning efforts including but not limited to progress metrics on the 2017-2020 Strategic Plan (which sunset on December 31, 2020), FY20 Annual Report data, 2020-21 Needs Assessment and priority areas identified by stakeholders for the 2022-2024 Strategic Plan and progress on FFY2020-2021 Block Grant activities.

Discussion and/or Recommendations by the Committees at the April 8, 2021 meeting included the ability of community members to stay engaged with their community during the pandemic and the data trends presented. Members identified their interest in more information about the impact of COVID-19 on women that appears to be captured in FY20 substance use disorder service data. Following discussion, the committees entertained a motion to recommend the state continue current priority areas and targets for FY2022 and review potential change to targets for stable housing and employment. The motion on recommendation was accepted.

The Planning Council August 12, 2021 meeting, which had the committees return to regular order following expiration of Executive Order 21-02 that provided continued limited waiver of public meeting requirements through April 30, 2021, engaged in a presentation and discussion of the SAMHSA FFY2022-2023 Block Grant application. Application materials were reviewed, including the planning process, prioritization process, planned expenditures and proposed Priority Areas for the FFY2022-2023 Combined Substance Abuse Prevention and Treatment and Community Mental Health Services Block Grant application. Discussion included review of the Priority Areas for FY2022-2023 which the committee had recommended be retained at the April meeting. No formal recommendations were entertained by the committees at the August meeting.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022
Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

*Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51)* requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?
   a) Public meetings or hearings?  
      Yes ☐ No ☐
   b) Posting of the plan on the web for public comment?  
      Yes ☐ No ☐
      If yes, provide URL:
      The URL will be added once posted on DBH web site for comment and then updated at time of submission.
   c) Other (e.g. public service announcements, print media)  
      Yes ☐ No ☐

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Footnotes:
Environmental Factors and Plan

23. Syringe Services (SSP)

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the Consolidated Appropriations Act, 2018 (P.L. 115-141) signed by President Trump on March 23, 2018.

Section 520. Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, or any program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.

States may consider making SABG funds available to either one or more entities to establish elements of an SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs: These documents can be found on the Hiv.gov website: [https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs](https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs).


Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC
- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
  - Include proposed protocols, timeline for implementation, and overall budget
  - Submit planned expenditures and agency information on Table A listed below
- **Step 3** - Obtain State Project Officer Approval
Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds only and is consistent with guidance issued by SAMHSA.

Section 1931(a)(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C.§ 300x-31(a)(1)(F)) and 45 CFR § 96.135(a)(6) explicitly prohibits the use of SABG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(a)) and 45 CFR § 96.127 requires entities that receive SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR § 96.128 requires “designated states” as defined in Section 1924(b)(2) of the PHS Act to set-aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-28(c)) and 45 CFR § 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

1 Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016 describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a description of the elements of an SSP that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;
• Provision of naloxone to reverse opioid overdoses

• Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;

• Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;

• Communication and outreach activities; and

• Planning and non-research evaluation activities.

Footnotes:
Nebraska - FFY 2022-2023 Block Grant Application

Environmental Factors and Plan
23. Syringe Services (SSP)

Nebraska Department of Health and Human Services Division of Behavioral Health does not use SABG or state funds to support elements of any Syringe Services Program.

The State of Nebraska does not have a State Project Officer approved plan to repurpose SABG funds for an SSP and does not use SABG funds for this purpose.
Syringe Services (SSP) Program Information - Table A

If the state is planning to expend funds from the COVID-19 award, please enter the total planned amount in the footnote section.

<table>
<thead>
<tr>
<th>Syringe Services Program SSP Agency Name</th>
<th>Main Address of SSP</th>
<th>Planned Dollar Amount of SABG Funds Expended for SSP</th>
<th>SUD Treatment Provider (Yes or No)</th>
<th># Of Locations (include mobile if any)</th>
<th>Narcan Provider (Yes or No)</th>
</tr>
</thead>
<tbody>
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</table>

No Data Available

Footnotes:
Nebraska - FFY 2022-2023 Block Grant Application
Environmental Factors and Plan
Syringe Services (SSP) Program Information - Table A

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