Nebraska

UNIFORM APPLICATION
FY 2026/2027 Combined MHBGSUPTRS BG ApplicationBehavioral Health Assessment and Plan

SUBSTANCE ABUSE PREVENTION AND TREATMENT
and
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 05/28/2025 - Expires 01/31/2028
(generated on 08/12/2026 9.03.42 AM)

Center for Substance Abuse Prevention
Division of Primary Prevention

Center for Substance Abuse Treatment
Division of State and Community Systems (DSCS)

and

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

State Information

State Information

Plan Year

Start Year	2026
End Year	2027

State SUPTRS BG Unique Entity Identification

Unique Entity ID	HKQDEXRXGKL1

I. State Agency to be the SUPTRS BG 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, Fourth Floor PO Box 95026
City	Lincoln
Zip Code	68509-5026

II. Contact Person for the SUPTRS BG Grantee of the Block Grant

First Name	Thomas
Last Name	Janousek
Agency Name	NE DHHS Division of Behavioral Health
Mailing Address	301 Centennial Mall South, Fourth Floor PO Box 95026
City	Lincoln
Zip Code	68509-5026
Telephone	(402) 875-3763
Fax	(402) 742-8314
Email Address	Thomas.Janousek@nebraska.gov

State CMHS Unique Entity Identification

Unique Entity ID	HKQDEXRXGKL1

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, Fourth Floor PO Box 95026
City	Lincoln
Zip Code	68509-5026

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

First Name	Thomas
Last Name	Janousek
Agency Name	NE DHHS Division of Behavioral Health
Mailing Address	301 Centennial Mall South, Fourth Floor PO Box 95026
City	Lincoln
Zip Code	68509-5026
Telephone	(402) 875-3763
Fax	(402) 742-8314
Email Address	Thomas.Janousek@nebraska.gov

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	8/29/2025 4:43:22 PM
Revision Date	8/11/2026 1:22:09 PM

VI. Contact Person Responsible for Application Submission

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

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

State Information

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

Fiscal Year 2026

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
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

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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 19 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, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the 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).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
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 [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," 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)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

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: Thomas Janousek, PsyD

Signature of CEO or Designee[1]: _____

Title: Director Division of Behavioral Health

Date Signed: _____

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

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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 [sam.gov]**
    b. Collecting a certification statement similar to paragraph (a)
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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," 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)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

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: Nebraska

Name of Chief Executive Officer (CEO) or Designee: Thomas Janousek, PsyD

Signature of CEO or Designee[1]: 

Title: Director Division of Behavioral Health

Date Signed: 08/11/2025

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Jim Pillen
Governor

STATE OF NEBRASKA
OFFICE OF THE GOVERNOR
P.O. Box 94848 • Lincoln, Nebraska 68509-4848
Phone: (402) 471-2244 • jim.pillen@nebraska.gov

October 30, 2024

Ms. Odessa F. Crocker
Division of Grants Management, Office of Financial Resources
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane, 17E22
Rockville, MD 20857

Dear Ms. Crocker:

On behalf of the State of Nebraska, I hereby authorize Dr. Steve Corsi, Chief Executive Officer of the Department of Health and Human Services, or his designee, to make all required applications, agreements, certifications and reports related to the Community Mental Health Services Block Grant (CFDA 93.958); the Substance Use Prevention, Treatment, and Recovery Services Block Grant (CFDA 93.959), the Projects for Assistance in Transition from Homelessness (PATH) grant (CFDA 93.150):

Dr. Steve Corsi, PsyD
Chief Executive Officer
Nebraska Department of Health and Human Services
P.O. Box 95026
Lincoln, NE 68509-5026

Effective immediately and until further notice, please send all Grant Awards and similar notices concerning the three programs listed above to:

Thomas Janousek, PsyD, Director
Division of Behavioral Health
Nebraska Department of Health and Human Services
P.O. Box 95026
Lincoln, NE 68509-5026

Thank you for your attention to this matter.

Sincerely,

Jim Pillen
Governor

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Jim Pillen, Governor

October 30, 2024

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Sincerely,

Dr. Steve Corsi, PsyD
Chief Executive Officer
Nebraska Department of Health and Human Services

State Information

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

Fiscal Year 2026

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Section 1920	Early Serious Mental Illness	**42 USC § 300x-9**
Section 1920	Crisis Services	**42 USC § 300x-9**

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**

Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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 19 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, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
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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).

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18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
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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
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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)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

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: Thomas Janousek, PsyD

Signature of CEO or Designee[1]: _____

Title: Director Division of Behavioral Health

Date Signed: _____

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

State Information

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

Fiscal Year 2026

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Section 1920	Early Serious Mental Illness	**42 USC § 300x-9**
Section 1920	Crisis Services	**42 USC § 300x-9**

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**

Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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 19 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, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State

management program developed under the 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).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
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 [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 182by:

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,"

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.

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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.

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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)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

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: Thomas Janousek, PsyD

Signature of CEO or Designee[1]: 

Title: Director Division of Behavioral Health

Date Signed: 08/11/2025

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Jim Pillen
Governor

STATE OF NEBRASKA
OFFICE OF THE GOVERNOR
P.O. Box 94848 • Lincoln, Nebraska 68509-4848
Phone: (402) 471-2244 • jim.pillen@nebraska.gov

October 30, 2024

Ms. Odessa F. Crocker
Division of Grants Management, Office of Financial Resources
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane, 17E22
Rockville, MD 20857

Dear Ms. Crocker:

On behalf of the State of Nebraska, I hereby authorize Dr. Steve Corsi, Chief Executive Officer of the Department of Health and Human Services, or his designee, to make all required applications, agreements, certifications and reports related to the Community Mental Health Services Block Grant (CFDA 93.958); the Substance Use Prevention, Treatment, and Recovery Services Block Grant (CFDA 93.959), the Projects for Assistance in Transition from Homelessness (PATH) grant (CFDA 93.150):

Dr. Steve Corsi, PsyD
Chief Executive Officer
Nebraska Department of Health and Human Services
P.O. Box 95026
Lincoln, NE 68509-5026

Effective immediately and until further notice, please send all Grant Awards and similar notices concerning the three programs listed above to:

Thomas Janousek, PsyD, Director
Division of Behavioral Health
Nebraska Department of Health and Human Services
P.O. Box 95026
Lincoln, NE 68509-5026

Thank you for your attention to this matter.

Sincerely,

Jim Pillen
Governor

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Jim Pillen, Governor

October 30, 2024

Ms. Odessa F. Crocker
Division of Grants Management, Office of Financial Resources
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane, 17E22
Rockville, MD 20857

Dear Ms. Crocker:

On behalf of the State of Nebraska, I hereby designate and authorize Thomas Janousek, Director, Division of Behavioral Health of the Department of Health and Human Services, to make all required applications, agreements, certifications and reports related to the Community Mental Health Services Block Grant (CFDA 93.958); the Substance Use Prevention, Treatment, and Recovery Services Block Grant (CFDA 93.959), the Projects for Assistance in Transition from Homelessness (PATH) grant (CFDA 93.150):

Thomas Janousek, PsyD, Director
Division of Behavioral Health
Nebraska Department of Health and Human Services
P.O. Box 95026
Lincoln, NE 68509-5026

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Lincoln, NE 68509-5026

Thank you for your attention to this matter.

Sincerely,

Dr. Steve Corsi, PsyD
Chief Executive Officer
Nebraska Department of Health and Human Services

Nebraska proposes to use supplemental funds to fill gaps in our systems serving children and youth, including those with serious emotional disturbance (SED), and experiencing a first psychotic episode. The work we propose to undertake will also support families that may include someone with a serious mental illness (SMI).

The state's behavioral health all-hazards disaster response and recovery plan serves as the organizing umbrella for goals and activities proposed in this document. This plan was updated in 2022 after a series of stakeholder engagement activities. The plan describes how Nebraska organizes and mobilizes behavioral health resources during all phases of disaster recovery. All disasters begin and end locally, so Nebraska relies heavily on local and regional involvement for any behavioral health response. Nebraska's 244 public school districts have not been active participants in disaster behavioral health planning, though they have been directly impacted by disasters and large-scale emergencies. Nebraska's Department of Education has a school safety and security director/staff focused on developing school emergency operations plans since. Additionally, for the last three years they have been offering training to schools in psychological first aid for schools (PFA-S). PFA-S is an evidence-informed practice used by school crisis teams when responding to school related deaths or similar crises. This is tied to the schools' emergency operations plans via an annex denoting PFA-S trained crisis teams as the primary entity meeting school stakeholders' behavioral health needs after a disaster event or crisis. However, these plans are not in sync with the state or regional disaster behavioral plans. For example, school plans do not reference use of community behavioral health disaster resources during recovery, nor do they specifically account for ongoing needs of children/youth with SED and families with someone who has a SMI after a disaster or large-scale event. This gap in knowledge and awareness is what we plan to fill via this funding opportunity.

We propose activities in support of three goals that will be addressed across funding years.

Goal 1.0. Align 100% of school emergency operations plans with state and regional crisis-disaster behavioral health plans by 2025.

Goal 2.0. Train 60 people each year who are part of Nebraska's behavioral health disaster teams to augment school crisis teams during recovery phases of disaster.

Goal 3.0. Distribute crisis message maps with behavioral health content in multiple languages annually to 244 school districts, 17 educational service units, 6 regional behavioral health authorities, and via the Nebraska Emergency Management Agency in Nebraska.

The Nebraska Department of Health and Human Services, Division of Behavioral Health (DHHS-DBH) proposes to partner with the Nebraska Department of Education (NDE) and the University of Nebraska Public Policy Center (NUPPC) to ensure activities are carried out promptly and professionally in conjunction with other active initiatives across the state directed at enhancing the state's crisis and disaster behavioral health responsibilities. DHHS-DBH will maintain oversight of all project activities. All partners will work together to ensure stakeholders (such as the regional behavioral health authorities, educational service units) are involved in the project.

1. Describe any plans to utilize the BSCA supplemental funds to develop/enhance components of your state's mental health emergency preparedness and response plan that addresses behavioral health. Please include in your discussion how you plan to coordinate with other state and federal agencies to leverage crisis/mental health emergency related resources.

Nebraska recently finalized the revision of its behavioral health all-hazards disaster response and recovery plan[1] and is in the process of implementing a plan for the 988 system (call center, mobile crisis response, & crisis facilities)[2]. The disaster plan serves as the organizing umbrella for behavioral health response and recovery efforts. Nebraska's disaster plan includes training and use of volunteers (clinicians and community peers) if needed. They are organized by Regional Behavioral Health Authority areas. Mobile crisis response teams are also organized by this same regional structure. Nebraska's mental health professional workforce is limited, with 90 of 93 counties considered federal mental health professional shortage areas. The limited behavioral health workforce across the state means that many of the mobile crisis providers may also be trained to respond as part of the disaster behavioral health workforce. To date, Nebraska school-based crisis teams have been developed in parallel to community-based disaster and crisis response entities. The BSCA funds will be used to enhance connectivity among these entities by working with the Nebraska Department of Education (NDE) to ensure school-based plans for disasters and emergencies are integrated with existing behavioral health disaster plans.

Schools work with community based behavioral health providers in some areas for treatment, but most schools operate their own crisis response systems serving all students, staff, and families, including those with SED/SMI and those at risk for first episode psychosis. NDE is fostering the use of a single crisis response framework using Psychological First Aid for Schools (PFA-S) put forward by the National Child Traumatic Stress Network (NCTSN).

We plan to build on the work in progress by helping school districts, via their regional networks (Educational Service Units) become familiar with existing behavioral health crisis and disaster plans and test / edit their own plans to ensure all plans work together. We do this by creating tabletop exercises addressing a variety of scenarios designed to test plans, particularly after an event in the recovery phases. The scenarios test screening, referral, and provision of services for children and youth (including those with SED or developmental issues) and families (including those with SMI). Our partners, NDE and NUPPC have worked with the Nebraska Department of Health and Human Services (DHHS), Division of Behavioral Health to bring relevant stakeholders together to create the tabletops, then worked with regional structures to disseminate and use the packages with schools. The goal is to make this package customizable. Lessons learned from the tabletops will be gathered and used to enhance existing disaster / crisis plans. Year four will focus on incorporation of lessons learned in plans, revising the tabletops based on lessons learned, emerging threats, and building sustainable regional competence in plan development and exercise facilitation.

[1] https://www.disastermh.nebraska.edu/resources/state-plan/ Funded in part by a grant from ASPR to Nebraska Department of Health and Human Services, Division of Public Health.

[2] https://dhhs.ne.gov/Pages/988.aspx Funded in part by a cooperative agreement from Vibrant Emotional Health and the Substance Abuse and Mental Health Services Administration.

2. Describe any plans to utilize the BSCA supplemental funds to develop/enhance a state behavioral health team that coordinates, provides guidance, and gives direction in collaboration with state emergency management planners during a crisis.

Nebraska will not use funds to develop or enhance a state team in year four.

3. Describe any plans to utilize the BSCA supplemental funds to develop/enhance a multidisciplinary mobile crisis team that can be deployed 24/7, anywhere in the state rapidly to address any crisis.

Nebraska relies upon regionally developed assets to respond to crises across the state. The 988 system enhancements planned for Nebraska's mobile crisis response teams (for youth and adults) include standards for training and knowledge expectations for all team members. Additionally, teams are now able to respond virtually and/or in-person across the state and may be dispatched locally or by the 988-call center. The disaster response workforce is also maintained regionally and is mostly volunteer unless Nebraska qualifies for a federal disaster declaration making the state eligible for crisis counseling program (CCP) funds to support longer term outreach. Because professional clinical resources are limited, the clinicians and peers staffing mobile crisis teams may also be called upon to be part of a disaster response workforce.

Crises and emergencies in schools are mostly dealt with by school staff trained in PFA-S. Larger events may create a need for neighboring school teams or Educational Service Unit personnel (education regions) to come to the school to augment this response. This system has developed in parallel to Nebraska's crisis and disaster workforce development efforts. This project will set the stage for more integrated response capabilities, particularly during recovery periods after an event. This begins with exposing school teams to existing plan elements via tabletop exercises, and by ensuring school and community behavioral health providers, mobile crisis teams, and disaster providers (if applicable) use the same crisis response language. Currently community providers are trained using disaster PFA. The school version (PFA-S) includes specific resources for schools that we will orient community providers to school procedures so they are prepared to augment a school-based crisis response team effort.

We will offer elements of the PFA-S training to community providers, disaster response providers, and crisis teams who may be asked to support schools after an event in year four with ongoing training opportunities opened to these entities including PFA-S training offered in conjunction with the state school mental health conference. This training will be provided by members of the cadre of trainers prepared in years two & three to deliver PFA-S training with fidelity to the field operations guide maintained by the National Child Traumatic Stress Network. In addition, NDE will contract with PFA-S trainers to provide a virtual refresher for school staff on the PFA-S toolkit.

In year four, we will continue to support PFA-S and community provider exposure to school-based efforts. The Nebraska Department of Education developed a Nebraska-specific Standard Reunification (SRM) and Standard Response Protocol (SRP) toolkit in year three with the "Iloveuguys" Foundation. The toolkit helps ensure common language is used during and after

an incident between all community partners, including school personnel, Nebraska behavioral health crisis-disaster teammates, fire and rescue, parents and the students. The online availability of the toolkit ensures sustainability of this project. SRM training will be conducted during the fourth fiscal year of the project in addition to SRP training. Both the training and toolkit include considerations for students with special needs, which include those with SED or first episode psychosis. Offering these training sessions will help to establish contacts between all responding community partners. The SRP and SRM trainings, like the toolkit and PFA-S trainings, will support the use of common language among multiple community partners, ultimately helping all students establish a sense of routine, calmness. and familiarity during and after an incident.

4. Describe any plans to utilize the BSCA supplemental funds to develop/enhance crisis/mental health emergency services specifically for young adults, youth and children, or their families, including those with justice involvement and having SED/serious mental illness (SMI).

Our plan to use funds to support tabletop exercise packages and training will directly impact services provided to children and families with SED, SMI, and / or justice involvement. Specific expenditures directed toward developing and enhancing services for young adults, youth and children and their families with SED/SMI and/or first psychotic episode include:

1) Developing and testing a tabletop exercise specifically addressing how school systems identify, refer, and reintegrate students with first episode psychosis or serious emotional disturbance. A workshop in year four will prepare behavioral health regions to deliver the final package exercises with their local schools.

2) Developing four brief videos designed to remind school personnel and parents about how to identify, refer and reintegrate students with first episode psychosis or serious emotional disturbance after a drill or emergency. Accompanying handouts will reinforce referral pathways and be customizable for each local area to add their own resource lists. The Nebraska School Mental Health Advisory Group will be involved in reviewing content for the videos & handouts.

3) Orienting community providers about how schools intend to use PFA-S to identify, refer, and reintegrate students with first episode psychosis or serious emotional disturbance; Orientation for community providers will include a brief about protocols and expectations schools have of providers, including discussion of how to work collaboratively with families and schools to ensure smooth transitions for the student.

4) Providing a webinar for schools to reinforce use of crisis message maps developed in earlier years of the grant about what to look for and how to find help for students with first episode psychosis or serious emotional disturbance. These are new message maps developed by a multi-disciplinary team consisting of public information professionals, family representatives, behavioral health professionals, and school personnel.

5. Describe any plans to utilize the BSCA supplemental funds to develop/enhance services provided to communities that are affected by trauma and mass shootings/school violence.

Nebraska will be better positioned to provide services to communities after trauma or mass shootings/school violence by implementing our plans detailed in this application.

6. Describe any plans to utilize the BSCA supplemental funds to develop/enhance culturally and linguistically tailored messaging to provide information about behavioral health in a crisis/mental health emergency and/or to identify culturally/linguistically appropriate supports for diverse populations.

Nebraska has developed message maps appropriate for use by schools in response to a threat, crisis or disaster. These message maps were developed by education, public information, and mental health professionals using best practices in risk / crisis communication. They are designed for easy adaptation by local entities based on need and context. In year two we convened the partners with risk communication specialists to review the message maps, then translated them into two languages Spanish and Vietnamese). Year three added two more languages (French and German). In year four, we will provide a webinar to school personnel and community providers to reinforce use of this resource and will update messages as new research or practice guidelines emerge. Message maps are on the NDE website and have been distributed through the public health and behavioral health systems, and Nebraska Emergency Management Agency.

7. What other mental health emergency/crisis behavioral health practices or activities does the state plan to develop or enhance using the BSCA supplemental funds?

N/A

8. Clearly describe the proposed/planned activities utilizing the funds for FY 2026. States will be required to report on what activities have been completed using this funding.

FY 2026

Goal	Activity	Deliverable	Responsible Entity
1.0. Align 100% of school plans with state and regional crisis-disaster behavioral health plans by 2025	1.1c Revise tabletop exercises developed in year two and tested in year three.	1.1c Updated tabletop exercises	NUPPC – lead NDE, DHHS-DBH
	1.2c Develop and distribute a behavioral health annex template for school safety plans.	1.2c Annex template	NUPPC – lead NDE, DHHS-DBH
	1.3c. Develop four videos, two for schools and two for parents, on first episode psychosis & SED.	1.3c. Four videos posted and ready for distribution by schools	NUPPC – Lead NDE, DHHS-DBH
	1.4c Hold workshop for community-based crisis-disaster leads on how to customize the tabletop package for local schools.	1.4c List of attendees, date, location, and workshop materials	NUPPC – lead NDE, DHHS-DBH

Goal	Activity	Deliverable	Responsible Entity
2.0. Provide school intervention training to 60 people each year who are part of Nebraska's multidisciplinary crisis -disaster teams.	2.1c1. Hold PFA-S at school mental health conference.	2.1c1 Training date, location, and attendees	NUPPC – Lead NDE
	2.1c2. Provide scholarships for community-based crisis-disaster teams to PFA-S training.	2.1c2. List of scholarship recipients, along with their agency/sector	NUPPC – Lead NDE
	2.2c Update the PFA-S toolkit., providing virtual refreshers to PFA-S trained personnel.	2.2c List of dates, participant lists, and refreshed toolkit content	NDE – Lead
	2.3c1. Conduct 2 SRM/SRP training & exercises that involve school and community crisis / disaster response team members.	2.3c1. List of dates, locations, and attendees	NDE – Lead NUPPC, DHHS-DBH
	2.3c2 Provide scholarships for community-based crisis-disaster teams to SRM/SRP training & exercises	2.3c2. List of scholarship recipients and their agency/sector	NUPPC – Lead NDE, DHHS-DBH
3.0. Distribute crisis message maps with behavioral health content in multiple languages annually to 244 school districts, 17 educational service units, 6 regional behavioral health authorities, and via the Nebraska Emergency Management Agency in Nebraska.	3.1c..Update full behavioral health crisis and emergency risk message manual, incorporating messages related to children and schools developed and refined in years two and three.	3.1c. Updated message manual	NUPPC – Lead NDHHS-DBH, NDE
	3.2c. Provide a webinar for schools and community-based crisis-disaster team leads on using the message maps.	3.2c. Webinar date, list of participants.	NUPPC – Lead NDHHS-DBH, NDE

Budget Narrative – University of Nebraska Public Policy Center

Budget

Activity	Set-aside Budget Subtotals	Year 4 Budget
Personnel		$0
Travel		$2,459
Supplies		$150
Other Direct Costs		
NUPPC Services		$117,297
SRM Scholarship* (**BHCS**)	$2,000	$2,000
PFA-S Scholarships* (**BHCS**)	$6,660	$6,660
PFA-S Training costs* (**BHCS**)	$2,510	$2,510
Exercise Workshop* (**BHCS**)	$6,400	$6,400
BHCS Subtotal	**$17,570**	
Video Production** (Part **ESMI**)	$60,000	$60,000
ESMI Subtotal	**$30,000**	
Communications		$844
Total Other Direct Costs		**$195,711**
Total Direct Costs		**$198,320**
MTDC		$195,798
F&A (26%)		**$50,907**
TOTAL		**$249,227**
MTDC Exclusions		
Rent		$2,522

*Meets the Crisis Services 5% Activities Requirement (**BHCS**), costs fully described below (required amount 5% of $298,227= $14,911, amount allocated here $17,570).
Meets the ESMI/SED First Episode Psychosis Requirement (ESMI**), costs fully described below (required amount 10% of $298,227= $29,823, amount allocated here = $30,000 allocated for First Episode Psychosis videos).

A. Personnel—No funds requested.
B. Fringe Benefits—No funds requested.
C. Travel
Travel requests are estimated at $2,459 for the project period for PPC staff to attend the workshop for community-based crisis-disaster leads on how to customize the tabletop package for local schools as well as attend/staff a PFA-S training in Omaha. Estimated rates are based on UNL mileage reimbursement rates ($.70/mile), recent lodging costs, and federal per diem rates $68/day. Actual travel costs will be charged to the grant, per UNL policy.

D. Equipment—no funds requested

E. Supplies—$150 is allocated to purchase PFA-S training materials (handouts, manuals, etc.)

F. Contractual—no funds requested

G. Construction—no funds requested

H. Other Costs

NUPPC Services fees are estimated at $117,297 for the project period. The NUPPC is an authorized University of Nebraska-Lincoln self-supporting service center. NUPPC Services rates charged to the project at established break-even hourly rates for the actual number of billable hours recorded by project personnel. The loaded hourly rate incorporates salary, benefits, and operating costs such as rent (NUPPC has an off-campus location), computer/technical support services, communications, and other costs in support of the project that are not included in the university's facilities and administrative costs, as allowed by 2 CFR §200 Uniform Guidance. Clients are billed at the actual approved hourly rates for each individual, at the time services are rendered.

Dr. Denise Bulling, *Senior Research Director*, will serve as the project lead and oversee project management and reporting. Dr. Bulling will lead the project team consisting of: **Dr. Stacey Hoffman, *Senior Research Manager,*** to provide content expertise for activities and reporting; **Mr. Kurt Mantonya, *Research Manager,*** to provide coordination of project activities and reporting; a ***Research Specialist*** to assist with scheduling, record-keeping, and reporting; a ***Design Specialist***, who will assist with material production and reporting. A ***Finance Specialist*** will assist with reimbursements and financial tracking, and a ***Project Assistant*** will assist with scheduling, and coordination. A table of *estimated* rates and hours for the project period is included below. The project will be billed at the NUPPC's actual authorized hourly rates for each individual at the time services are rendered. The NUPPC regularly employs a team approach to project management that enables us to provide a breadth and depth of expertise tailored to the specific needs of the client. Continuity is assured through the leadership of the Project Lead, who is responsible for all aspects of the project, progress, and product delivery. We reserve the right to interchange qualified project personnel, based on availability, ability to perform tasks, as needed. A table of estimated hours is included below.

Name	Rate	Hours	Cost
Denise Bulling	$162.22	160	$25,955
Stacey Hoffman	$100.22	200	$20,044
Kurt Mantonya	$93.61	400	$37,444
Research Specialist	$60.82	400	$24,328
Design Specialist	$69.40	80	$5.552
Finance Specialist	$71.38	40	$2,855
Project Assistant	$55.95	20	$1,119
		1300	**$117,297**

Other Direct Costs include

- $2,000 community-based behavioral health responders to attend SRM trainings/ Estimated rates are based on UNL mileage reimbursement rates ($.70/mile), recent lodging costs, and federal per diem rates $68/day. Actual travel costs will be charged to the grant, per UNL policy (counts towards requirements for 5% of funds to be used towards crisis services).
- $6,660 to provide scholarships for the six Behavioral Health Region's community-based behavioral health responders to attend a PFA-S training PFA-S training offered in conjunction with the state school mental health conference. Estimated rates are based on registration fees for the school mental health conference ($250), UNL mileage reimbursement rates ($.70/mile), lodging costs, and federal per diem rates $80/day (Omaha, NE). Actual travel costs will be charged to the grant, per UNL policy (counts towards requirements for 5% of funds to be used towards crisis services).
- $2,510 to host a PFA-S training which included $500 for meeting facility costs and 2,010 for trainer costs (mileage at $.70/mile, lodging, and meal per diem). (counts towards requirements for 5% of funds to be used towards crisis services).
- $6,400 to hold workshop for community-based crisis-disaster leads on how to customize the tabletop package for local schools. Workshop costs include workshop facilities (meeting room, A/V costs) estimated at $2,500 and $3,900 to provide travel costs for participants (mileage at $.70/mile, lodging, and meal per diem) (counts towards requirements for 5% of funds to be used towards crisis services).
- $60,000 to produce four video-based educational tools on first episode psychosis (FEP) and on social emotional disturbance (SED) in children (one targeted at parents and one targeted at schools for each subject) related to emergencies (meets requirements for 10% of funds required to be used for ESMI/SED with $30,000 toward First Episode Psychosis videos).
- $844 for internal communication costs (copying/printing and translation services) to cover development, piloting/proofing, and final printing and postage costs for any hardcopy materials such as meeting materials, surveys, presentations, and other documents. The NUPPC uses copier codes to track and bill costs to the project. Project-specific translation charges will be billed to the project based on use.

Indirect Costs are included according to UNL's negotiated federal F&A rate agreement at the rate of 26% for "off-campus" research against modified total direct costs (MTDC). Modified total direct costs exclude, for example, equipment purchase, capital expenditures, charges for tuition remission, rent, and portions of subawards that exceed $25,000. Under UNL's F&A agreement, services fees are not excluded from modified total direct costs. MTDC for this proposal includes all direct costs except the project's portion of off-campus office rent ($2,522).

Budget Narrative – Nebraska Department of Education

Budget

Activity	Year 4 Budget
Travel	$9,700
Other Direct Costs	
Supplies/Materials	$0
Contractual	$33,778
Other	$0
BHCS Subtotal	$0
ESMI Subtotal	$0
Total Direct Costs	$43,478
Indirect Costs	$5,522
Total Costs	$49,000

A. Personnel—no funds requested for year 4
B. **Fringe Benefits**—no funds requested for year 4
C. Travel
In-state travel includes mileage, lodging, meals & incidental expenses as applicable:

Year 4: **$9,700**
Travel to training locations **$9,700**
(15 nights lodging @ $150/night) **-** 15 days meals @$45/day, Mileage at .70/mile, miscellaneous travel expenses

D. Equipment—no funds requested for year 4
E. Supplies— no funds requested for year 4
F. Contractual— Year 4: $33,778
Contracts with iloveuguys Foundation to host 2 SRP/SRM exercises
Contract with trainers to provide PFA-S toolkit overview refresher trainings
G. Construction—no funds requested for year 4
H. Other Costs- no funds requested for year 4

Indirect Charges

Nebraska Department of Education estimate indirect cost is 12.7% based on a negotiated indirect cost rate agreement. Nebraska Department of Education estimate indirect cost is 12.7%. $5,522.

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

Thomas Janousek, PsyD

Title

Director Division of Behavioral Health

Organization

NE Department of Health and Human Services - Division of Behavioral Health

Signature: Date:

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

The Nebraska DHHS Division of Behavioral Health affirms it has not undertaken any lobbying during the most recently completed (prior to the application) state fiscal year. No lobbying activities to disclose or report.

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

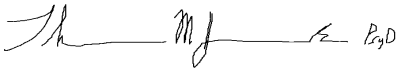
Thomas Janousek

Title

Director Division of Behavioral Health

Organization

NE Department of Health and Human Services - Division of Behavioral Health

Signature: 

Date: 08/11/2025

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

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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 prevention system (description of the current prevention system's attention to individuals in need of substance use primary 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 behavioral health 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 mental health and SUD services. States should also include a description of regional, county, tribal, and local entities that provide mental health and SUD services or contribute resources that assist in providing these services. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

1. Please describe how the public mental health and substance use services system is currently organized at the state level, differentiating between child and adult systems.

Revised 11/6/25

The Division of Behavioral Health (DBH) is the chief behavioral health authority for the State of Nebraska and it is responsible for the administration and coordination of the Public Behavioral Health System [§71-806 (1)]. This includes the duty to ensure the statewide availability of an appropriate array of community-based behavioral health services and continuum of care and the allocation of such funds to support the consumer and his or her plan of treatment [§71-811]. This encompasses the provision of planning, funding, oversight, and technical assistance to a network of Community-Based Services delivered through Nonprofit Agencies and Organizations, and the Regional Behavioral Health Authorities (RBHAs).

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The DBH contracts with the six RBHAs for community-based adult and youth mental health and substance use services, including primary prevention, crisis/emergency and housing coordination. Each regional behavioral health authority is responsible for the development and coordination of publicly funded behavioral health services within their respective behavioral health region [§§71-807-809].

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Behavioral Health in Nebraska covers services needs for mental health, substance use and co-occurring 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 mental health and substance use services are administered by many different agencies including three of six different Divisions within the Nebraska Department of Health and Human Services (NeDHHS): Division of Behavioral Health (DBH); Division of Medicaid and Long-Term Care (MLTC); and Division of Children and Family Services (CFS).

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The Nebraska DBH 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 focuses on consumer and peer support services, relationships, planning, and advocacy for all consumers. The OCA provides education and technical assistance support for consumers and families throughout the state and across DHHS Divisions for the development of programs and services that are recovery focused and consumer and family driven.

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At the state level, DBH is comprised of DBH Central (Community-Based Services and Prevention) and Regional Centers (State Psychiatric Hospitals).

DBH Central

Community-Based Services (CBS Adult and Youth) consists of services, programs and the workforce essential for delivery of statewide, community-based mental health, substance use and co-occurring disorder treatment, recovery support services, in addition to prevention programs and practices.

DBH Central is comprised of nine operational teams.

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1. Clinical: Oversight for continuum of care service definitions; liaison with Medicaid; service quality assurance; CCBHC certification; fidelity audits
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. Housing: Coordination and initiatives for DBH-supported supported housing services, facilitating expansion of sober-living Recovery Homes based on the Oxford House, Inc. model, addressing issues related to homelessness through management of the PATH program and providing financial assistance to Nebraska SOAR programs.
5. Network: Contract management for Community-Based Services (CBS Adult and Youth) with the Regional Behavioral Health

Authorities (RBHAs) and the Tribes.
6. Outpatient Competency Restoration: Nebraska state statute (29-1823) allows for alternative treatment plans to restore an individual for competency to stand trial.
7. Prevention: Promotes safe and healthy environments that foster youth, family, and community development through the implementation of early intervention and Primary Prevention.
8. Youth and Emergency Services: Liaison for Youth community-based mental health and substance use services, Crisis and Emergency services, and Disaster relief initiatives.

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Regional Centers are the state's public psychiatric hospitals located in Norfolk and Lincoln,
• Norfolk Regional Center (NRC) provides intensive sex offender treatment services.
• Lincoln Regional Center (LRC)
o Main Campus provides types of services:
• psychiatric services for people with severe and persistent mental illness;
• forensic services to provide evaluation, assessment, and treatment for persons as ordered by the Nebraska legal system; and
• adult offender reentry services.
o Whitehall Campus 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.

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In addition to funding mental health, substance use and co-occurring disorder services and prevention programs and practices through the RBHAs, DBH Community-Based Services also contracts with entities for recovery and support services and initiatives. 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 Boys Town to operate the new 988 Nebraska Children and Family Support Helpline (888-866- 8660) where youth, families, and individuals in need of behavioral health crisis services and 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 individual youth and families with youth experiencing mental/emotional disorders, support the family voice and offer supportive services such as education, support groups, advocacy, and mentoring;

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• Nebraska Rural Response Hotline to provide the Counseling, Outreach and Mental Health Therapy (COMHT) Program. COMHT is a telephone hotline service serving the rural population providing cost free, confidential mental health crisis counseling readily available to distressed farm and rural families. During the call, the person may be 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. Individuals and families who have continued needs are referred to the state Network of Services to obtain services through the RBHA Network of Care or other systems.

2. Please describe the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of mental health and substance use services.

Revised: 11/06/25
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 promotes making America Healthy Again. The DBH is responsible for managing both the Community Mental Health Services Block Grant (CMHSBG) and the Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRSBG). 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 Office of Consumer Affairs focuses on recovery initiatives, planning, research, and advocacy for behavioral health consumers.

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Other state and federal agencies (for example, the Administrative Office of Probation within 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 eligible 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.

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DBH Partnerships with Other State Agencies
The DBH and the 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 divisions have an ongoing review of service expectations for those services that are available through each funding stream. Most recently, DBH worked closely with MLTC on the service expectations for Medically Managed Withdrawal Management and Opioid Treatment Programs as two services added into the MLTC benefit through an 1115 SUD waiver.

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The MLTC provides funding for an array of services to address mental health and substance use issues of children and adults, including the Medicaid Rehabilitative 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. DBH utilizes MLTC data on opioid and stimulant treatment utilization which helps inform DBH needs assessments.

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And, DBH with MLTC and NeDHHS Division of Developmental Disabilities (DD) have created a new partnership to bring up a new Medicaid State Plan Amendment/Waiver to serve a target population with serious mental illness that will provide options for community-based services with targeted case management. Work is currently ongoing to connect with DBH providers, Medicaid providers and DD providers to provide informational webinars on the Serious Mental Illness (SMI) Waiver and the services to be offered to those determined eligible for waiver services. These services will be offered in the community and provide options for those consumers looking for services outside of inpatient or residential institutions. The current timeline for anticipated approval by the Centers for Medicare & Medicaid Services is January 2026.

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DBH has been working closely with the Division of Developmental Disability (DDD) to provide continuity of care. Additionally, DBH and DD, along with Vocational Rehabilitation, are collaborating on supported employment service expectations and payment methodology.

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Veteran's Affairs and DBH have led Nebraska's efforts on the Governor's Challenge to reduce suicide among veterans. DBH is sharing a behavioral health position co-located within Veteran's Affairs to help facilitate the combined effort.

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DBH collaborates with the NeDHHS Division of Public Health on a regular basis on substance use activities. This includes the Nebraska Opioid Rapid Response Plan and team, the Overdose Data to Action (OD2A) CDC grant, and activities of the SEOW, Tobacco Cessation Work Group, and Tobacco Free Nebraska.

DBH is a member of the Justice Behavioral Health Committee (JBHC), created in 2003 by the Administrative Office of Probation to gather representation from the state Executive and Judicial branches as well as behavioral health treatment providers and consumers for justice-involved individuals. DBH continues to expand its collaboration with the Nebraska Judicial System – Administrative Office of Probation through exploring opportunities for information exchange across data systems to address efficiency in service utilization and funding and avoidance of duplication of services.

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Nebraska's AWARE-SEA Project is being jointly undertaken by the Nebraska Department of Education (NDE) and 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, 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.

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NDE and DBH are partnering at the State level to collaborate with three Local Education Agencies (LEAs) to improve school-based mental health services.

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3. Please describe how the public mental health and substance use services system is organized at the regional, county, tribal, and local levels. In the description, identify entities that provide mental health and substance use services, or contribute resources that assist in providing these services. This narrative must include a description of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

Revised: 11/6/25

The Division of Behavioral Health (DBH) ensures block grant funds and state dollars are used in accordance with SAMHSA's expectations that the block grants funds 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 SUPTRS BG 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.

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Services are provided by the SSA/SMHA to non-Medicaid eligible consumers in the state and are paid for with a combination of SUPTRS BG, MHBG and state funding. NeDHHS MLTC contracted plans provide the an array of services for behavioral health consumers, many of which are also contracted for by the SSA/SMHA. DBH continues its collaboration with MTLC/Medicaid to update and keep current all mental health and substance use service definitions. http://dhhs.ne.gov/Pages/Medicaid-Behavioral-Health-Definitions.aspx

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Funding from the MHBG and SUPTRS BG, along with state dollars, pass through from DBH directly to providers or to Regional Behavioral Health Authorities (RBHAs) who distribute via sub-grants to local providers. DBH works with the RBHAs and the Nebraska Association of Behavioral Health Organizations (NABHO) to assess needs and develop plans for service delivery. In

addition, the DBH encourages RBHAs to work collaboratively with Federally Qualified Health Centers in their catchment areas to provide integrated opportunities to receive co-occurring behavioral/physical healthcare. This collaborative effort is further being extended to the seven Certified Community Behavioral Health Clinics that will be active across all six RBHAs in January 2026.

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DBH funds a continuum of services for persons with mental illness, including those with co-occurring mental and substance use disorders, to live, work, and receive treatment and supports in the least restrictive environment to meet their needs. Using SAMHSA's components of recovery support services that focus on individuals to remain in the community when appropriate. Rehabilitative services support individuals to strengthen skills to alleviate functional deficits related to an individual's mental illness. Support services focus on access to housing, employment, with recovery support services if needed such as peer support.

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The Nebraska Continuum of Care Manual (COC) describes services developed to provide an array of services for individuals according to need. The COC Manual is incorporated by reference in contracts. A list of contracted services is reported below. Also provided is a link to the Nebraska Behavioral Health System Service Definitions, known as the Continuum of Care manual: https://dhhs.ne.gov/Behavioral%20Health%20Documents/Continuum%20of%20Care%20Manual.pdf

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Behavioral health services funded through the MHBG and the SUPTRS BG are available to maintain a continuity of care for eligible individuals who have been served through programs providing outreach and services for children with SED/SMI, dually diagnosed SMI/SUD, co-occurring SMI/SUD, IPWWDC, PWWDC, Injecting users and those at increased risk for TB, homelessness in treatment services, The Division of Behavioral Health (DBH) collaborates with public and private systems, and individuals, families, and communities to ensure eligible individuals are connected with services to meet their needs.

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Partnerships and collaborations with public and private systems, and individuals, families, and communities are important components in systems of care surrounding everyone 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 Nebraskans. The DBH collaborates with the NDCS to ensure individuals released from correctional facilities are connected with services to meet their needs. The DBH works with NDE-VR to provide Supported Employment for individuals with serious mental illness, substance use disorders, and co-occurring. Below are examples of targeted services.

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The state's services specific to the co-occurring SMI/SUD population.

The coexistence of both a mental illness and a substance use disorder is common among people in treatment. DBH services are designed to meet the level of care needs of each individual. DBH conducts data monitoring and evaluations ensure services effectively meet co-occurring needs.

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To accomplish these outcomes, DBH and the Behavioral Health Education Center of Nebraska (BHECN) continue to collaborate and align strategic planning, to advance the implementation of evidence-based practices (EBP) through workforce training and growing the behavioral health workforce.

The state's services specific to the criminal justice involved population.

The DBH has established expectations for system treatment and care of criminal justice involved individuals. Through contractional requirements with the Regional Behavioral Health Authorities (RBHA), the RBHA provides leadership and resource development with system partners to improve diversion, engagement, connection, and intervention of services by successfully promoting access, coordinating, and sustaining a community-based emergency and crisis service system designed to meet the complex needs of individuals experiencing a behavioral health crisis or emergency by building a robust prevention, treatment, and recovery system that supports the end outcome of Making America Healthy Again.

Including:

a. Identification of behavioral health crisis system cores services.

b. Capacity Development with system partners for a prevention continuum including, suicide prevention, treatment, recovery, adult, youth, and integrated systems of care.

i. Partnering with the Administrative Office of the Courts and Probation (AOCP), Justice Behavioral Health Partners, etc.

ii. Continue capacity development related to 988 "somewhere to call, someone to respond, somewhere to go" partnerships. Crisis/Emergency services development including opportunities to connect individuals for Psychiatric Emergency Observation, urgent care, open access appointments, same day services, etc.

iii. Identify strategies to divert individuals from emergency rooms and jails.

c. Coordinate activities and collaborate with community-based partners to ensure that individuals experiencing a behavioral health crisis receive the least restrictive and most appropriate level of care and services located within their community.

d. Collaborate with county attorneys and local mental health boards on local system issues, identified through individual cases and/or aggregate data.

e. Partner on strategies to improve system flow to and from all levels of care.

i. Assist with facilitating seamless movement of individuals to the most appropriate level of care by participating in case review and treatment team meetings and other activities designed to develop appropriate discharge plans for individuals receiving treatment in the emergency system (e.g., community-based hospitals, mental health crisis center and the Lincoln Regional Center (LRC)).

ii. Manage the LRC Mental Health Board waitlist by working with the community-based hospitals and/or crisis centers to make sure only the individuals who are clinically appropriate are added to the waitlist. They will also work with the community-based

hospitals and/or crisis centers to make sure the necessary admissions paperwork is filled out and submitted to the Network Administrator and/or designee and LRC. Partner in the development and implementation of specialized discharge planning to facilitate timely discharge of consumers receiving treatment at LRC and to support ending crime and disorder on America's streets.
iii. Consult with Department of Corrections' staff as requested to assist with discharge planning for consumers who are clinically and financially eligible, and who have citizenship/lawful presence, from correctional facilities.
iv. Participate in decreasing the LRC Court waitlist through promotion of diversion strategies, connections to services, and development of community-based options to help decrease higher levels of care.
v. Promote Sequential Intercept Mapping and Stepping Up initiatives. Continue to partner with, and develop, early intercept services, supports, and processes at the local level.
f. Implementation of the LRC hospital action plan and submission of data required for the plan (as applicable).
g. Engage in activities that promote quality improvement by reviewing emergency system data, preparing reports, monitoring outcome measures, and providing technical assistance to community providers when needed, and as appropriate.
h. Participate in statewide emergency system coordination activities and other calls as scheduled by DBH.
i. Assist DBH with implementing and operationalizing a bed registry strategy within the Region.
j. Collaborate with DBH regarding 988 crisis service system implementation.
k. Ensure consumer level data for the Emergency System is submitted through the CDS or other data systems as designated by DBH.

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Outpatient Competency Restoration (OCR) treatment has been provided by DHHS DBH since 2021. In 2019, Legislative Bill 686 was passed which allowed for DHHS to enter into contracts with facilities or providers to offer competency restoration and went into effect in July 2021. Prior to July 1, 2021, the only option available for competency restoration was in a state hospital or state-operated facility. OCR programs are available through contracted OCR Providers across the state.

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Nebraska has implemented targeted efforts to partner with Community Corrections agencies and jails directed to individuals involved in the competency restoration system to 1) better divert individuals into outpatient competency restoration services when appropriate, and 2) to improve re-entry for individuals with low level offenses involved in inpatient competency restoration services.

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Jail In-Reach services are provided by DBH to facilitate and support treatment engagement and address barriers to participation in OCR and facilitate referrals to OCR when appropriate.

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Jail In-Reach services are pre-treatment or consultation services provided to individuals committed to DHHS for competency restoration but are currently in a correctional setting and not yet admitted into a competency restoration program. Individuals served have active mental health symptoms, who need assistance with managing their mental health symptoms, who need assistance with communication skills in order to interact with their attorney, and who need encouragement to take prescribed psychotropic medications.

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DBH is addressing the need for behavioral health services for individuals with mental illness who are in jails. DBH is paying with couny and state general funds for services by behavioral health providers in jails with no behavioral health staff to meet this need. DBH contracts through the RBHA with network providers include services of Assessment (MH and SUD), Outpatient Psychotherapy—Individual (MH and SUD), Outpatient Psychotherapy – Group (MH and SUD), and Intensive Outpatient Services (SUD) and added the service Assessment Addendum in April 2024.

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Integration work has required building on existing and building new partnerships to increase the number of primary care practices offering behavioral health services within the practice, to increase identification and access.

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DBH and the Nebraska Medical Association are collaborating on a project that promotes the integrated healthcare models in primary and behavioral health care settings. The project has developed the capacity to engage with various practices to provide mentoring, technical assistance, training, and general integration guidance to primary care sites interested in integrating behavioral health services into their practice. Partnerships have been developed with 45 organizations to date and over 1,400 participants have been trained on such topics as medications for opioid use disorder, behavioral health for justice involved population, physician wellness and burnout and the effects of COVID on mental health and substance use disorder.

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DBH works with providers in the Network of Services to review proposals to address barriers (transportation, etc.) as they come up to improve delivery of services.

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The Nebraska Director of Behavioral Health is a member of the Rural Health Advisory Commission and serves as a consultant and advocate for behavioral health issues in rural areas. The Commission activities include a tuition reimbursement program for rural providers such as physicians and licensed mental health practitioners.

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Recent investments of the state include the Children's Nebraska Hospital & Medical Center of Omaha's new Walk-In Urgent Care center in Kearney, Nebraska (central Nebraska). This new facility became operational in 2023. The center supports innovative

pediatric mental health and improves access to mental health care in rural central Nebraska.

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As part of its strategy to grow Nebraska's rural behavioral health workforce, the Behavioral Health Education Center of Nebraska (BHECN) has launched multiple rural sites. The rural sites help ensure BHECN's efforts to strengthen the state's workforce are tailored to meet the unique training, recruitment and retention needs of various regions in the state. BHECN presently has rural sites in Kearney, Chadron and Wayne. BHECN is also planning to expand with a BHECN Southwest office located in rural southwest Nebraska.

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The BHECN Central office is located in the Health Sciences Education Complex on the University of Nebraska - Kearney campus. The BHECN Panhandle office is located at Chadron State College in Chadron. The BHECN Northeast office is located at Wayne State College. The BHECN Southeast office is located in the City of Lincoln. The BHECN East office is located in Omaha at the University of Nebraska at Omaha.

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Other plans to expand access to care for children and youth include a new behavioral health center for children on the campus of the Immanuel Center in Omaha. Immanuel Center is building a new 40 bed inpatient facility (with room for eight more) facility planned to open in January 2026. The Center's seamless continuum of care to improve the physical and mental wellbeing of youth 19 years of age and less. That more than doubles the capacity in the community. See https://nebraskaexaminer.com/briefs/114m-omaha-mental-health-center-for-kids-on-track-for-2026-opening/

And, Community Alliance, an Omaha nonprofit integrated health care organization that psychiatric services, mental health and substance use counseling, primary medical care and a range of rehabilitation, employment, community supports and family and peer support, has expanded services with the construction of a new 120,000 square foot facility in Omaha in 2025.

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The state's services specific to the older adult population.

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DBH staff work with system partners on training and outreach to nursing facilities and assisted living facilities serving older adults to better identify, screen, and respond to behavioral health needs. The Pre-Admission Screening and Resident Review (PASRR) functionality resides within DBH to ensure individuals appropriately meet the nursing facility level of care, and if needed, access to specialized behavioral health is provided.

DBH also is working on funding a therapeutic consultation service which would be able to assist individuals in assisted living and nursing facilities in receiving specific behavioral health care plans.

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The state's services specific to the homeless population supports Ending Crime on America's Streets:

Persons who are experiencing homeless and while also living with 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 providers in areas with the highest rates of homelessness. Providers prioritize outreach and case management services to address individuals' immediate needs, while also assisting consumers in developing self-sufficiency through referrals and attainment of services. In addition to PATH funds the Nebraska Homeless Assistance Program (NHAP), located within the DHHS Division of Public Health, supports a statewide network of shelters, supportive housing, and service providers. These providers plan for, and provide, emergency, transitional, and permanent housing resources. They also provide resources to address the needs of people experiencing homelessness to make the critical step from homelessness to employment, independent living, and permanent housing. For more information on NHAP see the DHHS

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DBH collaborates with the Continuums of Care across the state. All three Nebraska PATH Providers actively participate in their Continuum of Care. The HUD funded Continuum of Care (CoC) Program is designed to promote community-wide commitment to the goal of ending homelessness and crimes on America's streets. Sixty four percent of CoC Coordinated Access Point locations are Community Action Partnership agencies and 18% of all CoC Coordinated Entry Access Point locations are also behavioral health service providers in the DBH Network of Care. Over the last several state fiscal years, Community/Social Services Agencies were the fourth largest referral source of individuals experiencing homelessness representing 6% each year. Over this same time period, the three largest referral sources of individuals experiencing homelessness consistently have been Self at 34%, Mental Health Services Provider at 18% and Law Enforcement Agency at 14%.

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New admissions to the DBH Supported Housing Program of individuals experiencing homelessness have on average over the last three state fiscal years represented 18% of all new admissions. DBH will expand the opportunity to serve individuals experiencing homelessness and ending crime and disorder on America's streets.

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The state's services specific to the dually diagnosed SMI/IDD population.

Supported Employment as funded by DBH in cooperation with the Office of Vocational Rehabilitation (VR) is designed to provide recovery and rehabilitation services and supports to consumers engaged in community-based competitive employment in integrated settings. DBH and the Division of Developmental Disabilities (DDD) work to align Supported Employment programs for Dually Diagnosed SMI/IDD to support the consumer as needed with all aspects of employment, including job search, acquisition and retention, and as requested. The intent of the service is to support the consumer in the recovery process so the consumer's employment goals can be successfully obtained.

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DBH provides specialty discharge planning for individuals with SMI or SPMI as an augmentation to existing services for

individuals. These “Plans for One” are not only intended to support a consumer’s re-integration into the community from our state hospital, but to deter individuals from being admitted to the state hospital if they are at risk. They allow for a combination of services provided by both in-network and out-of-network providers. Funding can be used for development of wraparound or innovative service approaches that meet individualized needs.

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Collaboration occurs across systems. This maximizes the use of resources to best meet consumer need and is supported by training staff, including administration, management and employment.

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Revision 10/29/25

1. Pregnant Women

Local and Regional Services:

• Women’s Set-Aside Providers (DBH Network):

Local and regional programs offer specialized substance use disorder (SUD) treatment for pregnant women through various modalities:

o Intensive Outpatient Therapy (Community Action Partnership of Western NE)

o Short-Term Residential (Human Services, Inc.)

o Recovery Support (Region II Human Services, Heartland Counseling Services Inc., Heartland Family Services)

o Halfway House, Outpatient, Therapeutic Community, and Recovery Support (St. Monica’s, Santa Monica, The Bridge, The Well)

• Additional Regional Services:

o Heartland Family Works Residential SUD/co-occurring treatment program, specifically designed for women (including pregnant women) with dependent children.

o Opioid Treatment Programs (4 statewide) providing MAT (Medication-Assisted Treatment) to pregnant women using opioids.

• Interim Services (if immediate admission unavailable):

o Counseling on drug/alcohol effects on fetus

o Prenatal care referrals

o HIV/TB education and prevention counseling

o Documentation and follow-up for all referrals

• Public Awareness Requirements:

o Regions must ensure public posting of service availability and admission preference for pregnant women (via brochures, posters, flyers).

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2. Women with Dependent Children

Local and Regional Services:

• Access to all Women’s Set-Aside programs and recovery housing allowing children to remain with their mothers (e.g., St. Monica’s, Santa Monica, Heartland Family Works).

• Family-focused case management and recovery support services coordinated regionally to stabilize both parent and child.

• Supportive housing and family reunification services offered through some RBHA providers.

• Community-based recovery support networks that address child care, parenting education, and connection to social services.

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3. Persons Who Inject Drugs

Local and Regional Services:

• Comprehensive continuum of care (minimum of 9 core services) required in all regions:

o Substance Use Assessment

o Outpatient, Intensive Outpatient, and Residential Treatment (ASAM 1–3.5 levels)

o Social Detoxification and Medically Monitored Withdrawal (ASAM 3.2–3.7)

o Co-occurring Residential Services

o Opioid Treatment Programs (OTPs) offering MAT and counseling

o Oxford Houses for sober living and recovery support

• Interim Services (when waiting for treatment):

o HIV/TB risk education and prevention

o Referral to medical, and social support services

• Regional Coordination:

o If a service is not available locally, Letter of Agreement (LOA) arrangements allow clients to receive care from providers in other regions.

o Weekly Statewide Waitlist Management System reviews ensure priority placement.

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4. Persons at Risk for Tuberculosis (TB)

Local and Regional Services:

• All DBH-funded network providers must offer TB-related services directly or through formal agreements with public health entities.

• Required Local/Regional TB Services:
o Screening of all admissions for TB symptoms
o Testing for individuals with positive screenings
o TB counseling and education
o Referral for diagnostic evaluation and treatment
o Case management to ensure service follow-up
o Reporting of active cases to the State Department of Health and Human Services (DHHS), Division of Public Health
o Documentation of all screenings, referrals, and infection control actions
• Regional Quality Assurance:
Each RBHA monitors compliance with TB screening, documentation, and infection control procedures.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system, including state plans for addressing identified needs and gaps with MHBG/SUPTRS BG award(s)

Narrative Question

This narrative should describe your states needs assessment process to identify needs and service gaps for its population with mental or substance use disorders as well as gaps in the prevention system. A needs assessment is a systematic approach to identifying state needs and determining service capacity to address the needs of the population being served. A needs assessment can identify the strengths and the challenges faced in meeting the service needs of those served. A needs assessment should be objective and include input from people using the services, program staff, and other key community stakeholders. Needs assessment results should be integrated as a part of the state's ongoing commitment to quality services and outcomes. The findings can support the ongoing strategic planning and ensure that its program designs and services are well suited to the populations it serves. Several tools and approaches are available for gathering input and data for a needs assessment. These include use of demographic and publicly available data, interviews, and focus groups to collect stakeholder input, as well as targeted and focused data collection using surveys and other measurement tools.

Please describe how your state conducts needs assessments to identify behavioral health needs, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

Grantees must describe the unmet service needs and critical gaps in the state's current systems identified during the needs assessment described above. The unmet needs and critical gaps of required populations relevant to each Block Grant within the state's behavioral health system, including for other populations identified by the state as a priority should be discussed. Grantees should take a data-driven approach in identifying and describing these unmet needs and gaps.

Data driven approaches may include utilizing data that is available through a number of different sources such as the **National Survey on Drug Use and Health (NSDUH)**, **Treatment Episode Data Set (TEDS)**, **National Substance Use and Mental Health Services Survey (N-SUMHSS)**, the **Behavioral Health Barometer**, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the CDC mortality data, and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention, treatment, and recovery support services planning. States with current Strategic Prevention Framework - Partnerships for Success discretionary grants are required to have an active SEOW.

This step must also describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss their plan for implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations listed above, and any other populations, prioritized by the state as part of their Block Grant services and activities are addressed in these implementation plans.

1. Please describe how your state conducts statewide needs assessments to identify needs for mental and substance use disorders, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

revised 11/6/25

As the chief behavioral health strategist for the state, the Nebraska Department of Health and Human Services, Division of Behavioral Health (DBH) is charged to plan, organize, coordinate and budget for a statewide system of care for individuals and families that need public mental health and substance use disorder services. To accomplish this work DBH utilizes expert consultation in three key areas to create needs assessments, gap analyses of the needs assessments, and a strategic planning process to use as a roadmap for the facilitation of a changes to take the DBH system into the future to achieve an integrated and sustainable approach to behavioral health care and behavioral health outcomes.

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Working with contracted consulting firms, these three key areas are accomplished through comprehensive planning activities for a statewide strategic plan or a more focused purpose, such as opioid use/misuse and stimulants, suicide prevention, and Certified Community Behavioral Health Clinics assessments.

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The needs assessment evaluates Nebraska's behavioral health landscape to inform change and implementation. The assessment examines demographic trends, provider availability, behavioral health prevalence, and service gaps.

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Components of the needs assessment include establishing performance objectives and creating needs assessment tools. Initial objectives are established with visioning sessions with stakeholders, partners and advocacy entities to establish goals and objectives and create the needs assessment tool.

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Next steps will conduct research to assess system. This can include compilation of system and national data, review of previous needs assessments and studies, feedback from community focus groups, surveys and/or e-surveys, interviews with selected stakeholders, partners and managers. These in-depth profiles of the behavioral health system in Nebraska and database of behavioral health provider organizations and healthcare practices and systems are then analyzed. The analysis is another core element in creating the needs assessment. Using the information and data gathered from the initial and next steps, the complete needs assessment report is compiled.
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The second component, gap analysis, involves a process to gather comparative behavioral health system performance metrics on each performance measure. The information from the needs assessment and the comparative behavioral health system performance metrics is used to provide a complete gap analysis. The gap analysis includes identification of high-priority initiatives for consideration when developing the strategic plan.
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The findings identify and highlight key challenges and opportunities for strengthening the area of interest and provide the basis for DBH designing policies and strategic initiatives that align services, infrastructure, information systems, etc. with Nebraska's identified needs.
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Examples of implementation accomplishments of the most recent strategic plan include:
• 988 Implementation and Ongoing Integration with 911 System
o Capacity development of "somewhere to call, someone to respond, somewhere to go" partnerships (connect individuals for crisis stabilization, mobile response, urgent care, open access appointments, same day services, recovery supports)
• Forensic Justice Behavioral Health Reorganization
o Outpatient Competency Restoration providing diversion and improving re-entry
• Workforce Enhancement
o Expansion of telehealth and other technologies
• Alternative Service Delivery
o Planning Alternative Payment Arrangements such value-based contracting and pay-for-performance
• DHHS Cross-Division Behavioral Health Collaboration
o Cross system partnerships for data sharing, services for older adults, improve system flow
• Healthcare – Primary and Behavioral – Integration Partnership
o DBH and Nebraska Medical Association project that promotes the integrated healthcare models in primary and behavioral health care settings across the state
• OpenBeds Behavioral Health Bed Registry Implementation
o Real-time behavioral health crisis capacity management and referral network system
• Capacity Development with Prevention System Partners
o Cross system collaboration to integrate Public Health, Children & Family Services, Corrections, Veterans
Please see attached Planning Step 2 - Identify the Unmet Service Needs and Critical Gaps

2. Please describe the unmet service needs and critical gaps in the state's current mental and substance use systems identified in the needs assessment described above. The description should include the unmet needs and critical gaps for the required populations specified under the MHBG and SUPTRS BG "Populations Served" above. The state may also include the unmet needs and gaps for other populations identified by the state as a priority.

Revised: 11/6/25

Nebraska Behavioral Health Needs Assessment Summary
The needs assessment conducted across Nebraska's six regions identified several critical service gaps and priorities for enhancing behavioral health services. Key findings and recommendations are as follows:

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1. Service Expansion for Priority Populations
Nebraska must expand behavioral health service capacity, particularly for priority populations, by increasing access to:
• Intensive outpatient services (IOP)
• Medication management
• OTP and OBOT services
There is also a significant need to bolster crisis response infrastructure, with a focus on:
• Increasing same-day appointments
• Implementing a "no wrong door" approach across providers

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2. Peer Support and Transportation Access
• Expansion of peer support services is essential for both mental health and substance use populations.
• Strengthening the peer workforce may also help alleviate transportation barriers identified across the state.

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3. Treatment and Recovery Services
Nebraska must increase availability and access to:
• Medication-Assisted Treatment (MAT), OTP, OBOT

• Withdrawal management services
• Residential treatment programs
• Crisis stabilization programs

These expansions are crucial to meeting the needs of all priority populations.

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4. Workforce Development and Retention

Workforce challenges were consistently reported, especially in rural areas. Needs include:
• Recruitment and retention strategies (e.g., incentives, wellness activities)
• Evidence-based training, including for First Episode Psychosis (FEP)
• Statewide coordination of training and placement via partnerships (e.g., with BHECN)

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5. Cross-Sector Collaboration

Stronger cross-sectional partnerships between behavioral health providers and other sectors—such as primary care, OB/GYN, housing, corrections, and probation—can improve care continuity of federal priority populations as well as other Ne Identified populations.

Particular attention is needed for improving warm hand-offs and care transitions for:
• Individuals with serious mental illness (SMI)
• Justice-involved individuals
• Youth aging out of foster care
• Tuberculosis referral warm hand offs when needed
• HIV/Hep C warm hand off among providers and specialist

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6. Data, Monitoring, and Prevention

To ensure quality and accessibility, Nebraska should:
• Develop data-driven performance monitoring frameworks to evaluate service utilization and outcomes
• Support regional prevention coalitions in aligning efforts with data-informed priorities (e.g., NPIRS)
• Address underage and young adult drinking through statewide prevention collaboration

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Priority Recommendations

To improve outcomes for priority populations, Nebraska should focus on the following action items:
• Expand provider training and technical assistance using validated tools (e.g., CompassEZ, TIC)
• Align regional prevention strategies with data-driven needs
• Strengthen peer support networks for individuals navigating behavioral health systems
• Maintain real-time service capacity tracking and weekly waitlist reporting
• Increase mobile crisis response services across all regions
• Fully operationalize a statewide Crisis Response Dashboard
• Ensure timely, integrated care access for women with complex needs (e.g., IPWWDC, PWWDC programs)
• Collaborate with RBHAs and BHECN to implement workforce development strategies
• Expand First Episode Psychosis (FEP) services across all regions

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This assessment and its aligned recommendations provide a strategic framework for advancing Nebraska's behavioral health system and improving outcomes for its most vulnerable populations.

Begin Revision Request: 11/1/25

Needs and Gaps of Persons in Need of Recovery Support Services

Identified Needs and Gaps:

Nebraska's most recent needs assessments highlight several critical areas where recovery support services require enhancement to better meet the needs of individuals in recovery from serious mental illness (SMI), serious emotional disturbance (SED), and substance use disorders (SUD).

1. Peer Support and Navigation Capacity:

There is a significant need to expand the capacity and availability of trained peer support specialists and peer navigators, particularly for individuals transitioning from higher levels of care such as hospital acute stays, Regional Centers, and SUD residential treatment programs. Strengthening peer support at these transition points is essential to reduce relapse, promote community integration, and improve long-term recovery outcomes.

2. Training and Development for Recovery-Oriented Services:

Nebraska intends to expand statewide training and professional development for providers by implementing SMI/SED Wellness Recovery Action Plan (WRAP) models, particularly through the Professional Partners Program (PPP). These efforts aim to reduce inpatient hospitalizations and increase community tenure among individuals with behavioral health challenges.

3. Employment and Economic Stability:

Increasing employment opportunities for individuals in recovery remains a statewide priority. Nebraska aims to raise employment rates among all federal block grant priority populations, as well as specific state-identified groups. The Recovery Friendly Workplace Initiative, certified by the Division of Behavioral Health (DBH), will continue to expand the number of employers recognized as recovery-supportive, fostering healthy employment environments.

4. Transportation Barriers:
Transportation remains one of the most persistent barriers to accessing and sustaining recovery supports across Nebraska. Each Behavioral Health Region continues to allocate funds to address local transportation needs, but ongoing investment and creative solutions are required to ensure appropriate access, particularly in rural and frontier areas.
Summary:
Nebraska's recovery support system demonstrates strong commitment and progress, yet continued efforts are needed to expand peer workforce capacity, enhance provider competencies in recovery-oriented care, promote employment among individuals in recovery, and address transportation barriers. These priorities will guide upcoming planning and implementation efforts to ensure individuals have the necessary supports to achieve and maintain recovery within their communities.

End Revision Request: 11/1/25

3. Please describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss plans for the implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations and any other populations prioritized by the state as part of the Block Grant services and activities are addressed in the implementation plan.

Revised 11/6/25
The Division of Behavioral Health (DBH) completed a comprehensive statewide needs assessment in February 2025. This assessment provided critical insights into the burden of behavioral health across Nebraska, identified system strengths and gaps, highlighted the needs of special populations, reviewed workforce status, and evaluated relevant national and state initiatives.
In addition to the needs assessment, DBH utilizes a range of data sources and collaborative structures, including:
• Data mining and analytics,
• Regular monthly partnership meetings with Regional Behavioral Health Authorities (RBHAs),
• Monthly coordination meetings with emergency, prevention, juvenile justice, and quality improvement coordinators across all six regional behavioral health bodies,
• Governor-appointed committees on mental health and substance use, which assist in developing system goals and strategic objectives.
Together, these efforts inform DBH's strategic plan and roadmap for advancing the behavioral health system in Nebraska and addressing the needs of priority populations.

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Data Systems Supporting Strategic Planning
A critical recommendation stemming from the needs assessment is to optimize existing data systems:
• Nebraska's Prevention Information Reporting System (NPIRS)
• Electronic Billing System (EBS)
• Centralized Data System (CDS)
The CDS plays a central role in:
• Data-driven decision-making using key performance indicators,
• Assessing service capacity across residential and outpatient settings,
• Conducting longitudinal follow-ups to evaluate outcomes,
• Facilitating formal data sharing to coordinate services and measure cross-system outcomes.
DBH also collaborates closely with regional coordinators to address region-specific unmet needs.

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Workforce Development
Workforce development remains a top priority, particularly in the areas of co-occurring disorders and trauma-related diagnoses. Every two years, contracted providers submit workforce data to evaluate competencies in these areas. Valid and reliable national tools—such as the Trauma Care (TIC) assessment and CompassEZ—are used to identify training needs by catchment area.
Once collected, DBH and the RBHAs respond with:
• Technical assistance,
• Free or low-cost training opportunities for workforce development
The Behavioral Health Education Center of Nebraska (BHECN) further supports workforce development by:
• Offering incentives to attract professionals to shortage areas (e.g., rural, frontier, and psychiatry),
• Expanding access to care for all priority populations in geographically specific areas of Nebraska.

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Substance Use Prevention and Community Coalitions
DBH continues to work with RBHAs to support local coalitions in effectively using prevention funding. Data from NPIRS and other surveys guide the evaluation and redirection of resources to better address substance use prevention needs, especially related to alcohol use—a top priority.

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Focus on Priority Populations

Nebraska's behavioral health system emphasizes increased access, with a "no wrong door, no wrong time" commitment to care. Based on comprehensive data reviews and stakeholder feedback, DBH has identified eight priority populations for FY26–FY27:

1. Youth and young adults – Prevention of binge drinking
2. Prevention coalitions – Increased use of evidence-based practices
3. Individuals experiencing housing insecurity – Increased support for permanent housing, Recovery support services, (All federal Block Grant priority Populations IPWWDC, PWWDC, Injecting drug users)
4. Unemployed individuals – Support to secure and sustain employment, recovery support services for IPWWDC, PWWDC, Injecting drug users
5. Geographically specific populations – Access to community-based behavioral health services
6. Individuals with first-episode psychosis – Increased access to early intervention treatment
7. Individuals with tuberculosis – Improved referrals to appropriate services
8. Crisis response – Enhanced 988 and Mobile Crisis Response systems, monitored through a new

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Priority Populations: Focus on Pregnant Women and Intravenous Drug Users

Special emphasis is placed on populations with overlapping vulnerabilities, such as:

• Intravenous drug-using pregnant women with dependent children (IPWWDC)
• Pregnant women with children (PWWDC)
• Men and women using intravenous substances

These populations are often dually diagnosed with co-occurring mental health and trauma-related disorders. DBH and RBHAs continue to improve:

• Access to integrated primary and behavioral healthcare,
• Peer support services for system navigation,
• Crisis response team resources tailored to these populations.

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Service Capacity, Waitlists, and Opioid Treatment

DBH monitors capacity and waitlist reports, which providers are required to submit weekly. When appropriate, providers must offer interim services to those awaiting treatment. For Opioid Treatment Programs (OTPs), DBH and RBAs encourage a "treatment-on-demand" model. Notably, interim services have not been needed in OTPs for over 20 years in Nebraska, demonstrating strong responsiveness and access.

Additionally, transportation remains a persistent barrier to care across all priority populations, and DBH continues to explore strategies to address this need.

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This comprehensive strategic approach positions Nebraska's behavioral health system to more effectively serve its residents, particularly those most in need, through data-informed decisions, workforce development, and targeted interventions for priority populations.

I. Executive Summary

The Nebraska Division of Behavioral Health (DBH), under the Department of Health and Human Services, is seeking funding to implement key components of its FY26–FY27 Strategic Plan aimed at advancing accessible, and evidence-based behavioral health services across the state. DBH will focus on priority populations (with a focus on the priority populations first as defined by the federal block grant), support ongoing workforce development, expand community-based service capacity, and enhance crisis response infrastructure, particularly for federal high-risk populations including pregnant injecting woman with Dependent children, Pregnant Injecting woman, all injecting drug users, with substance use disorders, individuals with co-occurring diagnoses.

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II. Statement of Need

Nebraska's behavioral health system faces multiple challenges, including workforce shortages, limited rural access, gaps in EBP's for FEP diagnosis and co-occurring disorder care, and insufficient prevention, crisis infrastructure in some regions. A comprehensive statewide needs assessment, completed in February 2025, revealed:

• A shortage of behavioral health professionals, particularly in psychiatry and geographically specific areas for mental health services.
• The need for improved data systems to track outcomes, service utilization, and capacity in real time.
• Inadequate support for critical areas such as housing, employment, and early intervention for first-episode psychosis.

DBH identified eight priority areas based on national data, stakeholder input, and regional analysis to drive system improvement over FY26–FY27.

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III. Project Goals and Objectives

Goal 1: Improve Behavioral Health Access and Outcomes for Priority Populations
Goal 2: Strengthen the Prevention System and Reduce Substance Use
Goal 3: Expand Workforce Development and System Capacity
Goal 4: Enhance Crisis Response and Continuum of Care
Goal 5: Improve Integration of Care and System Coordination

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IV. Description of Target Population

A. Target Populations

This initiative prioritizes services for:
1. Youth and young adults engaging in binge drinking
2. Pregnant injecting women with dependent children, pregnant injecting women, intravenous drug users
3. Individuals with co-occurring mental health and substance use disorders
4. Nebraskans with limited access to services
5. Persons experiencing first-episode psychosis
6. Priority populations experiencing housing and employment instability
7. Individuals with tuberculosis needing referrals
8. Crisis-affected individuals requiring immediate response via 988 or mobile crisis teams

B. Project Activities

• Expand training and technical assistance for providers using valid assessment tools and EBP's
• Support regional prevention coalitions in aligning programming with data-identified needs (via NPIRS) to ensure early intervention is an early risk behavior are identified to help decrease the future risk of chronic diseases and make American healthy again.
• Enhance peer support networks to assist individuals navigating behavioral health systems for recovery support services
• Continue real-time tracking of service capacity and enforce weekly waitlist reporting
• Continue to operationalize a statewide Crisis Response Dashboard
• Ensure timely access to integrated care options for women with complex needs (e.g., IPWWDC, PWWDC)
• Collaborate with RBHAs and BHECN to implement workforce placement and training strategies for EBP practices to address the needs of the state.

C. Partnerships and Collaboration

DBH meets monthly with the Regional Behavioral Health Authorities and all regional coordinators including emergency services, prevention, juvenile justice, and quality improvement staff. These ongoing partnerships, along with guidance from Governor-appointed advisory committees, ensure data-informed decision-making and collaborative system oversight. Nebraska will ensure we enhance our behavioral health system through strategic collaboration and partnerships that support and align with all of the current executive orders such as ending crime and disorder in America Streets.

V. Evaluation Plan

DBH will utilize its Centralized Data System (CDS), NPIRS, and the Electronic Billing System (EBS) to collect, track, and evaluate 988 and maintain the 988:
• Service utilization and outcome data by population and region
• Waitlist trends and response timelines
• Crisis call volume and mobile team response rates
• Treatment initiation for opioid use and first-episode psychosis
• KPI's to measure employment, housing, and hospital stays to name a few will be measured and reviewed with DBH's QI staff and RBHA's QI coordinators for continuous improvement in these areas.

VI. Sustainability

This application for funding builds upon existing infrastructure and partnerships, making it highly sustainable beyond the grant period. By optimizing data systems and workforce development efforts, DBH is institutionalizing improvements that will continue to benefit Nebraskans statewide. Funding will be leveraged with existing federal and state resources, and Medicaid/Medicare. Ongoing training and capacity-building will ensure a lasting impact.

VII. Budget Overview

Funding is requested to support:
• Workforce training and technical assistance
• Expansion of crisis response infrastructure (Crisis Dashboard, mobile teams)
• Data system enhancements for real-time service monitoring
• Community coalition support for evidence-based prevention programming
• Peer support staffing and navigator services, increase awareness for Recovery Friendly workplace to increase revery support services for IPWWDC, PWWDC, injecting drug users, and persons at increased risk of TB.
• Integration support for behavioral and primary health care services
• Expansion of FEP services across all regions

Conclusion

The Nebraska Division of Behavioral Health is committed to improving behavioral health service access, based on data and the gold standard of science for or all Nebraskans. With this funding, DBH will implement a strategic, data-driven approach to improve outcomes, strengthen the behavioral health workforce, and ensure timely care across the state. DBH will ensure that all federal funding is expending on services that align with the current administration.

Footnotes:

Planning Tables

Table 1: Priority Area and Annual Performance Indicators

Priority #: 1

Priority Area: Increase Use of Evidence-based Strategies

Priority Type: SUP

Population(s): PP

Goal of the priority area:

Increasing the use of evidence-based strategies supported through Block Grant funding.

Strategies to attain the goal:

Strategies to Increase the Use of EBPs
1. Build Provider Capacity Through Training
• Develop and implement a statewide EBP training plan for prevention providers.
• Offer certified training on approved EBPs (e.g., LifeSkills Training, Strengthening Families, Botvin).
• Create tiered learning paths (basic → intermediate → advanced) to improve workforce competency.
2. Strengthen Fidelity and Quality Assurance
• Implement fidelity checklists, coaching, and regular site visits.
• Use standardized monitoring tools to ensure programs are delivered as designed.
• Provide technical assistance to strengthen adherence and reduce implementation drift.
3. Establish Clear EBP Selection and Approval Processes
• Create or update a state-approved list of EBPs eligible for block-grant funding.
• Develop guidance to help communities select EBPs based on local data and readiness.
• Require providers to justify program selection and describe expected outcomes.
4. Support Implementation with Technical Assistance (TA)
• Offer statewide or regional TA to support rollout and sustainability of EBPs.
• Provide specialized TA for data collection, fidelity monitoring, and implementation barriers.
• Use “implementation coaches” to work one-on-one with new programs.
5. Enhance Data Systems to Track EBP Use
• Integrate EBP reporting fields into block-grant reporting systems.
• Track implementation quality, reach, dosage, and outcomes.
• Use data dashboards to give providers real-time feedback.
6. Incentivize the Adoption of EBPs
• Allocate a percentage of block-grant funds that must be used for EBPs.
• Offer mini-grants or competitive funding for communities adopting new EBPs.
• Provide financial incentives for demonstrating high fidelity.
7. Strengthen Partnerships and Collaboration
• Partner with schools, coalitions, and community-based organizations to expand EBP reach.
• Promote cross-sector collaborations with public health, mental health, and youth-serving agencies.
• Create communities of practice to share lessons and success stories.
8. Increase Communication and Awareness
• Develop EBP toolkits, implementation guides, and communication materials.
• Share success stories and evidence demonstrating EBP effectiveness.
• Host webinars, regional meetings, or learning collaboratives focused on EBPs.
9. Use Local Assessment & Needs Data to Drive EBP Selection
• Provide templates and guidance for conducting needs assessments.
• Require providers to select EBPs that align with local risk and protective factors.
• Use data to prioritize populations with the highest prevention needs.
10. Build Long-Term Sustainability
• Build EBP costs into multi-year block-grant planning cycles.
• Support providers in braiding and blending additional funding sources.
• Develop sustainability plans for programs that show strong outcomes.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of evidence-based strategies used in Block Grant funded activities /programs

Baseline measurement (Initial data collected prior to and during 2026): 48.5%

First-year target/outcome measurement (Progress to the end of 2026): 55%

Second-year target/outcome measurement (Final to the end of 2027): 55%

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 and system agility.

Priority #: 2

Priority Area: Alcohol Use among Youth and Young Adults

Priority Type: SUP

Population(s): PP

Goal of the priority area:

Reduce harmful alcohol use among youth and young adults.

Strategies to attain the goal:

• 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.
Strategies
• Education & Awareness
• Launch social media and community campaigns highlighting the risks of binge drinking and promoting healthy alternatives.
• Engage influencers, such as youth ambassadors, and peer educators to deliver prevention messages.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Prevalence of binge drinking reported by youth and young adults, ages 18 to 24

Baseline measurement (Initial data collected prior to and during 2026): 24.7%

First-year target/outcome measurement (Progress to the end of 2026): 26%

Second-year target/outcome measurement (Final to the end of 2027): 26%

Data Source:

Behavioral Risk Factor Surveillance Survey (BRFSS)

Description of Data:

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 methodological assistance provided by the Centers for Disease Control Prevention (CDC). States use a standardized core questionnaire, optional modules, and state-added questions to ask variety important health-topics. The BRFSS is administered annually to non-institutionalized adults 18 years and older. Nebraska Department Health Human Services DHHS) Division Public DPH) contracts with the University of Nebraska-Lincoln, Bureau Sociological Research BOSR) to manage data collection.

Data issues/caveats that affect outcome measures:

Although this survey has historically been implemented every year, the Division of Behavioral Health does not directly coordinate and is thereby dependent on availability results through coordination with DPH CDC. The survey is based on self-report. Additionally, there is typically a two-year lag for public release of this CDC data, which impacts trend assessment, outcomes/impact of program activities, and planning of targets.

Priority #: 3

Priority Area: Consumers in Stable Living Arrangements at Discharge

Priority Type: SUT, SUR, MHS

Population(s): SMI, SED, PWWDC, PWID, PRSUD

Goal of the priority area:

Increase the number of individuals in stable living arrangements at discharge from DBH funded services.

Strategies to attain the goal:

• Increase system and community-level planning efforts to focus on targeted resources for priority populations.
• Regions provide community-based wrap-round services where appropriate to help consumers have permanent and stable housing.
• Collaborate with providers and community partners to understand local housing experiences and needs and to help support response efforts.
• Increase the attention and focus on the priority area at monthly meetings with the Regional Behavioral Health Authority (RBHA) partners and service providers.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of consumers in stable living arrangements at discharge from select DBH-funded services

Baseline measurement (Initial data collected prior to and during 2026): 82%

First-year target/outcome measurement (Progress to the end of 2026): 83%

Second-year target/outcome measurement (Final to the end of 2027): 85%

Data Source:

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

Description of Data:

Providers enter consumer level demographic and service specific information for consumers MH and SU Disorders receiving DBH funded services, either directly or through regional contracts. CDS warehouses data entered so that such data can be analyzed at any time. For identified priority population consumers admitted into service in FY25, their living arrangement is collected at admission and relevant changes are attested to throughout their episode of care. Status at the end of the Fiscal Year is noted for this measure.

Data issues/caveats that affect outcome measures:

The CDS access reporting function is monitored for completeness and accuracy on a regular basis. Individuals reporting this data point may not wish to disclose whether they are or are at risk of experiencing homelessness.

Priority #: 4

Priority Area: Consumer Employment

Priority Type: SUT, SUR, MHS

Population(s): SMI, SED, PWWDC, PWID, PRSUD

Goal of the priority area:

To improve functionality and work-life responsibilities among consumers of Behavioral Health services who are classified as in the Labor Market.

Strategies to attain the goal:

• Increase provider awareness of meaningful employment for those consumers who are classified as being in the Labor Market (employed part time, full time, or unemployed but are looking for a job).
• Collaborate with providers and community partners to understand local employment opportunities and needs to help support response efforts.
• Increase the attention and focus on the priority area at monthly meetings with the Regional Behavioral Health Authority (RBHA) partners and service providers.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of consumers in the labor market who are employed at discharge from select DBH-funded services

Baseline measurement (Initial data collected prior to and during 2026): 63%

First-year target/outcome measurement (Progress to the end of 2026): 63%

Second-year target/outcome measurement (Final to the end of 2027): 65%

Data Source:

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

Description of Data:

Providers enter consumer level demographic and service specific information for consumers MH and SU Disorders receiving DBH funded services, either directly or through regional contracts. CDS collects consumer-level information to report to the Treatment Episode Date Set (TEDS) of MH and SU Disorders. CDS warehouses the data entered so that it can be analyzed at any time. For identified priority population consumers admitted into service in FY25, employment status is collected at admission and relevant changes are attested to throughout their episode of care.

Data issues/caveats that affect outcome measures:

Individuals reporting this data point may not wish to employment status and thus would be excluded from calculation. The CDS access reporting function is monitored for completeness and accuracy on a regular basis. Individuals who only access crisis, emergency, or inpatient services are not included in the analyses. 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.

Priority #: 5

Priority Area: Timely access to Residential Substance Use Services for PWID

Priority Type: SUT

Population(s): PWID

Goal of the priority area:

Timely access to SUD residential services for persons who inject drugs

Strategies to attain the goal:

• Monitor access data a regular basis.
• Additionally, the issue of timely access for priority populations is addressed during Super User Calls and attention drawn directly with the Regional Behavioral Health Authority (RBHA) partners and service providers when there are notable changes or anomalies.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Time waiting to be admitted into Residential Treatment Services for PWID (CDS-identified) within the given Fiscal Year.

Baseline measurement (Initial data collected prior to and during 2026): 5 Days

First-year target/outcome measurement (Progress to the end of 2026): 5 Days (maintain)

Second-year target/outcome measurement (Final to the end of 2027): 14 Days

Data Source:

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

Description of Data:

Consumer waitlist confirmation and admission data from CDS. Providers enter consumer level demographic and service specific information for consumers MH and SU Disorders receiving DBH funded services, either directly or through regional contracts. CDS warehouses data entered so that such data can be analyzed at any time.

Data issues/caveats that affect outcome measures:

Timely data input by providers to create encounters and waitlist entry is essential for the algorithm to alert Region partners and providers about priority populations. Additional training in classification and waitlisting of priority population. Preadmission documentation starts for persons incarcerated or in jails prior to release, and changes to release date could impact service availability.

Priority #: 6

Priority Area: First Episode Psychosis/Coordinated Specialty Care

Priority Type: MHS, ESMI

Population(s): SED, ESMI

Goal of the priority area:

To increase number of persons served in Coordinated Specialty Care service among those who have experienced a first episode of psychosis

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, fidelity to the Coordinated Specialty Care model, and increasing community awareness of available FEP services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of individuals served CSC/FEP programs

Baseline measurement (Initial data collected prior to and during 2026): 25

First-year target/outcome measurement (Progress to the end of 2026): 25

Second-year target/outcome measurement (Final to the end of 2027): 25

Data Source:

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

Description of Data:

Providers enter consumer level demographic and service specific information for consumers receiving DBH funded services, either directly or through regional contracts. CDS collects consumer-level information to report to the Treatment Episode Date Set (TEDS) of MH and SU Disorders. CDS warehouses the data entered so that it can be analyzed at any time.

Data issues/caveats that affect outcome measures:

Computation of the data in this measure is based on number of persons served in the SFY. Participation in the service is voluntary and responsive to experience of first episode of psychosis.

Priority #: 7

Priority Area: Tuberculosis

Priority Type: SUT

Population(s): TB

Goal of the priority area:

All persons seeking substance use treatment are screened for TB and appropriately referred as needed.

Strategies to attain the goal:

• DBH has contractual agreement with all the Regional Behavioral Health Authorities (RBHA) to ascertain that individuals who are seeking admission to Substance Use Treatment services are screened for TB.
• As per contract, when screening deems it appropriate, consumers are referred to relevant services.
• DBH conducts fidelity audits to ascertain compliance for implementation of contractual TB screening.

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline measurement (Initial data collected prior to and during 2026): 100% contract compliance

First-year target/outcome measurement (Progress to the end of 2026): 100% contract compliance

Second-year target/outcome measurement (Final to the end of 2027): 100% contract compliance

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 Regional Behavior Health Authorities to ensure that all persons admitted to an SUD service are screened for TB.

Data issues/caveats that affect outcome measures:

RBHAs directly manage contracts with the providers.

Priority #: 8

Priority Area: 988 Crisis Calls and Mobile Crisis Response Dashboards

Priority Type: SUR, BHCS

Population(s): BHCS, PRSUD

Goal of the priority area:

To have regularly updated resources that are accessible pertinent to 988 Suicide and Crisis Lifeline and DBH Crisis response service

Strategies to attain the goal:

• To increase awareness of 988 as a crisis resource.
• To increase awareness of the location of the public-facing dashboard is shared in monthly and quarterly meetings.
• The internal dashboard is used to create reports (as needed) that are aggregated to be following HIPAA 20,000 rule and best practices for sharing small N data.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: a. Maintain the public-facing 988 call/text/chat volume dashboard b. Maintain the internal Mobile Crisis Response dashboard

Baseline measurement (Initial data collected prior to and during 2026): An external dashboard is operational for data on 988 call/text/chat volume and modality. An internal Mobile Crisis response dashboard is operational

First-year target/outcome measurement (Progress to the end of 2026): Maintain and update the dashboards as needed

Second-year target/outcome measurement (Final to the end of 2027): Maintain and update the dashboards as needed

Data Source:

Boystown Call Center and CDS.

Description of Data:

The external dashboard data are collected and provided by Boystown regarding Nebraska's 988 calls/text/chat volume and Mobile Crisis Response activation metrics. For the internal dashboard, data are extracted from the CDS for which referral source is a key component for Mobile Crisis Response (activation) and information collected in the MCR Follow-up Questionnaire.

Data issues/caveats that affect outcome measures:

Adherence to HIPAA 20,000 rule and best practices for sharing small N data, limits sharing of certain data associated with internal dashboard for Mobile Crisis Response.

Priority #: 9

Priority Area: Access for PWWDC to Substance Use Disorder Services

Priority Type: SUT

Population(s): PWWDC

Goal of the priority area:

Timely access to OTP services among women who have responsibilities of caring for vulnerable children/fetus.

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 OTP to determine if additional service locations are necessary to meet the needs of priority populations seeking treatment.
• Algorithms within the CDS also alert regional partners and providers when a priority population individual is put on a waitlist for opioid treatment.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Priority PWWDC, identified in CDS, seeking Opioid Treatment Services time on the waitlist is less than a week (within 48 hours for pregnant women).

Baseline measurement (Initial data collected 7 Days

prior to and during 2026):

First-year target/outcome measurement (Progress to the end of 2026): 6 Days

Second-year target/outcome measurement (Final to the end of 2027): 3 Days

Data Source:

Nebraska DHHS Division of Behavioral Heath Centralized Data System (CDS). Data are analyzed for priority women (pregnant and/or with dependent children) who are admitted to Opioid Treatment Program in the given Fiscal Year,

Description of Data:

Providers input consumer level demographic and service specific information for all consumers including waitlist confirmation dates into the CDS. The CDS warehouses data entered so that such data can be analyzed at any time. CDS algorithms include an alert to contract manager and provider regarding compliance for priority populations on waitlist, and status for interim services to pregnant women seeking SU Disorder services.

Data issues/caveats that affect outcome measures:

- The CDS access reporting function is monitored for completeness and accuracy on a regular basis.
- Accurate pregnancy status is not always shared by the consumer.
- External factors sometimes impact women's timely acceptance for service.

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Footnotes:

Planning Tables

Table 2: SUPTRS BG Planned State Agency Budget for Two State Fiscal Years (SFY)

ONLY include funds budgeted by the executive branch agency (SSA) administering the SUPTRS BG. This includes only those activities that pass through the SSA to administer substance use primary prevention, substance use disorder treatment, and recovery support services for substance use disorder.

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

Activity	Source of Funds							
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. Bipartisan Safer Communities ACT Funds
1. Substance Use Disorder Prevention[a] and Treatment	$9,493,868.88		$70,101,009.66	$9,176,658.00	$48,740,734.16	$0.00	$0.00	
a. Pregnant Women and Women with Dependent Children (PWWDC)[b]	$1,558,583.48		$165,236.64		$348,761.72			
b. All Other	$7,935,285.40		$69,935,773.02	$9,176,658.00	$48,391,972.44			
2. Recovery Support Services[c]	$837,607.12				$1,609,523.12			
3. Primary Prevention[d]	$3,847,224.00			$2,429,581.10				
4. Early Intervention Services for HIV[e]								
5. Tuberculosis								
6. Evidence-Based Practices For Early Serious Mental Illness including First Episode Psychosis (10 percent of total MHBG award)								
7. State Hospital								
8. Other Psychiatric Inpatient Care								
9. Other 24-Hour Care (Residential Care)								
10. Ambulatory/Community Non-24 Hour Care								
11. Crisis Services (5 percent Set-Aside)								
12. Other Capacity Building/Systems Development[f]	$1,922,736.00							
13. Administration[g]	$847,444.00							
14. Total	**$16,948,880.00**		**$70,101,009.66**	**$11,606,239.10**	**$50,350,257.28**	**$0.00**	**$0.00**	

[a] Prevention other than primary prevention.

[b] Grantees must plan expenditures for Pregnant Women and Women with Dependent Children in compliance with Women's Maintenance of Effort (MOE) over the two-year planning period.

[c] This budget category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of planned expenditures allowable under the 2023 guidance, "Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG." Only plan RSS for those in need of RSS from substance use disorder.

[d] Row 3 should account for the 20 percent minimum primary prevention set-aside of SUPTRS BG funds to be used for universal, selective, and indicated substance use prevention activities.

[e] The most recent AtlasPlus HIV data 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 SUPTRS BG 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.

[f] Other Capacity Building/Systems development include those activities relating to substance use per **45 CFR §96.122 (f)(1)(v)**

[g] Per **45 CFR § 96.135** Restrictions on expenditure of the SUPTRS BG, the state involved will not expend more than 5 percent of the BG to pay the costs of administering the SUPTRS BG.

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Footnotes:

Planning Tables

Table 2: MHBG Planned State Agency Budget for Two State Fiscal Years (SFY)

States are asked to present their projected two-year budget at the State Agency level, including all levels of state and applicable federal funds to be expended on mental health and substance use services allowable under each Block Grant. When planning their budgets, states should keep in mind all statutory requirements outlined in the application Funding Agreement/Certifications and Assurances.

Table 2 addresses funds budgeted to be expended during State Fiscal Years (SFY) 2026 and 2027 (for most states, the 24-month period is July 1, 2025, through June 30, 2027).Table 2 includes columns to capture state planned budget of BSCA funds (MHBG only)

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: 7/1/2025 Planning Period End Date: 6/30/2027

Activity	Source of Funds							
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. Bipartisan Safer Communities ACT Funds[a]
1. Substance Use Disorder Prevention and Treatment								
a. Pregnant Women and Women with Dependent Children (PWWDC)								
b. All Other								
2. Recovery Support Services								
3. Primary Prevention								
4. Early Intervention Services for HIV								
5. Tuberculosis								
6. Evidence-Based Practices For Early Serious Mental Illness including First Episode Psychosis (10 percent of total MHBG award)[b]		$872,345.00						$30,000.00
7. State Hospital				$14,000,000.00	$188,000,000.00			
8. Other Psychiatric Inpatient Care			$46,697,750.22		$18,066,840.94			
9. Other 24-Hour Care (Residential Care)			$48,965,409.84		$3,487,978.22			
10. Ambulatory/Community Non-24 Hour Care		$6,542,584.00	$320,375,258.12	$576,000.00	$83,028,925.50			$250,657.00
11. Crisis Services (5 percent Set-Aside)[c]		$872,345.00	$5,478,918.50	$892,326.00	$32,457,854.42			$17,570.00
12. Other Capacity Building/Systems Development								
13. Administration		$436,172.00						
14. Total		**$8,723,446.00**	**$421,517,336.68**	**$15,468,326.00**	**$325,041,599.08**	**$0.00**	**$0.00**	**$298,227.00**

[a]The expenditure period for the 3rd and 4th allocations of Bipartisan Safer Communities Act (BSCA) supplemental funding will be from **September 30, 2024 through September 29, 2026** (3rd increment), **September 30, 2025 through September 29, 2027** (4th increment). Column H should reflect the state planned expenditure for this planning period (FY2026 and FY2027) [July 1, 2025 through June 30, 2027, for most states].

[b]Row 6 in Columns B and H: per statute, states are required to set-aside 10 percent of the total MHBG and BSCA awards for evidence-based practices for Early Serious Mental Illness (ESMI), including Psychotic Disorders.

[c]Row 11 in Columns B and H: per statute, states are required to set-aside 5 percent of the total MHBG and BSCA awards for Behavioral Health Crisis Services (BHCS) programs.

[d]Per statute, administrative expenditures for the MHBG and BSCA funds cannot exceed 5 percent of the fiscal year award.

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Footnotes:

RevReq030526: Updated the amounts in Table 2 State Agency Planned Expenditures [MH], Column B using the Final Allocation for FY2026. Table 2 reflects the funds budgeted to be expended during State Fiscal Years (SFY) 2026 and 2027 [24-month planning period].

Planning Tables

Table 3: Persons in Need of/Receiving SUD Treatment – Required for SUPTRS BG Only

This table allows states to present their estimated current need and baseline reach of the priority populations laid out in the SUPTRS BG statute. This information is intended to assist the state in demonstrating the unmet need of these populations that informs their plans for FY2026 - 2027. The estimates provided should represent the unmet need at the time of the application.

To complete the Aggregate Number Estimated in Need (Column A), please refer to the most recent edition of the **National Survey on Drug Use and Health** (NSDUH) or other federal/state data that describes the populations of focus in rows 1-5.

To complete the Aggregate Number in Treatment (Column B), please refer to the most recent edition of the **Treatment Episode Data Set** (TEDS) data prepared and submitted to the Behavioral Health Services Information System (BHSIS).

States should contact their federal points of contact for assistance in drawing these estimates from national and state survey data.

Estimates should utilize the most recent data from NSDUH, TEDS, and other data sources.

	A. Aggregate Number Estimated in Need of SUD Treatment	B. Aggregate Number in SUD Treatment
Pregnant Women	2840	76
Women with Dependent Children	10000	309
Individuals with a co-occurring M/SUD	125000	4412
Persons who inject drugs	2000	725
Persons experiencing homelessness	763	847

Please provide an outline of how the state made these estimates, including data sources and values used for each row. For any cell which the state is

unable to estimate the need or number in treatment, please provide an explanation for why these estimates could not be drawn.
Source Row 1-Col 1 PW: Estimate obtained by multiplying 2021 ACS estimated count of Nebraska women between ages 15 to 49, (433,443) by 2021 BRFSS estimated percent of pregnant Nebraska women, 3.9% , by 2021 NSDUH (table 25) estimated percent 18+ SUD, 16.8%. Col 3, Row 1: Aggregate Number in SUD Treatment: based on TEDS source FY2024 (unduplicated Pregnant women in SUD services considering pregnant status, up to 6 weeks post-partum, and priority populations). . Source Row 2-Col 1WWDC: 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." Col 3, Row 2: Aggregate Number in SUD Treatment: based on TEDS source for FY2024 (unduplicated women with dependent children priority group 4]. . Source Row 3-Col 1: Table 35. Individuals with a co-occurring M/SUD: Table 35. Co-occurring Substance Use Disorder and Any Mental Illness in the Past Year: Among People Aged 18 or Older; by Age Group and State, Annual Average Numbers (in Thousands), 2022 and 2023. Col 3, Row 3: Aggregate Number in SUD Treatment: based on TEDS source for FY2024 (anchor dataset with analyses as per URS for FY2024. Calculation of co-occurring disorders is based on diagnosis code and admitted service across all encounters served in the fiscal year for a given consumer. A consumer is indicated as co-occurring if they have: at least one SUD diagnosis code entered across all encounters or at least one encounter served in a SUD service AND at least one MH diagnosis code entered across all encounters or at least one encounter served in a MH service). . Source Row 4-Col 1 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." Col 3, Row 4: Aggregate Number in SUD Treatment: based on TEDS source for FY2024 (total is based on unduplicated count of persons served with indication of priority group 1 or 3). . Source Row 5-Col 1 Persons experiencing homelessness: Need estimated based on HUD 2024 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations with a chronic SUD 2024 Point-in-Time Count (PIT). The PIT Count is conducted on a single day across the nation and SUD is self-reported. Data current as of 12/9/2024. Col 3, Row 5: Aggregate Number in SUD Treatment: based on TEDS source for FY2024 (unduplicated count based on Living Arrangements status as Homeless or Homeless Shelter for people served in SUD services during FY24. The data is based on self-report and current as of 8/15/2025).
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Footnotes:

Planning Tables

Table 4: SUPTRS BG Planned Award Budget by Federal Fiscal Year

In addition to projecting planned budget by State Fiscal Year (Table 2b), states must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations and expenditure categories. Therefore, Plan Table 4b must be completed for the SUPTRS BG awarded for Federal Fiscal Year (FFY) 2026 and FFY 2027. The totals for each FFY planning year should match the SUPTRS BG Final Allotments for the state in that award year.

Note: The FFY presented in the table is that of the award year, however states have up to two years to expend the award received. For example, the FFY 2026 award may be expended from October 1, 2025 through September 30, 2027.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Expenditure Category	FFY 2026 SUPTRS BG Award	FFY 2027 SUPTRS BG Award
1 . Substance Use Disorder Prevention[a] and Treatment	$4,746,934.44	$4,827,081.00
2 . Recovery Support Services[b]	$418,803.56	$317,544.00
3 . Substance Use Primary Prevention[c]	$1,923,612.00	$1,950,526.00
4 . Early Intervention Services for HIV[d]		
5 . Tuberculosis Services		
6 . Other Capacity Building/Systems Development[e]	$961,368.00	$961,368.00
7 . Administration[f]	$423,722.00	$424,027.00
8. Total	$8,474,440.00	$8,480,546.00

[a]Prevention other than primary prevention. The amount in this row should reflect the planned budget for direct services during the planning period. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[b]This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of budget allowable under the 2023 guidance, "Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG." Only present the estimated budget for RSS for those in need of RSS from substance use disorder. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[c]This row should reflect the state's planned budget of direct primary prevention activities that are intended to meet the SUPTRS BG 20 percent set aside. Activities include those used for universal, selective, and indicated substance use prevention activities. The budget for direct activities in this row should match the total budget planned in Table(s) 5a and 5b. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[d]The most recent AtlasPlus HIV data 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 SUPTRS BG 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.

[e]Other Capacity Building/System Development include those activities relating to substance use per **45 CFR §96.122 (f)(1)(v)**. The amount presented here should reflect the total found in Planning Table 6 across treatment, recovery, and primary prevention.

[f]Per **45 CFR §96.135** Restrictions on expenditure of grant, the State involved will not expend more than 5 percent of the BG to pay the costs of administering the SUPTRS BG.

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Footnotes:

Planning Tables

Table 4: MHBG State Agency Planned Budget

Table 4 addresses the planned budget for MHBG. Please use this table to capture your estimated budget for MHBG-funded services and programs over a 24-month period (for most states, it is July 1, 2025 - June 30, 2027).

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

MHBG-Funded Services	MHBG Funds Budgeted for This Item
1. Services for Adults	
1a. EBPs for Adults	$851,329.00
1b. Crisis Services for Adults	$872,345.00
1c. CSC/ESMI program for Adults	$0.00
1d. Other outpatient/ambulatory services for Adults	$357,454.00
1e. *Other Direct Services for Adults	$0.00
2. Subtotal of Services for Adults	$2,081,128.00
3. Services for Children	
3a. EBPs for Children	$3,474,257.00
3b. Crisis Services for Children	$0.00
3c. CSC/ESMI program for Children	$872,345.00
3d. Other outpatient/ambulatory services for Children	$0.00
3e. *Other Direct Services for Children	$0.00
4. Subtotal of Services for Children	$4,346,602.00
5. Other Capacity Building/Systems Development[a]	$1,859,544.00
6. Administrative Costs[b]	$436,172.00
7. *Any Other Cost	$0.00
8. Total MHBG Allocation[c]	**$8,723,446.00**

Please provide brief explanation for services with an asterisk* below:

> 1. Services for Adults, 1e. *Other Direct Services for Adults: Budget is for Psychiatric Residential Rehabilitation which is designed to provide individualized treatment, psychiatric rehabilitation and support for individuals with a severe and persistent mental illness and/or co-occurring disorder needing structured recovery and rehabilitation activities within a residential setting.

[a] This row for Other Capacity Building/Systems Development should be equal to the total of your planned budget in Table 6

[b] Administrative Costs should not exceed 5 percent of total MHBG allocation

[c] The total budget should be equal to your MHBG allocation for the next two years.

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Footnotes:

RevReq030526: Updated the amounts in Table 4 State Agency Planned Budget using the Final Allocation for FY2026. Table 2 reflects the funds budgeted during State Fiscal Years (SFY) 2026 and 2027 [24-month planning period].

Planning Tables

Table 5a: SUPTRS BG Primary Prevention Planned Budget by Strategy and Institutes of Medicine (IOM) Categories

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Strategy	IOM Classification	FFY 2026 SUPTRS BG Award	FFY 2027 SUPTRS BG Award
1. Information Dissemination	Universal	$115,955	$157,775
	Selective	$62	
	Indicated	$465	
	Unspecified	$0	
	Total	**$116,482**	**$157,775**
2. Education	Universal	$481,839	$526,009
	Selective	$113,564	
	Indicated	$30,785	$26,590
	Unspecified	$0	
	Total	**$626,188**	**$552,599**
3. Alternatives	Universal	$12,554	$21,237
	Selective	$0	$131,676
	Indicated	$16,047	$2,000
	Unspecified	$0	
	Total	**$28,601**	**$154,913**
4. Problem Identification and Referral	Universal	$9,000	$20,896
	Selective	$178,488	$145,439
	Indicated	$0	
	Unspecified	$0	
	Total	**$187,488**	**$166,335**
	Universal	$493,760	$444,224
	Selective	$0	

5. Community-Based Processes	Indicated	$0	
	Unspecified	$0	
	Total	**$493,760**	**$444,224**
6. Environmental	Universal	$431,711	$435,298
	Selective	$0	
	Indicated	$0	
	Unspecified	$0	
	Total	**$431,711**	**$435,298**
7. Section 1926 (Synar)-Tobacco	Universal	$39,382	$39,382
	Selective	$0	
	Indicated	$0	
	Unspecified	$0	
	Total	**$39,382**	**$39,382**
8. Other	Universal		
	Selective		
	Indicated		
	Unspecified		
	Total	**$0**	**$0**
Total Prevention Budget		**$1,923,612**	**$1,950,526**
Total Award [a]		**$8,474,440**	**$8,480,546**
Planned Primary Prevention Percentage		**22.70%**	**23.00%**

[a] Total SUPTRS BG Award is populated from Plan Table 4 SUPTRS BG Planned Award Budget by Federal Fiscal Year

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Footnotes:

Planning Tables

Table 5b: SUPTRS BG Planned Primary Prevention Budget by Institutes of Medicine (IOM) Categories

States should identify the planned budget for primary prevention disaggregated by IOM Categories the state plans to prioritize with primary prevention set-aside dollars from the FFY 2026 and FFY 2027 SUPTRS BG allotments.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Strategy	FFY 2026 SUPTRS BG Award	FFY 2027 SUPTRS BG Award
1. Universal Direct	$800,118	$645,014
2. Universal Indirect	$784,083	$1,074,807
3. Selective	$292,114	$131,676
4. Indicated	$47,297	$99,029
5. Column Total	**$1,923,612**	**$1,950,526**
6. Total SUPTRS Award[a]	**$8,474,440**	**$8,480,546**
7. Primary Prevention Percentage	**22.70%**	**23.00%**

[a] Total SUPTRS BG Award is populated from Plan Table 4 SUPTRS BG Planned Award Budget by Federal Fiscal Year

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Footnotes:

Planning Tables

Table 5c: SUPTRS BG Planned Primary Prevention Priorities

States should identify the categories of substances the state plans to prioritize with primary prevention set-aside dollars from the FFY 2026 SUPTRS BG award.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Priority Substances	FFY 2026 SUPTRS BG Award	FFY 2027 SUPTRS BG Award
Alcohol	☑	☑
Tobacco/Nicotine-Containing Products	☑	☑
Cannabis/Cannabinoids	☑	☑
Prescription Medications	☑	☑
Cocaine	☐	☐
Heroin	☑	☑
Inhalants	☐	☐
Methamphetamine	☑	☑
Fentanyl or Other Synthetic Opioids	☐	☐
Other	☐	☐
Priority Populations		
Students in College	☑	☑
Military Families	☑	☑
American Indian/Alaska Native	☑	☑
African American	☐	☐
Hispanic	☐	☐
Persons Experiencing Homelessness	☐	☐
Native Hawaiian/Pacific Islander	☐	☐
Asian	☐	☐
Rural	☑	☑

Footnotes:

Planning Tables

Table 6: SUPTRS BG Other Capacity Building/Systems Development Activities

Please enter the total amount of the SUPTRS BG budgeted for each activity described above, by treatment, recovery support services and primary prevention. In budgeting for each activity, states should break down the row budget by funds planned for SSA activities and those planned to be contracted out under other subrecipient contracts. States should plan their budgets on a single Federal Fiscal Year (FFY), specified in the table below.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Activity	FFY 2026			FFY 2027		
	A. SUPTRS Treatment	B. SUPTRS Recovery Support Services	C. SUPTRS Primary Prevention	A. SUPTRS Treatment	B. SUPTRS Recovery Support Services	C. SUPTRS Primary Prevention
1. Information Systems	$200,000.00	$0.00	$0.00	$200,000.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$200,000.00	$0.00	$0.00	$200,000.00	$0.00	$0.00
2. Infrastructure Support	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3. Partnerships, community outreach, and needs assessment	$50,000.00	$0.00	$0.00	$50,000.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$50,000.00	$0.00	$0.00	$50,000.00	$0.00	$0.00
4. Planning Council Activities	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
5. Quality Assurance and Improvement	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
6. Research and Evaluation	$0.00	$0.00	$298,584.00	$0.00	$0.00	$298,584.00

a. Single State Agency (SSA)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$298,584.00	$0.00	$0.00	$298,584.00
7. Training and Education	$347,784.00	$0.00	$65,000.00	$347,784.00	$0.00	$65,000.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$347,784.00	$0.00	$65,000.00	$347,784.00	$0.00	$65,000.00
8. Total	**$597,784.00**	**$0.00**	**$363,584.00**	**$597,784.00**	**$0.00**	**$363,584.00**

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Footnotes:

Planning Tables

Table 6: MHBG Other Capacity Building/Systems Development Activities

MHBG Plan 6 address MHBG funds to be expended on other capacity building /systems development during State Fiscal Year (SFY) 2026 and 2027 (for most states, the 24-month period is July 1, 2025, through June 30, 2027). This table includes columns to capture planned state budget for BSCA supplemental funds. Please use these columns to capture how much the state plans to expend over a 24-month period. Please document the planned uses of BSCA funds in the footnotes section.

MHBG Planning Period Start Date: 07/01/2025 MHBG Planning Period End Date: 06/30/2027

Activity	FFY 2026 MHBG[1]	FFY 2026 BSCA Funds[2]	FFY 2027 MHBG[3]
1. Information Systems	$400,000.00		$200,000.00
2. Infrastructure Support	$1,009,544.00		$504,772.00
3. Partnerships, Community Outreach, and Needs Assessment	$100,000.00	$180,000.00	$50,000.00
4. Planning Council Activities			
5. Quality Assurance and Improvement			
6. Research and Evaluation			
7. Training and Education	$350,000.00	$416,454.00	$175,000.00
8. Total	**$1,859,544.00**	**$596,454.00**	**$929,772.00**

[1] The standard MHBG planned expenditures captured in column A should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [**July 1, 2025 – June 30, 2027**, for most states].

[2] The expenditure period for the 3rd and 4th allocations of the Bipartisan Safer Communities Act (BSCA) funding is **September 30, 2024 – September 29, 2026** (3rd increment) and **September 30, 2025 – September 29, 2027** (4th increment). Column B should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [**July 1, 2025, through June 30, 2027** for most states].

[3] The standard MHBG planned expenditures captured in column A should reflect the state planned budget for this planning period (SFY2027) [**July 1, 2026 – June 30, 2027**, for most states].

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

RevReq030526: There are no revisions made to Table 6: MHBG Other Capacity Building/Systems Development Activities due to the update from the CR Allocation amount to the Final Allocation amount.

Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required for MHBG & SUPTRS BG

Narrative Question

Across the United States, significant proportions of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not have access to or do not otherwise access needed behavioral healthcare. **States should focus on improving the range and quality of available services and on improving the rate at which individuals who need care access it**. States have a number of opportunities to improve access, including improving capacity to identify and address behavioral health needs in primary care, increasing outreach and screening in a variety of community settings, building behavioral health workforce and service system capacity, and efforts to improve public awareness around the importance of behavioral health. When considering access to care, states should examine whether people are connected to services, and whether they are receiving the range of needed treatment and supports.

A venue for states to advance access to care is by **ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections**. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: **The Essential Aspects of Parity: A Training Tool for Policymakers**; **Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States**.

The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.[1] Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. **States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings**. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

Navigating behavioral health, physical health, and other support systems is complicated and many individuals and families require care coordination to ensure that they receive necessary supports in and efficient and effective manner. **States should develop systems that vary the intensity of care coordination support based on the severity and complexity of individual need**. States also need to consider different models of care coordination for different groups, such as High-Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with serious mental illness who are at a high risk of institutional placement; and connecting people in recovery from substance use disorders with a range of recovery supports. States should also provide the care coordination necessary to connect people with mental and substance use disorders to needed supports in areas like education, employment, and housing.

[1]Druss, B. G., Zhao, L., Von Esenwein, S., Morrato, E. H., & Marcus, S. C. (2011). Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Medical care, 599-604.Avaiable at: **https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding_Excess_Mortality_in_Persons_With.11.aspx**

1. Describe your state's efforts to improve **access to care for mental disorders, substance use disorders, and co-occurring disorders**, including details on efforts to increase access to services for:

a) Adults with serious mental illness (SMI)

b) Adults with SMI and a co-occurring intellectual and developmental disabilities (I/DD)

c) Pregnant women with substance use disorders

d) Women with substance use disorders who have dependent children

e) Persons who inject drugs

f) Persons with substance use disorders who have, or are at risk for, HIV or TB

g) Persons with substance use disorders in the justice system

h) Persons using substances who are at risk for overdose or suicide

i) Other adults with substance use disorders

j) Children and youth with serious emotional disturbances (SED) or substance use disorders

k) Children and youth with SED and a co-occurring I/DD

l) Individuals with co-occurring mental and substance use disorders

The Nebraska Department of Health and Human Services (DHHS) Division of Behavioral Health is engaged in multiple strategies and activities that have at 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 SUPTRSBG and MHBG and provides leadership in funding for substance use disorder programs and mental health programs in the state. DBH provides funds primary prevention and priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time and that are not covered by Medicaid, Medicare, or private insurance. DBH collaborates with other state agencies providing behavioral health services.

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

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MLTC implemented a new integrated managed care program: Heritage Health, with the signing of contracts with MCOs in April 2016 and going live January 2017. Whereas previously behavioral health was a carve out, the MCOs' 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. In September 2022, Heritage Health was rebid and, following an evaluation of bids, DHHS selected three health plans to provide services beginning January 2024. The new contracts are for five years with optional two-year renewals.

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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 though updated data sharing governance activities.

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System integration through managed care policy and practice includes improved health outcomes based on the 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 available to 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 regularly.

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MLTC Medicaid expansion went live in October 2019 and offered 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. https://dhhs.ne.gov/Pages/Medicaid-Expansion.aspx

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Integration work has required enhanced partnerships with the sister DHHS Divisions, including the DBH, to implement a program that is seamless and available to 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 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. DBH and the Nebraska Medical Association are collaborating on a project that promotes the integrated healthcare models in primary and behavioral health care settings. The project has developed the capacity to engage with various practices to provide mentoring, technical assistance, training and general integration guidance to primary care sites interested in integrating behavioral health services into their practice. Partnerships have been developed with 45 organizations to date and over 1400 participants have been trained on such topics as medications for opioid use disorder, behavioral health for justice involved population, physician wellness and burnout and the effects of COVID on mental health and substance use disorder. See URL: https://nebmed.org/how-we-help/integrated-heathcare-project/

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The Extension for Community Healthcare Outcomes (Project ECHO) remains a 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. Project management is currently managed through a contract with the Nebraska Medical Association, the primary physician organization for Nebraska. Current training offerings can be accessed: https://www.nebmed.org/resources/education-cme/project-echo

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Services are provided by the SSA/SMHA to non-Medicaid eligible consumers in the state and are paid for with a combination of SUPTRSBG, 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. Medicaid continues to collaborate with DBH to maintain and update all mental health and substance use service definitions. http://dhhs.ne.gov/Pages/Medicaid-Behavioral-Health-Definitions.aspx http://dhhs.ne.gov/Pages/Heritage-Health-Contacts.aspx

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System integration work includes partnerships and collaborations with public and private systems, as well as with individuals, families, and communities, all important components in systems of care surrounding each individual served. Other state agencies fund or support behavioral health services for populations, such as MLTC, 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 such populations.

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The DBH system integration collaborative activities include working with:

• the MLTC and DBH are currently in the process of implementing Certified Community Behavioral Health Clinics (CCBHCs) which will provide around-the-clock crisis care to any Nebraskan who may need mental health or SUD assistance. MLTC and DBH systems with CCBHCs will go live in January 2026.

• the Nebraska Department of Correctional Services (NDCS) to ensure those individuals released from correctional facilities are connected with the services they need to meet their rehabilitation needs.

• the Nebraska Department of Education Vocational Rehabilitation (NDE-VR) in the provision of Supported Employment services to individuals with serious mental illness and substance use disorders.

• the Nebraska Director of Behavioral Health is a member of the Rural Health Advisory Commission and serves as a consultant and advocate for behavioral health issues in rural areas.

• 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.

• the Regional Behavioral Health Authorities to work collaboratively with Federally Qualified Health Centers (FQHCs) in their catchment areas to provide integrated opportunities to receive co-occurring behavioral/physical healthcare.

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The Mental Health and Addiction Act of 2008 prevents group health plans and health insurance issuers that provide mental health or substance use disorder benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits. DBH monitors federal regulations and has an established working relationship with the Department of Insurance (DOI) to provide input and guidance on legislation as well as communication for consumers. A Systems workgroup provides the framework for this integrated work. 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. Nebraska uses the federally facilitated health insurance marketplace. Five insurers offer plans in the exchange in 2024-2025 compared to four insurers in 2023. In 2023 the Kaufman Family Foundation estimated 121,800 people in Nebraska were uninsured, representing 6.3% of the state's population.

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The DOI solicits feedback from DBH and individuals across the state on an annual basis. Questions for public forums and feedback from same are provided to DBH and committee membership.

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.

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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. BHECN continues to expand its footprint in non-metropolitan Nebraska to support efforts to increase retention of behavioral health providers, recruitment in rural Nebraska, and establishing a statewide network of behavioral health providers. BHECN has established offices across Nebraska, including in communities that have state college and university campuses. BHECN offices

include 1) BHECN Central in Kearney at the University of Nebraska at Kearney, 2) BHECN Northeast in Wayne at the Wayne State College, 3) BHECN Panhandle in Chadron at the Chadron State College, 4) BHECN Southeast in Lincoln; and 5) BHECN East in Omaha at the University of Nebraska at Omaha. BHECN is also planning to expand with a BHECN Southwest office located in southwest Nebraska.

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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.

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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 less resourced 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.

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Project ECHO, as described earlier, is operational with the Nebraska Medical Association.. 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.

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Nebraska will have seven Certified Community Behavioral Health Clinics (CCBHC) when development of services needed to meet state and federal requirements is completed by January 2026. The CCBHC model provides integrated care and ensures care coordination with local primary care and hospital partners, and integration with physical health care. Nebraska passed Legislation in 2023 (LB276) adopting the CCBHC Act.

2. Describe your efforts, alone or in partnership with your state's department of insurance and/or Medicaid system, to advance **parity enforcement and increase awareness of parity protections** among the public and across the behavioral and general health care fields.

The DHHS Division of Behavioral Health partners with the Nebraska Department of Insurance (DOI) who 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.

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The framework for the group permits a ready review of plans as well as insurance legislation impacting behavioral health services. 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. The availability of QHPs provides access to healthcare for all Nebraskans and DBH's focus is on ensuring behavioral healthcare is part of that access.

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3. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and substance use disorders**, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders.

Nebraska strongly encourages providers and programs to maintain dual credentials and licenses to treat both mental health and substance use disorders. When a provider is not dually credentialed, they are required to refer individuals to services that are equipped to treat co-occurring conditions.

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Certified Community Behavioral Health Clinics (CCBHCs) across the state exemplify the "no wrong door" philosophy, offering integrated treatment for mental health and substance use disorders. Additionally, Nebraska's crisis stabilization programs are structured to address the needs of individuals with co-occurring disorders, providing timely and appropriate support.

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Many of Nebraska's Opioid Treatment Programs (OTPs) employ clinicians who are dually credentialed, enabling the clinicians to deliver both substance use and mental health counseling. Acute psychiatric hospitals throughout the state are also equipped to treat co-occurring conditions, even during crisis situations. These hospitals are increasingly experienced in continuing medication regimens for consumers already engaged in OTP services.

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Furthermore, several residential treatment programs for both mental health and substance use disorders have committed to continuing OTP services as a complement to their residential treatment models, further supporting the continuum of care for individuals with complex needs.

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Nebraska's integrated approach ensures that individuals with co-occurring disorders receive comprehensive, coordinated care—no matter where they enter the system.

a. Please describe how this system differs for youth and adults.

Youth mental health and substance use services in Nebraska begin with a thorough screening and assessment—just like adult programs—so that emerging mental health concerns and substance use needs are identified and addressed as early as possible.

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Specialized initiatives such as the Professional Partner Program and Coordinated Specialty Care (CSC) offer tailored support for youth with complex behavioral health challenges. Whenever these programs can't deliver both mental health and substance use treatment on site, they streamline referrals to ensure young people receive timely, appropriate care.

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A key partnership between the Division of Behavioral Health and Children's Hospital & Medical Center—Nebraska's only full-service pediatric specialty center—extends expertise into primary care. Through the Children's Outreach & Provider Education (COPE) initiative, pediatricians and family doctors gain virtual access to child and adolescent mental health specialists, hands-on training in best practices, and on-demand telehealth consultations for urgent or complicated cases.

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The continuum of care is further strengthened by the Child Savings Institute, which provides a broad menu of services: teen and young parent programs, a youth triage center, independent living skills training, domestic violence recovery support, and school- and family-based enrichment activities.

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By weaving together comprehensive assessment, specialized programming, clinical collaboration, and community resources, Nebraska ensures its youth receive coordinated, developmentally appropriate care that addresses the full spectrum of their behavioral health needs.

b. Does your state provide evidence-based integrated treatment for co-occurring disorders (IT-COD), formerly known as IDDT? Please explain.

Nebraska does not have providers implementing IDDT.

c. How many IT-COD teams do you have? Please explain.

None because Nebraska does not have providers implementing IDDT.

d. Do you monitor fidelity for IT-COD? Please explain.

Not Applicable

e. Do you have a statewide COD coordinator? ○ Yes ◉ No

4. Describe how the state **supports integrated behavioral health and primary health care**, including services for individuals with mental

disorders, substance use disorders, co-occurring M/SUD, and co-occurring SMI/SED and I/DD. Include detail about:

a) Access to behavioral health care facilitated through primary care providers

b) Efforts to improve behavioral health care provided by primary care providers

c) Efforts to integrate primary care into behavioral health settings

d) How the state provides integrated treatment for individuals with co-occurring disorders

Nebraska has implemented a multi-faceted approach to integrating primary care and behavioral health services to enhance access and deliver comprehensive, person-centered care across the state.

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A cornerstone of this effort is the Integrated Healthcare Project (IHP), which is entering Phase 3 in Fiscal Year 2026. This phase will expand the initiative to 20 additional sites, complementing the 14 existing rural locations. These sites co-locate behavioral health professionals within primary care settings, improving access and coordination. Currently, 21 behavioral health providers—including mental health practitioners, psychiatric nurse practitioners, a psychologist, and a psychiatric physician assistant—are delivering care across the state.

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The IHP also includes a strong training component, led by a board-certified addiction psychiatrist. To date, more than 1,182 providers have received formal training in integrated healthcare practices and substance use disorder treatment, including participants from medical and community-based organizations.

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In alignment with these efforts, Nebraska encourages that all Certified Community Behavioral Health Centers (CCBHCs) provide integrated behavioral and primary care. CCBHCs must also have MOUs with Opioid Treatment Programs (OTPs) or offer OTP services on-site. Additionally, Community Health Centers across the state use the Client Assistance Program (CAP) to support mental health and substance use treatment services, utilizing evidence-based practices such as Screening, Brief Intervention, and Referral to Treatment (SBIRT).

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Nebraska's behavioral health system offers a full continuum of care, including assessments, outpatient and intensive outpatient services, medication management, detox, Medication-Assisted Treatment (MAT), peer support, residential treatment, and 24/7 crisis services. All programs undergo routine auditing to ensure services meet the whole-person needs of clients and maintain high standards of care.

5. Describe how the state **provides care coordination**, including detail about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs. Describe care coordination available to:

a) Adults with serious mental illness (SMI)

b) Adults with substance use disorders

c) Adults with SMI and I/DD

d) Children and youth with serious emotional disturbances (SED) or substance use disorders

e) Children and youth with SED and I/DD

The Division of Behavioral Health (DBH) within Nebraska's Department of Health and Human Services serves as the single state behavioral health authority, overseeing statewide coordination, quality assurance, and service delivery. DBH contracts with six Regional Behavioral Health Authorities (RBHAs), which manage and fund local networks of behavioral health providers.
Funding Sources:
• State general funds (primary source for DBH staff and coordination infrastructure)
• Federal block grants (supplemental funding for services such as prevention, SUD treatment, and OpenBeds platform)
• County funds (support regional justice coordination services)
• Medicaid, Medicare, commercial insurance, and opioid settlement funds (provider-level funding sources)
Coordination Structure:
• DBH employs administrators overseeing key service areas (Youth, Crisis, SMI, Prevention, Housing, Forensic, etc.).
• Each RBHA has regional coordinators who serve as counterparts to DBH administrators.
• Monthly coordination meetings between DBH and each RBHA address needs, waitlists, audits, service gaps, funding, and capacity.
• Providers meet regularly with RBHAs to align on service delivery and reporting.
Care coordination models are tiered and adaptive—ranging from intensive, individualized coordination for those with serious and

complex needs to broader, preventive, or system-level coordination for individuals with lower acuity or early intervention needs.

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a) Adults with Serious Mental Illness (SMI)

Care Coordination Approach

• Entry points include ERs, crisis centers, law enforcement, hospitals, jails, mobile crisis teams, the 988 line, and community providers.

• Coordination begins immediately upon system entry—often led by regional emergency coordinators and DBH staff.

• Services and coordination are tailored to illness severity and stability.

Key Coordination Models

• Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP) — Evidence-Based Practice funded by DBH for early SMI intervention.

• Assertive Community Treatment (ACT): 24/7 multidisciplinary team providing intensive, community-based care to maintain stability and avoid hospitalization.

• Day Support Programs: Structured daytime support for SMI consumers who live in the community at night.

• Supported Employment: DBH-funded service helping SMI adults achieve meaningful community integration through work.

• Plan for One (PFO): Highly individualized, DBH-approved care plans for the most severe SMI cases requiring one-to-one staffing or unique service arrangements.

Funding

• State general funds, Medicaid, Medicare, and federal block grants (varies by service level and setting).

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b) Adults with Substance Use Disorders (SUD)

Care Coordination Approach

• Entry through courts, probation, parole, hospitals, crisis lines, shelters, or primary care.

• DBH and RBHAs closely monitor access, waitlists, capacity, and service utilization.

• DBH Network and Prevention Administrators coordinate SUD system oversight with regional directors.

Key Coordination Features

• Justice Coordination: County-funded coordinators ensure smooth movement to SUD services during or after incarceration.

• Opioid and Methamphetamine Initiatives: Jointly managed by DBH's Prevention team and regional coordinators.

• OpenBeds Platform: Federally funded, real-time statewide referral and bed availability system for SUD and co-occurring services.

• Care Movements: Warm handoffs between detox, residential, and outpatient services; coordination with corrections and courts to ensure continuity.

Service Continuum

• From Medically Monitored Inpatient Withdrawal Management (ASAM 3.7) to outpatient, peer support, and assessment services.

Funding

• State general funds (coordination), federal block grants, county funds, Medicaid, and other payer sources at provider level.

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c) Adults with SMI and Intellectual/Developmental Disabilities (I/DD)

Care Coordination Approach

• Receive the same coordination structure as SMI adults, but DBH collaborates closely with the Division of Developmental Disabilities (DDD).

• If the I/DD diagnosis is established in childhood, coordination may shift primarily to DDD, which operates waiver-based, long-term supports focused on habilitation and I/DD-specific care.

Cross-System Collaboration

• Joint planning and coordination between DBH, DDD, and RBHAs to ensure integrated, person-centered service delivery addressing both psychiatric and developmental needs.

Funding

• Combination of DBH and DDD funds, including Medicaid Home and Community-Based Services (HCBS) waivers and state general funds.

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d) Children and Youth with Serious Emotional Disturbances (SED) or Substance Use Disorders

Care Coordination Approach

• Entry through schools, courts, CPS, hospitals, probation, crisis lines, or mobile response teams.

• Each RBHA employs Youth Coordinators (funded by DBH state general funds) to manage service access and placements.

• Coordination is family-driven and youth-guided, with strong collaboration between DBH, schools, probation, CPS, and providers.

Key Care Models

• Professional Partner Program (PPP): A DBH-funded wraparound program providing individualized, community-based care coordination for youth with SED.

• Mobile Crisis and Outpatient Services: Coordinated through regional networks for timely access.

• Partial-Day and Intensive Outpatient Programs: Used as step-up or step-down services from residential care.

• Youth Rehabilitation and Treatment Centers (YRTCs): Serve youth with co-occurring behavioral health and justice needs at the most restrictive level.

Funding

• DBH state general funds, federal block grants, county dollars, and Medicaid (for eligible youth).

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e) Children and Youth with SED and I/DD
Care Coordination Approach
• Coordinated between DBH, RBHAs, and the Division of Developmental Disabilities.
• Coordination emphasizes cross-system integration, family partnership, and individualized service planning.
System-of-Care (SOC) Principles
DBH applies a System of Care framework to guide coordination for SED and SED/I/DD youth:
1. Family and youth partnership in all planning and policy decisions.
2. Flexible, community-based array of supports addressing emotional, social, and educational needs.
3. Strengths-based, individualized service planning.
4. Evidence-informed and practice-based interventions.
5. Least restrictive, most normative environments possible.
6. Cross-agency system integration (DBH, DDD, CPS, Probation, Education).
7. Care management and wraparound service planning for multi-system cases.
8. Developmentally and trauma-informed care promoting resilience and positive outcomes.
9. Supports for youth entering adulthood.
10. Early identification and prevention to address emerging behavioral health needs.
11. Continuous quality improvement and performance monitoring.
12. Protection of rights and advocacy for children and families.

End of Revision dated 10/29/25

The Nebraska Division of Behavioral Health (DBH) supports and promotes coordination and collaboration related to the provision of person-centered, person-directed and trauma-related diagnoses. 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, 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 advocacy and 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 and traumas.

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DBH requires via its Network Operations Manual, incorporated into the RBHA contracts by reference, for behavioral health RBHAs and 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 wellness, improved health outcomes, and improved quality of life for persons with behavioral health conditions.

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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.

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DBH collaborates with the Nebraska Network of Care, an online platform dedicated to individuals living with behavioral health and substance use conditions, as well as their caregivers and service providers. The platform offers valuable information about treatments, resources, and diagnoses, allowing users to access up-to-date features such as guided search and text messaging. This user-friendly website is accessible through the Nebraska Network of Care for Behavioral Health, and it is completely free of charge. Through this site, individuals can easily find information about behavioral health providers, making it a convenient and comprehensive resource. Since 2013, Network of Care has been providing a web-based platform to aid individuals in researching available services and supports, connecting individuals with service providers. Access site Nebraska Network of Care for Behavioral Health - Network of Care at URL: https://portal.networkofcare.org/NebraskaBehavioralHealth

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The Living Well curriculum is designed to educate consumers on chronic disease self-management. Backed by the evidence-based research conducted in the chronic health and self-management study, this curriculum is a valuable resource for Certified Peer Support Specialist. The Nebraska certified Peer Support Specialist (CPSS) can train as facilitators and are providing this education on chronic disease self-management through various settings such as day programs, county hospitals, shelters, jails, churches, and community settings. This curriculum, known for its self-directed approach, enables individuals to take control of their own health by developing self-regulation skills and fostering resiliency.

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Through the coordination with and support of the Nebraska Chronic Disease Prevention and Control Program in the Division of Public Health, the Living Well curriculum serves as an essential tool in addressing the needs of individuals with chronic mental health and substance use conditions, who may also experience concurrent physical health issues. By expanding the availability of

this program, Nebraska will be able to enhance its programming and develop additional capacity to effectively manage chronic diseases.

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The Office of Consumer Affairs (OCA) plays a crucial role in facilitating communication between consumers and the DBH. The OCA organizes and facilitates, either directly or through vendor contracts, community forums where consumers and their families can provide feedback on the quality of services, identify any gaps in these services, and offer suggestions on policies and service definitions. DBH contracts with a peer run organization charged with seeking feedback from individuals and families and organizations and communities on the best way to give as many people as possible the opportunity to have their voice heard by DBH leadership. The OCA and its various partnerships ensure that the consumer voice is heard and that efforts are made to improve the quality of behavioral health services in Nebraska while reducing stigma.

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The OCA's Peoples Council is specifically designed to advise DBH on meaningful consumer involvement. The Council consists of members who represent the geographic and population of the community. These members are either current or former consumers of behavioral health services or caregivers/family members of individuals receiving or having received services in the past. Their personal experiences are utilized to advocate for system transformation and to identify and advocate for a Recovery-Oriented Systems of Care (ROSC).

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The DBH OCA administrator collaborates with six Regional Consumer Specialists (RCSs) throughout the state to coordinate strategies and activities related to consumer advocacy, education, and overcoming stigma. Regular meetings are held to gather input from each geographic region on gaps in services, recommend areas of focus for consumer and family member training, strategize to overcome stigma, and provide feedback on DBH program and policy guidelines.

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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. There is an ongoing review of service expectations for those services that are available through each funding stream. Most recently, DBH worked closely with MLTC on the service expectations for Medically Managed Withdrawal Management and Opioid Treatment Programs as two services added into the MLTC benefit through an 1115 SUD waiver and initiated coordinated CCBHC planning.

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The Medicaid Managed Care, Heritage Health, MCOs require person centered planning practices as part of a recovery oriented system of care. The Nebraska Division of Medicaid & Long-Term Care (MLTC) began operations of Heritage Health on January 1, 2017, a managed care system in which the State contracts with managed care organizations (MCO) to provide health care benefits and services to Medicaid enrollees. MLTC developed Heritage Health to create a health care delivery system in which all of a Medicaid member's behavioral health, physical health, and pharmacy services are provided by one of three statewide health plan. Each of the MCOs operates statewide.

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In Plan Year 2025, there are three MCOs providing health and dental services. The three MCOs are Nebraska Total Care, UnitedHealthcare Community Plan of Nebraska, and MOLINA Healthcare. The contracts began January 1, 2024 and are for five years with optional two-year renewals.

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The MCOs are required to ensure a care management program that focuses on collaboration between the MCO and (as appropriate) the member, his/her family, providers, and others providing services to the member, including HCBS service coordinators. They assist members in the coordination of services using person-centered strategies, manage co-morbidities, and not focus solely on the member's primary condition. They incorporate interventions that focus on the whole person and empower the member (in concert with the medical home, any specialists, and other care providers), to effectively manage conditions and prevent complications through adherence to medication regimens; regular monitoring of vital signs; and, an emphasis on a healthful diet, exercise, and other healthy choices. They engage members in self-management strategies to monitor their disease processes and improve their health, as appropriate. They must work with providers to ensure a patient-centered approach that addresses a member's medical and behavioral health care needs in tandem.

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To promote a collaborative effort to enhance patient centered delivery system, the MCOs have established and maintained a member advisory committee that is accountable to the MCO's governing body to provide input and advice regarding program and policies. Membership of the Advisory Committee must include members, members' representatives, providers, and advocates that reflect the MCO's population and communities served. The Member Advisory Committee must represent the geographic and population of the MCO's membership.

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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. The first five year grant was awarded in 2018 and the second in 2021.

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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 have a scarcity of mental health resources. Two sites have higher free/reduced lunch rates, indicative of poverty and student mobility. Each differs in population characteristics. 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.

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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-related diagnoses 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 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.

6. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and substance use disorders**, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders. Please describe how this system differs for youth and adults.

Funding from the block grants, 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.

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Services are provided by the SSA/SMHA to individuals without insurance or for whom coverage is terminated for short periods of time and that are not covered by Medicaid, Medicare, or private insurance in the state and are paid for with a combination of SUPTRSBG, 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 MLTC and the SSA/SMHA. http://dhhs.ne.gov/Pages/Medicaid-Behavioral-Health-Definitions.aspx http://dhhs.ne.gov/Pages/Heritage-Health-Contacts.aspx

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LB1173 (2022) required DHHS to establish a child welfare practice model; a practice and finance model that integrates case management, physical and behavioral health care, prevention, post-adoption, court and probation services. Workgroups on finance, synergy across systems and services engaged in statewide meetings to develop a framework to transform and integrate systems. In November 2023, the LB 1173 Work Group established the Intersectoral Objective for the Child Welfare Practice Model to drive DHHS overarching strategic activity as well as impact Division plans going forward. For more information see URL: https://nebraskalegislature.gov/FloorDocs/108/PDF/Agencies/Child_Welfare_Practice_Model_Work_Group/813_20231130-133321.pdf

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

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The DBH supported a Nebraska partnership for Mental Healthcare Access in Pediatrics project aimed at integrating perspectives of educators, healthcare providers, and parents or caregivers of children to gain a view of the current state of pediatric mental and behavioral health in Nebraska. A September 2022 report was presented to DBH and provided recommendations to better identify and address the behavioral and mental health needs among children and adolescents in Nebraska. For more information about the Nebraska Partnership for Mental Healthcare Access in Pediatrics (NEP-MAP) please see URL: https://dhhs.ne.gov/Pages/Nebraska-Pediatric-Mental-Healthcare-Access-Partnership.aspx

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The Munroe-Meyer Institute completed the project to improve access to pediatric mental health services in Nebraska, working as a sub-recipient in a $2.2 million five-year grant (2019-2024) awarded to the Nebraska DHHS Title V Maternal and Child Health program. The project design for the clinical demonstration project included development of an expert pediatric mental/behavioral health consultation team, development of a consultation services network between the expert consultation team and the primary care clinics, education for providers and the expert team. After the initial phase of implementation the work to scale up and spread the project is underway.

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The Nebraska Connecting Families Steering Committee began meeting on June 30, 2023. Stakeholders are charged with designing a framework for sharing and advancing individual knowledge and skills to navigate a continuum of family support and to maximize the interaction of family and service providers. The desired outcome is to enhance the services and supports available for youth in schools who need mental and behavioral health supports across the state of Nebraska. The work has been separated into four phases. With assistance from the Interdisciplinary Program Evaluation (ICPE) program in the Department of Education

and Child Development at Monroe Meyer Institute (MMI), the Steering Committee will look to acquire and review previous needs surveys that families in Nebraska have completed on this topic and if needed develop a survey about families' needs across Nebraska respective to mental/behavioral health supports and resources in educational settings. Families will be recruited from across the state to participate in focus groups. The Steering Committee is utilizing the information and recommendations to identify a formalized, statewide support structure, and is completing a plan that includes the following seven initiatives:
1. Identify existing mental/behavioral health resources with emphasis on connection to educational settings.
2. Identify gaps in resources.
3. Identify how caregivers access existing resources.
4. Identify how we can improve accessibility and engagement of resources.
5. Identify how we can address gaps in resources.
6. Identify training/education that needs to be implemented for caregivers, providers and educators to improve access and engagement with resources.
7. Identify steps for funding, implementing and sustaining plans.
Initially planned to be released in April 2025, the project is still working on a white paper and an action plan.

7. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and intellectual/developmental disorders (I/DD)**, including screening and assessment for co-occurring disorders and integrated treatment that addresses I/DD as well as mental disorders. Please describe how this system differs for youth and adults.

The state supports the provision of integrated services and supports for individuals with co-occurring mental and intellectual/developmental disorders (I/DD), by having a clinician conduct a Functional Behavior Assessment (FBA) which determines the reason for why some of the behaviors are occurring from their mental health diagnosis. The FBA then states the recommendation for a behavior support plan to assist the person in decreasing noted behaviors. The state also has providers who are noted as Risk Providers – these are providers who can work with those whose behaviors are more intense and the requirement is to have a clinician from the provider monitoring the programs to assist the person with their behaviors. This allows individuals with I/DD the proper supports for their co-occurring disorder.

8. Please indicate areas of **technical assistance needs** related to this section.

Not applicable.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

2. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) – 10 percent set aside – Required for 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 individuals 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 as soon as possible following initial symptoms and reducing possible lifelong negative impacts such as loss of family and social supports, unemployment, incarceration, and increased hospitalizations *[Note: 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 SMI or SED].* The duration of untreated mental illness, defined as the time interval between the onset of symptoms and when an individual gets into appropriate treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be a negative prognostic factor. However, earlier treatment and interventions not only reduce acute symptoms but may also improve long-term outcomes.

The 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-5TR (APA, 2022). 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 the 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 experiencing first episode of psychosis (FEP). RAISE was a set of federal government- sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The 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.

States 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 experiencing 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.

Please respond to the following items:

1. Please name the evidence-based model(s) for ESMI, including psychotic disorders, that the state implemented using MHBG funds including the number of programs for each.

Model(s)/EBP(s) for ESMI	Number of programs
NAVIGATE	2.00
	0.00
	0.00
	0.00
	0.00

	0.00

2. Please provide the total budget/planned expenditure for ESMI for FY 26 and FY 27 (only include MHBG funds).

FY2026	FY2027
440,531.50	440,531.50

3. Please describe the status of billing Medicaid or other insurances for ESMI services. How are components of the model currently being billed? Please explain.

Nebraska does not have a bundled rate for ESMI services. Individual services within the model, including individual therapy, family therapy, medication management, community support, supported employment and education and peer support are billable to Medicaid or private insurance. Providers bill program expenses and services for individuals who are uninsured through the Block Grant.

4. Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI.

Nebraska will ensure all federal dollars are only utilized for those that are American Citizens and are federally eligible for services funded by the federal block grant. Nebraska will also prioritize ending crime and disorder on America's streets, as well as ensuring housing programs/assistances includes treatment services.

There are two programs currently running in Nebraska that offer the NAVIGATE program.

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NAVIGATE teams are funded through appropriations from the SAMHSA Mental Health Block Grant. NAVIGATE teams serve persons who may have private or both public and private insurance. NAVIGATE teams work with both public and private insurance entities to manage reimbursement and to cover individuals participating in the Nebraska NAVIGATE program service Coordinated Specialty Care/First Episode Psychosis.

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NAVIGATE is a team-based approach. Each team is composed of the following staff members:

- Program Director/Team Leader
- Family Education Clinician
- Prescriber (psychiatrist, nurse practitioner or physician's assistant)
- Individual Resiliency Trainer
- Supported Employment and Education Specialist,

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Provider: Community Alliance (located in Omaha, NE)
1. Program Name: Navigate to Success
2. Program Address: 7150 Arbor Street, Omaha, Nebraska 68106
3. Program Contact (Phone number & E-mail address): Phone: (402) 341-5128; E-Mail: info@commall.org
4. Program Type: NAVIGATE model
5. Age Range Accepted: 14 to 35
Please indicate which of the following services are offered:
6a. Medication - Yes
6b. Psychotherapy - Yes
6c. Supported Employment and Education - Yes
6d. Peer Services - No
6e. Primary Care - No
6f. Family Education and Support - Yes
6g. Case Management - Yes
End Info for Provider Community Alliance

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Provider: Mid-Plains Center for Behavioral Healthcare Services (located in Grand Island, NE).
1. Program Name: NAVIGATE
2. Program Address: 914 Baumann Drive, Grand Island, NE 68801
3. Program Contact (Phone number & E-mail address): Phone: (308) 385-5250; E-Mail: contact@midplainscenter.org
4. Program Type: NAVIGATE model
5. Age Range Accepted: 15 to 40
Please indicate which of the following services are offered:
6a. Medication - Yes
6b. Psychotherapy - Yes
6c. Supported Employment and Education - Yes

6d. Peer Services - No
6e. Primary Care - No
6f. Family Education and Support - Yes
6g. Case Management - Yes
End info for Mid-Plains Center for Behavioral Healthcare Services.

5. Does the state monitor fidelity of the chosen EBP(s)? (●) Yes ( ) No

6. Does the state or another entity provide trainings to increase capacity of providers to deliver interventions related to ESMI? (●) Yes ( ) No

7. Explain how programs increase access to essential services and improve client outcomes for those with an ESMI.

Nebraska will continue to provide data driven, innovative solutions based on gold standard science to improve outcomes for those wit ESMI. Nebraska will also continue to support and adopt standards that address individuals who are a danger to themselves or others and suffer from mental illnesses or substance use disorders or who are living on the streets and cannot care for themselves. Nebraska currently has a civil commitment process which supports the notion of helping those that are not able to help themselves.

There are two programs running in Nebraska that offer the NAVIGATE program: Mid-Plains Center and Community Alliance.

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Mid-Plains Center is using the NAVIGATE program for their First Episode Psychosis clients.
Mid-Plains Center Program Structure: Referral and Clientele
• Clients ages 15-40 are referred to Mid-Plains Center as a result of their first hospitalization where psychosis is the presenting problem.
• An intake assessment is completed to confirm eligibility criteria are met, including:
• Diagnosis of schizophrenia, schizoaffective disorder, or schizophreniform disorder
• Have received antipsychotic medications for less than one year
• R/O of significant intellectual disability, autism, or TBI;
• R/O if symptoms of psychosis are related to diagnoses of affective disorders (such as Bipolar disorder or anxiety disorders) or personality disorders.
• Weekly team conferences are held to staff cases and collaborate on needs and referrals
• Teams consist of the Director, Family Counseling, Prescriber, Individual Resiliency Training Specialist, Supported Employment and Education Specialist, along with Peer Specialist and Case Managers

.

Their NAVIGATE Program Goals include:
• Learn what families already know about the symptoms, causes, course, medications, and impact of stress on the loved one's life;
• Provide information that addresses any gaps in knowledge about psychosis, treatment, substance use, adopting a healthy lifestyle, strategies to cope with stress, and the role of family in recovery;
• Provide realistic hope for recovery;
• Support relatives;
• Enlist relatives input to, and cooperation with, the treatment plan;
• Help relatives assist their loved one to monitor his or her symptoms and prevent relapses

.

NAVIGATE Program Utilization:
• Currently serving four individuals, with a recent referral for a fifth pending assessment/intake
• Therapist caseload can support up to six individuals being served in the NAVIGATE model
• Intensity and mix of services varies somewhat
• Some prefer primary focus to be on employment supports, whereas others not at all
• Early services experience higher frequency/intensity, then recedes as symptoms stabilize

.

NAVIGATE Program Changes, Challenges, and Improvements:
• Training is expensive and a significant time investment for all team members (one full week for most team members, plus lost productivity).
• Staff turnover creates challenges in keeping a full team trained and ready to meet capacity needs as they grow.
• Model supports doing family psychotherapy concurrently with individual sessions, but this requires two trained therapists and at times limits family participation in the individual session.
• High turnover in hospital settings can make keeping primary referral sources aware of the program difficult – marketing/education efforts are proving important.
• Attendance and engagement is generally good, and family involvement is good when kids are the service recipients, though attendance can tend to drop off as improvement and stability are achieved.

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Benefits of NAVIGATE:
• NAVIGATE's model thrives on wrapping around services and ensuring a full team is committed to a person and aware of goals/progress.
• Cognitive-Behavioral Therapy and Family Psychoeducation components provide a strong basis for an effective program
• Benefits are particularly pronounced around high rates of medication compliance, enhanced coping skills, and improve self-care

and employability.
• Helps to overcome an otherwise significantly impacted trajectory for individuals and families
.
Community Alliance's "Navigate to Success" First Episode Psychosis Program
Community Alliance began offering the full cadre of FEP services in 2020. Services are based on the NAVIGATE model, an evidence-based practice by NAVIGATE Consultants. Team members completed training by NAVIGATE staff
.
Program Details:
• Serves individuals ages 14-35 who have recently experienced a first episode of psychosis
• Individuals must live in Douglas County or an immediate surrounding county
• Must have experienced a psychotic episode lasting longer than 1 week but less than two years
.
NAVIGATE Team
Referral Sources Include:
• Psychiatric hospitals, Outpatient clinics, Adult and Adolescent, Schools, Psychiatric Residential Treatment Facilities (PRTF), Juvenile Court, DHHS, Probation, and Families
.
Measuring Success:
• Assessing and measuring success has been defined by
• Completion of activities from the IRT manual and application of concepts –
• Compliance with medication treatment
• Consistent participation in IRT and SEE program components
• Observed improvement in daily functioning, interpersonal interactions, and self-advocacy
• The individual's perception of functioning and symptom improvement
.
Utilization
• Utilization between January 2023 – December 2023:
• Referrals received: 15
• Admissions: 8
• Individuals served: 24
• Primary reasons for Referral/Admission variance
• Diagnostic/Duration criteria not met
• Declined services due to not wanting to change medication provider
• Unable to contact after referral was sent
.
Benefits of the Program
• Continuity of Care among providers working with the individual
• Individuals have displayed increased insight of their diagnosis and more awareness of their symptoms by working with the FEP team and embracing the NAVIGATE teaching modules
• Decrease in number of hospitalizations
• Consistent coordination with school teachers, counselors and employers increasing the chance for success
.
Challenges of the Program
• Prescriber sees clients via telehealth
• Measuring Success – Defining what a successful discharge is
• Consistent and ongoing engagement and participation of clients in all components of the FEP model
• Family involvement, interest, and participation in the Family Education component
• Access to ongoing training from NAVIGATE consultants when staff members change
• Consistent Referrals
• IRT clinician provides both IRT and Family Education
.
Community Alliance's Plan of Action
• Introduction of in person prescriber
• Collaboration with Region 6 for additional referral sources
• Active assertive outreach taking place – visiting community clinics in person
• Current search for licensed clinician to lead team and provide Family Education component
• Ensure individuals meet all members of the team at time of orientation
• Offering Family Education consistently in successive meetings
• Continue to utilize the NAVIGATE training manuals with individuals to provide diagnosis awareness and skill building regarding symptom management.

8. Please describe the planned activities in FY2026 and FY2027 for your state's ESMI programs.

For the FY2026 and FY2027, DBH has planned to provide NAVIGATE training to any and all providers and agencies within the state that are interested in providing this EBP. This program will provide supports and services for those with early serious mental illness and not for primary prevention or preventive interventions for those at risk of serious mental illness. Funding will be used

to build a program team approach which will support early detection and intervention. This program team will support persons with early psychotic disorders, specifically first episode psychosis between the ages of 15 to 36; Early intervention programs are designed to bridge existing services for these groups and eliminate gaps between child, adolescent, and adult mental health programs.

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This program will provide innovative, evidence-based, recovery-oriented treatment to young people who have recently begun experiencing psychotic symptoms. Teams will help people achieve their goals for school, work, and relationships. Each participant in the program will have access to an array of community-based services and other resources.

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NAVIGATE is a team-based approach to implement CSC for early psychosis. The team is comprised of members that include: a Program Director who educates the community, recruits individuals who have begun to experience psychosis, and leads the team; a Prescriber, trained in using low doses of medications and addressing special issues of clients with first episode psychosis; an Individual Resiliency Trainer (IRT), who helps individuals work towards their goals, teaching them strategies and skills to build their resiliency in coping with psychosis while staying on track with their lives; a Family Education (FE) Clinician, who helps the whole family learn about psychosis and how to manage it, and also how to support each other and build family resiliency; a Supported Employment and Education (SEE) Specialist, who helps people identify and achieve their educational and/or employment goals; and, Case Management, provided either by a separate case manager or by a specified NAVIGATE team member

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Received this proposal May 2025 - Example of Proposal for NAVIGATE Training
Prepared by Susan Gingerich, MSW for Oklahoma
NAVIGATE Training Coordinator; gingsusan@yahoo.com

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Note that the NAVIGATE training described below is conducted on-line, using the trainers' zoom accounts. More than one team can be trained at one time. Because the training is highly interactive and involves role playing (with the exception of the overview training and the medication training) there are limitations on the # of participants in each training component, as follows:
•Overview and team training: limit of 30 participants
•Director training : limit of 8 participants
•Family Clinician training : limit of 8 participants
•IRT training: limit of 8 participants
•SEE training: limit of 10 participants
•Medication and Health training: limit of 30 participants

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We recommend reserving a few spots in each training if possible that could be used for NAVIGATE teams in other states who have experienced staff turnover. This will allow you to be considered for other states' training when you experience staff turnover.

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Costs of Training for a Whole Team
•Training component • Developing a proposal, a plan for implementation and training and coordinating the training itself
• To be attended by • Training coordinator communicates with state or agency leadership, team director, trainers and contracting personnel
• Usually Provided by • Susan Gingerich, Training Coordinator
• Time • Takes equivalent of one training day, but spread out over several weeks
• Cost • $4000

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•Training component • On-line overview and team training
• To be attended by • All team members (limit of 30)
• Usually Provided by • Susan Gingerich
• Time • ½ day
• Cost • $2000

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•Training component • Director training
• To be attended by • Director (limit of 8)
• Usually Provided by • Susan Gingerich
• Time • ½ day
• Cost • $2000

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•Training component • Family Clinician Training
• To be attended by • Family Clinician (limit of 8)
• Usually Provided by • Susan Gingerich
• Time • 1 ½ day
• Cost • $6000

.

•Training component • IRT training
• To be attended by • IRT (limit of 8)
• Usually Provided by • Piper Meyer-Kalos
• Time • 3 days

• Cost • $12,000

.

•Training component • SEE training
• To be attended by • SEE (limit of 10)
• Usually Provided by • Shirley Glynn
• Time • 2.5 days
• Cost • $10,000

.

•Training component • Medication training
• To be attended by • First two hours for all team members and second two hours for prescribers and open to whole team (limit of 30)
• Usually Provided by • Delbert Robinson, MD
• Time • 4 hours
• Cost • $4400

.

•Training component • Wrap up training
• To be attended by • All team members (limit of 30)
• Usually Provided by • 3 trainers
• Time • 90 minutes
• Cost • $2000

.

•Training component • Director/family clinician consultation calls (post training)
• To be attended by • Director and family clinicians
• Usually Provided by • Gingerich
• Time • Twice monthly calls for 6 months, monthly calls for 6 months
• Cost • 18 calls X 300 = $5400

.

•Training component • IRT consultation calls (post training)
• To be attended by • IRT clinicians
• Usually Provided by • Meyer-Kalos
• Time • Twice monthly calls for 6 months, monthly calls for 6 months
• Cost • 18 calls X 300 = $5400 =

.

•Training component • SEE consultation calls (post training)
• To be attended by • SEE specialists
• Usually Provided by • Glynn
• Time • Twice monthly calls for 6 months, monthly calls for 6 months
• Cost • 18 calls X 300 = $5400

.

•Training component • Medication consultation calls (post training)
• To be attended by • Prescribers
• Usually Provided by • Robinson
• Time • Monthly for 12 months
• Cost • 12 calls X $425= $5100

.

•Training component • One team observation (trainer uses zoom to join a team meeting for each team and observes and rates each meeting)
• To be attended by • Whole team
• Usually Provided by • Gingerich
• Time • 1 team meeting observation for each team, scheduled 2-3 months after initial training
• Cost • $350 per team X 3 teams = 1,050

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•Training component • Discussion of implementation at each agency
• To be attended by • Agency and/or state leaders
• Usually Provided by • Gingerich
• Time • 1 phone call or zoom meeting, approximately 6 months after training
• Cost • $300 per team X 3 teams = $900

.

Total cost=$65,650
End

9. Please list the diagnostic categories identified for each of your state's ESMI programs.

Coordinated Specialty Care/First Episode Psychosis-NAVIGATE MODEL
Admission Criteria:
Individual must meet all of the following admission guidelines to be admitted to this service.

1. Age:14 through 35
2. The individual has a primary diagnosis, as outlined in the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association, that includes psychosis and may include individuals with co-occurring disorders. Accepted diagnosis from this service include:
• a. F20.0 Paranoid schizophrenia
• b. F20.1 Disorganized schizophrenia
• c. F20.2 Catatonic schizophrenia
• d. F20.3 Undifferentiated schizophrenia
• e. F20.5 Residual schizophrenia
• f. F20.81 Schizophreniform disorder
• g. F20.89 Other schizophrenia
• h. F20.9 Schizophrenia, unspecified
• i. F21 Schizotypal disorder
• j. F22 Delusional disorders
• k. F23 Brief psychotic disorder
• l. F24 Shared psychotic disorder
• m. F25.0 Schizoaffective disorder, bipolar type
• n. F25.1 Schizoaffective disorder, depressive type
• o. F25.8 Other schizoaffective disorders
• p. F25.9 Schizoaffective disorder, unspecified
• q. F28 Other psych disorder not due to a sub or known physical cond.
• r. F29 Unspecified psychosis not due to a substance or known physical condition
3. Symptoms of a psychotic disorder for a period lasting more than one week and no more than two years.
4. Presence of functional deficits in two of three functional areas: Vocational/Education, Social Skills, and Activities of Daily Living
• a. Vocational/Education: inability to be employed or an ability to be employed only with extensive supports; or deterioration or decompensation resulting in inability to establish or pursue educational goals within normal time frame or without extensive supports; or inability to consistently and independently carry out home management tasks.
• b. Social Skills: repeated inappropriate or inadequate social behavior or ability to behave appropriately only with extensive supports; or consistent participation in adult activities only with extensive supports or when involvement is mostly limited to special activities established for persons with mental illness; or history of dangerousness to self/others.
• c. Activities of Daily Living: Inability to consistently perform the range of practical daily living tasks required for basic adult functioning.
5. Individual can reasonably be expected to benefit from the Coordinated Specialty Care model.
6. It is expected that the individual will be able to benefit from this treatment

10. What is the estimated incidence of individuals experiencing first episode psychosis in the state?

The Division of Behavioral Health (DBH) sponsored a project by the University of Nebraska Medical Center College of Public Health to conduct a study to collect data on First Episode Psychosis (FEP) individuals This study was shared with all Nebraska providers. This data was used to determine the community needs of FEP clients across the state and determined the number of programs needed to serve this population. There are two current teams/programs in the state using the RAISE NAVIGATE model.

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Disclaimer: In the absence of known published studies specific to Nebraska about first episode psychosis, in 2023 the DBH commissioned the University of Nebraska Medical Center College of Public Health to conduct a study to identify needs of individuals with First Episode Psychosis (FEP).

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The study also addressed the following objectives: 1) Estimate the first episode admission rates in Nebraska in 2021. 2) Estimate psychotic disorder admission rates in Nebraska during the period 2017-2021, and 3) Compare the characteristics of patients with psychotic disorder diagnoses and those without psychotic disorder diagnosis. The study used Nebraska hospital discharge data to estimate the prevalence, at-risk groups, and service utilization patterns. In addition, interviews among stakeholders were used to understand their perspectives on the care of individuals with FEP.
The findings were used to identify key the community needs for individuals with FEP across the state and to estimate the number of programs needed to serve this unique population.

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Notably, the study identified there were 675 individuals with a first episode psychosis (FEP) from among Nebraska's 14-35 years age group (estimated population of 584,182), hence a prevalence rate of 116 per 100,000.

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For individuals experiencing FEP, Nebraska currently has two operational programs using the DBH's Coordinated Specialty Care (CSC) service. In 2021, both programs switched from the OnTrack New York model and began to use the RAISE NAVIGATE model for which a single CSC service was established in the Centralized Data System (CDS) for reporting on consumers admitted to the CSC service. During FY 2023-2024, CDS data indicated that 32 individuals were served in CSC and another 25 served in FY 2024-2025.

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In FY2024, a request for applications (RFA) was issued by the Division of Behavioral Health (DBH) to determine the interest of providers for these services in other regions. Additionally, the DBH made a call to upcoming CCBHC providers, and those in the community, to enhance their current programming by adding CSC/FEP using the NAVIGATE model to their service array. This

discussion is on-going and two additional providers have expressed interest in adding CSC/FEP using the NAVIGATE model, one of which is expected to be operational within FY26.

11. What is the state's plan to outreach and engage those experiencing ESMI who need support from the public mental health system?

In FY 2026 and FY 2027, Nebraska's First Episode Psychosis (FEP) program will continue to strengthen outreach, education, and access to care across the state for individuals experiencing ESMI and their loved ones. The Division of Behavioral Health (DBH) has been in conversation with each program to discuss additional and new strategies to education the community providers, local health organizations, and individuals about the program. Each program has been encouraged to start a marketing campaign along with doing outreach.

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In addition, the FEP Program will conduct outreach to populations to provide education around psychosis and how to seek help (for example, college students and other Nebraskans). Together, these initiatives aim to promote early identification, reduce treatment delays, and expand access to high-quality support for young people experiencing psychosis and in need of support. The FEP programs provide education and outreach in their communities via: hospitals, schools, colleges, and a large social media campaign.

12. Please indicate area of technical assistance needs related to this section.

None at this time.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

3. Person Centered Planning (PCP) – Required for MHBG, Requested for SUPTRS BG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning (PCP) is a process through which individuals develop their plan of service based on their chosen, individualized goals to improve their quality of life. The PCP process 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 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.

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. PCP resources may be accessed from **https://acl.gov/news-and-events/announcements/person-centered-practices-resources**

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.

3. Describe how the state engages people with SMI and their caregivers in making health care decisions, and enhances communication.

Revised 11/6/25

The Nebraska DHHS 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 a person-centered assessment, and actively and directly participate (when clinically appropriate) in decisions which incorporate independence, 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 advocacy and 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 needs, strengths, and goals that supports and complies with "Make America Healthy Again as well as ending crime on America's streets.

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DBH requires via its Network Operations Manual, incorporated into the RBHA contracts by reference, for behavioral health RBHAs and 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 long-term recovery, which in turn will decrease chronic illnesses and diseases. wellness, improved health outcomes, and improved quality of life for persons with behavioral health conditions.

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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.

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DBH collaborates with the Nebraska Network of Care, an online platform dedicated to individuals living with behavioral health and substance use conditions, as well as their caregivers and service providers. The platform offers valuable information about treatments, resources, and diagnoses, allowing users to access up-to-date features such as guided search and text messaging. This user-friendly website is accessible through the Nebraska Network of Care for Behavioral Health, and it is completely free of charge. Through this site, individuals can easily find information about behavioral health providers, making it a convenient and comprehensive resource. In FY 23, the total number of page visits was 146,806. Since 2013, Network of Care has been providing a web-based platform to aid individuals in researching available services and supports, connecting them with service providers. Access site Nebraska Network of Care for Behavioral Health - Network of Care at URL: https://portal.networkofcare.org/NebraskaBehavioralHealth

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The Nebraska certified Peer Support Specialist (CPSS) can train as facilitators, and are providing this education on chronic disease self-management through various settings such as day programs, county hospitals, shelters, and community settings. This curriculum, known for its self-directed approach, enables individuals to take control of their own health by developing self-regulation skills and fostering resiliency.

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Through the coordination with and support of the Nebraska Chronic Disease Prevention and Control Program in the Division of Public Health, the Living Well curriculum serves as an essential tool in addressing the needs of individuals with chronic mental health and substance use conditions, who may also experience concurrent physical health issues. By expanding the availability of this program, Nebraska will be able to enhance its programming and develop additional capacity to effectively manage chronic diseases and make America Healthy Again.

The Office of Consumer Affairs (OCA) plays a crucial role in facilitating communication between consumers and the Department of Behavioral Health (DBH). The OCA organizes and facilitates, either directly or through vendor contracts, community forums where consumers and their families can provide feedback on the quality of services, identify any gaps in these services, and offer suggestions on policies and service definitions. DBH currently as a contract with a peer run organization charged with seeking feedback from individuals and organizations and communities on the best way to give as many people as possible the opportunity to have their voice heard by DBH leadership.

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The DBH Advisory Committee is comprised of members who represent state, regional, and community partnerships. Their purpose is to provide leadership in substance use and mental health prevention within Nebraska's behavioral health system at the state and regional levels.

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The DBH OCA administrator collaborates with the six RBHA Regional Consumer Specialists (RCSs) throughout the state to coordinate strategies and activities related to consumer advocacy, education, and outreach. Regular meetings are held to gather input from each geographic region on gaps in services, recommend areas of focus for consumer and family member training.

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The OCA and its various partnerships ensure that the consumer voice is heard and that efforts are made to improve the quality of behavioral health services in Nebraska.

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The DBH OCA's Recovery Friendly Workplace initiative (RFWI) is underway. The RFWI objectives include providing business owners with the resources and support they need to foster a supportive environment, that encourages the success of their employees by promoting individual wellness through resources and support for people with mental health and substance use challenges and their family members. This initiative will help normalize the conversation around behavioral health challenges; and create sustainable organizational change in providing support to employees and their families.

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The Nebraska Medicaid Managed care system, called Heritage Health, managed care organizations (MCOs) require person centered planning practices as part of a recovery-oriented system of care. The Nebraska Division of Medicaid & Long-Term Care (MLTC) began operations of Heritage Health on January 1, 2017, a managed care system in which the State contracts with MCOs to provide health care benefits and services to Medicaid enrollees. MLTC developed Heritage Health to create a health care delivery system in which all of a Medicaid member's behavioral health, physical health, and pharmacy services are provided by a statewide health plan. Each of the MCOs operates statewide. I

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The MCOs are required to ensure a care management program that focuses on collaboration between the MCO and (as appropriate) the member, his/her family, providers, and others providing services to the member, including HCBS service coordinators. They assist members in the coordination of services using person-centered strategies, manage co-morbidities, and not focus solely on the member's primary condition. They incorporate interventions that focus on the whole person and empower the member (in concert with the medical home, any specialists, and other care providers), to effectively manage conditions and prevent complications through adherence to medication regimens; regular monitoring of vital signs; and, an emphasis on a healthful diet, exercise, and other lifestyle choices. They engage members in self-management strategies to monitor their disease processes and improve their health, as appropriate. They must work with providers to ensure a patient-centered approach that addresses a member's medical and behavioral health care needs in tandem.

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To promote a collaborative effort to enhance patient centered delivery system, the MCOs have established and maintained a member advisory committee that is accountable to the MCO's governing body to provide input and advice regarding program and policies. Membership of the Advisory Committee must include members, members' representatives, providers, and advocates that reflect the MCO's population and communities served. The Member Advisory Committee must represent the geographic and population of the MCO's membership.

4. Describe the person-centered planning process in your state.

Revised 11/6/25

Nebraska's Adult System of Care (ASOC) is a recovery-oriented system of care that is long-term recovery focused, person-centered, strength-based, integrated, outcomes-driven, and based on gold standard science. 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 access to evidenced based services (OTP's) decreasing the spread of infectious

diseases, educating on toxic drug supplies, increasing the use of OORM's, lifesaving prevention and response services, enhancing recovery support services (RFW's, supported housing, peers), partnerships, braided/blended services to end crime and disorder on America's streets. mental health and substance use prevention, treatment, recovery and support services at the right time, in the right amount and in the right place.

5. What methods does the SMHA use to encourage people who use the public mental health system to develop Psychiatric Advance Directives (for example, through resources such as **A Practical Guide to Psychiatric Advance Directives**)?

Revised 11/6/25
A key accomplishment of the OCA is the creation of a comprehensive Nebraska Mental Health Advance Directive FAQ. This resource provides valuable information on LB247, which passed in 2020 and established the legal framework for Mental Health Advance Directives in Nebraska. The FAQ includes important communication materials and wallet cards that can be distributed to providers and community members, ensuring that individuals are aware of their rights to create a Mental Health Advance Directive and that providers understand their responsibility to follow these directives. The OCA has provided technical assistance to Disability Rights Nebraska in developing a public training program. This program is specific to Nebraskans and aims to educate individuals about the importance of Mental Health Advance Directives and provides guidance on how to create them. To date many individuals have received this training. The educational information, along with access to the necessary forms, is easily accessible on the DHHS website, facilitating ease of use for individuals seeking to create their own Mental Health Advance Directives.
.
Steps have also been taken to add the question, “Would you like to create a mental health directive?” to the intake evaluation of our Family Providers. By actively promoting and supporting the implementation of Mental Health Advance Directives, the OCA contributes to improving the quality of mental health services in Nebraska and empowering individuals to have control over their own mental health treatment.

6. Please indicate areas of technical assistance needs related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

4. Program Integrity – Required for MHBG & SUPTRS BG

Narrative Question

There is a strong emphasis on ensuring that Block Grant funds are expended in amanner consistent with the statutory and regulatory framework. This requires that the federal government and the states have a strong approach to assuring program integrity. Currently, the primary goals of the federal government's 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 behavioral health services, states are reminded of restrictions on the use of Block Grant funds outlined in **42 U.S.C. § 300x–5** and **42 U.S.C § 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)**, there are periodic site visits to MHBG and SUPTRS BG 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 SUPTRS BG funds can only be used for individuals with or at risk for SUD. The 20% minimum primary prevention set-aside of SUPTRS BG funds should be used for universal, selective, and indicated substance use prevention. 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**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SUPTRS BG resources are to be used to support, not supplant, services that will be covered through private and public insurance. In addition, the federal government and states need to work together to identify strategies for sharing data, protocols, and information to assist Block Grant program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SUPTRS BG funds are allocated to support evidence-based substance use primary 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 behavioral health services funded by the MHBG and SUPTRS BG. 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 mental health and SUD benefits; (3) ensuring that consumers of mental health and SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of mental health and 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. With rare exception, contracts require providers to be/become Medicaid enrolled, which adds additional quality control and oversight mechanisms. The Centralized Data System (CDS) further aids providers in determining if clients are enrolled in Medicaid as it crosschecks against a Medicaid eligibility file. RBHAs, with review and approval of DBH, issue proposals for bidding or direct contracts for new services or capacity needed in the network. RBHA staff, DBH staff, and consumers evaluate proposals for quality based on bid and contract requirements and best practices.

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DBH relays its standards of care through service definitions, contracts and within regulations. The service definitions detail the basic definition, admission guidelines, service expectations, staffing, hours of operations, desired outcomes, and continued stay

guidelines related to each level of care. Service definitions and Manuals are incorporated by reference into contracts/subawards. The Network Operations Manual defines consumer rights, consumer grievances, expectations for 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. DBH and the RBHAs monitor, review, and perform programmatic, administrative, quality improvement, fiscal accountability, and oversight functions regularly with all providers and sub awardees/subcontractors. The use of block grant funds is restricted to specific services and activities allowable under federal regulations are within contracts and payment processes.

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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 improving service delivery and receiving technical assistance. Additional technical assistance and training can be provided to the RBHAs or providers during monthly CDS Super User Calls, monthly Network Contract Meetings, and monthly Network Director Meetings. The State requires most providers to hold National Accreditation to ensure quality and safety infrastructure within provider organizations. The DBH and RBHA are required to monitor, review, and perform programmatic, administrative, quality improvement, and fiscal accountability and oversight functions regularly with all subcontractors. Both entities are required to review to promote an appropriate array of services/continuum of care within the state and the RBHA. This includes gathering and maintaining waitlist and capacity data, which should be continuously reviewed to determine the State and RBHA's continued capacity for providing an appropriate array of services/continuum of care. DBH monitors whether RBHAs are using the Federal Block Grant Program Fidelity Tool during site visits to ensure that SAPTBG requirements are met.

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

4. Please indicate areas of technical assistance needs related to this section.

None at this time.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

5. Primary Prevention – Required for SUPTRS BG

Narrative Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. 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 primary 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 SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must serve both the general population and sub-groups that are at high risk for substance use. 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, misuse and substance use disorders 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 priority populations in activities that exclude alcohol, tobacco, and other drug use.
4. ***Problem identification and Referral*** that aims at identification of those who have engaged in illegal/age-inappropriate use of tobacco or alcohol, and those individuals who have engaged in initial use of illicit drugs, in order to assess if the behavior can be addressed by education or other interventions to prevent further use.
5. ***Community-based processes*** 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 use 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 serve populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

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 misuse.

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

- **a)** ☐ Children (under age 12)
- **b)** ☑ Youth (ages 12-17)
- **c)** ☑ Young adults/college age (ages 18-26)
- **d)** ☑ Adults (ages 27-54)
- **e)** ☑ Older adults (age 55 and above)
- **f)** ☑ Rural communities

i) ☐ Other (please list)

4. Does your state use data from the following sources in its primary prevention needs assesment? (check all that apply):

a) ☐ Archival indicators (Please list)

b) ☑ National survey on Drug Use and Health (NSDUH)

c) ☑ Behavioral Risk Factor Surveillance System (BRFSS)

d) ☑ Youth Risk Behavioral Surveillance System (YRBS)

e) ☐ Monitoring the Future

f) ☐ Communities that Care

g) ☑ State-developed survey instrument

h) ☑ Other (please list)

+ Nebraska Young Adult Alcohol Opinion Survey (NYAAOS)
+ Youth Tobacco Survey (YTS)
+ Adult Tobacco Survey (ATS)
+ Nebraska Community Alcohol Opinion Survey (NCAOS)
+ MH/SA Treatment
+ Vital Statistics

5. Does your state use needs assessment data to make decisions about the allocation of SUPTRS BG primary prevention funds? ◉ Yes ○ No

a) If yes, (please explain in the box below)

DBH allocates funding to the behavioral health regions that then utilize needs assessment data (SHARP survey data, NCAOS survey data, NSDUH data, etc.) to allocate funding to prevention coalitions.

b) If no, please explain how SUPTRS BG funds are allocated:

Narratve Question

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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 priority populations in activities that exclude alcohol, tobacco, and other drug use.
4. ***Problem identification and Referral*** that aims at identification of those who have engaged in illegal/age-inappropriate use of tobacco or alcohol, and those individuals who have engaged in initial use of illicit drugs, in order to assess if the behavior can be addressed by education or other interventions to prevent further use.
5. ***Community-based processes*** 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 use 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 serve 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 primary prevention workforce? ○ Yes ◉ No

a) If yes, please describe.

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

a) If yes, please describe mechanism used.

The State utilizes multiple different avenues to ensure robust training and technical assistance opportunities for prevention providers. 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. RPCs continue to build on existing success by further providing extensive community-based training and technical assistance to assess community readiness. The State also leverages partnerships with different technical assistance centers to ensure ample training and technical assistance opportunities. The Strategic Prevention Technical Assistance Center (SPTAC) and the Prevention Technology Transfer Center (PTTC) both assist in customizing trainings for the needs of the Nebraska Prevention Workforce. Additionally, the state implements quarterly grantee meetings with recipients of the SUPTRS BG primary prevention set aside to provide technical assistance regarding barriers in implementation of primary prevention activities. Attached is the evaluation from our first grantee meeting.

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

a) If yes, please describe mechanism used.

The State utilizes the Strategic Prevention Framework to assess community readiness to implement prevention strategies.

The State conducts annual surveys of both community coalition coordinators and coalition members. area-specific reports with quantitative and qualitative data are made available to RBHAs and community coalitions.

Narratve Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. 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 primary 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 SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must serve both the general population and sub-groups that are at high risk for substance use. 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, misuse and substance use disorders 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 priority populations in activities that exclude alcohol, tobacco, and other drug use.
4. ***Problem identification and Referral*** that aims at identification of those who have engaged in illegal/age-inappropriate use of tobacco or alcohol, and those individuals who have engaged in initial use of illicit drugs, in order to assess if the behavior can be addressed by education or other interventions to prevent further use.
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In implementing the comprehensive primary prevention program, states should use a variety of strategies that serve 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 primary prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in WebBGAS

Please attached Nebraska's 2025 Prevention Strategic Plan.

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SUPTRS BG?

- [x] Yes
- [ ] No
- [ ] Not applicable (no prevention strategic plan)

3. Does your state's prevention strategic plan include the following components? (check all that apply):

- **a)** [x] Based on needs assessment datasets the priorities that guide the allocation of SUPTRS BG primary prevention funds
- **b)** [x] Timelines
- **c)** [x] Roles and responsibilities
- **d)** [ ] Process indicators
- **e)** [ ] Outcome indicators
- **f)** [ ] Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? (●) Yes ( ) No

- **a)** Does the composition of the Advisory Council represent the demographics of the State? (●) Yes ( ) No

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

a) 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) and Statewide Epidemiological Outcomes Workgroup (SEOW), 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.

Narratve Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. 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 primary 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 SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must serve both the general population and sub-groups that are at high risk for substance use. The program must include, but is not limited to, the following strategies:

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

Implementation

1. States distribute SUPTRS BG 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 SUPTRS BG primary prevention dollars in at least one 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, misuse, and addiction on individual's families and communities. Many of our community coalitions showcase their products via brochures, flyers, public service (radio) announcements, billboards, newspaper 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
- Alcohol: True Stories
- All Stars
- Circle of Security
- Healthy Alternatives for Little Ones (HALO)
- LifeSkills Training Program
- Me360
- Parent and Family Skills Training
- Project Northland
- PRIME For Life
- Second Step
- Seeking Safety
- Strengthening Families
- Too Good for Drugs
- Well Initiatives for Senior Education (WISE)
- Educational materials developed in support of Red Ribbon Week, Prevention Week, and safe Prescription Drug disposal.

c) Alternatives:

DBH sponsors a variety of alternative activities such as youth trainings and/or summits throughout the school year and summer breaks designed to develop youth leadership within their home communities. Another frequently used strategy is partnerships with law enforcement to coordinate promotional letters sent to students to encourage safer and wise choices during prom and graduation season. Nebraska also has many successful mentoring programs, namely Teammates and the Big Brothers Big Sisters Mentoring Program that provide positive alternatives to our youth. Other strategies include Girls on the Run, Community drop-in centers and drug free dances/parties.

d) Problem Identification and Referral:

DBH has one direct prevention provider, Lincoln Medical Education Partnership's School Community Intervention and Prevention (SCIP) program, which provides statewide problem identification and referral services. SCIP provides prevention, education, and early intervention services and trains teams within schools to help recognize a child's behavioral health needs at early on-set, rather than waiting until they have progressed to a more critical level and are more difficult to address. Following a student's referral to SCIP, the team assesses the need for further action, coordinating an intervention with the student and/or their parent/guardian when necessary. A plan is developed to address the concerns and increase the student's opportunity to succeed in school. This plan may include a referral to a school resource or to partnering behavioral health agencies who can provide a screening for the student, at no cost to the family. A number of contracted prevention providers offer DUI/DWI Education Programs as well as Parent and Family Skills Training throughout the year to selective and indicated populations. Several institutes of higher learning also fund Brief Alcohol Screening Intervention of College Students (BASICS).

e) Community-Based Processes:

Much of the SUPTRS BG is dedicated to the support of community-based processes that include organizing, planning, evaluating and enhancing the effectiveness of funded programs, policies, practice implementation, interagency collaboration, coalition building, and networking. Regional Prevention Coordinators and coalition leads are specifically funded to provide training, technical assistance, systematic planning, multi-agency coordination and guidance for community teambuilding activities. Funding through this strategy for coordination of local coalitions and other community activities is intended to ensure prevention services are available, accessible and that duplication of efforts is minimized.

f) Environmental:

Environmental strategies represent the other majority half of funding efforts to 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. The primary programs used for this strategy is Communities Mobilizing for Change on Alcohol (CMCA) and Challenging College Alcohol Abuse (CCAA). Other environmental strategies implemented throughout the year include compliance checks for alcohol and tobacco, sobriety checkpoints and party patrols. In support of the State's social norms campaign to prevent underage drinking, the prevention system continues to focus on preventing the sale and use of alcoholic beverages products to minors. This includes implementation of social host ordinances at the local level, regular provision of Responsible Beverage Server Training (RBST) and Training for Intervention Procedures (TIPS). Specific program activities include: revision of student codes of conduct to support healthy life choices; policy changes that encourage positive behavior among the athletic community; youth leadership training to

develop team unity; and student athlete, coach, parent, and community education on the impact of life choices and how to make healthier ones.

3. Does your state have a process in place to ensure that SUPTRS BG dollars are used only to fund primary prevention services not funded through other means? (●) Yes ( ) No

a) Yes (if so, please describe)

DBH updates and provides annual budgetary guidance for use of SUPTRS BG dollars through a number of methods. The first has been to ensure the language within our State to RBHA contract is consistent with the federal register and SUPTRS BG application instructions. Thus, it is a standard contractual requirement that SUPTRS BG 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 SUPTRS BG dollars for prevention. The programmatic review is required for all community coalitions funded by the SUPTRS BG and is conducted annually in partnership with Regional Prevention Coordinators.

Narratve Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. 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 primary 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 SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must serve both the general population and sub-groups that are at high risk for substance use. 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, misuse and substance use disorders 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;
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6. ***Environmental strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the use 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 serve 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 primary prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in WebBGAS

Please attached Nebraska Substance Abuse Prevention Block Grant Evaluation Report FY24.

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- **a)** ☑ Establishes methods for monitoring progress towards outcomes, such as prioritized benchmarks
- **b)** ☑ Includes evaluation information from sub-recipients
- **c)** ☑ Includes National Outcome Measurement (NOMs) requirements
- **d)** ☑ Establishes a process for providing timely evaluation information to stakeholders
- **e)** ☑ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- **f)** ☐ Other (please describe):
- **g)** ☐ Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SUPTRS BG funded prevention services:

- **a)** ☑ Numbers served
- **b)** ☑ Implementation fidelity
- **c)** ☑ Participant satisfaction
- **d)** ☑ Number of evidence based programs/practices/policies implemented
- **e)** ☑ Attendance
- **f)** ☑ Demographic information
- **g)** ☐ Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SUPTRS BG funded prevention services:

- **a)** ☑ 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** ☐ Heavy alcohol use
- **c)** ☑ Binge alcohol use
- **d)** ☑ Perception of harm
- **e)** ☑ Disapproval of use
- **f)** ☑ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- **g)** ☑ Other (please describe):

Perception of peer use (primarily used for social norming).

Footnotes:

Environmental Factors and Plan

6. 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.

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The Nebraska Continuum of Care Manual (COC) describes services developed to provide an array of services for individuals according to need. The COC Manual is incorporated by reference in contracts. A list of contracted services is reported below. Also provided is a link to the Nebraska Behavioral Health System Service Definitions, known as the Continuum of Care manual: https://dhhs.ne.gov/Behavioral%20Health%20Documents/Continuum%20of%20Care%20Manual.pdf

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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 Psychotherapy ..... No 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.** No YES
Dual Residential** ..... YES YES
Halfway House** ..... No YES
Inpatient Post Commitment Treatment Days ^^ .. YES YES
Intermediate Residential** ..... YES 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** .....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
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 use prevention and SUD treatment services	● Yes	○ No
h)	Medical and dental services	○ Yes	● No
i)	Recovery 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-occuring 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 like Assertive Community Treatment, Community Support, Youth Transition, Professional Partner Program, Peer Support, and Intensive Community Services. Services focus on identifying needs that may contribute to illness or impact recovery, as such, a biopsychosocial evaluation and treatment and/or support plan addressing identified 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 services. Service definitions delineate requirements to coordinate care with other providers, particularly healthcare providers.
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The link to Nebraska Behavioral Health System Service Definitions is: https://dhhs.ne.gov/Behavioral%20Health%20Documents/Continuum%20of%20Care%20Manual.pdf

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

DBH provides a continuum of crisis services intended to reduce hospitalization and the number of hospital stays. Crisis services include crisis stabilization, 988 Crisis Line, Family Help Line, Hospital Diversion, Intensive Community Service and mobile crisis response services. These services assist in stabilizing crisis situations and assist with linkage to other services as needed. Services are intended to provide appropriate care in the least restrictive setting. Outpatient services serve as a viable alternative to hospitalization. Case management services aid in reducing hospital readmissions. DBH, in collaboration with Regional Behavioral Health (RBHA) Emergency Coordinators, work with the State's Inpatient Psychiatric facility to transition persons with complex needs to appropriate community settings.

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Emergency Protective Custody (EPC) holds are tracked and reviewed monthly with Emergency Coordinators across the state. The DBH identified performance measures to drive improved emergency system services and reduce hospital admissions and inpatient length of stay. Continued efforts with community providers and inpatient care providers (community based and state hospital) to implement process improvement activities and utilize the Centralized Data System (CDS) 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. Using CDS Dashboards, the DBH and Regional Behavioral Health Authorities (RBHAs) monitor EPC holds and focus on diversion where possible.

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The DBH conducts Mental Health Board training with individuals serving on Mental Health Boards to promote consistent application of clinical criteria when determining if an individual needs committed for outpatient or inpatient care.

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The DBH works with Regional Emergency Coordinators to identify individuals with frequent readmissions to service and shorter community tenure. After identifying individuals, specific coordination with the RBHA and network providers begins to assist in establishing appropriate service referrals and crisis planning to support the individual in the community. Annual Regional Governing Board presentations and quarterly Regional Data calls review key metrics by RBHA, allowing for targeted problem solving and planning. Metrics include EPCs, diversion rates, community tenure, and provider information.

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The DBH continues to prioritize access to medication management after discharge from inpatient care (IP), thereby addressing a key factor in preempting hospital readmission. It is expected that improving access to medication management after IP discharge will positively impact readmission rates.

5. Please indicate areas of technical assistance needs related to this section.

None at this time.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

1. In order to complete column B of the table, please use the most recent federal prevalence estimate from the National Survey on Drug Use and Health 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

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	80,510	9,722
2.Children with SED	14,992	1,271

2. 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.

Sources:
Prevalence data: URS Tables 2023 (last updated 2/13/2025).
Incidence data: URS Tables 2024 (last updated 7/25, 2025).

3. Please indicate areas of technical assistance needs related to this section.

None at this time.

Criterion 3: Children's Services

Provides for a system of integrated services for children to receive care for their multiple needs.

Criterion 3

1. Does your state integrate the following services into a comprehensive system of care?[1]

a)	Social Services	● Yes	○ No
b)	Educational services, including services provided under IDEA	● Yes	○ No
c)	Juvenile justice services	● Yes	○ No
d)	Substance use prevention and SUD treatment services	● Yes	○ No
e)	Health and mental health services	● Yes	○ No
f)	Establishes defined geographic area for the provision of services of such systems	● Yes	○ No

2. Please indicate areas of technical assistance needs related to this section.

None at this time.

[1] *A system of care is a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.*

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 tailored services to rural population with SMI/SED. See the federal **Rural Behavioral Health** page for program resources.

The DHHS Division of Behavioral Health (DBH) provides community-based services to individuals with mental health and/or substance use disorders living in rural areas, which geographically represents over 99% of Nebraska. As of July 1, 2024, the U.S. Census estimated that Nebraska's total population was 2,005,465. Nebraska has 530 incorporated places, of which 90% of these communities having fewer than 3,000 people. There are 383 (72%) of Nebraska communities that have a population between 100-800 .

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Nebraska is a geographically large area with 99.3% of its land area classified as rural based on population size in 2022, according to the U.S. Census Bureau. In 2020, the National Center for Frontier Communities, using the state Office of Rural Health definition of "frontier," classified 12 of Nebraska's 93 counties as frontier with populations less than 1000. A HRSA November 2024 update on Nebraska counties designated as a mental health professional shortage area reported that 88 of 93 counties continue to meet the federal criteria as federal mental health professional shortage areas. DBH directs mental health funding to programs supporting residents living in all 93 counties.

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A tool that individuals across the state can utilize to identify and locate the behavioral health services nearest to their home is through the Network of Care (NOC) website. DBH contracts for the NOC, an online resource, with information about treatment, resources and diagnoses, and wellness recovery action plans. DBH completed an update to the NOC in 2024. The URL for the NOC website is:
https://portal.networkofcare.org/NebraskaBehavioralHealth

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Behavioral health services funded through the CMHSBG and the SUPTRS BG 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, and individuals, families, and communities are important components in systems of care surrounding everyone 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 individuals released from correctional facilities are connected with services to meet their needs. The DBH works with NDE-VR to provide Supported Employment for individuals with serious mental illness and substance use disorders.

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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. Access to this program is gained by calling the Nebraska Rural Response Hotline. The program is formally named Counseling, Outreach and Mental Health Therapy (COMHT) Program. 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.

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The Nebraska Director of Behavioral Health is a member of the Rural Health Advisory Commission and serves as a consultant and advocate for behavioral health issues in rural areas.

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Telehealth is an increasingly important method of alternative service delivery to rural areas. Although it was reimbursable before the pandemic, telehealth use increased during pandemic restrictions and provided a tremendous benefit for consumers traveling significant distances to access care. DBH began collecting method of service delivery data in January 2021. Data from SFY2023 identified that delivery of services via remote health options (telehealth and telephone) accounted for 29.3% of utilization overall (20.2% via telehealth only, 4.3% via telephone only, and 4.8% in part or combined with other delivery methods). Data from SFY2025 indicate that delivery of services via remote health options (telehealth and telephone) accounted for 19.3% of utilization overall (14.1% via telehealth only, 1.9 via telephone only, and 3.3% in part or combined with other delivery methods). DBH will continue to capture and analyze the data and trend the information.

b. Describe your state's tailored services to people with SMI/SED experiencing homelessness. See the federal **Homeless Programs and Resources** for program resources[1]

Persons who are experiencing homeless and while also living with 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 providers in areas with the highest rates of homelessness. Providers prioritize outreach and case management services to address individuals immediate needs, while also assisting consumers in developing self-sufficiency through referrals and attainment of services. In addition to PATH program services, the Nebraska Homeless Assistance Program (NHAP), located within the DHHS Division of Public Health, supports a statewide network of shelters, supportive housing, and service providers. These providers plan for, and provide emergency, transitional, and permanent housing resources. They also provide resources to address the needs of people experiencing homelessness to 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

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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 to support transition to safe and affordable permanent housing by providing rental and utility assistance to individuals who are either homeless or at risk of homeless, while also providing treatment or support services to individuals in need. DBH supports recovery housing, such as Oxford Houses, which provide access to housing for persons in recovery who might otherwise be homeless.

c. Describe your state's tailored services to the older adult population with SMI. See the federal **Resources for Older Adults** webpage for resources[2]

The Nebraska Care Management Program was created through a legislative mandate in 1987. It established a statewide system of care management units through the Area Agencies on Aging. Care managers assist older persons with functional disabilities, physical and mental, and their families. Care managers assist individuals in selecting and obtaining various services that allow them to remain in a residence of their choosing. Counseling Services provides information and advice for older individuals regarding public and private insurance, public benefits, lifestyle changes, legal matters and more. 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 aims to address a diagnosed mental health condition.

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DBH staff work with system partners on training and outreach to nursing facilities and assisted living facilities serving older adults to better identify, screen, and respond to behavioral health needs. The Pre-Admission Screening and Resident Review (PASRR) functionality resides within DBH to ensure individuals appropriately meet the nursing facility level of care, and if needed, access to specialized behavioral health is provided.

d. Please indicate areas of technical assistance needs related to this section.

None at this.

[1] **https://www.samhsa.gov/homelessness-programs-resources**

[2] **https://www.samhsa.gov/resources-serving-older-adults**

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

1. 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 less resourced 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 Division of Behavioral Health (DBH), in collaboration with the University of Nebraska Public Policy Center, hosts and provides a training infrastructure system for regular trainings to strengthen the knowledge base and skill set of providers including the peer workforce. 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. The Office of Consumer Affairs (OCA) within the DBH, manages aspects of peer workforce training and the certification of the peer workforce.

.

Training provided through subawards to Regional Behavioral Health Authorities (RBHA) is monitored by the DBH to ensure it meets the needs of consumers, providers, and the funding requirements. Trainings provided by the RBHAs are readily located on their websites and include topics such as suicide prevention, Mental Health First Aid, Compassion Fatigue, Motivational Interviewing, and Dialectical Behavior Therapy.

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The DHHS website has online training on the Nebraska Mental Health Commitment Act Reference Manual to ensure compliance with statute and that the Mental Health Commitment Boards are current on process, consumer rights, and technical requirements. This training is required every four years for board members.

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In May 2024, DBH co-sponsored the 2024 Nebraska Juvenile Justice Association Conference. Over 350 juvenile justice professionals across prevention, education, juvenile justice, and treatment systems received training on topics aimed at improving services and outcomes for youth involved in the justice system.

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In October 2024, DBH, in collaboration with SAMHSA Region 7 (Iowa, Missouri, Kansas, Nebraska) conducted a Peer Support Summit in Kansas City, Kansas. Participant Peer Support Specialists and those working with Peer Support Specialists attending the two-day conference received training on topics including but not limited to: Trauma 'Care, Youth Peer Support, Addiction Psychology, Naloxone Education, and more. There were 250 participants at the 2024 conference which was the first year for the event

.

The Division of Behavioral Health (DBH) ensures block grant funds and state dollars are used in accordance with SAMHSA's expectations that the FFY2026-2027 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.

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DBH regulations define financial eligibility criteria for consumers seeking care. Within these regulations (NAC 206, Chapter 5.002.05), 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. Data is collected through the Nebraska Prevention Information and Reporting system (NPIRS) database. Trainings for suicide prevention, interventions and post-

intervention is coordinated by contracts with RBHA for Prevention Coordination and subsequent contracts with community coalitions.

.

Each service provider funded through the DBH directly, or through a RBHA, is required to submit client demographic, service and encounter data to the DBH Centralized Data System (CDS) 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 an environment that fosters improvement; an environment 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
• Service 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 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 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. RBHAs are statutorily required to submit annual Regional Budget Plans. The Plan demonstrates a comprehensive array of mental health and substance use disorder services with sufficient capacity based on a comprehensive needs assessment/strategic plan, fiscal, and utilization data. Budget Plans are submitted to the DBH as outlined in annual Regional Budget Plan Guidelines. Within these guidelines, federal program requirements are listed, including the populations to be served, allowable and unallowable expenditures, and audit requirements. The guidelines also include block grant goals as specified by SAMHSA. The guidelines and budget plans are incorporated into the subsequent subawards issued by the DBH. The RBHAs then incorporate the same terms and requirements into awards for subrecipients. This is verified annually during Network Compliance monitoring which DBH reviews and verifies compliance with contractual requirements.
.
DBH and the RBHAs share responsibility to monitor, review, and perform programmatic, administrative, and fiscal accountability and oversight functions regularly with subcontractors. If a RBHA is a direct provider of services, DBH performs all oversight functions. DBH is statutorily charged with administrative oversight and accountability of the public behavioral health system.
.
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 a RBHA, and include:
1. Services Purchased Verifications (unit/fiscal - ensures that services billed were provided and verified via client file review, and that expenditures billed were allowable and reasonable)
2. Program Fidelity Reviews (verifies adherence to service, statutory, and regulatory requirements by 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)
.
The DBH completes an annual Network Compliance audit of RBHAs. The Nebraska Department of Health and Human Services (NDHHS) Internal Audit Section reviews Single Audit Act reports to identify any areas of non-compliance. The DBH staff contacts the recipient to follow-up on any areas of non-compliance identified and solicits corrective action plans to be accepted, corrected, or modified by NDHHS. A RBHA is charged to conduct a similar review and follow-up with any entity they award federal dollars.

Telehealth is a mode of service delivery that has been used in clinical settings for over 60 years and empirically studied for just over 20 years. Telehealth is not an intervention itself, but rather a mode of delivering services. This mode of service delivery increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across diverse behavioral health and primary care settings. Practitioners can offer telehealth through synchronous and asynchronous methods. A priority topic is increasing access to treatment for SMI and SUD using telehealth modalities. Telehealth is the use of telecommunication technologies and electronic information to provide care and facilitate client-provider interactions. Practitioners can use telehealth with a hybrid approach for increased flexibility. For instance, a client can receive both in-person and telehealth visits throughout their treatment process depending on their needs and preferences. Telehealth methods can be implemented during public health emergencies (e.g., pandemics, infectious disease outbreaks, wildfires, flooding, tornadoes, hurricanes) to extend networks of providers (e.g., tapping into out-of-state providers to increase capacity). They can also expand capacity to provide direct client care when in-person, face-to-face interactions are not possible due to geographic barriers or a lack of providers or treatments in a given area. However, implementation of telehealth methods should not be reserved for emergencies or to serve as a bridge between providers and rural areas. Telehealth can be integrated into an organization's standard practices, providing low-barrier pathways for clients and providers to connect to and assess treatment needs, create treatment plans, initiate treatment, and provide long-term continuity of care. States are encouraged to access the federal resource guide **Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders.**

2. Describe your state's current telehealth capabilities, how your state uses telehealth modalities to treat individuals with SMI/SED,

and any plans/initiatives to expand its use.

During the COVID-19 pandemic, Nebraska expanded telehealth access and use for consumers seeking community-based MH and SUD services. Telehealth access reduced barriers and improved access to care, which promoted treatment and recovery and maintained patient and provider health and safety. Since 2023, service utilization has moved back towards pre-COVID levels for primarily face-to-face delivery (traditional) at 81% of services provided in SFY25, compared to 70.7% in SFH23. DBH has 17 MH and 7 SUD services available via telehealth. Examples include: crisis response services, mental health assessments, outpatient psychotherapy, community support, peer support, supported employment, substance use assessments, and outpatient opioid treatment programming. The services not eligible for telehealth expansion included hospital-based and residential treatment. DBH is evaluating telehealth trended data for any future revisions necessary to support and expand utilization. Data from SFY2023 identified that delivery of services via remote health options (telehealth and telephone) accounted for 29.3% of utilization overall (20.2% via telehealth only, 4.3% via telephone only, and 4.8% in part or combined with other delivery methods). Data from SFY2025 indicate that delivery of services via remote health options (telehealth and telephone) accounted for 19.3% of utilization overall (14.1% via telehealth only, 1.9 via telephone only, and 3.3% in part or combined with other delivery methods).

3. Please indicate areas of technical assistance needs related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

7. Substance Use Disorder Treatment – Required for SUPTRS BG

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 (with medications for addiction treatment included in v-x):

i)	Screening	◉ Yes	○ No
ii)	Education	◉ Yes	○ No
iii)	Brief intervention	◉ Yes	○ No
iv)	Assessment	◉ Yes	○ No
v)	Withdrawal Management (inpatient/residential)	◉ Yes	○ No
vi)	Outpatient	◉ Yes	○ No
vii)	Intensive outpatient	◉ Yes	○ No
viii)	Inpatient/residential	◉ Yes	○ No
ix)	Aftercare/Continuing Care	◉ Yes	○ No
x)	Recovery support	◉ Yes	○ No

b) Services for special populations:

i)	Prioritized services for veterans?	○ Yes	◉ No
ii)	Adolescents?	◉ Yes	○ No
iii)	Older Adults?	◉ Yes	○ No

Criterion 2

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. Does your state 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.

Since July 2017, the DHHS Division of Behavioral Health (DBH) 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. Compliance with data entry, accuracy and program adherence is addressed through contact management calls, regional dashboard and network management sessions.

.

The DBH continues to work with the Regional Behavioral Health Authorities (RBHAs) providing guidance on expectations for PWWDC, providing information and annually collecting information on trainings on this topic done by RBHAs. The RBHAs conduct annual audits of providers to ensure compliance to contractual standards for activities and services for PWWDC. Any issues identified are remediated as soon as possible, with corrective action plans developed for violations of contract or quality care standards. The DBH completes an annual network compliance audit as oversight.

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Previously, the DBH has partnered with the University of Nebraska nursing students, who have assisted in monitoring program compliance with activities that also function as quality assurance learning tools for the students while monitoring PWWDC standards.

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) Monitoring requirements as outlined in the authorizing **statute** and implementing **regulation**? (●) 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 activites and services for PWID. 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.

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 insertion in the RBHA to Network Provider contract.

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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 year, 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.

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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.

.

Since 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, the online capacity tracking provides 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.

.

DBH completes annual Network Compliance to ensure adherence by the RBHA to contractual requirements.

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 DHHS Division of Behavioral Health (DBH).

.

These processes are achieved through the propagation of the annual Regional Budget Plan Guidelines and State to Regional Behavioral Health Authority (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 insertion 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.

.

The DBH Program Fidelity Review process monitors program plans and services delivered to ensure consistence and conformance 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 annually for those agencies who receive SUPTRS BG 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 such 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

Hypodermic Needle Prohibition

1. Does your state have in place an agreement to ensure that SUPTRS BG funds are NOT expended to provide individuals with hypodermic needles or syringes for the purpose of injecting illicit substances **(42 U.S.C.§ 300x-31(a)(1)(F))**? ● Yes ○ No

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? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Workforce development efforts to expand service access? (●) Yes ( ) No

b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services? (●) Yes ( ) No

c) Establish a peer recovery support network to assist in filling the gaps? (●) Yes ( ) No

d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, persons experiencing homelessness)? (●) Yes ( ) No

e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, such as primary healthcare, public health, VA, and community organizations? (●) Yes ( ) No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person -centered care? (●) Yes ( ) No

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 (●) Yes ( ) No

b) Establish a program to provide trauma-informed care (●) Yes ( ) No

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 system, adult criminal justice system, and education. (●) Yes ( ) No

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**)? (●) Yes ( ) No

2. Does your state provide any of the following:

a) Notice to Program Beneficiaries? ( ) Yes (●) No

b) An organized referral system to identify alternative providers? ( ) Yes (●) No

c) A system to maintain a list of referrals made by religious organizations? (●) Yes ( ) No

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? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Review and update of screening and assessment instruments? ( ) Yes (●) No

b) Review of current levels of care to determine changes or additions? (●) Yes ( ) No

c) Identify workforce needs to expand service capabilities? (●) Yes ( ) No

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.

a) Please provide an estimate of the number of Block Grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

Since July 1, 2013 the Division of Behavioral Health (DBH) has followed SAMHSA program policy on using private accreditation bodies to meet the Independent Peer Review requirement under both the MHBG and SABG. There is an expectation of SABG and MHBG fund recipients to have National Accreditation through 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 (Title 206, Chapter 4, section 001.(C)).

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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)

Council on Accreditation

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

If the answer is No to any of the above, please explain the reason.

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[1] (TTCs)?

a) Prevention TTC? (●) Yes ( ) No

b) SMI Adviser (●) Yes ( ) No

c) Addiction TTC? (●) Yes ( ) No

d) State Opioid Response Network? (●) Yes ( ) No

e) Strategic Prevention Technical Assistance Center (SPTAC) (●) Yes ( ) No

Waivers

*Upon the request of a state, the Secretary may waive the requirements of all or part of the sections **42 U.S.C.§ 300x-22(b)**,**300x-23**,**300x-24**, and **300x-28** (**42 U.S.C.§ 300x-32(e)**).*

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations regarding women (300x-22(b)) (●) Yes ( ) No

2. Is your state considering requesting a waiver of any requirements related to:

a) Intravenous substance use (300x-23) ○ Yes ◉ No

3. Is Your State Considering Requesting a Waiver of any Requirements Related to Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus (300x-24)

a) Tuberculosis ○ Yes ◉ No

b) Early Intervention Services Regarding HIV ○ Yes ◉ No

4. Is Your State Considering Requesting a Waiver of any Requirements Related to Additional Agreements (**42 U.S.C. § 300x-28**)

a) Improvement of Process for Appropriate Referrals for Treatment ○ Yes ◉ No

b) Professional Development ○ Yes ◉ No

c) Coordination of Various Activities and Services ○ Yes ◉ No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

1. NDHHS Division of Behavioral Health Rules & Regulations – Title 206 Behavioral Health Services public access via URL: http://dhhs.ne.gov/Pages/Title-206.aspx

2. NDHHS Division of Public Health – Title 172 Professional And Occupational Licensure public access via URL: https://dhhs.ne.gov/Pages/Title-172.aspx

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[1] **https://www.samhsa.gov/technology-transfer-centers-ttc-program**

Footnotes:

1. Criterion 4,5&6 - Section: Early Intervention Services for HIV (for "Designated States" Only): Nebraska is not a Designated State and is excluded from responses to the questions in this section.

Environmental Factors and Plan

8. Uniform Reporting System and Mental Health Client-Level Data (MH-CLD)/Mental Health Treatment Episode Data Set (MH-TEDS) – Required for MHBG

Narrative Question

Health surveillance is critical to the federal government's ability to develop new models of care to address substance use and mental illness. Health surveillance data provides decision makers, researchers, and the public with enhanced information about the extent of substance use and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. Title XIX, Part B, Subpart III of the Public Health Services Act **(42 U.S.C. §300x-52(a))**, mandates the Secretary of the Department of Health and Human Services to assess the extent to which states and jurisdictions have implemented the state plan for the preceding fiscal year. The annual report aims to provide information aiding the Secretary in this determination.

42 U.S.C. §300x-53(a) requires states and jurisdictions to provide any data required by the Secretary and cooperate with the Secretary in the development of uniform criteria for data collection. Data collected annually from the 59 MHBG grantees is done through the Uniform Reporting System (URS), Mental Health Client-Level Data (MH-CLD), and Mental Health Treatment Episode Data Set (MH-TEDS) as part of the MHBG Implementation Report. The URS is an initiative to utilize data in decision support and planning in public mental health systems, fostering program accountability. It encompasses 23 data tables collected from states and territories, comprising sociodemographic client characteristics, outcomes of care, utilization of evidence-based practices, client assessment of care, Medicaid funding status, living situation, employment status, crisis response services, readmission to psychiatric hospitals, as well as expenditures data. Currently, data are collected through a standardized Excel data reporting template. The MHBG program uses the URS, which includes the National Outcome Measures (NOMS), offering data on service utilization and outcomes. These data are aggregated by individual states and jurisdictions.

In addition to the aggregate URS data, Mental Health Client-Level Data (MH-CLD) are currently collected. SMHAs are state entities with the primary responsibility for reporting data in accordance with the reporting terms and conditions of the Behavioral Health Services Information System (BHSIS) Agreements funded by the federal government. The BHSIS Agreement stipulates that SMHAs submit data in compliance with the Community Mental Health Services Block Grant (MHBG) reporting requirements. The MH-CLD is a compilation of demographic, clinical attributes, and outcomes that are routinely collected by the SMHAs in monitoring individuals receiving mental health services at the client-level from programs funded or provided by the SMHA.

MH-TEDS is focused on treatment events, such as admissions and discharges from service centers. Admission and discharge records can be linked to track treatment episodes and the treatment services received by individuals. Thus, with MH-TEDS, both the individual client and the treatment episode can serve as a unit of analysis. In contrast, with MH-CLD, the client is the sole unit of analysis. The same set of mental health disorders for National Outcome Measures (NOMs) enumerated under MH-CLD is also supported by MH-TEDS. Thus, while both MH-TEDS and MH-CLD collect similar client-level data, the collection method differs.

Please note: *Efforts are underway to standardize the client level data collection by requiring states to submit client-level data through the MH-CLD system. Currently, over three-quarters of states participate in MH-CLD reporting. Starting in Fiscal Year 2028, MH-CLD reporting will be mandatory for all states. States that currently submit data through MH-TEDS are encouraged to begin transitioning their systems now and may request technical assistance to support this transition process*

This effort reflects the federal commitment to improving data quality and accessibility within the mental health field, facilitating more comprehensive and accurate analyses of mental health service provision, outcomes, and trends. This unified reporting system would promote efficiency in data collection and reporting, enhancing the reliability and usefulness of mental health data for policymakers, researchers, and service providers.

Please respond to the following items:

1. Briefly describe the SMHA 's data collection and reporting system and what level of data are reported currently (e.g., at the client, program, provider, and/or other levels).

Nebraska's State Mental Health Authority (SMHA) is the Division of Behavioral Health (DBH), which is one of the divisions of the Department of Health and Human Services (DHHS). As of May 2016, DBH has had a customized Centralized Data System (CDS) in which providers enter client-level data. Providers have two options for data entry: directly into the system via the web-based platform or via large data transfers from Electronic Health Record Systems (EHRS). Data in the CDS are stored in a warehouse that is the property of the State of Nebraska and protected with security measures to ensure above and beyond compliance with Health Insurance Portability & Accountability (HIPAA) expectations. The primary purpose of the CDS is to track and report data that

describe treatment/services expressly funded through DBH. The architecture of the CDS was designed to be able to fulfill data requirements for Federal and State reporting and to be agile enough to accommodate changing needs over time. However, the CDS was not designed to track funding for behavioral health services through Medicaid or any other payer source.

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Nebraska also has a fiscally focused system, the Electronic Billing System (EBS), which integrates contract and billing information with CDS. All contracts between DBH, RBHAs, and Providers are entered into and managed within the EBS. This adds another layer of data security as Providers are only able to access or enter client-level data based on contract specifications transmitted from EBS to CDS. The EBS avails Providers a unified platform to enter financial information via the CDS which automatically populates relevant client-level identifiers by service which reduces burden and margins of error as Providers enter billable units. Additionally, providers and Regional Behavioral Health Authorities (RBHA) have direct access to EBS to enter expense-based and miscellaneous financial data.

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The CDS and EBS each have two sites: a Test Site and a Production Site (or Live Site). Both sites use the same credentialing process. Data from the CDS are used to upload to SAMHSA's Behavioral Health Services Information System (BHSIS) as Treatment Episode Data Sets (TEDS). DBH submits TEDS files on a quarterly basis and engages in the Data Quality Profile (DQP) revisions and attestations. Data in CDS and EBS are the primary sources for DBH to complete the annual Uniform Reporting System (URS) data tables and Substance Use Block Grant files.

.

For non-treatment services/activities, DBH has a custom-built system, the Nebraska Prevention Information Reporting System (NPIRS). This is an internet-based application designed to collect and report prevention programmatic activity. NPIRS collects community, regional and state level data from recipients of federal and state prevention funds administered by DHHS and DBH. This system is intended to support Nebraska’s community coalitions and RBHAs that receive funding through the Strategic Prevention Framework –Partnership for Success (PFS), Substance Abuse Prevention and Treatment Block Grant (SAPTBG), and/or State Opioid Response grants (SOR). This system captures and stores program-level data, it was not designed to collect and does not store client-level data. All users must register with the State of Nebraska Enterprise Registration System. To keep up with changing needs, there are periodic enhancement requests made to the system to both reduce the burden of reporting and to improve the quality of data.

2. Is the SMHA 's current data collection and reporting system specific to mental health services or it is part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

Centralized Data System (CDS): Client-Level data; Electronic Billing System (EBS): Fiscal data; Nebraska Prevention Information Reporting System (NPIRS): Prevention Program-Level data.

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The current data collection and reporting systems utilized by the Division of Behavioral Health (DBH) were all custom designed for data collection and reporting specific to Behavioral Health (mental health, substance use, and prevention). The CDS and EBS were not designed to track funding for behavioral health services through Medicaid or any other payer source. NPIRS tracks data associated with all prevention activities and programs sponsored and or managed by DBH, therefore it does contain data for activities/programs funded with Federal Block Grant dollars in addition to other funding sources.

3. What is the current capacity of the SMHA in linking data with other state agencies/entities (e.g., Medicaid, criminal/juvenile justice, public health, hospitals, employment, school boards, education, etc.)?

Centralized Data System (CDS): Client-Level data; Electronic Billing System (EBS): Fiscal data; Nebraska Prevention Information Reporting System (NPIRS): Prevention Program-Level data.

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Linking data in the CDS and EBS (client-level or service-level) to data from other state or government operated systems is possible but it would necessitate extracts and merges based on common key Personally Identifiable Information (PII) (sex, name, social security identification, date of birth) or using common data fields for higher level merge or aggregation (service name, service type, provider, region) that would be captured across the systems. Data in the NPIRS are program-level or activity based and thus not as easily linked to data captured and stored in systems managed by other state or government entities.

4. Briefly describe the SMHA 's ability to report evidence-based practices (EBPs) including Early Serious Mental Illness (ESMI and Behavioral Health Crisis Services (BHCS) outcome data at the client-level.

The Division of Behavioral Health (DBH), through continued consultations and partnership with Medicaid, has developed a Continuum of Care Manual that describes and provides specifications for services across the Behavioral Health services array. Fidelity and fiscal audits are scheduled and conducted by DBH’s Network and Clinical teams.

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To specifically address Early Serious Mental Illness (ESMI), Nebraska currently has two regionally designated entities (urban and rural) providing First Episode Psychosis services in the form of Coordinated Specialty Care (CSC), which operates on Raise NAVIGATE model.

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For Behavioral Health Crisis Services (BHCS) outcome data at the client-level, the CDS architecture allows for client-level data across crisis and emergency services. Given the urgency and divergent circumstances associated with these services, it is acknowledged that all data points sought might not be available to providers at the time the service is delivered, therefore the array of required fields for successful admission and discharge into the system is more relaxed than it is for treatment services. The exception is Mobile Crisis Response, in which data fields are required and there is a component for follow-up within 72 hours, at which time the Provider is expected to update “required fields” and complete a Crisis Response Questionnaire in the CDS that captures client-

level outcome data. For call or text driven crisis services like 24-Hour Crisis Line and the 988 Lifeline, the most reliable outcome data are secondary, such as “referral source” data collected in the CDS for other subsequently accepted services such as Mobile Crisis Response.

5. Briefly describe the limitations of the SMHA 's existing data system.

The current limitations of the Centralized Data System (CDS) are mostly hinged upon data entry: providers enter the data into the CDS; many data fields are based on self-reported information; and Providers with EHRs limit data upload to required fields. For authorized services, all associated data are manual (direct input from the web-based platform int the system and not via automated EHR data upload): authorizations (system approved or appealed), admissions, discharges, updates, questionnaires, reviews, and attestations. Another major limitation is that the system was designed to collect and manage data for DBH-Funded services and as such, the data represents only a small portion of the statewide utilization of Behavioral Health services.

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The current limitations of the Nebraska Prevention Information Reporting System (NPIRS) are mostly hinged upon data architecture: NPIRS captures activity/program-level data which is a limitation for any form of client-level data reporting. Additionally, there are some aspects of the system that collect narrative data which present some levels of difficulty to aggregate or analyze for reporting in the absence of qualitative software.

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One of the biggest limitations of the Electronic Billing System (EBS) is that there is not a unified platform or connectivity to the State’s fiscal system or procurement system.

6. What strategies are being employed by the SMHA to enhance data quality?

From a system perspective DBH conducts frequent operational and data quality reviews in addition to continuous maintenance within the systems.

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The Electronic Billing System (EBS) by design is connected with the Centralized Data System (CDS) to minimize duplicative efforts for data entry and billing.

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For CDS, data quality reviews are driven by internal initiatives as well as Data Quality Profiles (DQPs) derived from Treatment Episode Data Sets (TEDS) uploaded to SAMHSA. Some data quality areas that are monitored, tracked, or simply related to National Outcome Measures (NOMS) and Block Grant priorities are presented to Region Behavioral Health Authorities (RBHAs) in monthly and quarterly contract calls that include presentation of the Regional Data Outcomes (RDO) specific to the region and compared to the Statewide aggregate. To draw attention and action to specific areas, the division has developed some key performance issues with region specific targets. On a more granular level, at the monthly Super-User calls, data concerns, training, and guidance on specific areas are presented/discussed with Providers and RBHA partners. At every opportunity, RBHA partners and Providers are reminded of the importance of improving data quality in the CDS by ensuring that each entry is done with attention to and intention for accuracy, completeness, and timeliness.

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CDS end -users who experience difficulties or unexpected issues may call the Help Desk, use the option for Web support found on the login page or use the “Report a Data Issue” button found within the encounter page. Providers and RBHA partners are also encouraged to participate in the testing of system changes and enhancements on the Test Site, and they are strongly encouraged to provide feedback before implementation in Production (live site).

7. Please describe any barriers (staffing, IT infrastructure, legislative, or regulatory policies, funding, etc.) that would limit your state from collecting and reporting data to the federal government.

A not always readily recognized barrier to data collection that is now commonplace in the behavioral health field is staff turnover. This impacts the providers, contract managers, and system supports with the burden of frequent onboarding and training for those who become end-users of the systems. Frequent staff turnover at any level result in loss of institutional knowledge and challenges for employees to “connect the dots” in scenarios that arise in complex systems and analyses for complex reporting. We have been experiencing turnover at all levels and sectors of our behavioral health system.

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Data sharing agreement with Medicaid allows for some additional publicly funded treatment data to be included for some aspects of the reports submitted for Block Grant. Given the limitations of the data structures and data collection within DBH systems, DBH is limited in its capacity to deliver representative state level data.

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Timely continued fiscal and IT support are essential to ensure that the three systems are agile and relevant: Centralized Data System (CDS), Electronic Billing System (EBS), and Nebraska Prevention Information Reporting System (NPIRS. NPIRS is overdue for major system upgrades.

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A fiscal solution is needed to assist providers that utilize Electronic Health Record systems (EHR) to upgrade their platform/field allotment to upload ALL fields collected in the CDS and not be limited to just required fields. This could significantly reduce the percentage of “unknowns” coded into the Treatment Episode Data Set (TEDS).

8. Please indicate areas of technical assistance needs related to this section.

None at this time.

Footnotes:

Environmental Factors and Plan

9. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

There is a mandatory 5 percent set-aside within MHBG allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> *…….to support evidence-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*
>
> *CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to fund some or all of the core crisis care service components, as applicable and appropriate, including the following:*
>
> - *Crisis call centers*
> - *24/7 mobile crisis services*
> - *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*
>
> *STATE FLEXIBILITY: In lieu of expending 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence-based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.*

A crisis response system has 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.The expectation is that states will build on the emerging and growing body of evidence, including guidance developed by the federal government, for effective community-based crisis-intervention 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, stabilization services to support reducing distress, and the promotion of skill development and outcomes, all towards managing costs and better investment of resources.

Several resources exist to help states. These include **Crisis Services: Meeting Needs, Saving Lives**, which consists of the **National Guidelines for Behavioral Health Coordinated System of Crisis Care** as well as an **Advisory: Peer Support Services in Crisis Care** There is also the **National Guidelines for Child and Youth Behavioral Health Crisis Care** which offers best practices, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth, and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by the 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

When individuals experience a crisis related to mental health, substance use, and/or homelessness (due to mental illness or a co-occurring disorder), a no-wrong door comprehensive crisis system should be put in place. Based on the National Guidelines, there are three major components to a comprehensive crisis system, and each must be in place in order for the system to be optimally effective. These three-core structural or programmatic elements are: Crisis Call Center, Mobile Crisis Response Team, and Crisis Receiving and Stabilization Facilities.

Crisis Contact Center. In times of mental health or substance use crisis, 911 is typically called, which results in police or emergency medical services (EMS) dispatch. A crisis call center (which may provide text and chat services as well) provides an alternative. Crisis call centers should be made available statewide, provide real-time access to a live crisis counselor on a 24/7 basis, meet National Suicide Prevention Lifeline operational guidelines, and serve as "Air Traffic Control" to assess, coordinate, and determine the appropriate response to a crisis. In doing so, these centers should integrate and collaborate with existing 911 and 211 centers, as well as other applicable call centers, to ensure access to the appropriate level of crisis response. 211 centers serve as an entry point to crisis services in many states and provide information and referral to callers on where to obtain assistance from local and national social

services, government agencies, and non-profit organizations.

The public has become accustomed to calling 911 for any emergency because it is an easy number to remember, and they receive a quick response. Many of the crisis systems in the United States continue to use 911 for several reasons such as they are still building their crisis systems or because they have no mechanism to fund a call center separate from 911. However, they recognize that the sure way to minimize the involvement of law enforcement in a behavioral health crisis response is to divert calls from 911. There are basically three diversion models in operation at this time: (1) the 911-based system with dispatchers who forward calls to either law enforcement's responder team (law enforcement officer with a behavioral health professional) or to their Crisis Intervention Team (CIT) with law enforcement officers who have received Crisis Intervention Training, including awareness of mental health and substance use disorders, and related symptoms, de-escalation methods, and how to engage and connect people to supportive services; (2) the 911-based system with well-trained 911 dispatchers who triage calls to state or local crisis call centers for individuals who are not a threat to themselves or others; the call centers may then refer appropriate calls to local mobile response teams (MRTs), also called mobile crisis teams (MCTs); and (3) State or local Crisis Contact Centers with well-trained counselors who receive calls directly (without utilizing 911 at all) on their own toll-free numbers.

Mobile Crisis Response Team. Once a behavioral health crisis has been identified and a crisis line has been called, a mobile response may be required if the crisis cannot be resolved by phone alone. Historically, law enforcement has been dispatched to the location of the individual in crisis. But in an effective crisis system, mobile crisis teams, including a licensed clinician, should be dispatched to the location of the individual in crisis, accompanied by Emergency Medical Services (EMS) or police only as warranted. Ideally, peer support professionals would be integrated into this response. Assessment should take place on site, and the individual should be connected to the appropriate level of care, if needed, as deemed by the clinician and response team.

Crisis Receiving and Stabilization Facilities. In a typical response system, EMS or police would transport the individual in crisis either to an ED or to a jail. Crisis Receiving and Stabilization Facilities provide a cost-effective alternative. These facilities should be available to accept individuals by walk-in or drop-off 24/7 and should have a "no wrong door" policy that supports all individuals, including those who need involuntary services. When anyone arrives, including law enforcement or EMS who are dropping off an individual, the hand-off should be "warm" (welcoming), timely and efficient. These facilities provide assessment for, and treatment of mental health and substance use crisis issues, including initiating medications for opioid use disorder (MOUD), and also provide wrap-around services. The multi-disciplinary team, including peers, at the facility can work with the individual to coordinate next steps in care, to help prevent future mental health crises and repeat contacts with the system, including follow-up care.

Currently, the 988 Suicide and Crisis Lifeline (Lifeline) connects with local call centers throughout the United States. Call center staff is comprised of individuals who are trained to utilize best practices in handling behavioral health calls. Local call centers automatically engage in a safety assessment for every call; if an imminent risk exists and cannot be deescalated, they forward the call to either 911 or to a local mobile crisis team for a response. If there is no imminent risk, the call center will work with the individual (or the person calling on their behalf) for as long as needed or, if necessary, dispatch a local MRT.

988 – 3-Digit behavioral health crisis number. The National Suicide Hotline Designation Act (**P.L. 116-172**) provides an opportunity to support the infrastructure, service and long-term funding for community and state 988 response, a national 3-digit behavioral health crisis number that was approved by the Federal Communications Commission in July 2020. In July 2022, the National Suicide Prevention Lifeline transitioned to 988 Suicide & Crisis Lifeline, but the 1-800-273-TALK is still operational and directs calls to the Lifeline network. The 988 transition has supported and expanded the Lifeline network and will continue utilizing the life-saving behavioral health crisis services that the Lifeline and Veterans Crisis Line centers currently provide.

Building Crisis Services Systems. Most communities across the United States have limited, but growing, crisis services, although some have an organized system of services that provide on-demand behavioral health assessment and stabilization services, coordinate and collaborate to divert from jails, minimize the use of EDs, reduce hospital visits, and reduce the involvement of law enforcement. Those that have such systems did not create them overnight, but it involved dedicated individuals, collaboration, considerable planning, and creative methods of blending sources of funding.

1. Briefly describe your state's crisis system. For all regions/areas of your state, include a description of access to crisis contact centers, availability of mobile crisis and behavioral health first responder services, utilization of crisis receiving and stabilization centers.

Nebraska has one crisis call center for 988 which is located at Father Flanagan's Boys' Home (referred to as Boys Town) in Omaha, Nebraska. This call center serves the entire state of Nebraska. DBH contracts with the RBHAs that manage contracts with Mobile Crisis Teams to provide service coverage across all counties for the respective RBHA. Mobile Crisis Teams are activated through 988 Nebraska or if someone calls the provider or a RBHA directly. Mobile Crisis Services are available in all 93 counties in Nebraska. There are some rural areas in Nebraska where crisis response services are delivered via telehealth or over the phone. Various law enforcement agencies across the state have implemented a co-responder model in addition to mobile crisis response being available. There are two Crisis Stabilization Facilities in Nebraska. Planning is happening across

the state to bring up crisis receiving and stabilization centers in all six geographic Regions including CCBHC's across the state. Planning continues toward full implementation of Certified Community Behavioral Health Clinics (CCBHCs) by January 1, 2026. Once operational, CCBHCs will offer 24/7 crisis care, outpatient treatment, and care coordination statewide.

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

*a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.*
*b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the published guidance. This includes coordination, training and community outreach and education activities.*
*c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the published guidelines.*
*d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.*
*e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.*

Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to contact	☐	☐	☐	☐	☐	☑
Someone to respond	☐	☐	☐	☐	☐	☑
Safe place to be	☐	☐	☐	☐	☑	☐

3. Briefly explain your stages of implementation selections here.

Someone to Contact: Crisis Call Capacity. There is 1 call center in Nebraska. The call center has protocols in place to follow-up with callers who meet certain criteria. The vendor had previous experience in providing crisis calls as part of the Suicide Prevention Lifeline. 911 centers in Nebraska generally do not track the number of mental health related calls. As of 2025, Nebraska Public Service Access Points (PSAPs) are required to follow 911-988 connection standards, developed via Joint Protocols Workgroup, which details transfer protocols and training for behavioral health calls. While some PSAPs continue to offer access to mental health professional consultation, this is not yet available across all centers.

.

Someone to Respond: The number of communities that have mobile behavioral health crisis capacity includes 342 fire and rescue departments, 136 fire only departments, and 152 law enforcement agencies in Nebraska. Currently there are three regions/areas who participate in co responder partnerships. Them being Omaha/Region 6 and select law enforcement partnerships in Region 3. Across the state, some mobile crisis teams already include peer support specialists, and many others are actively exploring the addition of peers to enhance crisis response capacity.

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Somewhere to Go: There are approximately 20 Emergency Departments with 4 Emergency Departments that have a specialized behavioral health component in Nebraska. There are 3 Crisis Receiving and Stabilization Centers in Nebraska. With the implementation of the 7 CCBHCs across the state, these numbers will increase.

4. Based on the National Guidelines for Behavioral Health Crisis Care and the **National Guidelines for Child and Youth Behavioral Health Crisis Care**, explain how the state will develop the crisis system.

Regional Call Center - Nebraska has one call center with trained crisis counselors available 24/7 for calls, texts and chats through Boys Town. Boys Town had been the call center for the Suicide Prevention Lifeline in Nebraska since 2005 and meets the National Suicide Prevention Lifeline standards for risk assessment and engagement of individuals at imminent risk of suicide. Boys Town can activate the various mobile crisis response teams when appropriate. Each of the six contracted Regional Behavioral Health Authorities has identified open times for outpatient, assessments, or medication management appointments and this information is made available to the call center.

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Mobile Crisis Team Response - Nebraska has mobile crisis teams in each of the six regions (RBHA) and as such there is coverage available to serve all 93 counties. Please see the narrative in question number 1 for more details regarding Nebraska's Crisis Mobile Team Responses.

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Crisis Receiving and Stabilization Facilities - DBH subawards state and federal funds to six Regional Behavioral Health Authorities. Three Regions currently have Crisis Stabilization Facilities; Regions 3,5 and 6. Service development work is continuing with three other Regions as well as bringing up CCBHCs across the state. Peer run "adult" hospital diversion programs are operational in Lincoln and Omaha. Requests for Information have been released by Regions to develop additional crisis respite types of services including for youth.

5. Other program implementation data that characterizes crisis services system development.

Someone to contact: Crisis Contact Capacity

a. Number of locally based crisis call Centers in state
   i. In the 988 Suicide and Crisis lifeline network: 1
   ii. Not in the suicide lifeline network: 0
b. Number of Crisis Call Centers with follow up protocols in place
   i. In the 988 Suicide and Crisis lifeline network: 1
   ii. Not in the suicide lifeline network: 0
c. Estimated percent of 911 calls that are coded out as BH related: 0

Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the toal number of communities)

a. Independent of public safety first responder structures (police, paramedic, fire): 630
b. Integrated with public safety first responder structures (police, paramedic, fire): 291
c. Number that utilizes peer recovery services as a core component of the model: 2

Safe place to be

a. Number of Emergency Departments: 20
b. Number of Emergency Departments that operate a specialized behavioral health component: 4
c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis): 3

6. Briefly describe the proposed/planned activities utilizing the 5% set aside. If applicable, please describe how the state is leveraging the CCBHC model as a part of crisis response systems, including any role in mobile crisis response and crisis follow-up. As a part of this response, please also describe any state-led coordination between the 988 system and CCBHCs.

The MHBG 5% set aside will be used to support the 988 Call Center. Additionally, funds may be used to support OpenBeds, providing "real-time treatment facility availability, evidence-based therapy offerings, two-way digital provider communication, data aggregation and analytics, and clinical decision support" (Bamboo Health, OpenBeds Overview). The software will allow for crisis response teams, hospitals and local providers to connect people with SMI/SED to services in a more efficient and effective manner.

7. Please indicate areas of technical assistance needs related to this section.

None at this time.

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Footnotes:

1. Question 5.c. Someone to contact: Estimated percent of 911 calls that are coded out as BH related is not available at this time. The 911 centers in Nebraska do not track the number of mental health related calls. The state data shows that the amount of Crisis Response encounters that come from Emergency/Crisis Services as a referral source is 2%. Unfortunately, that data cannot be broken down to 911 calls.
.
In March 2024, a Joint Protocols workgroup was established with the Nebraska 911 Public Service Access Points (PSAPs), to develop protocols to identify appropriate callers experiencing a crisis and to warm transfer those callers to 988. After the Pilot Grant, no new efforts have been implemented to obtain these data metrics.

Environmental Factors and Plan

10. Recovery – Required for MHBG & SUPTRS BG

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality behavioral health care. The expansion in access to; and coverage for, health care drives the promotion of 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 health and substance use disorders.

Recovery is supported through the key components of health (access to quality physical 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 a recovery- guided approach to person-centered care is inclusive of shared decision-making, culturally welcoming and sensitive to social needs of the individual, their family, and communities. Because mental and substance use disorders can be chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management of recovery and personal success over the lifespan.

The following working definition of recovery from mental and/or substance use disorders has stood the test of time:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, there are 10 identified 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 **Working Definition of Recovery.**

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 several federally supported national technical assistance and training centers. States are strongly encouraged to take proactive steps to implement and expand recovery support services and collaborate with existing RCOs and RCCs. Block Grant guidance is also available at the **Recovery Support Services Table**.

Because recovery is based on the involvement of peers/people in recovery, their family members and caregivers, SMHAs and SSAs should engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing organizations and direct resources for enhancing peer, family, and youth networks such as RCOs and RCCs 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 behavioral health treatment system.

1. Does the state support recovery through any of the following:

a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? (●) Yes ( ) No

b) Required peer accreditation or certification? (●) Yes ( ) No

c) Use Block Grant funds for recovery support services? (●) Yes ( ) No

d) Involvement of people with lived experience /peers/family members in planning, implementation, or evaluation of the impact of the state's behavioral health system? (●) Yes ( ) No

2. Does the state measure the impact of your consumer and recovery community outreach activity? (●) Yes ( ) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

DBH promulgated new regulations for the training and certification of peer support (mental health/substance use) in 2021. Service standards, including peer run services, are within the Title 206 Behavioral Health Services Regulations and Service Definitions, Chapter 7 Peer Support. Please see URL: https://rules.nebraska.gov/rules?agencyId=37&titleId=122

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The Continuum of Care Manual includes updated service definitions, guidance on telehealth service provisions, and prevention information. The utilization management guidelines and billing processes have not changed. Please see URL: https://dhhs.ne.gov/Behavioral%20Health%20Documents/Continuum%20of%20Care%20Manual.pdf. One example of a service that utilizes a peer-run model is Hospital Diversion.

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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.

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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.

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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

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For additional information on service delivery, see the Continuum of Care Manual which includes updated service definitions, guidance on telehealth service provision, and prevention information. The URL is: https://dhhs.ne.gov/Behavioral%20Health%20Documents/Continuum%20of%20Care%20Manual.pdf.

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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.

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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.

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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.

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Funding administered through the RBHA's 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, 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.

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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.

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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, and safety.

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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 measurable and timely
- Team Members, both formal and informal
- Safety planning

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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.

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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 continuity, 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 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.

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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.

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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 measurable outcomes to children, youth and families as experienced in the context of everyday living.

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Values: Youth-guided; family-driven; individualized; 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. i.e., RCOs, RCCs, peer-run organizations.

The Nebraska DHHS Division of Behavioral Health (DBH) focus and planning strive to move the system to improve services for individuals with substance use disorders 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 custom adaptations within service delivery.

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The peer support service definition and requirements for training and certification are integrated for mental health and substance use. The curriculum is a trauma-informed model of peer support 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. http://dhhs.ne.gov/Pages/Consumer-Advocacy.aspx

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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 are offered on ethical issues and practical strategies designed to protect clients and practitioners. DBH continues to collaborate on peer workforce development, the role of peers, and curriculum improvements, and it is anticipated that the competency of and the role of peers in the workforce will grow.

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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?

The Office of Consumer Affairs (OCA) plays a significant role in promoting mental health and substance use recovery. The OCA has implemented various initiatives for May's Mental Health Awareness Month and September's Recovery Month, to raise awareness and reduce stigma surrounding these experiences.

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The OCA collaborates with consumer regional specialists and consumer advocates alike to promote awareness, end stigma, share resources, and empowering individuals and families within their own communities.

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The OCA collaborates with the Governor's Office to issue proclamations to promote awareness on recovery and wellness, to get the conversations going about different BH disorders, to normalize the conversations around BH and to help educate Nebraskans on behavioral health disorders while helping to connect people to community-based services.

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Overall, the Office of Consumer Affairs actively engages in activities and events that aim to raise awareness, reduce stigma, and promote recovery in the realm of mental health and substance use.

6. Please indicate areas of technical assistance needs related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

11. Children and Adolescents M/SUD Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG 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 disorder 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.[1] 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.[2] For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3]

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 using substances the age of 18. Of people who started using substances before the age of 18, one in four will develop a substance use disorder compared to one in 25 who started using substances after age 21.[4]

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 use, 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, states are encouraged to designate a point person for children to assist schools in assuring identified children relate to available prevention services and interventions, mental health and/or substance use screening, treatment, and recovery support services.

Since 1993, the federally funded Children's Mental Health Initiative (CMHI) has been used as an approach to build the system of care model 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, states have also received planning and implementation grants for adolescent and transition age youth SUD and MH treatment and infrastructure development. This work has included a focus on formal partnership development across child serving systems and policy change related to 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 functioning of children, youth and young adults in home, school, and community settings. 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.[5]

According to data from the 2017 Report to Congress on systems of care, services reach many children and youth typically underserved by the mental health system.

1. improve emotional and behavioral outcomes for children and youth.
2. enhance family outcomes, such as decreased caregiver stress.
3. decrease suicidal ideation and gestures.
4. expand the availability of effective supports and services; and
5. save money by reducing costs in high-cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

The expectation is that states will build on the well-documented, effective system of care approach. 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:

1. 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);
2. supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education

and employment); and

3. residential services (e.g., therapeutic foster care, crisis stabilization services, and inpatient medical withdrawal management).

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[1]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

[2]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[3]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[4]The National Center on Addiction and Substance use disorder at Columbia University. (June, 2011). Adolescent Substance use disorder: America's #1 Public Health Problem.

[5]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery of children and youth with SED? ◉ Yes ○ No

b) The resilience of children and youth with SED? ◉ Yes ○ No

c) The recovery of children and youth with SUD? ◉ Yes ○ No

d) The resilience of children and youth with SUD? ◉ Yes ○ No

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? ◉ Yes ○ No

b) Health care? ◉ Yes ○ No

c) Juvenile justice? ◉ Yes ○ No

d) Education? ◉ Yes ○ No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? ◉ Yes ○ No

b) Costs? ◉ Yes ○ No

c) Outcomes for children and youth services? ◉ Yes ○ No

4. Does the state provide training in evidence-based:

a) Substance use prevention, SUD treatment and recovery services for children/adolescents, and their families? ◉ Yes ○ No

b) Mental health treatment and recovery services for children/adolescents and their families? ◉ Yes ○ No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? ◉ Yes ○ No

b) for youth in foster care? ◉ Yes ○ No

c) Is the child serving system connected with the Early Serious Mental Illness (ESMI) services? ◉ Yes ○ No

d) Is the state providing trauma informed care? ◉ Yes ○ No

6. Describe how the state provides 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.

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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.

RBHA funding 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 supports not covered by Medicaid are available, ranging from emergency to resiliency-oriented supports to wraparound. System coordination is central to their purpose in each region. Each RBHA has established multi-stakeholder collaborative structures to coordinate efforts in formal functional areas for Consumers (including youth) and Family Involvement, Network Management, Emergency Services System, Prevention Services System, and Youth System of Care (YSC). Each RBHA has a Professional Partner Program (PPP) using a fidelity-based version of the high-fidelity wraparound care coordination model to support services to families who have children with serious emotional disorders.

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Each RBHA Network includes a Youth Systems coordination function, responsible for coordinating 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. Youth Systems Coordinators promote quality improvement by participating in statewide youth system coordination, enhance 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. Over time the DBH and CFS have coordinated services provided and to date both contract to provide FN/FPS. 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 SAs in their catchment area. This enhanced regional alignment is key to continuity, as both RBHAs and SAs have established networks among NeSOC stakeholders in each region.

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In addition, DBH contracts with the Lincoln Medical Education Partnership to make the School Community Intervention and Prevention (SCIP) program available statewide. SCIP provides prevention, education, and early intervention services and works to educate teachers and other school personnel to work on behalf of students and their families. Each school's SCIP team members are also educated on a variety of mental and behavioral health disorders that affect children and adolescents, providing team members with a knowledge-base of various disorders including risk factors, signs and symptoms, and effects. They are given strategies on how to interact and support affected students, and provided with additional resources. SCIP connects participating schools to area behavioral health agencies, providing all students with the opportunity to receive access to professional assistance when needed.

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DHHS DBH received a grant in September of 2016 to expand and continue the Nebraska System of Care. Nebraska refers to this grant as the NeSOC. Partners from across the state are working to implement the elements which were identified through the System of Care strategic plan. The NeSOC is a public/private partnership building on the strengths of our system partners.

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To ensure these goals are met and families are being better served, a baseline data analysis was completed as a starting point. The baseline data for the System of Care, included data from the DHHS Divisions of Medicaid, Behavioral Health, and Children and Family Services/Nebraska Families Collaborative and the Office of Probation.

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Annual analysis continues to measure statewide systemic progress in meeting targeted goals aimed at ensuring youth are supported academically, have access to the least intensive, community based service available to meet their needs and to expand system investment in prevention and early intervention approaches.

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Nebraska 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.

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Additionally the governance structure of the NeSOC was changed to be more encompassing of the larger child and family 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.

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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.

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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. 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.

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The SOC framework developed under the grant also continues to operate today, with ongoing commitment from multiple system partners. 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?

Nebraska is actively advancing a broad range of initiatives to improve access to mental health and substance use services for children and adolescents. The state participates in the HRSA-funded Nebraska Pediatric Mental Healthcare Access Partnership (NEP-MAP), which expands behavioral health consultation and training to primary care providers across all regions, particularly through telehealth. Complementing this is the COPE (Children's Outreach for Provider Education) program, which delivers intensive pediatric mental health training and ongoing consultation for providers managing conditions such as anxiety, depression, and suicidality. Nebraska is also constructing a $114 million Behavioral Health & Wellness Center at Children's Nebraska in Omaha, set to open in January 2026. This facility will include a crisis assessment center and offer a full continuum of mental health care for youth. At the policy level, Nebraska is part of the Zero to Three Infant and Early Childhood Mental Health Financing Policy Project, working to build sustainable infrastructure for early childhood behavioral health services. Additionally, state-supported training initiatives—such as DC:0-5TM training through the Nebraska Resource Project for Vulnerable Young Children—equip the workforce to deliver developmentally appropriate and trauma-informed care to young children. These efforts demonstrate Nebraska's strong and multi-level commitment to strengthening its youth behavioral health system statewide.

8. Please indicate areas of technical assistance needs related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

12. Suicide Prevention – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death nationally, with over 49,000 people dying by suicide in 2022 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance use, painful losses, exposure to violence, economic and financial insecurity, and social isolation. Mental illness and substance use are possible factors in 90 percent of deaths by suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, M/SUD agencies are urged to lead in ways that are suitable to this growing area of concern. M/SUD agencies are encouraged to 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 since the FY2024-2025 Plan was submitted? (●) Yes ( ) No

2. Describe activities intended to reduce incidents of suicide in your state.

A Nebraska Statewide Suicide Prevention Plan was updated and finalized for 2022-2025. In preparing for the statewide suicide prevention plan, Nebraska conducted focus groups, distributed surveys, reviewed history, and leveraged partners' expertise. This plan is a comprehensive document that serves as a roadmap for Nebraska in all aspects of suicide prevention. The statewide suicide prevention plan was developed to ensure that every Nebraskan can access the information they need, find what they are looking for, and implement it in their lives or community.

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Nebraska's 2022-2025 Statewide Suicide Prevention Plan was built on the National Strategy for Suicide Prevention. In addition to the four national strategies, additional strategies were added to enhance and strengthen efforts in Nebraska. These strategies and components include:

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>988 Connection and Implementation

Beginning on July 16, 2022, 988 became the new three-digit dialing code connecting people to the existing Lifeline, where compassionate, accessible care and support is available for anyone experiencing behavioral health-related distress – whether it's thoughts of suicide, a mental health or substance use crisis, or any other kind of emotional distress. The creation of 988 is the first step in building a crisis care continuum that mirrors 911 for physical emergencies. Nebraska is fortunate to have one of more than 200 existing local, independent, and state-funded call centers that house the Lifeline, ensuring a smooth change to 988.

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Text and chat features continue to grow in popularity, particularly among young adults, and are available alongside traditional phone calls. When someone reaches out to 988, they relate to a trained crisis counselor who can help de-escalate the caller, assess the severity of the situation, assist in creating a safety plan, and make a connection with additional services or resources as needed.

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• Objective 1: Utilize the stateside 988 marketing and communications plan to increase awareness of 988 and suicide prevention.

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• Objective 2: Designate a portion of 988 communication funds to develop and place quality, hopeful messaging that reaches every pocket of the state in through radio, social media boosted posts, printed materials, promotional items for communities to order, local communication avenues, newspapers, billboards, and other relevant communication outlets.

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• Objective 3: Create a 988-messaging toolkit that lives on the DHHS website for any Nebraskan to access for branded messaging, promotional items, and other relevant communication tools.

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• Objective 4: Create a grassroots effort to increase awareness of 988 with Nebraskans, while sharing warning signs, protective factors, and lethal means safety information. This grassroots effort should stretch far beyond the behavioral health sphere and include statewide organizations and associations, chambers of commerce, athletic clubs, civic groups, professional groups, corporations, schools, faith communities, movie theaters youth organizations, mentoring programs, and any existing group that is willing to offer their communication tools and networks to broaden the reach of 988 messaging.

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>Health and Empowered Individuals, Families, and Communities

Strategy 1: Create and /or enhance suicide prevention coalitions in all geographical regions.

This strategy focuses on implementing communications on the importance of coalitions that serve all populations, not just those already engaged in behavioral health. The Nebraska State Suicide Prevention Coalition (NSSPC) continues to serve as a valuable resource for communities looking to establish or revitalize local coalitions. For communities seeking guidance, NSSPC provides templates, examples, and peer support to help build or re-energize suicide prevention coalitions statewide.

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Strategy 2: Increase Nebraskans' Knowledge of factors promoting wellness and recovery concerning suicide prevention.
This strategy supports public awareness campaigns that focus on hope, connection, and recovery. Messaging efforts are intended to empower individuals with knowledge and encourage an environment of proactive mental health support. Campaigns are developed as public/private partnerships to amplify reach, consistency, and community relevance across Nebraska.

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Strategy 3: Collaborate with the physical health community to empower medical professionals to discuss behavioral health with patients, creating a safe space for patients to address concerns during regular appointments.
This strategy promotes suicide prevention as a core component of all health care services. Statewide coordination with medical associations is encouraged to help integrate behavioral health screenings into routine care and ensure that providers feel confident and prepared to talk about mental health and suicide risk with patients.

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> Clinical and Community Prevention Strategies
Strategy 1: Integrate evidence-informed, data driven, and Life-Saving overdose prevention and response service strategies in all systems that serve Nebraskans.
This strategy focuses populations that exist statewide to get a clear picture of suicide risk and need across the state. Utilize resources and systems such as 988 and suicide prevention training, enhancing family and/or support navigation programs for those in need.

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Strategy 2: Increase local and regional collaborations addressing health promotion and early prevention.
This strategy focuses on identifying suicide prevention leads across the state and ensuring statewide dissemination of consistent suicide prevention messaging and content.

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Strategy 3: Implement suicide prevention messaging across multiple sectors and everyday community settings.
This strategy promotes the normalization of mental wellness education and suicide prevention efforts within trusted community hubs—including corporate workplaces, school systems, faith-based organizations, and civic spaces—leveraging existing trust and rapport to increase engagement.

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Strategy 4: Expand mental wellness and suicide prevention education for all students in schools.
This strategy supports the continued growth of school-based prevention programs such as Hope Squads and emphasizes collaboration with the Nebraska Department of Education. It also prioritizes early emotional skill-building and supports for youth, including resources for coping, emotion regulation, and peer support.

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Strategy 5: Create and support more peer-support groups for both youth and adults.
This strategy focuses on increasing access to peer-led support systems statewide, recognizing their ability to build trust, share experiences, and provide timely, non-clinical emotional support.

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>Treatment and Support Services
Strategy 1: Enhance the continuum of care for Nebraskans in need of behavioral health services.
This strategy focuses on strengthening the entire continuum of behavioral health care—from prevention to recovery—by expanding access to community-based services, increasing crisis response capacity through 988, and enhancing peer-led respite care options. It also includes developing technological solutions to support care coordination for youth returning from behavioral health treatment back into school settings and growing public-private partnerships that support early intervention and recovery-oriented resources.

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Strategy 2: Collaborate with the Behavioral Health Education Center of Nebraska (BHECN) to address workforce shortages.
This strategy emphasizes the need for workforce development initiatives in behavioral health, including recruitment, retention, and training efforts. It includes building partnerships with universities, community providers, and advocacy organizations to address long-term workforce sustainability.

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Strategy 3: Expand the availability of crisis management services, with a focus on rural and frontier communities.
This strategy aims to increase access to urgent care and mobile crisis response, particularly in the western and rural regions of the state. It includes identifying sustainable funding streams and reimbursement models for crisis services, increasing access to drop-in and stabilization facilities, and developing standardized emergency department protocols that account for different levels of behavioral health crisis and clinical need.

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Strategy 4: Decrease population accessibility surrounding access to behavioral healthcare services statewide.
This strategy targets known barriers to care, including lack of transportation, technology infrastructure, workforce limitations, and insufficient funding. It calls for coordinated efforts to address these systemic barriers and ensure all Nebraskans have access to timely and appropriate behavioral health care.

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Strategy 5: Partner with law enforcement agencies while supporting a shift away from criminalizing mental illness.
This strategy acknowledges the vital role law enforcement can play in crisis response while emphasizing the need for alternative response models. It promotes collaboration between behavioral health and law enforcement, while expanding the use of responder models and encouraging crisis response systems that do not require law enforcement involvement when not needed for safety purposes. It also highlights the value of including individuals with lived experience in developing and evaluating these

efforts.

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>Surveillance, Research, and Evaluation

Strategy 1: Create a unified, consistent data collection process for the six Behavioral Health regions on suicide deaths and attempts.

This strategy focuses on identifying the most effective, timely data collection methods that can be implemented statewide. It includes working with regional and state partners to designate a central data coordination entity in each region and establish consistent protocols to ensure suicide-related data is complete, accurate, and actionable.

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Strategy 2: Leverage existing death review committees to inform prevention strategies.

This strategy focuses on mapping out active death review committee across Nebraska identifying key contacts and collaborating with those groups to review suicide deaths for potential trends. It also encourages exploration of psychological autopsy practices to gain deeper insight into contributing factors and system gaps with each region.

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Strategy 3: Strengthen the role of the State Suicide Prevention Coordinator to ensure that Nebraska has a dedicated lead for evaluating suicide related data, identifying statewide trends, and delivering timely findings to local and regional coalitions. The coordinator will also be responsible for translating data into actionable prevention recommendations.

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Strategy 4: Use data from public awareness efforts to improve outreach strategies.

This strategy focuses on evaluating their reach and impact of public messaging campaigns-=-such as those tied to 988, lethal means safety, and overcoming stigma—by collecting these metrics from digital platforms, partner organizations, and community groups. This data will be used to identify gaps, adjust messaging, and inform future campaign strategies to ensure messages are resonating with Nebraskans.

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Lethal Means Safety and Risk Reduction

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Strategy 1: Implement a wellness and safety plan policy for providers serving individuals at risk.

This strategy supports the promotion and adoption of standardized wellness and safety plans across behavioral health providers. It includes collecting and disseminating approved sample plans, creating provider guidance materials, and offering public messaging on the benefits of safety planning. Training and tutorials should also be made accessible to providers, caregivers, and community members on how to initiate and support the creation of personalized safety plan.

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Strategy 2: Promote the importance of connectedness as a protective factor against suicide.

This strategy centers on broadening the understanding of connectedness—what it looks like, why it matters, and how to foster it in communities. This includes promoting peer support programs, intergenerational outreach, and community-based activities that reduce isolation.

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Strategy 3: Expand screening for suicide risk across settings to improve early identification and follow-up.

This strategy promotes the use of evidence-based screening tools in healthcare, school, and community settings to identify individuals at risk for suicide or behavioral health concerns. It encourages collaboration with hospitals and medical associations to support the integration of screening into routine visits. Follow-up protocols and partnerships with local behavioral health providers should be reinforced to ensure identified individuals are safely connected to care. Routine screening should also include questions around access to lethal means.

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Strategy 4: Promote education and access to lethal means safety resources.

This strategy focuses on public education campaigns around the importance of safely storing medications and firearms. Messaging should emphasize that lethal means safety is a protective action, not a restriction of rights. Activities may include statewide distribution of prescription lockboxes and gun locks, signage on bridges and parking structures (e.g., HOPE signs), targeted outreach at sporting events, and training opportunities for firearm retailers and range staff. Partnerships with pharmacists and healthcare providers should be used to share materials on safe storage and disposal.

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>Governor’s Challenge to Prevent Suicide Among Service Members, Veterans, and Their Families

In March 2022, Nebraska Governor Pete Ricketts formally committed Nebraska to participate in the National Governors’ Challenges—a nationwide initiative encouraging states to bring together military and civilian interagency teams to collaboratively address suicide prevention among Service Members, veterans, and their Families (SMVF).

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Nebraska’s Governor’s Challenge team includes veterans, government agencies, community advocates, individuals with lived experience, and representatives from local and national organizations. This group has worked to develop a state-specific action plan aligned with national best practices and tailored to Nebraska’s unique needs. Their work is coordinated to align closely with broader statewide suicide prevention plan, ensuring synergy between efforts.

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The Nebraska Governor’s Challenge focuses on three primary goals:

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1. Identifying SMVF individuals and screening for suicide risk.
2. Promoting Connectedness and improving care.

3. Increasing safety planning and reducing access to lethal means among those at risk.

3. Have you incorporated any strategies supportive of the Zero Suicide Initiative? (●) Yes ( ) No

4. Do you have any initiatives focused on improving care transitions for patients with suicidal ideation being discharged from inpatient units or emergency departments? ( ) Yes (●) No

If yes, please describe how barriers are eliminated.

5. Have you begun any prioritized or statewide initiatives since the FFY 2024 - 2025 plan was submitted? (●) Yes ( ) No

If so, please describe the population of focus?

Since the submission of the FFY 2024-2025 plan, Nebraska has continued to advance its statewide suicide prevention efforts through both ongoing and new prioritized initiatives. The Nebraska Statewide Suicide Prevention Plan (2022-2025) remains the guiding framework, supported by measurable progress in several strategic areas.

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The University of Nebraska Public Policy Center continues to lead the GLS Suicide Prevention Grant. Prevention activities span across all Nebraska regions while also reaching the entire state through coordinated school health plans, workforce development for clinicians, and promotion of the Zero Suicide framework in health and behavioral health organizations. The Project maintains its four goals, including achieving 100% adoption of suicide prevention, postvention, and reintegration protocols in all Nebraska public school districts, and implementing evidence-based follow-up care after suicide crises.

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Since the last submission, Nebraska has expanded the implementation of 988, the statewide crisis line, with steady increases in call, text, and chat volume. Suicidal ideation contacts rose from 9,003 in FY23 to 11,891 in FY25, and “suicide in progress” calls increased from 223 to 384 over the same period. More individuals are now being safety planned over the phone, connected to mobile crisis teams, or referred for emergency intervention, strengthening Nebraska’s crisis care continuum.

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Additional prioritized initiatives include the expansion of LOSS Teams to support suicide loss survivors across more regions; broader lethal means safety efforts, such as statewide distribution of gun locks and prescription lockboxes, and increased CALM training; and enhanced prevention protocols. Nebraska has also sustained and grown coalition-based and grassroots outreach efforts, including the “More tomorrows” public awareness campaign, to reach communities and populations. These efforts are paired with ongoing partnerships with schools, healthcare providers, law enforcement, and community organizations to ensure a comprehensive approach to suicide prevention, intervention, and postvention across the state.

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The Nebraska Department of Education’s Project AWARE grant continues in partnership with the Division of Behavioral Health, focusing on prevention, promotion, early identification, and suicide prevention within schools. Mental health prevention and early intervention remain embedded in these activities to ensure that youth, families, and communities receive timely and responsive support. Nebraska's continuum of life saving response services continues to grow with more crisis stabilizations centers being added to areas that previously had no such service. All these services are to promote the concept of Making America Healthy Again.

6. Please indicate areas of technical assistance needs related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

13. Support of State Partners – Required for MHBG & SUPTRS BG

Narrative Question

The success of a state's MHBG and SUPTRS BG programs will rely heavily on the strategic partnerships that SMHAs and SSAs have or will develop with other health, social services, community-based organizations, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The State Medicaid Authority 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 prioritize risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of M/SUD, 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 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 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.
- The state's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults with M/SUD.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and co-occurring M/SUD.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state, and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.
- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- Enhancing the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states is crucial to optimal outcomes. In many respects, successful implementation is dependent on leadership and

collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

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?

The Nebraska DHHS Division of Behavioral Health (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 Commission for the Deaf and Hard of Hearing, Nebraska Departments of Correctional Services, Education and Insurance, Nebraska Tribes, Nebraska University System, Regional Behavioral Health Authorities (RBHA), and treatment, prevention and support service providers.

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DBH added a new partnership with Nebraska DHHS Divisions of Medicaid and Long-Term Care and Developmental Disabilities to bring up a new Medicaid State Plan Amendment/Waiver for those with serious mental illness that will provide those individuals with options for community-based services with targeted case management. This new waiver will partner with these two divisions to provide the services to those consumers who qualify. DBH is currently working on regulations and procedures for the new waiver. The waiver program will also work with current DBH, Medicaid and DD providers who wish to enroll as SMI Waiver providers.

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DBH added a new partnership with the Nebraska Investment Finance Authority (NIFA) to address housing issues with individuals with disabilities. NIFA is the Nebraska state housing agency. For example, NIFA has included a "DBH referral commitment" in their 2026/2027/2028 Qualified Allocation Plan (QAP). Since the effective date of the QAP, developers have started sending letters to Regional Behavioral Health Authorities stating their intent to prioritize the population DBH serves, reducing barriers to housing access for individuals with disabilities. The DBH also participates in NIFA's Low-Income Housing Tax Credit (LIHTC) program which will facilitate targeted trainings for DBH RBHA Regional Housing Coordinators and other relevant stakeholders, that focus on housing access to LIHTC properties in Nebraska.

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The Nebraska Olmstead workgroup and DBH have partnered to address Nebraska's Olmstead plan, specifically the Housing Workgroup. In this group, the DBH works with NIFA, the Nebraska Department of Economic Development (DED), and the Nebraska Department of Health and Human Services Division of Medicaid and Long-Term Care (MLTC). This future partnership will focus on a comprehensive array of action, such as creating a database for rental units, a coordinated referral system to streamline housing location and services, strengthening data collection and planning to address gaps in affordable and accessible housing. The overarching goal is to create an actionable plan by identifying process gaps which impede individuals with disabilities from accessing necessary housing within the communities in which they choose to live.

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DBH is exploring partnership with Nebraska's three Continuum of Care (CoC) networks that receive U.S. Department of Housing Urban Development (HUD) funding. This partnership will work to align goals, sharing resources, and coordinate efforts to better services Nebraskans with Severe Mental Illness (SMI) and Substance Use Disorders (SUD) who are experiencing or at-risk of homelessness. Within this partnership, expansion of capacity building, joint planning, and goal alignment will be identified.

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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.

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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.

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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 (CFS) and Medicaid and Long-Term Care (MLTC), Developmental Disabilities (DDD), Administrative Office of Probation and the Courts, county leaders, local system stakeholders, and community leaders and members.

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System partners include public agencies and private organizations, including state and local governmental agencies, Tribal organizations, community collaboratives, private organizations and individuals and families.
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
• 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 Families Care
...o Families Inspiring Families
...o Independence Rising
• 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
• Nebraska Commission for the Deaf and Hard of Hearing
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The Division of Behavioral Health has established Memoranda of Understanding (MOUs) and 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 1 Behavioral Health Authority
• Region II Behavioral Health Authority
• Region 3 Behavioral Health Services
• Region 4 Behavioral Health System
• Region 5 Systems
• Region 6 Behavioral Healthcare
• Behavioral Health Education Center of Nebraska
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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:
• Braided/blended funding models for joint services
• Transportation
• Improving access to care through telehealth service delivery
• 988 and crisis response, and
• CCBHC legislation and implementation
• Medicaid State Plan Amendment/Waiver for SMI target population
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Ongoing review of service expectations for those services that are available through each funding stream. Most recently, DBH worked closely with MLTC on the service expectations for Medically Managed Withdrawal Management and Opioid Treatment Programs as two services added into the MLTC benefit through an 1115 SUD waiver and initiated coordinated CCBHC planning.
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Through updated Memoranda of Understanding, the DBH and MLTC will share specific utilization data to better understand the utilization of services across these funding streams. An MOU permits the functionality within the DBH Centralized Data System to allow for Medicaid eligibility data to be auto-checked on service authorization requests; this will help to ensure that providers

who serve both Medicaid and non-Medicaid eligible services are billing the appropriate system. On January 1, 2017, the MLTC also implemented Heritage Health, a new managed care system that integrated physical health, behavioral health and pharmacy benefits. Through Medicaid expansion in 2019, the pandemic, Medicaid unwinding "post pandemic" and new Heritage Health MCOs vendors in SFY24, the DBH continues to work closely with these partners on joint needs and to coordinate initiatives. In 2025 DBH continues to engage Medicaid and the MCO vendors in initial and ongoing performance contracting and sharing of performance indicators.

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The DBH has been working closely with the Division of Developmental Disability (DDD) to provide continuity of care. The DDD has a monthly meeting with their key stakeholders (i.e. family of persons served, senators, providers, persons served) to inform and share the important topics that are occurring within the DDD and across DHHS. The DBH participates and presents important changes, trainings and the work DBH has been doing for that particular month. Additionally, DBH and DDD, along with Vocational Rehabilitation, are collaborating on supported employment service expectations and payment methodology.

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In support of DBH's goals to reduce the suicide rate for veterans, relationships have grown to include representatives from Veteran's Affairs on the Prevention Advisory Council. Collaborative partnerships exist to keep other prevention stakeholders across the state aware of suicide prevention efforts specific to veterans. Veteran's Affairs and DBH have led Nebraska's efforts on the Governor's Challenge to reduce suicide among veterans. DBH is sharing a behavioral health position to be co-located within Veteran's Affairs to help facilitate the combined effort.

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DBH is collaborating with the DHHS Division of Public Health on several initiatives including ongoing support for the work of PDMP partners in prescription drug overdose prevention. This has included prescriber and dispenser in-person, live webinar, and on-demand training (mandatory training was required on 5/10/2017), ongoing PDMP user registration, and increased access and use of the PDMP by medical professionals. Public Health and DBH lead the Nebraska Opioid Rapid Response team. Nebraska was called to action in 2022-23 and forged a strong team and protocols.

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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. As of 2020, providers are required to query PDMPs when prescribing controlled substances for Medicaid and Medicare patients. For more information please see: http://dhhs.ne.gov/Pages/Drug-Overdose-Prevention-Resources.aspx and https://dhhs.ne.gov/Pages/PDMP-Enhancements.aspx.

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DBH is engaged with the Commission for Deaf and Hard of Hearing. Through the mental health advisory committee, new partnerships have developed with a focus on a needs assessment driven by the Commission. Surveys are being designed to capture feedback from consumers, providers and interpreters as to training, services and quality in coverage of services and access.

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DBH continues to expand its collaboration with the Nebraska Judicial System – Administrative Office of Probation. through exploring opportunities for information exchange across data systems to address efficiency in service utilization and funding and avoidance of duplication of services. These discussions proved valuable in designing a new Probation treatment authorization and payment data system, with future state data interface on the planning table.

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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 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.

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Leadership from the Supreme Court, Probation Administration and DBH continue to review opportunities for collaboration with the Legislative body, cross system needs assessment and planning, evidenced based service delivery for the justice involved population and data integration.

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The DBH and the Office of Probation Administration are in continued discussion for planning future Justice and Behavioral Health statewide conferences. The Justice and Behavioral Health Conference is intended for individuals who work with Nebraska's justice system in a variety of ways, including Problem-Solving Court teams, behavioral health clinicians, probation officers, child welfare workers, judges, lawyers, and law enforcement. Previous conferences were well received with 950 professionals attending the 2022 conference.

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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 from 2019-2022. 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, and this work involves ongoing efforts between the State and local jurisdictions. Legislation was enacted authorizing the Division to move forward with implementing outpatient competency restoration services in FY22. The outpatient competency restoration program was implemented after a needs assessment, research into such programs offered by other states, consultation on best practices, and feedback obtained from stakeholders in the Administrative Office of Probation, Judiciary and Court Administration; defense attorneys; county attorneys; and community providers. Since its implementation, outpatient competency restoration has successfully diverted individuals from the state hospital and resulted in numerous cases

being restored to competency in a community-based setting. Ongoing program evaluation is occurring for the outpatient competency restoration program.

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Nebraska has implemented targeted efforts to partner with Community Corrections agencies and jails in some areas related individuals involved in the competency restoration system to 1) better divert individuals into outpatient competency restoration services when appropriate, and 2) to improve re-entry for individuals with low level offenses involved in inpatient competency restoration services.

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In 2022, two of Nebraska's most populated counties (Douglas and Sarpy) held Sequential Intercept Mapping events and included participants from State and local agencies that is involved at each intercept to recognize opportunities to further divert and support individuals with mental health and substance use disorders involved in the criminal justice system. This work continues.

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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, URL Heartland Crisis Intervention Team - Lutheran Family Services

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Behavioral Health Threat Assessment (BETA): The 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 recognize 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. An 8-hour Mini-BETA and a Youth BETA began in 2018 as an adaptation to reach rural partners. To date 238 law enforcement officers and 240 partners have been trained in those sessions. Training was cancelled in 2021 due to the pandemic and resumed in 2022. Funding has been secured for one training to be held in the winter of 2025 and another training to be scheduled in 2026.

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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.

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Administratively, DBH, through the annual regional budget planning process, sets expectations for criminal justice engagement at regional local levels. DHHS and DBH created a Director of Forensics position within the State hospital whose scope includes working with regional partners on justice related initiatives.

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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 in suicide prevention, prevention efforts related to underage drinking and education efforts related to prescription drug overdose.

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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.

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As an advisory member, DBH has continued collaboration 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 recent awards of more than $3 million to 27 projects to address Nebraska's behavioral health workforce shortage. This follows on the footsteps of the previous $20 million granted to 83 projects. Projects were across four categories, which are behavioral health training opportunities, telebehavioral health training, telebehavioral health support in rural areas and behavioral health workforce projects related to the pandemic including funding for provisionally licensed providers.
• 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.
• 2022-2023 core topics for providers include eating disorders in rural communities, ethically treating individuals in the justice system, and engaging all clients.
• 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.
• BHECN continues to expand its footprint in non-metropolitan Nebraska to support efforts increase retention of behavioral health providers, recruitment in rural Nebraska and establishing a statewide network of behavioral health providers. BHECN has established offices across Nebraska, including in communities that have state colleges and university campuses. BHECN offices include 1) BHECN Central in Kearney at the University of Nebraska at Kearney, 2) BHECN Northeast in Wayne at the Wayne State College, 3) BHECN Panhandle in Chadron at the Chadron State College, 4) BHECN Southeast in Lincoln; and 5) BHECN East in Omaha at the University of Nebraska at Omaha. BHECN is also planning to expand with a BHECN Southwest office located in southwest Nebraska.

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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.

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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.

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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 have varying levels of mental health resources. Two sites have higher free/reduced lunch rates, indicative of poverty and student mobility. 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 recognize and immediately respond to the mental health needs of students exhibiting behavioral or psychological signs requiring clinical intervention.
• Increase schools' capacity to recognize and intervene in bullying and aggressive or violent behaviors of students that may contribute to school violence.

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There is a strong collaborative relationship already established between NDE and DBH as a result of the Nebraska System of Care initiative and grant. This sustained effort puts Nebraska's AWARE Projects in a unique position to build upon infrastructure created through the NeSOC Initiative. 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.

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OpenBeds
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 recognize treatment services and refer patients to care in a few clicks. Data collected during the pilot will be used to spot capacity challenges and provide data driven opportunities to find solutions.

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Nebraska was selected as one of 23 states in a new crisis intervention registry project designed to reduce the time those with an 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.

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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 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.

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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.

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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.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

The DBH and the Nebraska Divisions of Medicaid and Long-Term Care and Developmental Disabilities have created a new partnership to bring up a new Medicaid State Plan Amendment/Waiver for those with serious mental illness that will provide those individuals with options for community-based services with targeted case management. Work is currently ongoing to connect with DBH providers, Medicaid providers and DD providers to provide informational webinars on the Serious Mental Illness (SMI) Waiver and the services to be offered to those determined eligible for waiver services. These services will be offered in the community and provide options for those consumers looking for services outside of inpatient or residential institutions. The purpose is to provide quality and cost-effective services which will produce the best possible outcomes.

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The DBH and the 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. Ongoing review of service expectations for those services that are available through each funding stream. Most recently, DBH worked closely with MLTC on the service expectations for Medically Managed Withdrawal Management and Opioid Treatment Programs as two services added into the MLTC benefit through an 1115 SUD waiver. Collaboration on shared service expectations for CCBHC was initiated in 2023 and is being implemented in January 2026 when the CCBHC providers go live.

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The DBH has been working closely with the Division of Developmental Disability (DDD) to provide continuity of care. Additionally, DBH and DDD, along with Vocational Rehabilitation, are collaborating on supported employment service expectations and payment methodology.

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In support of DBH's goals to reduce the suicide rate for veterans, relationships have grown to include representatives from Veteran's Affairs on the Prevention Advisory Council. Collaborative partnerships exist to keep other prevention stakeholders across the state aware of suicide prevention efforts specific to veterans. Veteran's Affairs and DBH have led Nebraska's efforts on the Governor's Challenge to reduce suicide among veterans. DBH is sharing a behavioral health position to be co-located within Veteran's Affairs to help facilitate the combined effort.

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DBH is engaged with the Commission for Deaf and Hard of Hearing. Through the mental health advisory committee, new partnerships have developed with a focus on a needs assessment driven by the Commission. Surveys are being designed to capture feedback from consumers, providers and interpreters as to training, services and quality in coverage of services and access.

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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 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.

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Leadership from the Supreme Court, Probation Administration and DBH are currently reassessing committee as to future membership, structure and scope. 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 have aligned strategic plans where applicable.

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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.

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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 have varying levels of poverty and scarcity of mental health resources. Two sites have higher free/reduced lunch rates, indicative of poverty and student mobility. 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.

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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 recognize and immediately respond to the mental health needs of students exhibiting behavioral or psychological signs requiring clinical intervention.
• Increase schools' capacity to recognize and intervene in bullying and aggressive or violent behaviors of students that may contribute to school violence.

4. Please indicate areas of technical assistance needs related to this section.

None at this time.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

14. State Planning/Advisory Council and Input on the Mental Health/Substance Use Block Grant Application – Required for MHBG, Requested for SUPTRS BG

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 assist with implementing and improving the Planning Council, states should consult the **State Behavioral Health Planning Councils: An Introductory Manual.**

Planning Councils are required by statute to review state plans and annual 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 advocates for individuals with M/SUD. States should include any recommendations for modifications to the application or comments to the annual report that were received from the Planning Council as part of their application, regardless of whether the state has accepted the recommendations. States should also submit documentation, preferably a letter signed by the Chair of the Planning Council, stating that the Planning Council reviewed the application and annual report. States should transmit these documents as application attachments.

Please respond to the following items:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g., meeting minutes, letters of support, letter from the Council Chair etc.)

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. These two committees meet jointly with a shared agenda and the two advisory committees serve as a behavioral health advisory council.

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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.

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The DBH web page URL for Joint Advisory Committee meeting agenda and minutes is: https://dhhs.ne.gov/Pages/behavioral-health-public-participation.aspx

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Recent activities include:

<> August 7, 2025 Joint Advisory Committee Meeting

Meeting presentations included: DBH Director Update; Substance Use Recovery Month; Presentation and review of the FFY2026-2027 SAMHSA Combined Mental Health and Substance Use Prevention, Treatment, and Recovery Services Block Grant Application; Presentation by Disability Rights Nebraska, Nebraska's designated Protection & Advocacy for Individuals with Mental Illness organization; and, Presentation by DBH acting as the designated Secretary of the Opioid Settlement Remediation Advisory Committee's Division presentation on the Opioid Treatment Infrastructure Cash Fund Request for Applications (RFA) to renovate, develop, or expand facilities to implement treatment programs and services for opioid use disorder (OUD) and/or substance use disorder (SUD). The presentation and review of the FFY 2026-2027 MH/SUPTRS BG Application included the two-year budgets and assessment for Planning Table 1 - Priority Areas and Annual Performance Indicators.

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<> May 1, 2025 Joint Advisory Committee Meeting

Meeting topics included: DBH Director Update including for example planning for CCBHCs, Opioid Settlement Funds, planning for CMS 1915i Waiver targeting services for individuals with SMI to support community living; Planning activity on Priority Areas for treatment and recovery success for the FFY 2026-2027 block grant application; and a Presentation on Synar – purpose, activity and reporting. The planning activity and discussion of the FFY 2026-2027 MH/SUPTRS BG Application introduced the Application and the next two-year Behavioral Health Systems Assessment and Plan for FFY 2026/27 Planning Table 1 – Priority Areas and Annual Performance Indicators.

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<> November 14, 2024 Joint Advisory Committee Meeting

Meeting topics included: DBH Director Update including the new Director's vision for a more holistic behavioral health system that

works more closely with Medicaid and has fewer barriers to accessing healthcare, planning for CCBHCs, planning for CMS 1915i Waiver targeting services for individuals with SMI to support community living; Presentation by the DBH Office of Consumer Affairs, including introduction of the new OCA Administrator and updates on the Recovery Friendly Workplace Initiative, Certified Peer Support Specialist recertification process and OCA consumers' council; Presentation and discussion of the annual SAMHSA MH and SUPTRS Block Grant Implementation Reports reporting on expenditures and Priority Areas annual performance and data indicators; and, Presentation of the Annual Synar Report.

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On August 20, 2025, the DBH posted an email notice on the DBH Listserv to invite DBH audiences to inspect and comment on the draft Combined FFY2026-2027 MH/SUPTRS Block Grant Application. The DBH Listserv distributes to 1,200 individuals and 140 organizations included members of the State Advisory Committee on Mental Health Services and the State Advisory Committee on Substance Abuse Services, state Prevention Advisory Council, Family Organizations, Certified Peer Specialists, Regional Behavioral Health Authorities, DBH NBHS Network Providers, the four federally recognized tribes in Nebraska and partner state, regional, and local agencies.

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-Start Notice-
Notice of Opportunity for Public Comment on the Combined FFY2026-2027 Mental Health/Substance Use Prevention, Treatment, and Recovery Services (MH/SUPTRS) Block Grant Application

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Comments are invited on the Nebraska DRAFT Combined FFY2026-2027 MH/SUPTRS Block Grant Application.

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Nebraska has been invited to submit an application to the federal Substance Abuse Mental Health Services Administration (SAMHSA) for the federal fiscal year (FFY) 2026-2027 Community Mental Health Services Block Grant (MHBG) and Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRSBG).

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To review the draft Nebraska Application for the SAMHSA Uniform FFY 2026-2027 Combined Block Grant Application for Community Mental Health Services Block Grant and the Substance Use Prevention, Treatment, and Recovery Services Block Grant please visit the Division of Behavioral Health Public Participation and State Committees web page https://dhhs.ne.gov/Pages/behavioral-health-public-participation.aspx

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To provide comment on the Combine FFY 2026-2027 Community Mental Health Services Block Grant and Substance Use Prevention, Treatment, and Recovery Services Block Grant – Draft Application public comment can be submitted via U.S. Postal Service or email to:
John Trouba – Federal Aid Administrator
John.Trouba@nebraska.gov
Nebraska Department of Health and Human Services
Division of Behavioral Health
301 Centennial Mall South, 4th Floor
PO Box 95026
Lincoln, NE 68509-5026

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Comments will be accepted between August 20, 2025 and 4:00 p.m. August 27, 2025.
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DBH did not receive any written comment from the public during the August 20 - August 27, 2025 public comment period as identified above via the DBH Listserv distribution of the opportunity to review the draft combined block grant application. DBH did not receive any other comments via other media up to the time of grant submission.

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The DBH webpage URL for the Joint Advisory Committee current meeting agenda and minutes is https://dhhs.ne.gov/Pages/Behavioral-Health-Public-Participation.aspx

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Once the application is submitted via WebBGAS, a copy of the submitted application will be uploaded to the DBH website page replacing the draft application. URL https://dhhs.ne.gov/Pages/Behavioral-Health-Public-Participation.aspx

2. Has the state received any recommendations on the State Plan or comments on the previous year's State Report?

a. State Plan ○ Yes ◉ No

b. State Report ○ Yes ◉ No

Attach the recommendations /comments that the state received from the Council (without regard to whether the State has made the recommended modifications).

3. What mechanism does the state use to plan and implement community mental health treatment, substance use prevention, SUD treatment, and recovery support 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.

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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.

4. Has the Council successfully integrated substance use prevention and SUD treatment recovery or co-occurring disorder issues, concerns, and activities into its work? (●) Yes ( ) No

5. Is the membership representative of the service area population (e.g., rural, suburban, urban, older adults, families of young children?) (●) Yes ( ) No

6. 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.”

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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.”

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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, including staff from the Office of Consumer Affairs, attend meetings to listen to committee discussion as well as public comment for a better understanding of the committee perspective.

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Each meeting may include individuals with lived experience or advocates, sharing successes, barriers and challenges in their individual roads to recovery, or presenters of current topical issues and/or behavioral health projects. Presentations by individuals with lived experience and advocates keep the consumer perspective in front of the committee as well as DBH staff, and allows successes and challenges to have a “face” to support the reality of challenges for those we serve.

7. Please indicate areas of technical assistance needs related to this section.

None at this time.

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Footnotes:

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 Mental Health Agency
State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Medicaid Agency

Start Year: 2026 End Year: 2027

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Ingrid Gansebom (MH)	Providers		54597 862 Road Osmond NE, 68765 PH: 402-380-5207	
Heather Bird (SA)	Persons in Recovery from or providing treatment for or advocating for SUD services		7149 N 163 Street Bennington NE, 68007 PH: 402-552-7461	
Verdell Bohling (MH)	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)		1145 Piedmont Road Lincoln NE, 68510 PH: 402-429-1315	
Mary Ann Borgeson (MH)	Advocates/representatives who are not state employees or providers		12503 Anne Street Omaha NE, 68137 PH: 402-444-6413	
Micki Charf (MH)	State Employees		500 S 84 Street Lincoln NE, 68510 PH: 402-937-5866	
Heather Crawford (SA)	Persons in Recovery from or providing treatment for or advocating for SUD services		501 Chateau 11 Bellevue NE, 68005 PH: 402-957-4925	
Margaret Damme (MH)	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		6433 Havelock Avenue Lincoln NE, 68507 PH: 402-326-1875	
Roger Donovick (MH)	State Employees		Folsom and West Prospector, LRC 9 Lincoln NE, 68509 PH: 402-479-5411	
Lindy Foley (MH)	State Employees		3410 N 205 Street Elkhorn NE, 68022 PH: 402-371-2745	
Victor Gehrig (MH)	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		200 Diamond Street Lyons NE, 68038 PH: 402-499-5387	
Jill Gregg (SA)	Providers		10310 N Osage Avenue Hastings NE, 68901	

			PH: 402-462-4677	
Leah Harms (SA)	Persons in Recovery from or providing treatment for or advocating for SUD services		1024 N 53rd Street Lincoln NE, 68504 PH: 402-440-9168	
Timothy Heller (MH)	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)		2110 S 25th Street Omaha NE, 68105 PH: 402-932-8197	
Susan Jensen (MH)	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)		15801 Cary Circle Omaha NE, 68136 PH: 402-618-7254	
Tracy Jordan (MH)	Providers		12306 Pintail Drive Papillion NE, 68046 PH: 402-979-8011	
David Kass (MH)	Parents of children with SED		306 S 15 Street Apt 502 Omaha NE, 68102 PH: 402-706-0152	
Kristen Larsen (MH)	State Employees		301 Centennial Mall South Lincoln NE, 68509 PH: 402-471-0143	
Kyle Long (MH)	Parents of children with SED		3616 Aspen Drive Scottsbluff NE, 69361 PH: 308-631-2913	
Kelli Means (SA)	Persons in Recovery from or providing treatment for or advocating for SUD services		714 E Park Avenue Norfolk NE, 68701 PH: 402-920-0103	
Angela Miles (MH)	State Employees		301 Centennial Mall South Lincoln NE, 68509 PH: 402-432-8022	
Jennifer Reyna (MH)	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		1014 Martha Street Omaha NE, 68108 PH: 402-905-1073	
Melody Sandona (MH)	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		501 Ann Street Chadron NE, 69337	
Carisa Schweitzer Masek (MH)	State Employees		301 Centennial Mall South Lincoln NE, 68509 PH: 402-471-1920	
Danielle Smith (MH)	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		6333 Glass Ridge Drive Lincoln NE, 68526 PH: 402-314-9387	
Gage Stermensky II (SA)	Persons in Recovery from or providing treatment for or advocating for SUD services		975 Crescent Avenue Gering NE, 69341 PH: 308-633-3268	
Mike Tefft (SA)	Persons in Recovery from or providing treatment for or advocating for SUD services		1804 S 116 Street Omaha NE, 68144 PH: 402-929-9102	
Paul Zeiger (MH)	State Employees		Nebraska Crime Commission Lincoln NE, 68509 PH: 402-480-1541	

*Council members should be listed only once by type of membership and Agency/organization represented.
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Footnotes:

State Council vacancies include nine vacancies. These include:
> One position is vacant in Type of Membership – Parents of children with SED. This is membership with the State Advisory Committee on Mental Health Services. Non-state employee.
> One position is vacant in Type of Membership – State Housing Agency. State employee. This is membership with the State Advisory Committee on Mental Health Services.
> One position is vacant in Type of Membership - Individuals in Recovery with SMI. This is membership with the State Advisory Committee on Mental Health Services. Non-state employee.
> One position is vacant in Type of Membership – Provider of treatment for MH services. Non-state employee. This is membership with the State Advisor Committee on Mental Health Services.
> Three positions are vacant in Type of Membership – Persons in recovery from or advocating for SUD services. Non-state employee. These are memberships with the State Advisor Committee on Substance Abuse Services.
> Two positions are vacant in Type of Membership – Provider of treatment for SUD services. Non-state employee. These are memberships with the State Advisor Committee on Substance Abuse Services.

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2026 End Year: 2027

Type of Membership	Number	Percentage of Total Membership
1. Individuals in recovery (including adults with SMI who are receiving or have received mental health services)	5	
2. Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)	3	
3. Parents of children with SED	2	
4. Vacancies (individuals and family members)	2	
5. Total individuals in recovery, family members, and parents of children with SED	**12**	**33.33%**
6. State Employees	7	
7. Providers	3	
8. Vacancies (state employees and providers)	2	
9. Total State Employees & Providers	**12**	**33.33%**
10. Persons in Recovery from or providing treatment for or advocating for SUD services	6	
11. Representatives from Federally Recognized Tribes	0	
12. Youth/adolescent representative (or member from an organization serving young people)	0	
13. Advocates/representatives who are not state employees or providers	1	
14. Other vacancies (who are not individuals in recovery/family members or state employees/providers)	5	
15. Total non-required but encouraged members	**12**	**33.33%**
16. Total membership (all members of the council)	**36**	

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Footnotes:

The new structure of FY 2026-2027 Combined MHBG/SUPTRS BG Application table “Advisory Council Composition by Member Type” does not accurately identify the voice of consumers, family members of consumers, and advocates-not state employees or providers based on how Nebraska’s advisory committees meet jointly as a behavioral health council. Specifically, “Row 5. Total individuals in recovery, family members, and parents of children with SED” under counts the voice of individuals in recovery who are identified in “Row 10. Persons in Recovery from or providing treatment for or advocating for SUD services” (2 Persons in Recovery and 4 Persons providing treatment services, respectively) and “Row 14. Other vacancies (who are not individuals in recovery/family members or state employees/providers)” (3 Persons in Recovery not meeting the definition of Row 5 and 2 Providers not meeting the definition of Row 9). By reporting these individuals by the new Row categories, the actual representation of consumers and family members of consumers (12 on SACMHS and 5 on SACSAS) plus Row 13.

Advocates/representatives who are not state employees or providers (1 on SACMHS) represents 18 (50.0%) individuals on the behavioral health council.

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Nebraska's State Advisory Committee on Mental Health Services (SACMHS) itself includes a) twelve consumers of behavioral health services or their family members, b) two providers of behavioral health services, c) one regional governing board member, d) one regional administrator, e) two representatives from the State Department of Education, including on representative from the Division of Vocational Rehabilitation [the other member represents the Division of Special Education], f) three representatives from the Department of Health and Human Services representing mental health, social services, and Medicaid [an additional member represents developmental disabilities], g) one representative from the Nebraska Commission on Law Enforcement and Criminal Justice [aka Nebraska Crime Commission], and h) one representative from the Housing Office of the Community and Rural Development Division of the Department of Economic Development.

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Nebraska's State Advisory Committee on Substance Abuse Services (SACSAS) itself includes a) at least three consumers of substance use services [there are five seats with two vacant] and providers of substance use services [there are seven seats with two vacant).

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State Council vacancies include nine vacancies. These include:

> One position is vacant in Type of Membership – Parents of children with SED. This is membership with the State Advisory Committee on Mental Health Services. Non-state employee.

> One position is vacant in Type of Membership – State Housing Agency. State employee. This is membership with the State Advisory Committee on Mental Health Services.

> One position is vacant in Type of Membership - Individuals in Recovery with SMI. This is membership with the State Advisory Committee on Mental Health Services. Non-state employee.

> One position is vacant in Type of Membership – Provider of treatment for MH services. Non-state employee. This is membership with the State Advisory Committee on Mental Health Services.

> Three positions are vacant in Type of Membership – Persons in recovery from or advocating for SUD services. Non-state employee. These are memberships with the State Advisory Committee on Substance Abuse Services.

> Two positions are vacant in Type of Membership – Provider of treatment for SUD services. Non-state employee. These are memberships with the State Advisory Committee on Substance Abuse Services.

Environmental Factors and Plan

15. Public Comment on the State Plan – Required for MHBG & SUPTRS BG

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, that 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 the federal government.

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:

To review the draft Nebraska Application for SAMHSA Uniform FFY 2026-27 Combined Block Grant Application for Community Mental Health Services Block Grant and the Substance Use Prevention Treatment Recovery Services Block Grant please visit the Division of Behavioral Health Public Participation and State Committees web page: https://dhhs.ne.gov/Pages/behavioral-health-public-participation.aspx

Once the application is submitted via WebBGAS, a copy of the submitted application will be uploaded to replace the draft application on the DBH website page https://dhhs.ne.gov/Pages/behavioral-health-public-participation.aspx

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

Yes, the previous Combined MHBG/SUPTRS BG Application draft and final application was posted. The submitted final application can be viewed here: https://dhhs.ne.gov/Behavioral%20Health%20Documents/FFY2024-25%20Combined%20MH-SUPTRS%20Block%20Grant-submitted%20090324.pdf

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The previous year Nebraska 2024 Mental Health Block Grant Report and Nebraska 2024 SUPTRS Block Grant Report are available for public inspection on the same web page, https://dhhs.ne.gov/Pages/behavioral-health-public-participation.aspx

c) Other (e.g. public service announcements, print media) (●) Yes ( ) No

d) Please indicate areas of technical assistance needs related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

16. Syringe Services Program (SSP) – Required for SUPTRS BG if Planning for Approval of SSP

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Narrative Question:
Use of SUPTRS BG funds to support syringe service programs (SSP) is authorized through appropriation acts which provide authority for federal programs or agencies to incur obligations and make payment, and therefore are subject to annual review. The following guidance for the application to budget SUPTRS BG funds for SSPs is therefore contingent upon authorizing language during the fiscal year for which the state is applying to the SUPTRS BG.

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SUPTRS BG to fund elements of an SSP other than to purchase sterile needles or syringes for the purpose of illicit drug use. States interested in directing SUPTRS BG funds to SSPs must provide the information requested below and receive approval from the State Project Officer.

States may consider making SUPTRS BG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SUPTRS BG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to persons who inject drugs (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. Federal funds cannot be supplanted, or in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

The federal government released three guidance documents regarding SSPs, These documents can be found on the **HIV.gov website.**

Please refer to guidance documents provided by the federal government on SSPs to inform the state's plan for use of SUPTRS BG funds for SSPs, if determined to be eligible. The state must follow the steps below when requesting to direct SUPTRS BG funds to SSPs during the award year for which the state is eligible and applying:

Step 1 - Request a **Determination of Need** from the CDC

Step 2 - Include request in the SUPTRS BG Application Plan to expend the funds for the award year which the state is planning support an existing SSP or establish a new SSP. Items to include in the request:

- Proposed protocols, timeline for implementation, and overall budget
- Submit planned expenditures and agency information on Table 16a listed below

Step 3 - Obtain SUPTRS BG State Project Officer Approval

Use of SUPTRS BG funds for SSPs future years are subject to authorizing language in appropriations bills, and must be re-applied for on an annual basis.

Additional Notes:

1. 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 SUPTRS BG 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.

2. 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 receives SUPTRS BG 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.

3. 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 SUPTRS BG 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 use prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to health services.

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Budget of SUPTRS BG for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Naloxone or other Opioid Overdose Reversal Medication Provider (Yes or No)
No Data Available					
Totals:		$0.00		0	

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Footnotes:

Nebraska - FFY 2026-2027 Combined Block Grant Application
Environmental Factors and Plan - Section 16 Syringe Services (SSP)
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Nebraska Department of Health and Human Services Division of Behavioral Health does not use SUPTRS BG or state funds to support elements of any Syringe Services Program nor has it developed or submitted a plan to the State Project Officer to repurpose SUPTRS BG funds for an SSP.