Nebraska

UNIFORM APPLICATION
FY 2024/2025 Combined MHBGSUPTRS BG ApplicationBehavioral Health Assessment and Plan

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

OMB - Approved 04/19/2021 - Expires 04/30/2024
(generated on 12/06/2023 3.10.51 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

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

State Information

State Information

Plan Year

Start Year	2024
End Year	2025

State SAPT Unique Entity Identification

Unique Entity ID	HKQDEXRXGKL1

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

Agency Name	Nebraska Department of Health and Human Services
Organizational Unit	Division of Behavioral Health
Mailing Address	301 Centennial Mall South, Fourth Floor PO Box 95026
City	Lincoln
Zip Code	68509-5026

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

First Name	Tony
Last Name	Green
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) 471-6038
Fax	(402) 742-8314
Email Address	Tony.Green@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	Tony
Last Name	Green
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) 471-6038
Fax	(402) 742-8314
Email Address	Tony.Green@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	8/31/2023 12:57:24 PM
Revision Date	11/7/2023 9:22:12 AM

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: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

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

Fiscal Year 2024

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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ASSURANCES - NON-CONSTRUCTION PROGRAMS

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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: Tony Green

Signature of CEO or Designee[1]: _____

Title: Interim-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: 04/19/2021 Expires: 04/30/2024

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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).

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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.

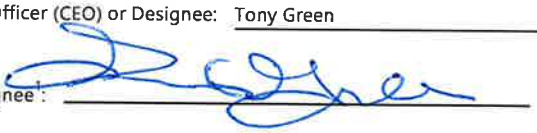
The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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: Nebraska

Name of Chief Executive Officer (CEO) or Designee: Tony Green

Signature of CEO or Designee[1]: 

Title: Interim-Director Division of Behavioral Health

Date Signed: 8.21.23

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: 04/19/2021 Expires: 04/30/2024

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

August 21, 2023

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 Bo Botelho, Interim Chief Executive Officer 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):

Bo Botelho
Interim 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:

Tony Green, Interim-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

August 17, 2023

Ms. Odessa F. Crocker
Division of Grants Management, Office of Financial Resources
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane, 17E22
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Division of Behavioral Health
Nebraska Department of Health and Human Services
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Lincoln, NE 68509-5026

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Sincerely,

Bo Botelho
Interim Chief Executive Officer
Department of Health and Human Services

State Information

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

Fiscal Year 2024

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 III of the Public Health Service Act		
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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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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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.
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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.

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   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
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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 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.

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: Tony Green

Signature of CEO or Designee[1]: _____

Title: Interim-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.

Please upload your state's Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

Based on the guidance issued on October 11th, 2022, please submit a proposal that includes a narrative describing how the funds will be used to help individuals with SMI/SED, along with a budget for the total amount of the second allotment. The proposal should also explain any new projects planned with the second allotment and describe ongoing projects that will continue with the second allotment. The performance period for the second allotment is from September 30th, 2023, to September 29th, 2025, and the proposal should be titled "BSCA Funding Plan 2024. The proposed plans are due to SAMHSA by September 1, 2023.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Nebraska proposes to use supplemental funds to fill gaps in our systems serving children and youth, including those with serious emotional disturbance (SED), involved with the justice system, 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 two 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 and have an opportunity to make recommendations for activities in subsequent project years.

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). This work is being supported by NDE with a variety of grants including a State Garrett Lee Smith Youth Suicide Prevention Grant awarded to our partners with the University of Nebraska Public Policy Center (NUPPC). Additionally, NDE has a grant from the US Department of Education to enhance the quality of school emergency operations plans and is actively working with local districts on their multi-disciplinary planning processes and products.

We plan to leverage all these resources and 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 will do this by creating tabletop exercises addressing a variety of scenarios designed to test plans, particularly after an event in the recovery phases (e.g., disillusionment phase). The scenarios will 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 will work with the Nebraska Department of Health and Human Services (DHHS), Division of Behavioral Health to bring relevant stakeholders together

[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.

to create the tabletops, then work with regional structures to disseminate and test the packages with schools. The goal is to make this package customizable and allow school districts to implement them independently, or with other neighboring districts. Lessons learned from the tabletops will be gathered and used to enhance existing disaster / crisis plans. Year one will focus on development and testing of the tabletop packages. Year two will feature widespread dissemination and implementation of the tabletops. Subsequent years will focus on incorporation of lessons learned in plans, revising the tabletops based on lessons learned and emerging threats, and building sustainable regional competence in plan development and exercise facilitation.

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 one or two. This will be revisited after year two to determine if it is necessary.

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 expose community providers to so they are prepared to augment a school-based crisis response team effort.

We propose to 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 one with ongoing training opportunities opened to these entities in subsequent years via an NDE

supported cadre of trainers at the Educational Service Unit level. This cadre of trainers will be prepared in year one to deliver PFA-S training with fidelity to the field operations guide maintained by the National Child Traumatic Stress Network.

In year two and subsequent years will propose continuing to support PFA-S and adding community provider exposure to school-based efforts to support reunification of students with their parents/caregivers after an event that requires evacuation or similar action. This activity is the responsibility of local school districts, but state entities will work with schools to ensure they are connected with community level disaster behavioral health response personnel in their area. Our desire is for community personnel to be invited to school level training and exercises in the standard reunification method (SRM) being promoted for use in Nebraska schools. The training will be offered in subsequent years along with PFA-S.

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; The final exercise package will be provided to local education agencies (public and private) with instructions. Follow-up will include a survey to inquire about implementation strategy, outcomes, and lessons learned so the exercise package can be adjusted if needed.

2) Including information in PFA-S training to ensure school personnel know how to identify, refer and reintegrate students with first episode psychosis or serious emotional disturbance. This includes information appropriate for classroom teachers, school counselors and nurses, and others who have direct contact with students. The material will be adjusted for use in frontier, rural, and urban areas and include appropriate resource listings.

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; Any 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) Purposefully developing 2-3 crisis message maps 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 that will be developed by a multi-disciplinary team consisting of public information professionals, family representatives, behavioral health professionals, and school personnel. Each message map will be structured using crisis messaging principles. The maps will be provided to schools and behavioral health agencies with instructions for their use.

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 items 1 and 3.

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 delivery to parents and community members in response to a threat or crisis. These message maps were co-developed with 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 one we will convene the partners with risk communication specialists to review the message maps, then translate them into at least two languages (dependent upon identified need). Year two we will add two more languages and add messages as needs are identified by schools, families, and/or behavioral health professionals in the field.

These message maps will also be 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?

Other activities will be considered for enhancement based on the outcome of work done in years one and two.

8. Clearly describe the proposed/planned activities utilizing the funds for both FY 2022 and FY 2023 as two separate sections, including an estimated budget for each year. States will be required to report on what activities have been completed using this funding.

FY 2022

Goal	Activity	Deliverable	Responsible Entity
1.0. Align 100% of school plans with state and regional crisis-disaster behavioral health plans by 2025	1.1a. Develop school tabletops for multidisciplinary use. 1.2a. Test tabletop package in 4 rural and 1 urban school area.	1.1. Tabletop package with multiple scenarios. 1.2. Tabletop results, attendance, & feedback.	NUPPC – lead NDE, DHHS-DBH NDE – lead NUPPC, DHHS-DBH
2.0. Provide school intervention training to 60 people each year who are part of Nebraska's multidisciplinary crisis -disaster teams.	2.1a. Prepare 2 people in each ESU to deliver PFA-S training. 2.2a. Deliver PFA-S training to 60 community crisis-disaster personnel.	2.1a. List of training and attendees 2.2b. List of training and attendees	NDE – Lead NDE – Lead NUPPC, 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.	3.1a. Update Nebraska's message maps related to children. 3.2a. Translate messages into at least two languages. 3.3a. Disseminate document with instructions for use.	3.1a. Updated message map document. 3.2a. Translated documents 3.3a. List of entities receiving document.	NUPPC – Lead NDHHS-DBH, NDE NUPPC – Lead NDE – Lead NDHHS-DBH, NUPPC

FY 2023

Goal	Activity	Deliverable	Responsible Entity
1.0. Align 100% of school plans with state and regional crisis-disaster behavioral health plans by 2025	1.1b. Prepare ESU's to use Tabletop package with schools. 1.2b. Convene tabletop exercises involving at least 48 school districts. 1.3b. Track changes made to school plans resulting from tabletops.	1.1b. List of ESU personnel participating 1.2b. Tabletop results, attendance, & feedback. 1.3b. List of changes.	NUPPC – lead NDE, DHHS-DBH NDE – lead NUPPC NDE – Lead NUPPC
2.0. Provide school intervention training to 60 people each year who are part of Nebraska's multidisciplinary crisis -disaster teams.	2.1b. Deliver PFA-S training to 60 community crisis-disaster personnel. 2.2b. Involve community crisis-disaster teams in SRM training and/or exercises in at least 10 districts.	2.1a. List of training and attendees 2.2b. List of training and attendees	NDE – Lead NDE – Lead
3.0. Distribute crisis message maps with behavioral health content in multiple languages annually to	3.1b. Translate messages into two additional languages. 3.2b. Assess how many and how ESUs	3.1b. Translated documents	NUPPC – Lead NDHHS-DBH, NDE NUPPC – Lead NDHHS-DBH, NDE

244 school districts, 17 educational service units, 6 regional behavioral health authorities, and via the Nebraska Emergency Management Agency in Nebraska.	and schools have used the message maps.	3.2b. School-ESU feedback on message map use.	

Budget Narrative – University of Nebraska Public Policy Center

Budget

PPC ESTIMATED BUDGET					
Total Budget		**Year 1 Budget**		**Year 2 Budget**	
Travel	**$177**	Travel	$87	Travel	$90
Other Direct Costs		**Other Direct Costs**		**Other Direct Costs**	
PPC Services	$119,008	PPC Services	$59,697	PPC Services	$59,311
PPS Srvcs - FEP/ESMI Specific	$30,018	PPS Srvcs - FEP/ESMI Specific	$15,013	PPS Srvcs - FEP/ESMI Specific	$15,005
Communications	$2,016	Communications	$1,025	Communications	$991
Supplies/Materials	**$0**	**Supplies/Materials**	**$0**	**Supplies/Materials**	**$0**
Total Direct Costs	$151,219	Total Direct Costs	$75,822	Total Direct Costs	$75,397
MTDC	$149,159	MTDC Costs	$73,760	MTDC Costs	$75,397
UNL F&A	$38,781	UNL F&A	$19,178	UNL F&A	$19,603
TOTAL COSTS	$190,000	Total Costs	$95,000	Total Costs	$95,000

A. Personnel—No funds requested.

B. Fringe Benefits—No funds requested.

C. Travel

Travel requests are estimated at $177 for the project period ($87 in Year 1 and $90 in Year 2) for in-state site visits. Estimated rates are based on UNL mileage reimbursement rates ($.29/mile). Actual travel costs will be charged to the grant, per UNL policy.

D. Equipment—no funds requested

E. Supplies—no funds requested

F. Contractual—no funds requested

G. Construction—no funds requested

H. Other

NUPPC Services fees are estimated at $149,026 for the project period ($74,710 in Year 1 and $74,316 in Year 2). 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. A 4% annual rate increase is estimated for Year 2.

Dr. Denise Bulling, *Senior Research Director*, will serve as the project lead and oversee project management, data collection and quantitative analysis, and reporting. Dr. Bulling will lead the

project team consisting of: **Mr. Quinn Lewandowski**, ***Senior Research Specialist* to** provide coordination of data collection, analysis, and reporting; **Mr. Kurt Mantonya, *Senior Research Specialist*** to provide coordination of data collection, analysis, and reporting; a ***Research Coordinator*** to assist with collection and reporting; and a ***Design Specialist***, who will assist with material production and reporting.

Included in the above PPC Services are *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*. Those PPC Services costs include Dr. Bulling and team's time specifically for developing and testing a tabletop exercise specifically addressing how school systems identify, refer, and reintegrate students with first episode psychosis or serious emotional disturbance, developing training materials 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 and lastly developing 2-3 crisis message maps about what to look for and how to find help for students with first episode psychosis or serious emotional disturbance. The table below estimates the hours required to conduct the FEP/ESMI activities.

PPC Estimated Hours	**Year 1**			**Year 2**		
Labor Category	**Rate**	**Hours**	**Cost**	**Rate**	**Hours**	**Cost**
Dr. Denise Bulling	**$146.76**	**20**	**$2,935**	**$152.63**	**16**	**$2,442**
Sr Research Specialist(s)	**$78.19**	**110**	**$8,600**	**$81.32**	**110**	**$8.946**
Design Specialist	**$54.81**	**17**	**$932**	**$57.00**	**17**	**$969**
Research Coordinator	**$53.05**	**48**	**$2,546**	**$55.17**	**48**	**$2,648**
		195	**$15,013**		**191**	**$15,005**

*hours listed are not in addition to the total hours for project but represent a specific allocation of the total hours required for project as part of the overall Services provided

Other Direct Costs include $2,016 ($1,025 in Year 1 and $991 in Year 2) 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 ($4,068), therefore, MTDC over the life of the project is $149,157. At 26%, F&A costs are calculated as $38,781 ($149,157 x 26%).

Budget Narrative – Nebraska Department of Education

Budget

NDE ESTIMATED BUDGET					
Total Budget		**Year 1 Budget**		**Year 2 Budget**	
Travel	$19,878	Travel	$9,939	Travel	$9,939
Other Direct Costs		**Other Direct Costs**		**Other Direct Costs**	
Supplies/Materials	$56,000	Supplies/Materials	$28,000	Supplies/Materials	$28,000
Contractual	$104,000	Contractual	$52,000	Contractual	$52,000
Other Costs (FEP/ESMI)	$197,642	Other Costs (FEP/ESMI)	$98,821	Other Costs (FEP/ESMI)	$98,821
Total Direct Costs	$377,520	Total Direct Costs	$188,760	Total Direct Costs	$188,760
Indirect Costs	$22,844	Indirect Costs	$11,422	Indirect Costs	$11,422
TOTAL COSTS	$400,364	Total Costs	$200,182	Total Costs	$200,182

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

- Travel to training locations – mileage $820
- 50 site visits (ESUs and school districts) – mileage $5,600
- Progressive Exercises – mileage $1,344
- Training sites and Site Visits (15 nights lodging @ $100/night) - $1,500, 15 days meals @$45/day – $450

D. Equipment—no funds requested
E. Supplies—$10,000 in printing cost and handout materials and training supplies needed for the PFA-S training facility rent (6 locations at $1,000 per location) - $6,000.
Facility rent for the community partner and project planning meetings (5 locations at $1,000 per location)- $5,000
Project-Specific Materials including curriculum, books, and other PFA-S and mental health supplies Training costs of $10,000
F. Contractual— Specialists will be contracted to develop and provide trainings across the state. $52,000
G. Construction—no funds requested
H. Other Costs-

FEP/ESMI Subgrants for ESUs: $88,821 ($5,224.75 per ESU X 17) to complete a PFA training and develop a multidisciplinary crisis team response to support the school districts and their families experiencing a first psychotic episode.

Tabletops for multidisciplinary use ($10,000). Test tabletop package in 4 rural and 1 urban school area. $2,000 per school x 5.

Indirect Charges

Nebraska Department of Education estimate indirect cost is 12.7%. $11,422.

State Information

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

Fiscal Year 2024

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 III of the Public Health Service Act		
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.

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: Tony Green

Signature of CEO or Designee[1]: 

Title: Interim-Director Division of Behavioral Health

Date Signed: 8-21-23

mm/dd/yyyy

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

Please upload your state's Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

Based on the guidance issued on October 11th, 2022, please submit a proposal that includes a narrative describing how the funds will be used to help individuals with SMI/SED, along with a budget for the total amount of the second allotment. The proposal should also explain any new projects planned with the second allotment and describe ongoing projects that will continue with the second allotment. The performance period for the second allotment is from September 30th, 2023, to September 29th, 2025, and the proposal should be titled "BSCA Funding Plan 2024. The proposed plans are due to SAMHSA by September 1, 2023.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

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

August 21, 2023

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 Bo Botelho, Interim Chief Executive Officer 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):

Bo Botelho
Interim 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:

Tony Green, Interim-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

August 17, 2023

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 Tony Green, Interim-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):

Tony Green, Interim-Director
Division of Behavioral Health
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:

Tony Green, Interim-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,

Bo Botelho
Interim Chief Executive Officer
Department of Health and Human Services

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

Tony Green

Title

Interim-Director Division of Behavioral Health

Organization

NE Dept. of Health and Human Services - Division of Behavioral Health

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

See attached SF-LLL form that affirmatively identifies there is not any lobbying activities to 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

Tony Green

Title

Interim-Director Division of Behavioral Health

Organization

NE Dept. of Health and Human Services - Division of Behavioral Health

Signature: 

Date: 8.21.23

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

See attached SF-LLL form that affirmatively identifies there is not any lobbying activities to report.

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C.1352

OMB Number: 4040-0013
Expiration Date: 02/28/2025

1. * Type of Federal Action:
- [ ] a. contract
- [x] b. grant
- [ ] c. cooperative agreement
- [ ] d. loan
- [ ] e. loan guarantee
- [ ] f. loan insurance

2. * Status of Federal Action:
- [ ] a. bid/offer/application
- [x] b. initial award
- [ ] c. post-award

3. * Report Type:
- [x] a. initial filing
- [ ] b. material change

4. Name and Address of Reporting Entity:

[x] Prime [ ] SubAwardee

*Name: NE Dept of Health & Human Services-Div of Behavioral Health

*Street 1: 301 Centennial Mall South Street 2: PO Box 95026

*City: Lincoln State: NE: Nebraska Zip: 68509-5026

Congressional District, if known: NE-ALL

5. If Reporting Entity in No.4 is Subawardee, Enter Name and Address of Prime:

Not Applicable - No lobbying activities to disclose or report.
Nebraska's SAMHSA Combined FFY2024-2025 MH/SUPTRS BG Application

6. * Federal Department/Agency:

7. * Federal Program Name/Description:

CFDA Number, *if applicable:*

8. Federal Action Number, *if known:*

9. Award Amount, *if known:*

$

10. a. Name and Address of Lobbying Registrant:

Prefix *First Name Middle Name

*Last Name Suffix

*Street 1 Street 2

*City State Zip

b. Individual Performing Services (including address if different from No. 10a)

Prefix *First Name Middle Name

*Last Name Suffix

*Street 1 Street 2

*City State Zip

11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when the transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

*Signature:

*Name: Prefix *First Name: Tony Middle Name

*Last Name: Green Suffix

Title: Interim Director of Div of Behavioral Health Telephone No.: Date: 8/21/23

Federal Use Only:

Authorized for Local Reproduction
Standard Form - LLL (Rev. 7-97)

Planning Steps

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

Narrative Question:

Provide an overview of the state's M/SUD prevention (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 M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. In general, the overview should reflect the MHBG and SUPTRS BG criteria detailed in "Environmental Factors and Plan" section.

Further, in support of the **Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government**, SAMHSA is committed to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Therefore, the description should also include how these systems address the needs of underserved communities. Examples of system strengths might include long-standing interagency relationships, coordinated planning, training systems, and an active network of prevention coalitions. The lack of such strengths might be considered needs of the system, which should be discussed under Step 2. 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."

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

FFY2024-2025 Instructions for Planning Steps updated

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

Provide an overview of the state's M/SUD prevention (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 M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. In general, the overview should reflect the MHBG and SUPTRS BG criteria detailed in "Environmental Factors and Plan" section.

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Nebraska's Behavioral Health System Overview

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. This includes the provision of planning, funding, oversight, and technical assistance to a network of Community-Based Services delivered through the Federally Recognized Tribes, Nonprofit Agencies and Organizations, and the Regional Behavioral Health Authorities.

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

The DBH provides the four federally recognized tribes state funds, consultation, and technical

assistance for both their Mental Health and Substance Use Disorder programs. DBH engages tribal representatives in planning, trainings, and initiatives, as well as supports the culturally appropriate provision of services to tribal members.

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

The Nebraska 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, research, 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.

Role of Division of Behavioral Health: SMHA and SSA

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

Strategic Planning

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

ONE NEBRASKA! ONE PLAN!

The Division of Behavioral Health Strategic Plan 2017-2020 was a twelve-month endeavor,

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

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

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

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

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

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

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

Visioning sessions occurred with Nebraska Department of Health and Human Services

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

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

The survey, in English and Spanish, was distributed statewide via a variety of State ListServs to behavioral health providers, systems partners, behavioral health authorities, consumers, families and Tribal Nations. The survey was designed to prioritize the needs identified under each of the five transformational pillars. The survey also offered each participant an opportunity to provide feedback on needs, gaps, and strategies.

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

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

The team then worked with Division staff and partners, including Regional Administrators, to establish key performance indicators, targets, timelines and resources needed to make the plan systemically feasible. Pillars, draft goals and objectives were reviewed with Advisory members. As the plan has considerable systemic change at its core, continued refinement with NeDHHS Leadership resulted in the public facing document located at URL DBH Strategic Plan_2022-2024.

NeDHHS, DBH leadership is currently scheduling statewide consumer forums to solicit feedback and craft activities to . August 2021 has been targeted for final prioritization of strategies and activities feasible per fiscal year along with completion of companion work plan to document "what must be achieved?" and "how will we know / be accountable?"

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

The new Strategic Plan framework, goals, objectives and strategies have been prioritized. A companion workplan with specific measures and timelines is currently in development. The FY2022-2024 Plan is located at URL DBH Strategic Plan_2022-2024.

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

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

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

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

Movement forward capitalizes on partner commitment and work completed to date. During the previous year, the Nebraska System of Care (NeSOC) efforts focused on increasing access

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

The Division of Behavioral Health Strategic Plans 2017-2020 and 2022-2024, encompass an overall behavioral healthcare system focus by integrating a Substance Abuse Prevention, and Recovery/Supports Statewide Strategic Plan into the documents. URL: https://dhhs.ne.gov/Behavioral%20Health%20Documents/Strategic%20Plan%202017-2020.pdf and URL DBH Strategic Plan 2022-2024.

In 2020, the population of Nebraska was 1,961,504 and expected to be 1.975 million in 2023, which is relatively slow growth. Nebraska is the 37th populous state in the nation. The state has 93 counties encompassing 77,347 sq miles. In terms of location, nearly 50% of the state population live in the two eastern metropolitan areas of greater Omaha and greater Lincoln.

Demographic characteristics of the state population by race is 87.8 % Caucasian, 4.74% Black/African America, 10.47% Hispanic or Latino, 2.2% Asian, 0.84% American Indian, 0.23% Sioux tribal. Other quick facts about the characteristics of the state population include: 14% are over age 65; 72,627 with hearing disabilities; 37,856 with vision disabilities; 73,958 with cognitive disabilities; 62,968 with independent living difficulty; and 34, 042 with self-care difficulty. It is estimated that 1 in 20 adults (62,000) with SMI and 1 in 5 adults experience a mental illness each year (275,000).

Public Behavioral Health System Organization: Division of Behavioral Health

State Level Organization

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

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

DBH Central

DBH Central is comprised of the following operational components:

1. Community-Based Services (CBS Adult and Youth): Consists of services and the workforce essential for delivery of statewide, community-based mental health and substance use disorder prevention, treatment, recovery and support services.

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

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

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

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

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

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

- Trilogy Integrated Services to provide a web portal (Network of Care) for consumers, providers, and the public to access: a comprehensive directory of behavioral health resources in their area, a databank of articles, factsheets and reports about behavioral health conditions, recovery and treatment, and recovery tools for their personal use;
- Father Flanagan's Boys Town to operate the new 988 Nebraska Family Helpline (888-866- 8660) where families can obtain assistance and provide a single contact point 24 hours a day, seven days a week; to connect callers with family organizations to advocate for families with youth experiencing mental/emotional disorders, support the family voice and offer supportive services such as education, support groups, advocacy, and mentoring; and,
- Four federally recognized Native American Tribes in the state, with whom the DBH awards 1.5 million dollars of state funds in contracts, for the provision of culturally specific mental health and substance use disorder treatment services as well as relapse prevention activities.

Regional Centers

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

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

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

- Psychiatric Services: These are services for people with severe and persistent mental illness who have been committed by a mental health board due to mental illness and dangerous behaviors and cannot be served at a community-based hospital facility. The primary mission of the programs is to help individuals stabilize and return to live in the community. Interdisciplinary treatment teams develop individualized treatment plans based upon assessments completed at the time of admission. Discharge planning is part of the treatment plan and starts when an individual is admitted.
- Forensic Services: Psychiatric Services provide evaluation, assessments, and treatment for individuals as ordered by the Nebraska legal system. The Forensic Program serves individuals who need competency evaluation, competency restoration, and who are found Not Responsible by Reason of Insanity. The program offers a structured treatment approach which is tailored to the specific needs of the individual patient.
- Sex Offender Service: This service provides treatment for individuals with a history of sexually harmful behavior. The population includes convicted sex offenders who have been committed under an inpatient mental health board order for sex offender treatment. Additionally, a residential level transition program works to release the patients with the necessary structure to allow them the opportunity to successfully return to the community.
- Whitehall Campus: Whitehall is designated for two distinct residential programs for adolescent males, one for young men who have sexually harmed and one for substance use disorder services. The Juvenile Chemical Dependency Program has relocated from the Hastings Facility to Whitehall, a program licensed and accredited as part of the Lincoln Regional Center. Whitehall provides residential substance use disorder treatment for young men. Most youth are on probation and have been in treatment an average of three times. Whitehall is a Psychiatric Residential Treatment Facility (PRTF) that

addresses the treatment needs of male adolescents who have sexually harmed. Each youth has his own room. The program is family-centered and has its own school on the campus. Youth who complete treatment at Whitehall have a low incidence of reoffending sexually based on an independent study that followed the youth over seven years from completion of treatment.

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

Office of Consumer Affairs

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

- Facilitation of community forums for consumers to give feedback on the quality of service and to identify gaps in these services.
- Administration of recovery initiatives, planning, research, and advocacy for behavioral health consumers.
- Administration of peer support training and certification.
- Administration of workforce development for peer support specialists.
- Facilitation of OCA's People's Council designed to advise the DBH around consumer involvement in system planning, evaluation, and inclusion.
- Administration of family navigator and peer support service provision in NE.
- Regional consumer coordination within the RBHAs
- System Transformation initiatives related to trauma informed care and cultural and linguistic appropriate standards.
- Community Health Worker (CHW) and Peer Support Workforce initiatives
- Administration of Peer Standards and Regulations.

The Office of Consumer Affairs (OCA) provides statewide leadership and resources for the behavioral health system that works to build, promote, and sustain services which incorporate consumer feedback as integral components of the recovery process throughout the system. Activities include planning, organizing, and creating consumer involvement initiatives to increase consumer involvement at all levels of service planning and delivery. Education, technical assistance, and support is provided to assist consumer organizations in expanding consumer participation as a priority in state system advocacy initiatives, program development, contract compliance, board development, fiscal management, and recruitment and retention of staff.

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

LB 417 was passed during the 105th legislative session. LB 417 added clarifying language to authorize the Division of Behavioral Health to set standards in peer services. Current statute charges the Division with ensuring quality services, including peer support. This bill amended state law to specifically authorize peer support standards for training, credentialing, and

competencies of a peer recovery workforce. OCA works to raise the bar for the profession and create a culture that widely integrates peers into the workforce and offers support to them as they perform their duties to increase access and quality of care for consumers in Nebraska. In 2019, new training curriculum and certification standards and processes have been implemented and regulations promulgated.

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

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

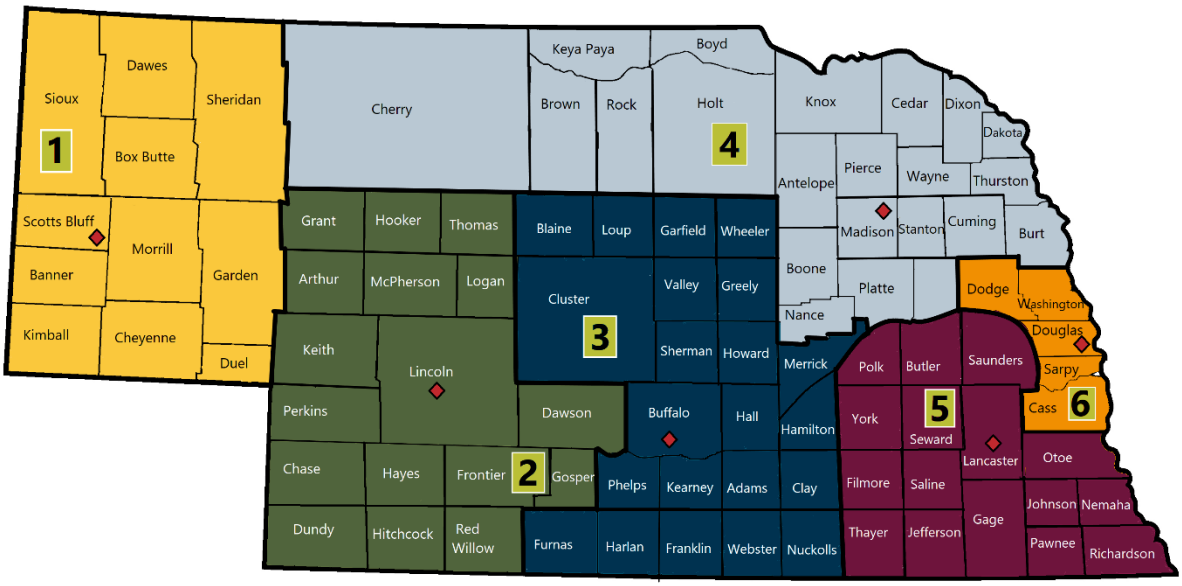
Through the above-mentioned functions, the Nebraska OCA People's Council provides recommendations to guide the DHHS DBH, including the OCA, and related state agency partners on ways to best support adults, children, and their families in the journey of healing, recovery, resiliency, and personal transformation.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

Regional and Local Level Organization

DBH contracts with six RBHAs which authorizes them to purchase services using state general

funds, funds received under the Community Mental Health Services block grant and the Substance Abuse Prevention Treatment block grant, and other discretionary federal grants.

Figure 3 Nebraska Behavioral Health Authorities



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

Table 1 Nebraska Census by Regional Behavioral Health Authority

Nebraska Population 5-Year (2017-2021) ACS Estimates by Regional Behavioral Health Authority (RBHA)

RHBA	RBHA Office	Counties	Population	Percent of State
Region 1: Panhandle/West	Scottsbluff	11	83,626	4.3%
Region 2: Southwest	North Platte	17	98,082	5.0%
Region 3: South Central	Kearney	22	230,827	11.8%
Region 4: Northeast & North Central	Norfolk	22	206,937	10.6%
Region 5: Southeast	Lincoln	16	480,279	24.6%
Region 6: East	Omaha	5	851,729	43.6%
Total		93	1,951,480	100.0%

Source(s): U.S. Census Bureau, American Community Survey 5-year population estimates, accessed 6.28.2023

As part of the RBHA responsibility for the development and coordination of publicly funded

behavioral health services in their region, each RBHA is under contract to provide:

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

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

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

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

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

Independent Peer Review

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

Prevention System Organization

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

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

In cooperation and partnership with Regional Prevention System Coordinators, training events are funded throughout the state to introduce, enhance, and improve the use of evidence-based, promising and local prevention strategies most appropriate to their local community goals utilizing the Strategic Prevention Framework (SPF) process. Local goals have included the reduction of underage drinking, reduction of driving under the influence, reduction of binge drinking, and preventing prescription drug abuse and marijuana use among youth. By requiring all communities to use the SPF model, and by providing effective statewide training and technical assistance in the use of the model, greater progress is being achieved in reducing substance abuse and related health consequences across the state.

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

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

The PAC objectives are as follows:

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

Youth and Adult Services

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

Table 2 List of Funded Services

Table 2

List of Funded Mental Health (MH) and Substance Use (SUD) Services

(** Shared Medicaid Service)
(^^ pending system update to shared status)

Emergency Services & Inpatient Services:	MH	SUD
24 Hour Crisis Line	X	X
Crisis Assessment**	X	X
Crisis Response	X	X
Crisis Stabilization**	X	X
Emergency Community Support	X	
Emergency Protective Custody	X	
Emergency Psychiatric Observation**	X	
Hospital Diversion <24 hrs.	X	
Hospital Diversion >24 hrs.	X	
Acute Hospitalization**	X	
Sub-Acute Hospitalization**	X	
Mental Health Respite	X	
Clinically Managed Residential Withdrawal Management**		X
Dual Residential**	X	X
Halfway House**		X
Inpatient Post Commitment Treatment ^^	X	X
Intermediate Residential**		X
Medically Monitored Inpatient Withdrawal Management **		X
Psychiatric Residential Rehabilitation**	X	
Psychological Testing**	X	
Secure Residential**	X	
Short Term Residential**		X
Therapeutic Community**		X
Outpatient Services:	**MH**	**SUD**
Assertive Community Treatment**	X	
Assessment**	X	X
Benefit Services	X	
Client Assistance Program**	X	X
Community Support**	X	X
Day Rehabilitation**	X	
Day Support	X	

Day Treatment**	X	
Family Navigator	X	
Family Peer Support **	X	
Intensive Community Service	X	X
Intensive Outpatient - Matrix**	X	X
Intensive Outpatient**	X	X
Medication Management**	X	
Multisystemic Therapy**	X	
Opioid Treatment Program (OTP)**		X
Outpatient Psychotherapy**	X	X
Peer Support**	X	X
Professional Partner	X	
Recovery Homes (Oxford)		X
Recovery Support	X	X
Secure Residential R&B		X
Substance Abuse Prevention Services		X
SOAR	X	X
Supported Education	X	
Supported Employment	X	X
Supported Housing	X	X
Therapeutic Consultation	X	
Warm Hand Off	X	X
Youth Assessment^^	X	X
Youth Transition Services		X

Public Behavioral Health System Organization: DHHS Division Partners

Other Division partners within the DHHS agency include the following:

Division of Medicaid and Long-Term Care

The Division of Medicaid and Long-Term Care (MLTC) provides funding for an array of services to address mental health and substance use issues of children and adults, including the Medicaid 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. The MLTC continues to work with the DBH to standardize service delivery expectations (service definitions) to ensure that Medicaid and non-Medicaid individuals are receiving similar services.

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

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

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

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

The Division of Public Health

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

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

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

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

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

Staff from the DBH/OCA and Public Health participate in Region VII SAMSHA sponsored focus meetings on integrated services and coordination of peer provided services with respect to

standards, training, and certifications. There have been renewed efforts to addressed curriculum as well as CHW standards and certification utilization the peer support framework implemented by the Division. This work is preliminary but ongoing.

Division of Children and Family Services

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

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

The CFS Protection and Safety Unit, is responsible for Title IV-B Subpart 1 (Child Welfare Services), IV-B Subpart 2 (Promoting Safe and Stable Families), Title IV-E (Foster Care and Adoption Assistance), Child Abuse Prevention and Treatment Act (CAPTA), Chafee Foster Care Independence Program (CFCIP), and Chafee Education and Training Vouchers (ETV). In addition, this section operates the statewide Child/Adult Abuse and Neglect Hotline and is responsible for conducting all initial safety assessments. Services are primarily delivered through the five, state-administered, local Service Areas and through tribal-administered child welfare programs.

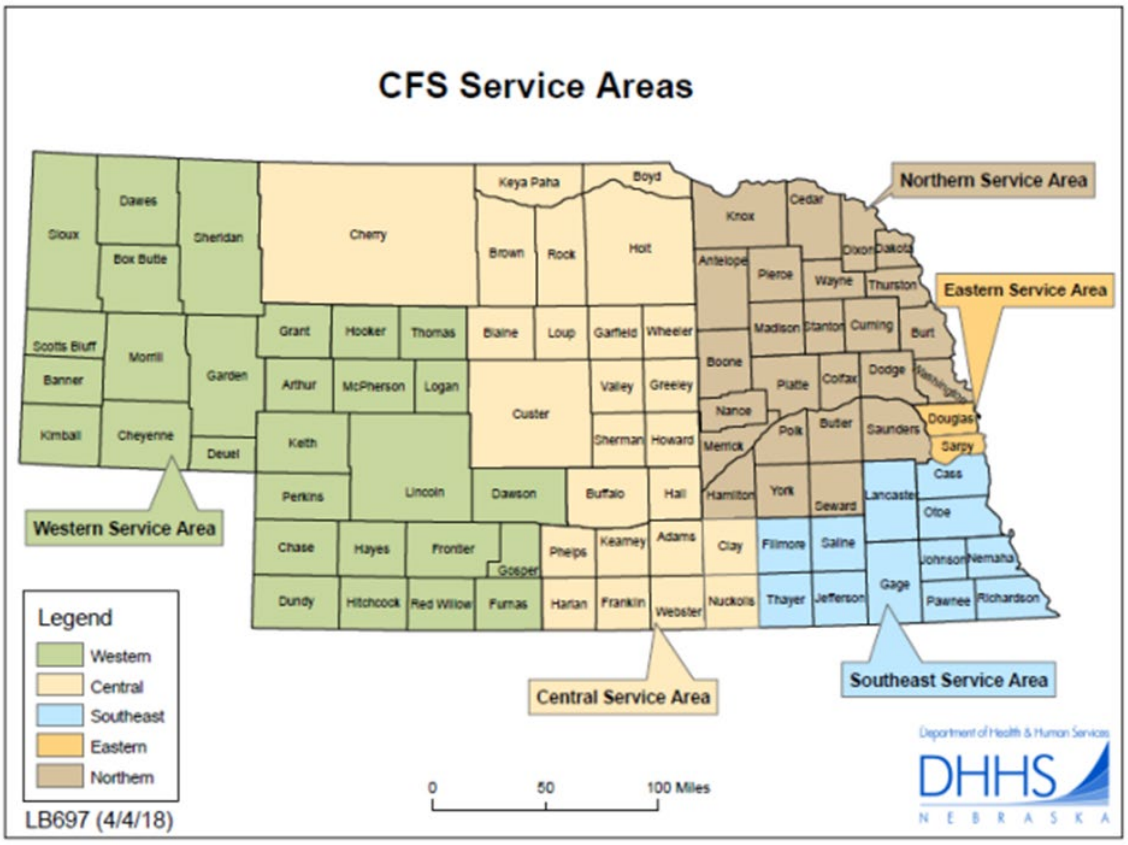
Case management functions are state administered in the Western Service Area (WSA), Central Service Area (CSA), Northern Service Area (NSA) and Southeast Service Area (SESA). CFS contracts for case management and service coordination in the largest service area, the Eastern Service Area (ESA), with Saint Francis Ministries as of January 1, 2020. The Judicial Districts as set forth by the Supreme Court do not conflict with the CFS service area boundaries which as a result allows for greater coordination of service delivery between CFS and the Judicial Branch across the state. The DBH works collaboratively with the CFS Service Areas/caseworkers in accessing services and monitoring waitlists for services for women with dependent children.

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

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

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

Figure 4 Division of Children and Family Services Service Areas



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

The Division of Developmental Disabilities

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

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

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

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

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

Nebraska Department of Correctional Services

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

Addressing the Needs of a Diverse Population

The DBH is dedicated to providing excellent behavioral health services that are accessible to all members of the community, including racial/ethnic minorities, Native Americans, refugees, and newly arrived immigrant groups. The DBH functions in accordance with the DHHS Office of Health Disparities & Health Equity (OHDHE), striving for appropriate cultural and linguistic specificity for all recipients of behavioral health services. All RBHAs and their contractors are

required to provide services that are culturally and linguistically appropriate. The DBH also contracts directly with the four federally recognized tribes of Nebraska (Ponca, Winnebago, Omaha and Santee Sioux) for behavioral health services and provides staff assistance to the tribes as needed and works to promote cultural awareness and diversity in the workforce through leadership, training, and direct funding of continuing education classes for providers.

Table 3 Nebraska 2019 Estimates of Population by Race and Ethnicity

Nebraska Population 5-Year (2017-2021) ACS Estimates by Race and Ethnicity		
Race	**Number**	**Percent of Total**
American Indian and Alaska Native	17,937	0.9%
Asian	48,379	2.5%
Black or African American	93,357	4.8%
Native Hawaiian and Other Pacific Islander	1,175	0.1%
Some other race alone	60,041	3.1%
Two or more races	100,214	5.1%
White	1,630,376	83.5%
Total	**1,951,480**	**100.0%**

Ethnicity	**Number**	**Percent of Total**
Hispanic	224,693	11.5%
Non-Hispanic	1,726,787	88.5%
Total	**1,951,480**	**100.0%**

Source(s): U.S. Census Bureau, American Community Survey 5-year population estimates, accessed 6.28.2023

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

Although Nebraska is often viewed as having a homogenous population, it is becoming increasingly diverse with African American, Hispanic, Native Americans, and immigrants from Latin America, Africa, and Asia. The consumer population remains nearly universal when it comes to language preference. In FY2022, 83.1% of individuals receiving Behavioral Health services funded through the DBH indicated English as their preferred language.

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

DBH Community Based Services Consumers by Race and Ethnicity, SFY22		
Race	**Total**	**Percent**
American Indian or Alaska Native	706	2.8%
Asian	162	0.6%
Black or African American	2,120	8.4%
Native Hawaiian or Other Pacific Islander	83	0.3%
White	17,982	71.3%
Two or More Races	309	1.2%
Not Available	3,869	15.3%
Total	25,231	100.0%

Ethnicity	**Total**	**Percent**
Hispanic	2,911	11.5%
Non-Hispanic	18,704	74.1%
Not Available	3,616	14.3%
Total	25,231	100.0%

Source: CDS, SFY22 Anchor Dataset; data current as of 10/1/2021

The RBHAs provide services to diverse populations as demonstrated by comparing the persons served data from State Fiscal Year 2022 to the U.S. Census 2021 population estimates. The percentages of persons who are other than Asian and White served are proportionally higher among all DBH service recipients, compared to their proportion in the total state population. The current data system does not capture LGBTQ information. The DBH continues to review policy on the collection of data pertaining to gender affiliation and sexual preference.

System Strengths Summary

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

In 2020 and 2021 DBH conducted two core statewide planning activities, the Nebraska NDHHS-DBH Strategic Plan & System Optimization Road Map and the Division of Behavioral Health

Strategic Plan 2022-2024. This document draws on these activities to summarize the behavioral health landscape.

Summary of System Strengths:

- A valuable and well thought out, data-driven Centralized Data System (CDS) which promotes standards for the delivery of care and offers real time outcome tracking and measurement,
- Development and implementation of the DBH Electronic Billing System (EBS) that provides an in-house system to collect, manage, and report financial information.
- Integration between the DBH CDS and EBS leverages technology platforms to provide comprehensive system planning,
- DBH funding of core Evidence-Based Practices (EBPs) and the requirement that RBHAs incorporate EBPs into their budgets,
- Suicide Prevention Plan that is holistic and evidenced-based,
- Quality Assurance/Performance Improvement (QA/PI) measures that are holistic, particularly the use of the
    - Compass EZ Tool,
    - Trauma Informed Care (TIC) tool,
    - Evidence-Based Practice Survey,
    - Quarterly Regional Data Outcomes (RDO) meetings,
    - Monthly Super User meetings,
- Multiple Continuous Quality Improvement (CQI) processes, ensuring checks and balances,
- Two fully engaged behavioral health advisory committees, State Advisory Committee on Substance Abuse Services and State Advisory Committee on Mental Health Services, whose members have a strong commitment to improving access to care throughout the state,
- A Mental Health Court that harnesses peer-support to provide an alternative to incarceration for Serious Mental Illness/Serious Emotional Disturbance (SED/SMI) population,
- A strong consumer group, called the *Peoples Council*, has the support of the SMHA/SSA, is focused on recovery and advocates for expansion of peer-support and access to services in rural areas,
- The development and implementation of behavioral health workforce development model,
- Leadership in promoting a culture of change through a multi-faceted approach to infuse health parity throughout the behavioral health care system,

- Employment of consumer surveys to inform programming and practices by DBH, RBHAs and providers; results also are shared with DBH advisory groups,
- In the FY21 full URS report (the most recent available):
    - Nebraska's consumer satisfaction with access to services (adults 84.2%; child/family 81.8%) were lower than the national averages (adults 87.8%; child/family 87.9%),
    - Readmission rates for state hospitals, both 30 and 180 days, were below the national averages, and
    - Nebraska's consumer employment rates for employed (61.9% in Labor Force) are higher than the national average (48.2%).

END Plan Step 1

Planning Steps

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

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's behavioral health system, including for other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps. The state's priorities and goals must be supported by data-driven processes. This could include data that is available through a number of different sources such as SAMHSA's National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), National Survey of Substance Use Disorder Treatment Services (N-SSATS), the Behavioral Health Barometer, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the **Uniform Reporting System** (URS), 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 and treatment planning. States with current Partnership for Success discretionary grants are required to have an active SEOW.

This narrative must include a discussion of the unmet service needs and critical gaps in the current system regarding the MHBG and SUPTRS BG priority populations, as well as a discussion of the unmet service needs and critical gaps in the current system for underserved communities, as defined under **EO 13985**. States are encouraged to refer to the **IOM reports**, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* and ***The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding***[1] in developing this narrative.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Nebraska - FFY 2024-2025 Combined MHBG/SUPTRS BG Application/Behavioral Health Assessment and Plan

FFY2024-2025 Instructions for Planning Steps

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

This step should identify the unmet service needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's behavioral health system, including for other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps. The state's priorities and goals must be supported by data-driven processes. This could include data that is available through a number of different sources such as SAMHSA's National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), National Survey of Substance Use Disorder Treatment Services (N-SSATS), the Behavioral Health Barometer, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the **Uniform Reporting System** (URS), 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 and treatment planning. States with current Partnership for Success discretionary grants are required to have an active SEOW.

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Identifying Unmet Needs and Critical Gaps within Current System

Nebraska understands the importance of a data driven approach to understand the dynamic needs of our state as well as is necessary to make informed decisions about the services funded for individuals dependent upon the Division of Behavioral Health (DBH) for treatment and

recovery. Nebraska has evaluated data from a variety of internal sources on treatment and prevention data collected in addition to external resources that have historically been used to monitor and inform decision making such as the National Survey on Drug Use and Health (NSDUH), the Treatment Episode Data Set (TEDS), and the Uniform Reporting System (URS). The 2022 Behavioral Health Barometer report for Nebraska was also used to identify specific areas of need.

As part of the NDHHS-DBH Strategic Plan & System Optimization Road Map planning process completed in December 2020, the DBH put together an initial needs assessment which was reviewed with the six Regional Behavioral Health Authorities in February 2019 as well as in April 2019 with both of the state *Joint Advisory Committees* and May 2019 with the State Epidemiological Outcomes Workgroup. These initial reviews provided opportunities for the DBH to receive feedback from valuable stakeholders necessary to help complete the needs assessment and identify priority areas and strategies for system improvement. Both committees again were provided information on behavioral health needs in Nebraska during a meeting in August 2019 and again at the Joint Advisory Committee meeting in April 2021. These planning processes culminated in the creation of the DHHS Behavioral Health Strategic Plan 2022-2024.

Review of the strategic planning activities, documents, and current data from National Survey on Drug Use and Health (NSDUH), the Treatment Episode Data Set (TEDS), and the Uniform Reporting System (URS) and presentation to the Joint Advisory Committees in April and August 2023 were followed by a posting of the draft Combined Block Grant Application sections which, covered identification of service system gaps and consumer needs. The draft application was also posted on the DBH website for public review and comment. Each of these provided opportunity for feedback and suggestions on which areas of need should be prioritized for FFY 2024-2025 Combined MHBG/SUPTRS BG Application/Behavioral Health Assessment and Plan.

State Epidemiological Outcomes Workgroup (SEOW)

Formed in March 2007, the SEOW is comprised of administrators, epidemiologists, and key stakeholders who collaborate to make decisions regarding the collection and reporting of data.

The SEOW seeks to produce sustained outcomes to prevent the onset and reduce the progression of substance abuse, mental illness, and related consequences.

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

One of the main functions of the SEOW is data review. The SEOW works collectively to identify the availability of data, utilization of data and prioritization of substance abuse data gaps, including missing or incomplete data. Through a formal charter, this work will be accomplished by continuation of the Strategic Planning Framework planning process, working across disciplines and implementing strategies that are specifically designed to create environments that support behavioral health and the ability of individuals to withstand challenges.

One of the many contributions the DBH provides to the workgroup is data from the community-based substance abuse treatment information which is collected and tracked within the DBH Centralized Data System (CDS) and the Nebraska Prevention Information Reporting System (NPIRS). The DBH leads the workgroup in its efforts to identify priority substance use disorder issues and problems associated with related mental health disorders to maximize use of resources at the state and community level. In many areas, the state has a wealth of data available from which the SEOW will be able to draw assessment information. For example, the Nebraska Young Adult Alcohol Opinion Survey, the Nebraska Risk and Protective Factor Student Survey and the Youth Risk Behavioral Survey provide excellent data for monitoring underage drinking and other youth substance abuse issues. However, in other areas, such as surveillance systems for monitoring Fetal Alcohol Spectrum Disorders or substance use among older adults, information is minimal. Often, data drives decisions about resources; absence of data impacts the attention directed toward major public health issues. Therefore, ensuring sustainability and ongoing

operation of a SEOW is vital to coordinate a public health surveillance system that is capable of providing a comprehensive, focused assessment and analysis.

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

Note on Community Behavioral Health Data

The DBH currently uses its own data management system, the DBH CDS, which was implemented in May 2016. The CDS collects all DBH data related to community behavioral health. The DBH contracts with the six Regional Behavioral Health Authorities (RBHAs) and the RBHAs contract with local providers or, in some cases, directly provide the services. At the service provision level, data are collected and reported directly into the CDS. In this section these notes apply:

1. Data source: Centralized Data System.
    i. Persons Served (unduplicated consumer-level data)
    ii. Service Utilization (encounter-level data)
    iii. Statistics reported do not include number of service utilization or number of persons served at the Regional Centers (state hospitals) unless otherwise noted
2. MH ONLY category means the individual was only served in one or more Mental Health (MH) services funded by the DBH via the six RBHAs.
3. SUD ONLY category means the individual was only served in one or more Substance Use Disorder (SUD) services funded by the DBH via the six RBHAs.
4. DUAL Primary category means the individual was only served in a service category where both *Mental Illness* and *Substance Use Disorder* are the primary diagnosis.

5. COMBO means the individual was served in a service category with a combination of both *Mental Illness* and *Substance Use Disorder*, where one is listed as the primary diagnosis and the other is listed as a secondary diagnosis.
6. Unless otherwise specified in this report, youth means age ***0-17 years***; adult means age 18 and older; even though in the State of Nebraska the age of majority is 19.

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

In Fiscal Year 2022 (FY22)[1], the DBH funded community-based services for 25,231 individuals. As reported in the FY22 Uniform Reporting System (URS) [2] tables, there were 9,702 adults served with SMI and 1,249 youth (under 18 years) with SED.

Adults with Serious Mental Illness (SMI)

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

- The person is 18 years old or older **AND**
- The person has an ICD-10 diagnosis of F06.0, F06.2, F20.0, F20.1, F20.2, F20.3, F20.5, F20.81, F20.89, F20.9, F21, F22, F23, F24, F25.0, F25.1, F25.8, F25.9, F28, F29, F30.10, F30.11, F30.12, F30.13, F30.2, F30.3, F30.4, F30.8, F30.9, F31.0, F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.8, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8, F33.9, F34.1, F34.8, F34.9, F39, F40.00, F40.10, F41.0, F41.1, F41.8, F41.9, F42, F43.10, F43.8, F44.0, F44.1, F44.4, F44.5, F44.6, F44.7, F44.81, F44.89, F44.9, F45.1, F45.21, F45.22, F48.1, F50.01, F50.02, F50.9, F60.0, F60.1, F60.2, F60.3, F60.4, F60.5, F60.6, F60.7, F60.81, F63.3, F63.81, F64.1, F93.0 **AND**
- The persons has a GAF score less than 60 **OR**

[1] CDS FY22 Community Based Services Dataset (data as of 10.01.2022)
[2] Source Profile and Treatment Data MH: FY2020 URS table 2A 14A

- The person is served in one of the Nebraska Behavioral Health System (NBHS) funded Community Mental Health Rehabilitation Based Services (Community Support, Assertive Community Treatment, Psychiatric Residential Rehabilitation, Day Treatment, Day Rehabilitation, Day Support, Vocational Support, or related psychiatric rehabilitation services) **OR**
- The service provider has indicated that the person has a functional deficit **OR**
- The person is SSI/SSDI eligible or potentially eligible **OR**
- The service provider indicates that the person meets SMI criteria.

The following data tables are from treatment data entered by providers into the DBH CDS and as reflected in the Nebraska **FY2022** Uniform Reporting System (URS).

Table 1 URS Table 2A for FY22. Profile of Persons Served in Mental Health Services Age 18+

Adult Consumers (18+) Served in Mental Health Services		
Total Age 18+	18,218	86.8%
Total in MH Services	20,989	100.0%

Source: FY22 URS Table 2A, data based on CDS Annual Anchor Dataset
data current as of 10/1/2022

Of this population reported on URS Table 2A, 42.7% (8,952) were between the ages of 25-44, 26% (5,450) are between the ages of 45-64, and 4.2% (871) were described as 65 years or older. In Table 14A, 53.3% of adults 18 years and older (18,218) receiving mental health services were described as having a Serious Mental Illness (SMI). The percentage of adults described as SMI has increased from FY20 (48.9%).

Youth with Serious Emotional Disturbance (SED)

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

- The person is between 3 and 17 years old (NE SED definition/URS) **AND**
- The person has and ICD-10 diagnosis of F06.0, F06.2, F20.0, F20.1, F20.2, F20.3, F20.5, F20.81, F20.89, F20.9, F21, F22, F23, F24, F25.0, F25.1, F25.8, F25.9, F28, F29, F30.10, F30.11, F30.12, F30.13, F30.2, F30.3, F30.4, F30.8, F30.9, F31.0, F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.8, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8, F33.9, F34.1, F34.8, F34.9, F39, F40.00, F40.01, F40.10, F41.0, F41.1, F41.8,

F41.9, F42, F43.10, F43.11, F43.12, F43.8, F44.0, F44.1, F44.4, F44.5, F44.6, F44.7, F44.81, F44.89, F44.9, F45.1, F45.21, F45.22, F48.1, F50.00, F50.01, F50.02, F50.2, F50.9, F60.0, F60.1, F60.2, F60.3, F60.4, F60.5, F60.6, F60.7, F60.81, F63.3, F63.81, F64.1, F63.81, F90.0, F90.1, F90.2, F90.8, F90.9, F93.0, F95.2 **AND**

- SSI/SSDI eligible or potentially eligible **OR**
- The persons has been admitted to Professional Partner Services, Special Education Services, Day Treatment Mental Health Services, Intensive Outpatient Mental Health Services, Therapeutic Consultation/School Wrap, Respite Care Mental Health Services **OR**
- The service provider indicated that the person meets SED criteria.

The following data tables are also from treatment data entered by providers into the DBH CDS and as reflected in the Nebraska **FY2022** Uniform Reporting System (URS).

Table 2 URS Table 2A for FY22. Profile of Persons Served, All Programs Age 0-17

Youth Consumers (0-17) Served in Mental Health Services		
Total Youth	2,771	13.2%
Total in MH Services	20,989	100.0%

Source: FY22 URS Table 2A, data based on CDS Annual Anchor Dataset
data current as of 10/1/2022

In FY2022, 13.2% (2,771) of all individuals receiving mental health services funded by the DBH were youth and of those 45.1% (1,249) were described as having a Serious Emotional Disturbance (SED). The percentage of youth described as SED has declined from FY2020 (49.3%).

Table 3 URS Table 14A for FY22. Profile of Persons with SED served Age 0-17

Youth Consumers (0-17) with SED		
Total Youth with SED	1,249	45.1%
Total Youth in MH Services	2,771	100.0%

Source: FY22 URS Table 14A, data based on CDS Annual Anchor Dataset
data current as of 10/1/2022

Capacity Management and Waiting List System for Priority Populations

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

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

Mental Health Priority Groups

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

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

Table 4 MHB Discharged from Lincoln Regional Center (LRC)

Priority Population: MHB Discharged from Lincoln Regional Center (LRC)							
	Total Service Encounters: MHB Discharged from LRC					Total # Unduplicated Consumers	
SFY	MH Only	Dual (Primary)	Combo	Total	Average wait time in days*	Priority: LRC	Overall
FY20	64	3	5	77	0.00	34	31,704
FY21	62	0	5	71	0.00	35	29,510
FY22	43	1	0	47	0.00	27	25,231

*Average wait time is based on encounters for which a value was reported
Data Source: CDS Anchor Datasets for FY20, FY21, FY22
Data current as of 10/1/2020, 10/1/2021, 10/1/2022

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

Priority Population: Mental Health Board Inpatient Commitment							
	Total Service Encounters: MHB Inpatient Commitment					Total # Unduplicated Consumers	
SFY	MH Only	Dual (Primary)	Combo	Total	Average wait time in days*	Priority: MHB (IPC)	Overall
FY20	41	12	7	64	0.02	29	31,704
FY21	61	17	6	88	0.00	23	29,510
FY22	46	6	7	62	0.68	29	25,231

*Average wait time is based on encounters for which a value was reported
Data Source: CDS Anchor Datasets for FY20, FY21, FY22
Data current as of 10/1/2020, 10/1/2021, 10/1/2022

Table 6 Table Mental Health Board (Out-Patient Commitment)

Priority Population: Mental Health Board Outpatient Commitment							
	Total Service Encounters: MHB Outpatient Commitment					Total # Unduplicated Consumers	
SFY	MH Only	Dual (Primary)	Combo	Total	Average wait time in days*	Priority: MHB (OPC) (only)	Overall
FY20	823	78	84	1,033	0.42	474	31,704
FY21	856	59	63	1,034	0.11	602	29,510
FY22	763	40	43	884	0.02	554	25,231

*Average wait time is based on encounters for which a value was reported
Data Source: CDS Anchor Datasets for FY20, FY21, FY22
Data current as of 10/1/2020, 10/1/2021, 10/1/2022

Substance Use Priority Groups

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

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

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

Priority Population 1 - Pregnant and Current Intravenous Drug Using Women

The DBH, through the six RBHA networks, serves youth and adults who are pregnant injecting drug users. The unduplicated counts in Table 7 do not include individuals served through Medicaid and other funding sources. Generally, this priority group represents only a small percentage of persons served. However, an increasing trend can be observed in Table 7. The percentage of women who were pregnant and using intravenous drugs has changed from FY2020 through FY2022 (0.038%, to 0.028%).

Table 7 Total Services to Pregnant Injecting Drug Users

	Priority Population: Pregnant Injecting Drug Users							
	Total Service Encounters: Pregnant Injecting Drug Users						Total # Unduplicated Consumers	
SFY	MH Only	SUD Only	Dual (Primary)	Combo	Total	Average wait time in days*	Priority #1	Overall
FY20	2	16	1	9	30	7.22	12	31,704
FY21	1	13	0	3	17	1.09	10	29,510
FY22	3	6	0	1	10	1.17	7	25,231

*Average wait time is based on encounters for which a value was reported
Data Source: CDS Anchor Datasets for FY20, FY21, FY22
Data current as of 10/1/2020, 10/1/2021, 10/1/2022

Priority Population 2 - Pregnant Substance Using Women

The DBH, through the six RBHA networks, serves youth and adults who are pregnant substance using women. The unduplicated counts in Table **8** do not include individuals served through Medicaid and other funding sources. Generally, less than one percent of the persons served are pregnant substance using women. Table 8 presents unduplicated data which indicates changes from FY2020 to FY2022 (0.057%, to 0.052%) in the total number of persons served and were classified as pregnant women who were using substances.

Table 8 Services to Pregnant Substance Users

	Priority Population: Pregnant Substance Users							
	Total Service Encounters: Pregnant Substance Users						Total # Unduplicated Consumers	
SFY	MH Only	SUD Only	Dual (Primary)	Combo	Total	Average wait time in days*	Priority #2	Overall
FY20	3	21	3	7	34	7.14	18	31,704
FY21	3	16	1	5	25	8.63	16	29,510
FY22	1	13	1	1	17	8.00	13	25,231

*Average wait time is based on encounters for which a value of one or above was reported
Data Source: CDS Anchor Datasets for FY20, FY21, FY22
Data current as of 10/1/2020, 10/1/2021, 10/1/2022

Priority Population 3 - Persons Who Inject Drugs

The DBH, through the six RBHA networks, serves youth and adults who are injecting drug users. The unduplicated counts in Table **9** do not include individuals served through Medicaid and other funding sources. There is a decreasing trend in the number of the persons served who are injecting drug users. Table **9** presents unduplicated data for persons served which indicate an increase in the total number of persons served and were classified as injecting drug users from 3.43% in FY20 to 2.80% in FY2022. The days waiting for admission has also decreased within the same period.

Table 9 Services to Injecting Drug Users

	Priority Population: Injecting Drug Users							
	Total Service Encounters: Injecting Drug Users						Total # Unduplicated Consumers	
SFY	MH Only	SUD Only	Dual (Primary)	Combo	Total	Average wait time in days*	Priority #3	Overall
FY20	39	1,737	276	431	2,516	2.83	1,086	31,704
FY21	31	1,284	187	227	1,786	1.57	856	29,510
FY22	39	1,098	87	95	1,351	1.79	706	25,231

*Average wait time is based on encounters for which a value was reported
Data Source: CDS Anchor Datasets for FY20, FY21, FY22
Data current as of 10/1/2020, 10/1/2021, 10/1/2022

Priority Population 4 - Women with Dependent Children

The DBH, through the six RBHA networks, serves youth and adults who are women with dependent children (WWDC). The unduplicated counts in Table **10** do not include women served through Medicaid and other funding sources. The percentage of women with dependent children served has decreased between FY2020 and FY2022 from 1.52% to 0.79%. There was also a continued decrease in their wait time for services across each of the years compared.

Table 10 Services to Women with Dependent Children

	Priority Population: Women with Dependent Children							
	Total Service Encounters: Women with Dependent Children						Total # Unduplicated Consumers	
SFY	MH Only	SUD Only	Dual (Primary)	Combo	Total	Average wait time in days*	Priority #4	Overall
FY20	40	559	86	206	920	3.41	483	31,704
FY21	35	360	47	95	570	2.83	331	29,510
FY22	14	248	7	45	345	2.45	199	25,231

*Average wait time is based on encounters for which a value was reported
Data Source: CDS Anchor Datasets for FY20, FY21, FY22
Data current as of 10/1/2020, 10/1/2021, 10/1/2022

Federal Interim Services for Substance Use

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

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

In FY2022, to enhance collection and monitoring in capacity and waiting list systems, CDS added additional system enhancement with internal alerts and specification of which "Federal Interim Services" and additional or "Engagement Services" were being delivered to priority populations. Providers enter the date interim services were provided to indicate the date of delivery and select from a drop down list the type(s) of services delivered, which allows DBH to track provider compliance to interim service expectations. Contracts with providers require data collection and tracking to maintain this monitoring and reporting capability.

The count of unique persons who received treatment services for substance use disorders in FY2022 was 6,393. Looking specifically at individual encounters where the individual was placed on a waitlist during FY2022 for SUD and Dual type services, there were 668 persons of which 180 were indicated to have a priority population status, leaving 488 with "None" or "Unknown" as the priority status indication (Table **11**). Federal Interim Service Delivery dates were recorded for 43[3] of the encounters where a priority population status was recorded. Work must continue to educate providers on the importance of offering Interim Substance Use Disorder Services to priority populations seeking treatment when a provider is not able to admit pregnant women within 48 hours or an individual who injects drugs within 14 days after making a request for admission to treatment.

[3] Data Source- Centralized Data System [Interim Service Delivered in FY22; data as of 8.11.2022]

Table 11 Persons Placed on a Waitlist for Admission to SUD or Dual Services in FY22

Consumers Placed on Waitlist* for Admission to SUD or Dual Disorder Services in FY22		
Priority Population	2020	2022
Pregnant Inject Drug Users	4	0
Pregnant Substance Users	3	4
Injecting Drug Users	179	141
Women with Dependent Children	65	31
Mental Health Board Commitment: Inpatient	1	0
Mental Health Board Commitment: Outpatient	5	0
Unknown	5	4
Total Placed on Waitlist	1,110	668

*Counts are based on consumers placed on the waitlist for one or more days
Data Source: CDS Anchor Datasets for FY20 and FY22
Data current as of 10/1/2020, 10/1/2022

Behavioral Health Services for Individuals in Rural Areas

The DBH provides community-based services to individuals with mental health and/or substance use disorders who live in rural areas, which geographically represents much of Nebraska. The U.S. Census Bureau defines an urban areas and urban clusters as relatively "densely developed territory", [which] encompass residential, commercial, and other non-residential urban land uses (2010 Census Urban and Rural Classification and Urban Area Criteria). Urban areas have populations of 50,000 or more people; urban clusters have populations of at least 2,500 but less than 50,000 people. All areas that are not urban are considered rural.[4] As of 6/28/2023, the U.S. Census estimated that Nebraska's total population was 1,951,480, with approximately 34.0% of persons living in rural counties[5] (Table 12).

[4] U.S. Census. (2010). https://www.census.gov/geo/reference/ua/urban-rural-2010.html
[5] U.S. Census Bureau; Vintage 2019 Population Estimates *(est.7/ 2019, released 6/2020, accessed 7.19.2021)*

Table 12 references the Statistical Metropolitan[6] Areas in accordance with the US Census for Nebraska,[7] which includes urban areas and urban clusters. Given the significant infrastructural difference between urban and rural counties in Nebraska, Table 13 presents encounters or unit counts by type of service, by age category, and fiscal year for persons residing in rural counties. Unduplicated data collected in Nebraska for FY2020, FY2021 and FY2022 indicated that 38.0%, 37.9% and 39.2%, of the total number of persons served resided in rural areas showed similar trend. The overall number of service encounters and persons served in rural counties indicated similar pattern to the state averages in FY20, FY21, and in FY22.

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

[7] U.S. Census Bureau, 2017-2021 American Community Survey Estimates, *accessed 6/28/2023*

Table 12 Urban Counties in Nebraska

Urban Counties in Nebraska		
Urban Areas and Clusters	**2019 Population***	**2021 Population****
Lincoln, NE		
Lancaster County, NE	319,090	320,301
Seward County	17,284	17,605
Omaha-Council Bluffs, NE-IA		
Cass County, NE	26,248	26,546
Douglas County, NE	571,327	578,771
Sarpy County, NE	187,196	188,464
Saunders County, NE	21,578	22,008
Washington County, NE	20,729	20,699
Grand Island, NE		
Hall County, NE	61,353	62,616
Hamilton County, NE	9,324	9,376
Howard County, NE	6,445	6,461
Merrick County, NE	7,755	7,687
Sioux City, IA-NE-SD		
Dakota County, NE	20,026	21,284
Dixon County, NE	5,636	5,632
State Totals		
Urban (above counties)	1,273,991	1,287,450
Rural (all counties not listed)	664,330	664,030
Nebraska State Total	1,929,268	1,951,480

*Data Source: U.S. Census Bureau, Vintage 2019 Population Estimates, accessed 7/19/2021

**Data Source: U.S. Census Bureau, 2017-2021 American Community Survey Estimates, accessed 6/28/2023

Table 13 Behavioral Health services to people living in rural areas

Behavioral Health Services Accessed by Consumers Residing in Rural Areas					
	Service Category		FY20	FY21	FY22
By Service Type: Rural Areas	MH (only)	Youth Service Encounters	1,370	1,301	1,147
		# Youth Consumers	1,135	1,055	906
		Adult Service Encounters	9,549	8,730	7,777
		# Adult Consumers	5,114	5,024	4,544
	SUD (only)	Youth Service Encounters	51	29	18
		# Youth Consumers	31	17	13
		Adult Service Encounters	5,672	4,986	3,908
		# Adult Consumers	2,477	2,401	2,050
	Dual (primary)	Youth Service Encounters	6	4	3
		# Youth Consumers	2	4	3
		Adult Service Encounters	784	795	667
		# Adult Consumers	334	358	312
	Combo	Youth Service Encounters	12	8	6
		# Youth Consumers	7	8	4
		Adult Service Encounters	2,016	1,460	986
		# Adult Consumers	1,016	657	520
Combined	Rural Total	Total Encounters	23,120	20,900	17,297
		# Consumers Served	12,046	11,175	9,889
		Average Wait Time in days*	0.71 days	0.44 days	0.26 days
	DBH Total	Total Encounters	60,891	51,914	42,114
		# Consumers Served	31,704	29,510	25,231
		Average Wait Time in days*	0.78 days	0.49 days	0.40

*Average wait based on number of cases for which a value was reported
Data Source: CDS Anchor Datasets for FY20, FY21, FY22
Data current as of 10/1/2020, 10/1/2021, 10/1/2022

Priority Areas for FFY2024/2025

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

1. Prevention of binge drinking among youth and young adults
2. Increasing the use of Evidence-Based Strategies employed by prevention coalitions to reduce alcohol and substance use
3. Increasing support for consumers to secure and maintain stable housing
4. Increasing support for consumers to acquire and sustain employment
5. Increasing access to community-based services for priority populations
6. Increasing the number of persons admitted into treatment for first-episode psychosis (Coordinated Specialty Care)
7. Referral to services for persons with tuberculosis
8. Crisis Response Dashboard (988 & Mobile Crisis Response)

Data in support of each focus area are provided below.

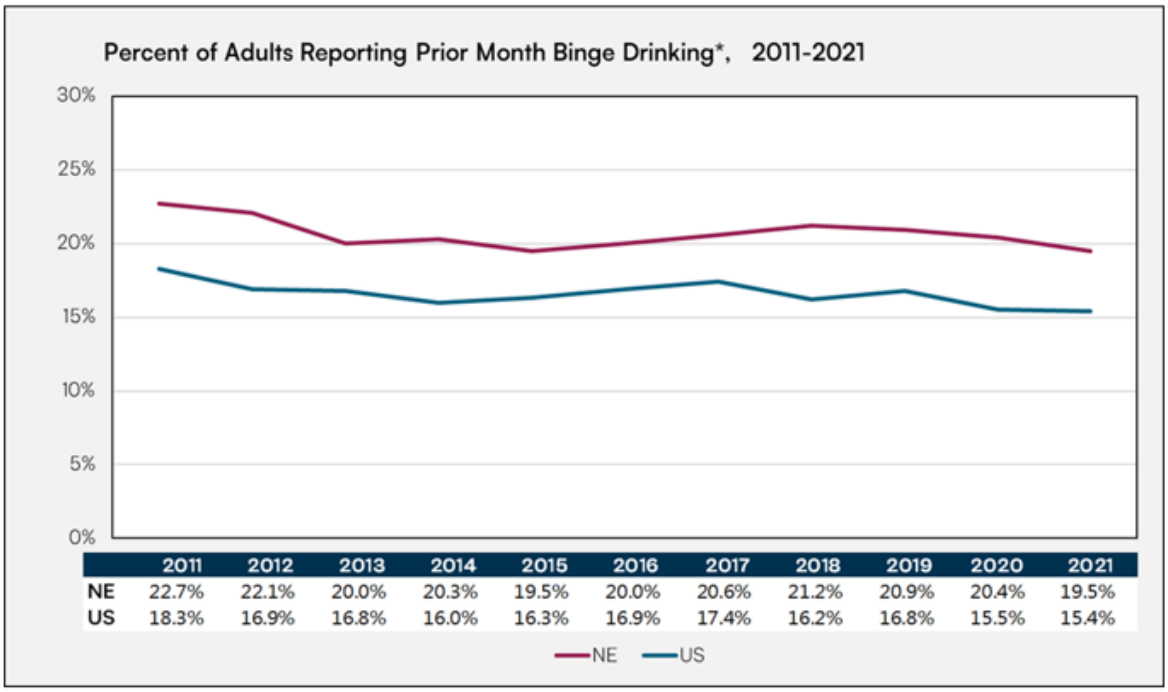
Alcohol Use among Youth and Young Adults

According to the *United Health Foundation for American's Health Rankings 2022* [8] Nebraska has a very high prevalence of binge drinking. This study indicated that 20.6% of Nebraska adults (ages 18+) report binge drinking, which places Nebraska as the 44th out of 50 states. In addition, underage alcohol consumption continues to be a problem among youth in Nebraska. The National Survey of Drug Use and Health (NSDUH) indicates youth alcohol use rates, and binge drinking in particular, are higher in Nebraska compared to national rates. According to 2018-2019 NSDUH results, 29.2% of people aged 12 or older in Nebraska reported binge drinking in the past month compared to the national average of 24.2%.

[8] 2022 Summary: Health Outcomes p.29 American's Health Rankings

Additionally, the Behavioral Risk Factor Surveillance System (BRFSS) survey has noted Nebraska binge drinking has been above the U.S. overall rate for the last decade (Figure 1). In 2019, it found that among Nebraska adults 18 and older, 20.9% reported binge drinking, compared to 16.8% among the U.S. population overall. In 2015 and 2021, the binge drinking for adults in Nebraska (19.5%) were the lowest level and only years observed below 20%. Nevertheless, Nebraska's percentage remained higher the U.S. population overall.

Figure 1 Percentage of Adults Indicating Binge Drinking in Past 30 Days, NE vs US

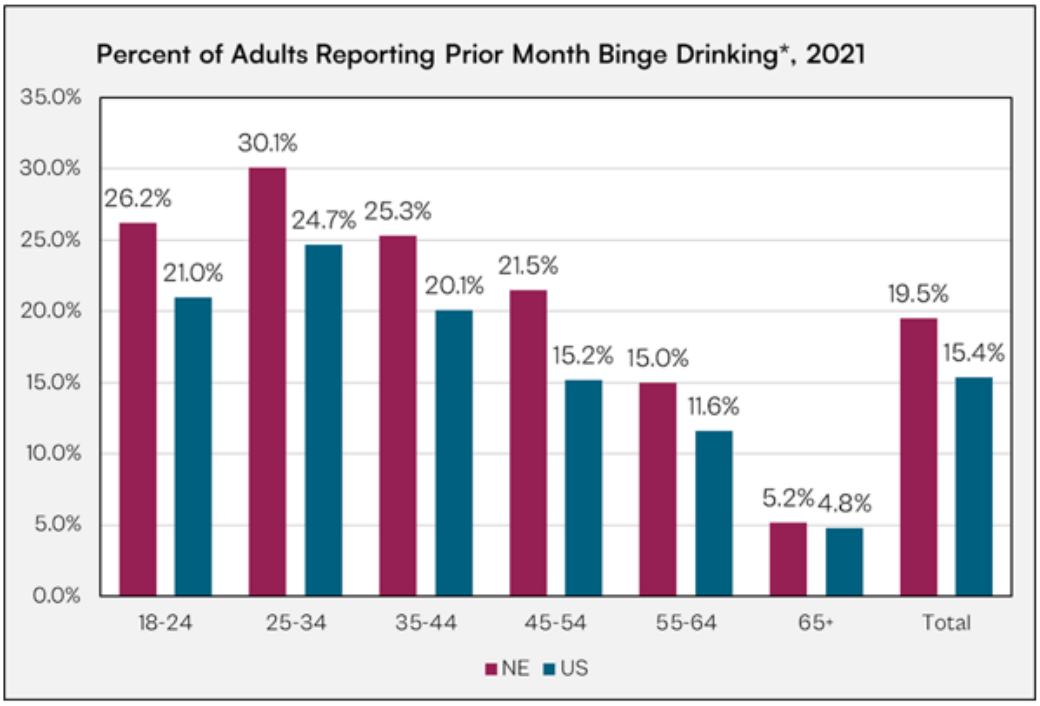


	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
NE	22.7%	22.1%	20.0%	20.3%	19.5%	20.0%	20.6%	21.2%	20.9%	20.4%	19.5%
US	18.3%	16.9%	16.8%	16.0%	16.3%	16.9%	17.4%	16.2%	16.8%	15.5%	15.4%

*Adults 18 and over reporting drinking 4/5 drinks at one occasion during the 30 days preceding the survey.
Source: Behavioral Risk Factor Surveillance Survey (BRFSS).

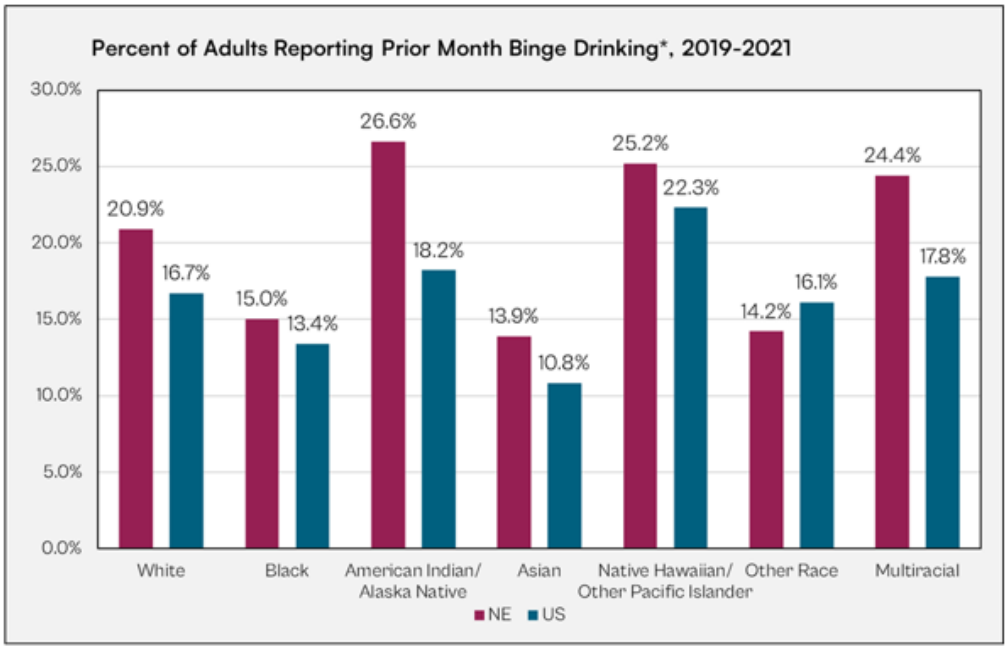
In a more granular breakout of BRFSS demographic data from to 2021 (Figure 2) the most common ages for binge drinking markedly involve those between 18 and 34 years old. Notably, the trend for binge drinking in Nebraska consistently parallels the trend seen overall for the nation, just at higher levels. Looking at the 2019-2021 statistics for racial demographics, those identifying with lowest representation in census indicated highest prevalence particularly for past-30 day binge drinking: Native American (26.6%), Native Hawaiian/Other Pacific Islander (25.2%) and Multiracial (24.4%) (Figure 3).

Figure 2 Adult Current Binge Drinking by Age



*Adults 18 and over reporting drinking 4/5 drinks at one occasion during the 30 days preceding the survey.
Source: Behavioral Risk Factor Surveillance Survey (BRFSS).

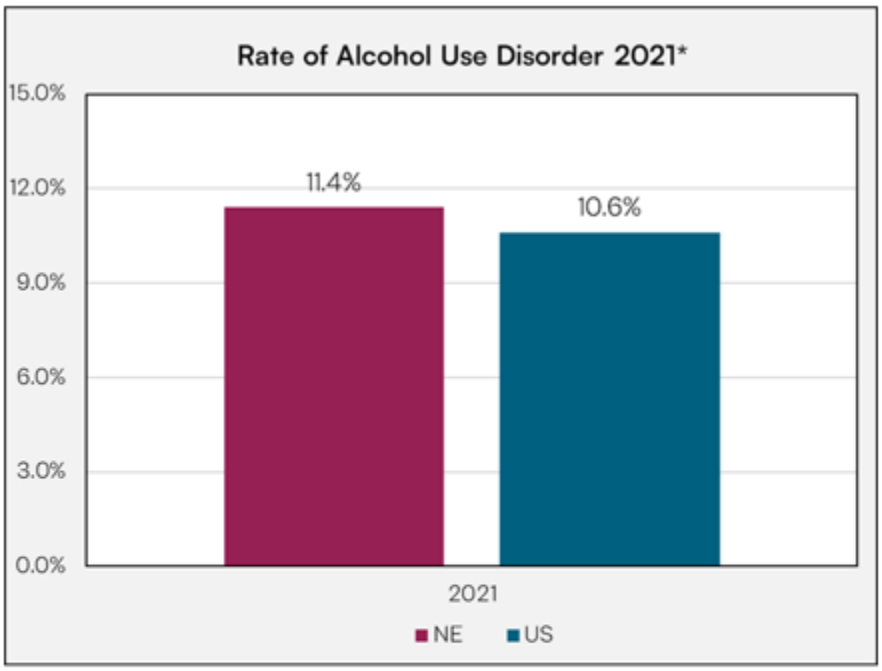
Figure 3 Binge Drinking (age-adjusted) among Adults by Race in Nebraska and US



*Adults 18 and over reporting drinking 4/5 drinks at one occasion during the 30 days preceding the survey.
Three years' data was combined to ensure a sufficient sample size of all racial categories.
Source: Behavioral Risk Factor Surveillance Survey (BRFSS).

Based on the 2021 NSDUH data for those 12 and older alcohol abuse and binge drinking in Nebraska continues to be similar to, but higher than the national percentages (Figure 4). With Nebraska consistently higher than the overall percentage for the U.S. for Young adults (18-25 years) it is a clear indication for the state to prioritize prevention and other services for this demographic.

Figure 4 NSDUH 2021- Rate of Alcohol Use Disorder Ages 12 Years and Older



*Respondents aged 12 and above identified as meeting the criteria for Alcohol Use Disorder according to the benchmarks outlined in DSM-V.
Source: National Survey on Drug Use and Health (NSDUH), preliminary 2021 state prevalence estimates.
Note: methodological changes inhibit the ability to compare NSDUH data for 2021 and later with earlier data

Data from NSDUH and BRFSS indicate the need to prioritize prevention efforts targeting alcohol abuse/disorder and to put emphasis on underage and binge drinking among Nebraska youth and young adults. The continued need for alcohol-related services to youth and young adults is further corroborated in the Behavioral Health Barometer[9] (p.12). In Nebraska, the trend

[9] Substance Abuse and Mental Health Services Administration. *Behavioral Health Barometer: Nebraska, Volume 6: Indicators as measured through the National Survey on Drug Use and Health, the National Survey of Substance Abuse Treatment Services, and the Uniform Reporting System.* HHS Publication No. SMA-20-Baro-19-States-NE. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020.

for alcohol use disorder among individuals aged 12 and older is consistently higher than the national average at every point of measure.

Table 14 Drug Prevalence in Substance Use Treatments

Drug Prevalence among Individuals Enrolled in Substance Use Treatments in Nebraska	
Substance Abuse Problem	**2020**
Drug Problem Only	38.5%
Alcohol Problem Only	19.1%
Both Drug and Alcohol Problem	42.3%
Alcohol Involved Treatments	*61.4%*

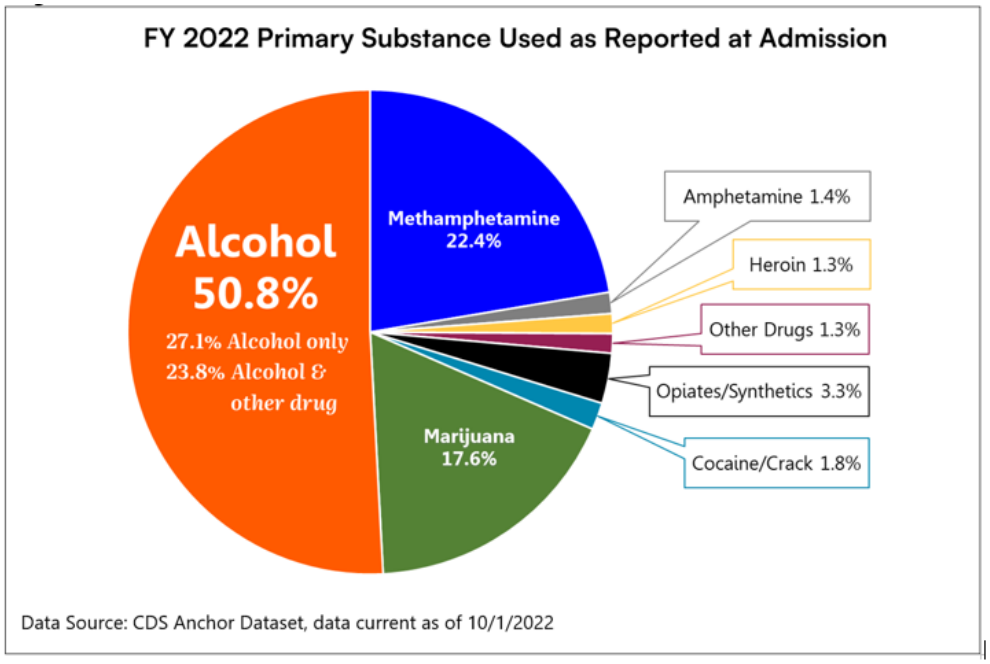
Data Source: Substance Abuse and Mental Health Services Administration, National Survey of Substance Abuse Treatment Services (N-SSATS): 2020.

Evidence-Based Programs on Alcohol Use and Substance Use

According to the 2020 National Survey of Substance Abuse Treatment Services Report, more than 60 percent of clients receiving treatment for substance abuse, had an alcohol abuse problem. This situation and the distribution of primary substances used, as reported at admission to DBH services in Figure 5, further illustrates the need for multifaceted approaches in treatment strategies and processes.

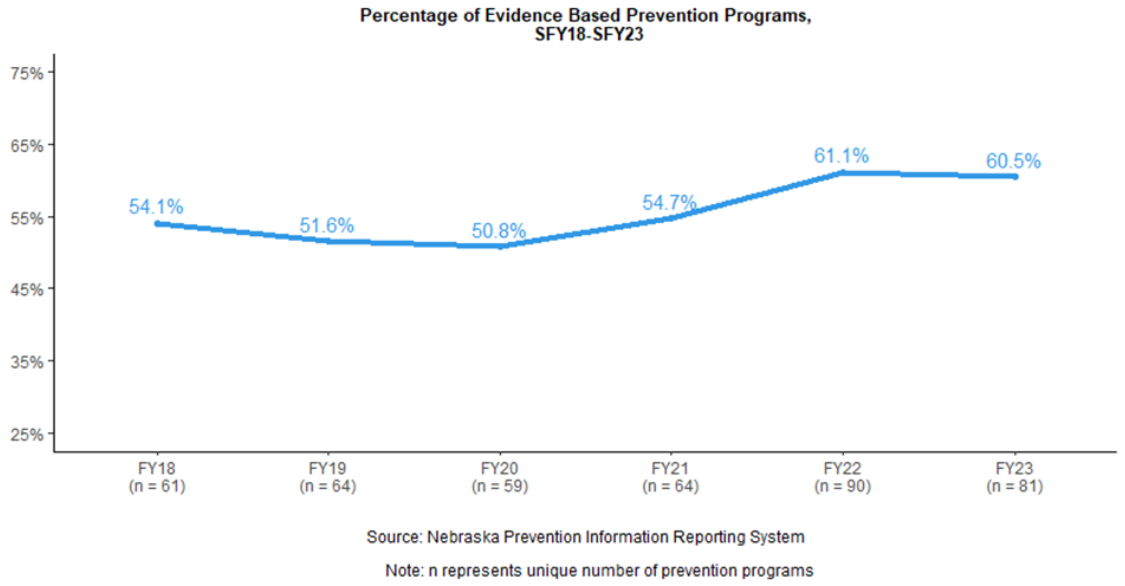
As a requirement of the DBH's annual Regional Budget Planning process, at least 60% of the Substance Abuse Block Grant (SABG) primary prevention dollars received by community coalitions is firmly allocated for community-based and environmental strategies. Emphasis is placed on using a multi-strategy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

Figure 5 FY2020 Primary substance of Use reported at admission



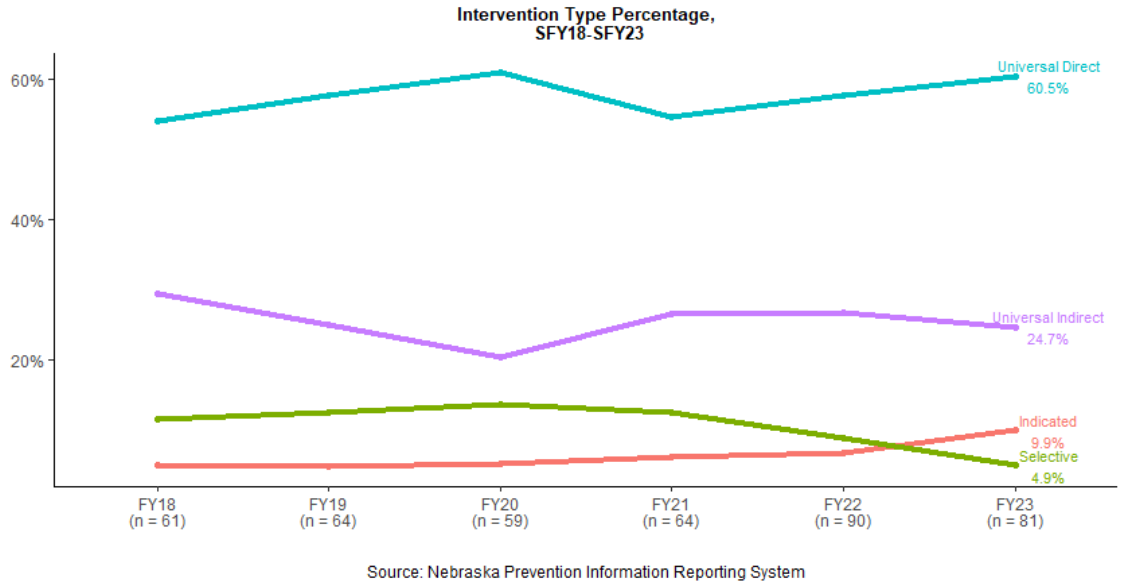
The Division of Behavioral Health tracks grantee and sub-grantee intervention activity using the Nebraska Prevention Information Reporting System (NPIRS). In FY23, SAPTBG-funded regional behavioral health authorities and community coalitions implemented 81 unique prevention programs. Of these, 49, or 60.5 percent, were designated as evidence based. This marks a near 6-point increase in the percentage of evidence-based programs since 2018. Programs are indicated as evidence-based if they appear in a federal registry of evidence-based interventions or if they are reported with positive effects on the primary targeted outcome in peer-review journals.

Figure 6 Evidence-Based Programs FY2018 – FY2023



Approximately 85 percent of prevention programs implemented across Nebraska in FY23 targeted the general public or whole population group (i.e., universal direct and indirect interventions), while 10 percent targeted individuals in high-risk environments (i.e., indicated interventions), and 5 percent targeted individuals or subgroups of the population whose risk of developing a disorder is significantly higher than average (i.e., selective interventions).

Figure 7 Intervention Types



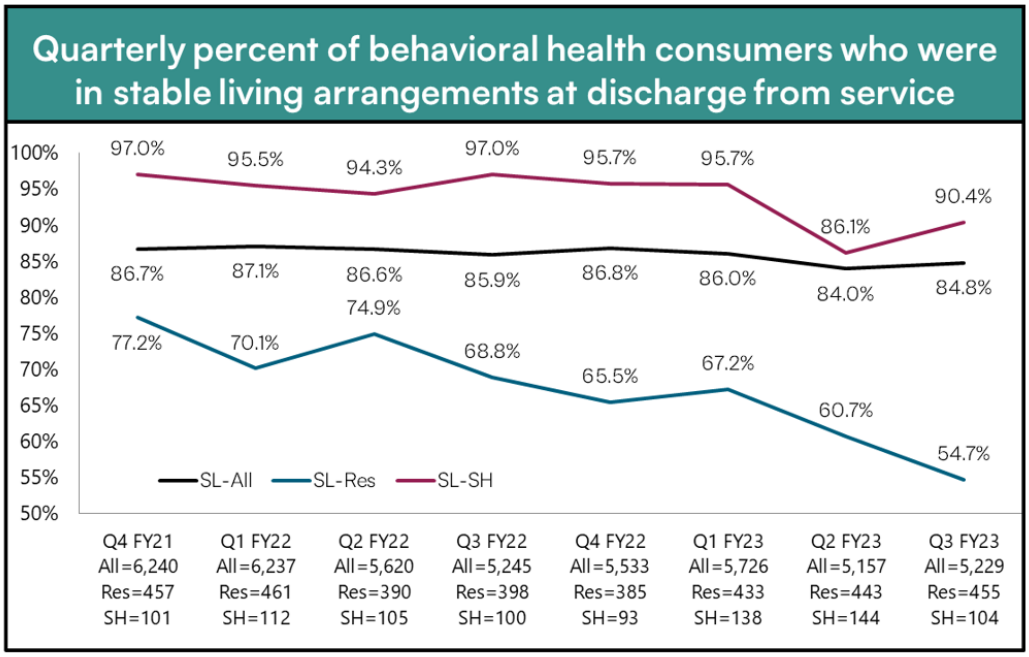
Housing: Increase support for consumers to secure and maintain permanent housing.

The lack of safe and affordable housing is a significant barrier to recovery from mental health and/or substance use disorders. (See DBH "Nebraska Supportive Housing Plan" [10]). Many adults with a serious mental illness live on Supplemental Security Income (SSI), a federal cash benefit program for those either 65 or older, blind, or disabled, and who have limited incomes. SSI provides a limited amount of cash; therefore, persons relying on SSI may have difficulty finding an affordable home.

In Nebraska, Figure 8 shows that overall, consumers are discharged to stable living situations across all community-based behavioral health services more than 80% of the time for the time period extending from Quarter 3 of FY21 through Quarter 3 of FY23 (weighted average, 86.0%). For those who were in *Supported Housing Services*, over that time 93.6% were discharged to stable living arrangements. During that same time, discharges from *Residential Services* into stable living arrangements saw progressive decline with only two quarters (Q2 FY22 and Q1 FY23) showing mild increases. Across the eight quarters presented, the weighted average was 67.3% discharged into stable living arrangements from *Residential Services*. The 18.7% difference between the weighted average discharge rates to stable living arrangements for consumers from overall and *Residential Services* highlights the escalating urgency for more availability of affordable housing options for consumers discharging from the most intensive community-based behavioral health services.

[10] "Nebraska Supportive Housing Plan" http://dhhs.ne.gov/Reports/DBH-Nebraska%20Supportive%20Housing%20Plan%20--%20August%202016.pdf

Figure 6 Behavioral Health Consumers in Stable Living Arrangements at Discharge



Data Source: DBH Centralized Data System (CDS);Encounters Current/Funding Region/Living Arrangements/Discharge/Any Service; Residential Services, Supported Housing
All=, Res=, SH= are all statewide counts(not including persons whose housing status was "not available")
Data current as of 6/21/2023

Employment: Increase support for consumers to sustain and acquire employment.
Much like housing, employment is another social determinant of health and consumers are more likely to maintain positive outcomes when they can obtain and sustain employment. As shown in Table 15, Nebraska serves a significant portion of consumers who are receiving mental health services and are not in the labor force. In FY22, those who were not employed and had not actively sought in the past 30 days made up 40.8% of Nebraska's consumers.

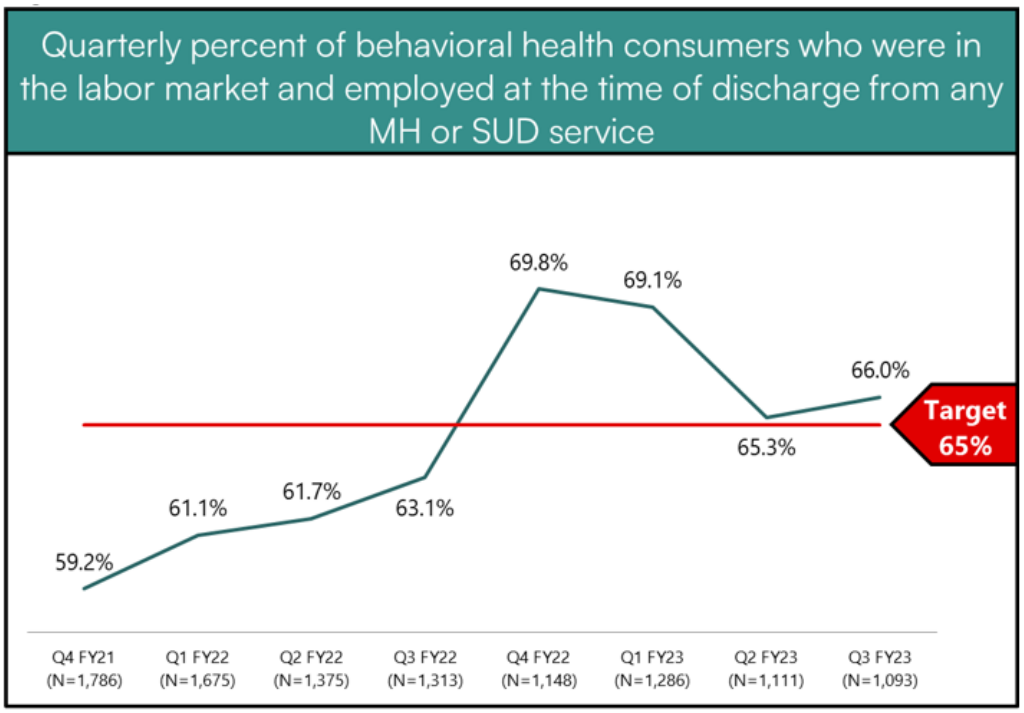
Table 14 Employment Status by Age Group

Employment Status by Age Group FY22			
Age Group	Employed	Unemployed	Not in Labor Force
18-20	35.3%	17.2%	47.5%
21-64	40.9%	20.7%	38.4%
Total (18+)	39.3%	19.9%	40.8%

Source: FY22 URS Table 4, data based on CDS Annual Anchor Dataset
Values calculated are based on consumers with known employment status
Data current as of 10/1/2022

Even when consumers can enter the labor market, those discharging from behavioral health services often struggle to obtain employment by the end of service delivery. Figure 9 shows the trend in quarterly discharge rates from mental health and substance use disorder services, with noted exceptions (63.9% weighted average across quarters presented). Classification of consumers in the labor market include those employed full or part time employment and those in the armed forces full or part time. These figures highlight employment as a continued priority area for Nebraska to address moving forward.

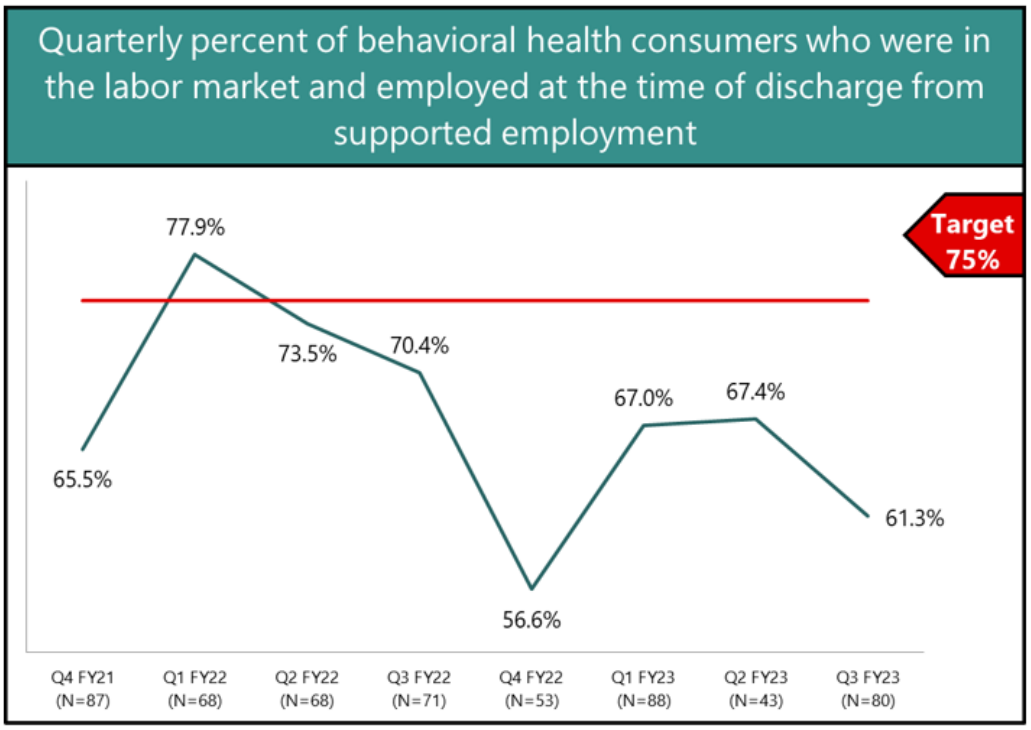
Figure 7 Discharge Rates from Any MH or SUD Service



Data Source: DBH Centralized Data System (CDS);Encounters Current/Funding Region/Employment Status/Discharge/Any Mh Or Sud Service
Numbers in parentheses represent statewide counts of consumers discharged into the labor market
Data current as of 6/21/2023

Continued focus on helping behavioral health consumers gain and sustain employment is a persistent need and challenge in our communities. Figure 10 which shows two-year quarterly trends for employment outcomes for those discharging from Supported Employment programs. Such trends, further emphasize that there are challenges and opportunities for growth.

Figure 8 BH Consumers Employed at Discharge from Supported Employment



Data Source: DBH Centralized Data System (CDS);Encounters Current/Funding Region/Employment Status/Discharge/Supported Employment
Numbers in parentheses represent statewide counts of consumers discharged into the labor market
Data current as of 6/21/2023

Increase access to community-based services for priority populations

The DBH uses information from multiple sources to consider needs associated with access to mental health and substance abuse services: The Nebraska Annual Social Indicators Survey (NASIS)[11]; Behavioral Health Barometer; Behavioral Health in Your Community Survey (BH provider survey)[12]; and the National Survey of Substance Abuse Treatment Services (N-SSATS)[13].

[11] NASIS is a multi-focused (inter-organizational) mailed in survey administered to a sample drawn from the general public. The 2019 administration had a historically low response rate (n=377); timing of the distribution was immediately before the catastrophic floods in March.
[12] The Behavioral Health in Your Community Survey sampled 17 local Health Departments of various sizes in Nebraska (n=33).
[13] N-SSATS is a survey directly soliciting feedback from state-approved facilities. In 2013, Nebraska's response rate was 96.3% (107 respondents).

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

Figure 9 NASIS 2019: Treatment Availability in Nebraska

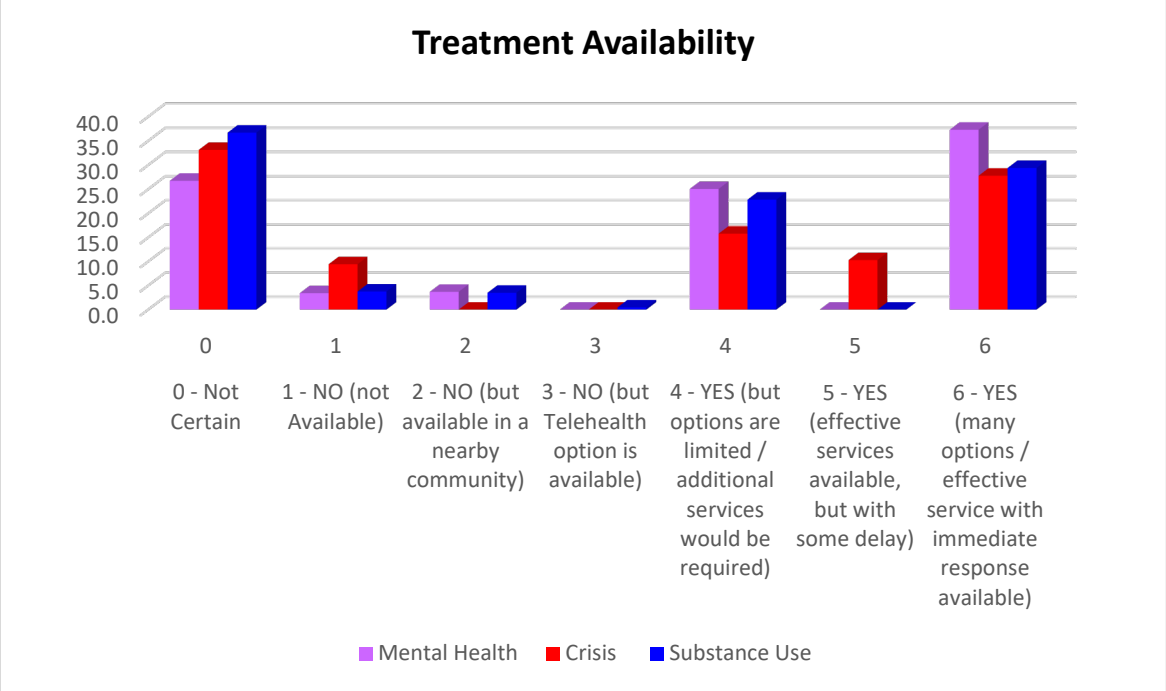
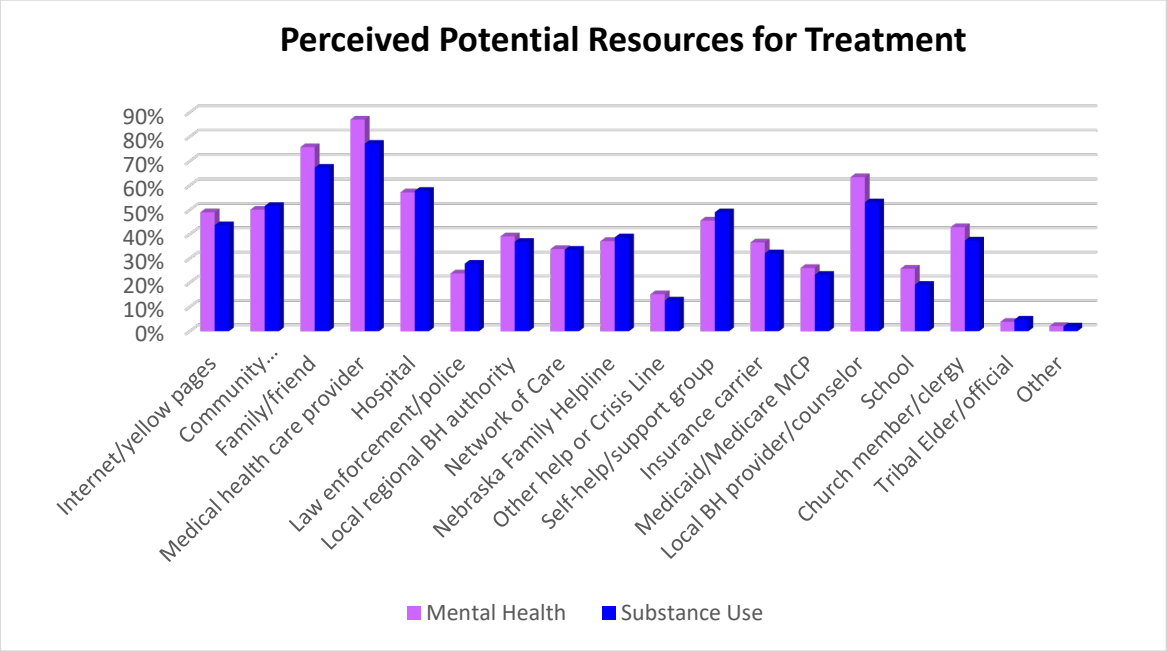


Figure 10 Potential Resources to Identify/Locate Services



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

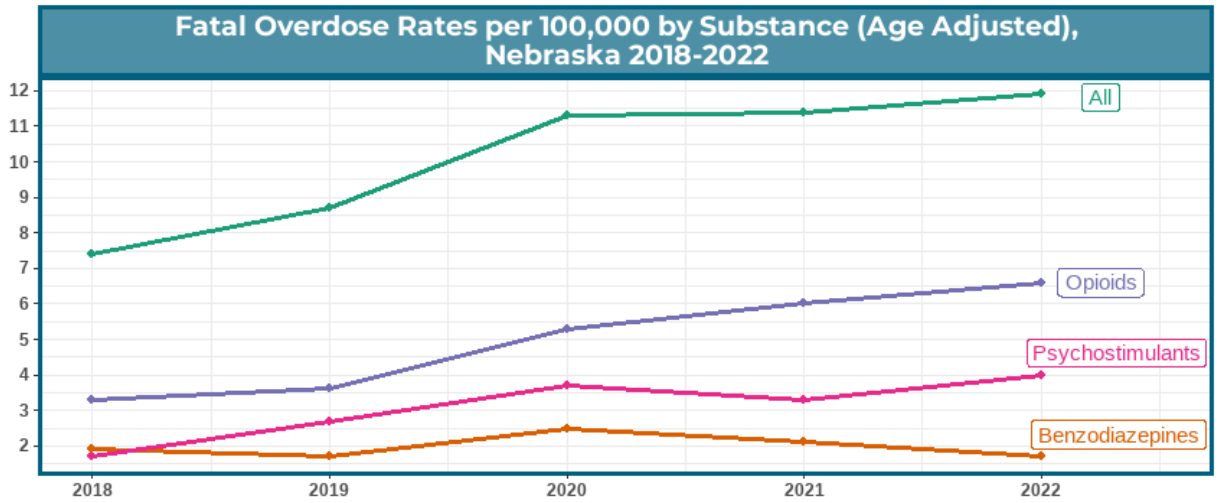
Additional survey work conducted in early 2019[i] captures the perspective of the respondents (employees) of local health departments across the state. The most apparent need is to get high quality care for either substance use disorders or mental health concerns across many areas of the state, and particularly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

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

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

In 2022, Nebraska reported 225 overdose deaths with a fatal overdose rate of 11.9 deaths per 100,000 population, the second lowest in the country. Among all overdose deaths, 122 were due to opioids, 75 due to psychostimulants (mostly methamphetamine), and 32 due to benzodiazepines. Death certificates for fatal overdoses may report the presence of multiple substances or the presence of an unknown substance. Approximately 45 percent of psychostimulant-involved overdoses and 78 percent of benzodiazepine-involved overdoses also indicated the presence of an opioid substance. Between 2018 (138 deaths; 7.4 deaths per 100,000) and 2022, the number of overdose deaths increased by 63 percent in Nebraska.

Figure 13 Fatal Overdose Rates in Nebraska



Data source: CDC Wonder Multiple Cause of Death
Notes: ICD-10 Code for opioids T40.0 (Opium); T40.1 (Heroin); T40.2 (Other opioids); T40.3 (Methadone); T40.4 (Other synthetic narcotics) T40.6 (Other and unspecified narcotics)
for psychostimulants T43.6 (Psychostimulants with abuse potential)
for Benzodiazepines Benzodiazepines (T42.4)
UCD - Drug/Alcohol Induced Causes: Drug poisonings (overdose) Unintentional (X40-X44); Drug poisonings (overdose) Suicide (X60-X64); Drug poisonings (overdose) Homicide (X85); Drug poisonings (overdose) Undetermined (Y10-Y14)
Provisional data for 2022
Visual: NE-DHHS-DBH 7.10.20223

Short Term Residential treatment is intended for adults with a primary substance use disorder requiring a more intensive treatment environment to obtain sobriety and engage in treatment. This service is highly structured and provides primary, comprehensive substance use disorder treatment. Each year the DBH funds *Short Term Residential* treatment for approximately 1,200 to 1,300 individuals. Of those admitted into this service in FY2022, the majority presented with a treatment need related to the use of methamphetamine/speed, alcohol, marijuana/hashish, or other opiates/synthetics. Table 16 describes the counts of each primary, secondary and tertiary substance type for those admitted in FY2022.

Table 15FY2022 Substances Reported for Consumers in Short Term Residential Treatment

Substances Reported by Consumers Admitted into Short Term Residential Treatment FY22			
Substance	Primary	Secondary	Tertiary
Methamphetamine	264	78	18
Alcohol	218	70	55
Marijuana	42	202	55
Other Opiates or Synthetics	17	10	14
Cocaine/Crack	16	13	21
Heroin	11	8	4
Other Drug	6	7	2
Amphetamine	4	1	3
Oxycodone (Oxycontin)	2	1	1
Alprazolam (Xanax)	1	2	2
Hydrocodone (Vicodin)	1	2	0
Not Available	0	188	407

Total Consumers Served SFY22: 582

Source: CDS, SFY22 Anchor Dataset; data current as of 10/1/2022

Consumers across the six behavioral health regions required treatment in *Short Term Residential* programs during FY2022. Wait times pertinent to distinct encounters by the priority populations for those admitted into *Short Term Residential* services can be found in Table 17. Distinct encounter is defined as one episode of care (starting with placement on a waitlist prior to admission) for one consumer, in one service, to one provider.

Table 16 Access to Short Term Residential Services (STR) for Substance Use Disorder (SUD) for Individuals Placed on Waitlist during FY22

Consumers Placed on Waitlist for Access to Short Term Residential (STR) Services for Substance Use Disorder Treatment, FY22			
Priority SUD Group	Overview of Waiting	2020	2022
Pregnant IV Drug User	# of STR encounters	3	1
	Average wait	7 days	0 days
	Admitted within 14 days	67%	100%
	Admitted within 30 days	100%	100%
	Percent of STR encounters	0.3%	0.3%
Pregnant Drug User	# of STR encounters	4	3
	Average wait*	4 days	5 days
	Admitted within 14 days	75%	67%
	Admitted within 30 days	100%	100%
	Percent of STR encounters	0.4%	0.8%
IV Drug User	# of STR encounters	244	107
	Average wait*	11 days	7 days
	Admitted within 14 days	75%	87%
	Admitted within 30 days	91%	94%
	Percent of STR encounters	24.0%	26.8%
Women with Dependent Children	# of STR encounters	89	22
	Average wait	12 days	13 days
	Admitted within 14 days	71%	73%
	Admitted within 30 days	100%	91%
	Percent of STR encounters	8.7%	5.5%
All Consumers	# of STR encounters	1,018	399
	Average wait	9 days	6 days
	Admitted within 14 days	77%	88%
	Admitted within 30 days	93%	96%

*All values reported in this table are based on encounters for which a value was entered for waitlist days
Data Source: CDS Anchor Datasets for FY20, FY21, FY22.
Data current as of 10/1/2020, 10/1/2021, 10/1/2022

When reviewing wait data for those individuals seeking *Short Term Residential* services, the average wait time was found to be around 9 days in FY2020 with 77% of all consumers admitted within 14 days. The wait time improved to 6 days in FY2022 with 88% of all consumers admitted within 14 days. Priority for admission is expected to be granted to those meeting criteria for substance use priority populations; however, the data demonstrates that for the very few (*n*=4 in FY20 and *n*=3 in FY22) Pregnant IV Drug Users there are barriers to admission as one in each of the years were not admitted into service within 14 days. A greater number of

Women with Dependent Children were served and of those with that priority classification, 71% in FY20 and 73% in FY22 were admitted into service within 14 days.

Coordinated specialty care for persons with first episode of psychosis

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

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

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

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

- The Families of individuals age 18 and younger would have to agree to participate

A review of recent DBH treatment data for those meeting the age and diagnostic criteria necessary for program eligibility indicates a continuous and even growing need for treatment. As described in Table 19, data from FY2016 to FY2020 shows a fairly consistent count for females and an increase for males between the ages of 14 to 35 who have a psychotic disorder diagnosis. In FY2020 there were 1,001 youth and young adults meeting this criteria amongst those in behavioral health services funded by DBH across the state; 285 were female and 714 were male.

Table 17 First Episode Psychosis by Gender*, FY2020-2022

First Episode Psychosis Potentially Eligible by Gender FY20-22			
Gender	FY20	FY21	FY22
Female	285	239	200
Male	714	613	489
Not Available	2	2	1
Total	1,001	854	690

Estimates based on consumers receiving services funded through DBH who meet revised criteria
Data Source: CDS Anchor Datasets for FY20, FY21, FY22
Data current as of 10/1/2020, 10/1/2021, 10/1/2022

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

Data from FY2016 to FY2020 shows that many of the youth and young adults meeting this criteria across the state (as were described in Table 18) reside in Regions which currently have a FEP Program (Table 19).

Table 19 First Episode Psychosis by FEP Pilot Program Catchment Areas*, FY2020-2022

First Episode Psychosis (FEP) Potentially Eligible by FEP Catchment Area FY20-22			
Regions with FEP Pilot Programs	FY20	FY21	FY22
Region 3	131	101	87
Region 6	372	295	236
Total	503	396	323

Estimates based on Regions 3 & 6 consumers who meet revised criteria for the service
Data Source: CDS Anchor Datasets for FY20, FY21, FY22.
Data current as of 10/1/2020, 10/1/2021, 10/1/2022

While the data indicates a much larger population who may potentially have a need for FEP treatment, admissions have been fairly small while the pilot programs have been getting established, training staff, and learning recruitment strategies. As shown in Table 20, there were 7 new admissions in FY2020 and 30 in FY2022 between the two programs.

Table 18 Statewide Count Total Enrolled FEP Pilot Programs

Statewide FEP Enrollment Counts FY20-22			
Year	New Admissions	Enrolled in Program	Discharged
FY20	7	8	9
FY21	10	9	14
FY22	30	24	7

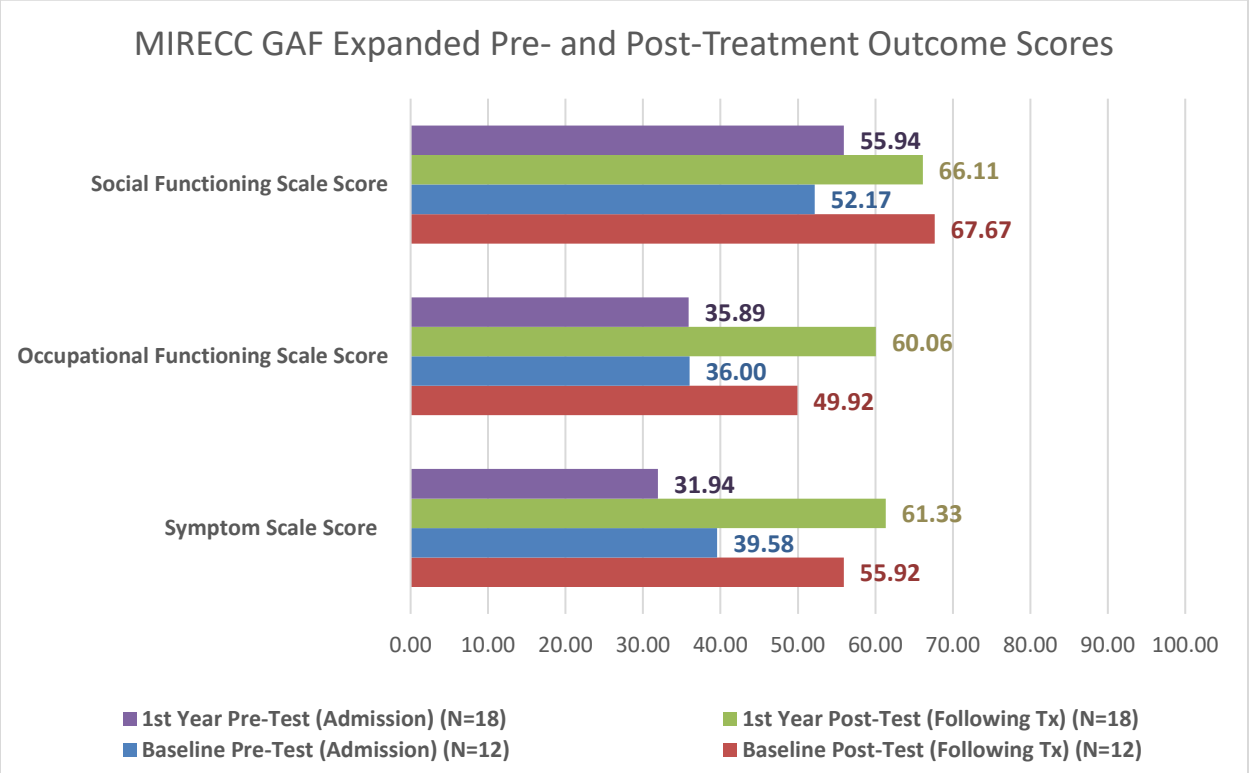
It is important during treatment of psychosis that areas of functioning are addressed. In a 2011 survey, NAMI asked the level of difficulty in managing aspects of daily life for individuals dealing with psychosis. Individuals who experienced psychosis rated social life as very difficult (51.1 percent) followed by work (47.5 percent) romantic relationships (47.4 percent), friendships (42.6 percent) and relationships with parents (39.2 percent).

The teams have been using the Columbia Suicide Severity Rating Scale, the MIRECC-GAF, the OnTrack NY Modified Colorado Symptom Index, the OnTrackNY Quality of Life, and OnTrackNY Experience scales. With the change in models, Nebraska intends to revise outcome reporting and data collection to focus on quality care and evaluate the clinical and organizational

changes related to the switch in EBP models. Metrics and tools supported by the NIMH EPINET project have been selected and include the Brief Adherence to Medication Rating Scale and the RAISE Illness and Management Recovery tool.

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

Figure 11 MIRECC GAF



Baseline Average Total Score Pre-test = 127.75

Baseline Average Total Score Post-test = 173.50

Average Baseline Total Score Difference = 45.75

First Year Average Total Score Pre-test = 123.77

First Year Average Total Score Post-test = 187.50

Average First Year Total Score Difference = 63.73

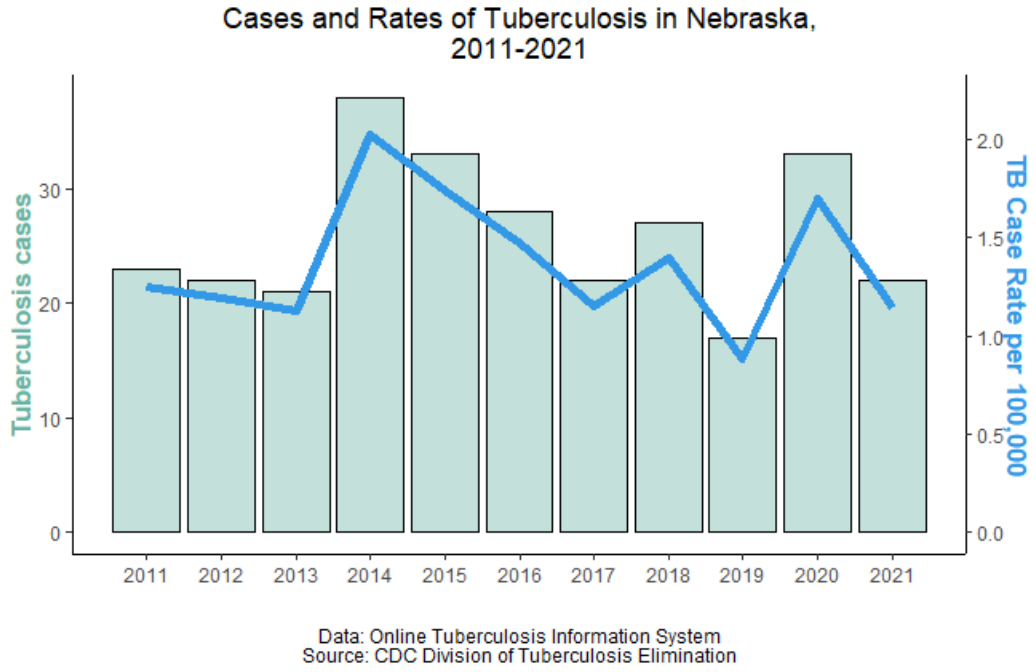
Additional Considerations

Requirements Regarding Tuberculosis

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

In 2021, Nebraska had TB a case rate of 1.14 persons per 100,000 population with a total of 22 verified TB cases, marking 33 percent decline from 2020 (Online Tuberculosis Information System).

Figure 15 Reported Tuberculosis Cases in Nebraska



Between 2017 and 2021, there were 121 new cases of tuberculosis. Approximately 80 percent of newly infected persons were born outside of the United States. Overall, 40 percent of cases were Asian, 25 percent Hispanic, 22 percent Black, and 9 percent White. Males were approximately 58 percent of all cases. Between 2.5 percent and 8.3 percent of TB cases were among persons experiencing homelessness (range provided due to suppressed data for small-n). Almost three-quarters of TB cases were among persons with a negative HIV status, while most of the remaining HIV statuses were not reported.

The DBH contract applicable to each of the six RBHAs requires programs to have working relationships with local health departments and to screen for communicable diseases for all persons requesting substance use disorder treatment services. As such, TB screening is provided to all persons entering a substance use disorder treatment service. Additional services and/or referrals for services are made available to those individuals whose screening indicates

"high risk" for TB. The Tuberculosis Program in the Nebraska Division of Public Health provides the overall coordination for the State of Nebraska. Therefore, the contract between the DBH and the RBHAs addresses the TB Screening and Services requirements. Pertinent language included in the DBH and RBHAs contract includes:

Tuberculosis (TB) screening and services

1. The RBHA will ensure that all providers receiving SAPTBG funds shall:
    a. Report active cases of TB to the Division of Public Health Tuberculosis Program Manager and adhere to all reporting requirements as set forth including NRS Sec.71-502, 71-1626 and 173 NAC Chapters 1-6, which can be found at: http://dhhs.ne.gov/Pages/Title-173.aspx
    b. Maintain infection control procedures that are consistent with those established by the State's infection control office.
    c. Adhere to State and Federal confidentiality requirements when reporting such cases.
2. The RBHA will ensure that providers receiving SAPTBG funding will routinely make TB services available to each individual receiving treatment for substance abuse and to monitor such service delivery.
3. The RBHA shall establish procedures that ensure that the following (TB) services are provided, either directly or through arrangements/agreements with other public or non-profit private entities:
    a. Screening of all admissions for TB,
    b. Positive screenings shall receive test for TB,
    c. Counseling related to TB,
    d. Referral for appropriate medical evaluations or TB treatment,
    e. Case management for obtaining any TB services,
    f. Report any active cases of TB to state health officials, and
    g. Document screening, testing, referrals and/or any necessary follow-up information.
4. The RBHA is responsible for providing DBH with documentation which illustrates facilitation or provision of the above listed services and ensure that any changes are reported and on file with DBH.

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

Services for HIV/AIDS

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

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

The term “designated state” means any state whose rate of cases of acquired immune deficiency syndrome (AIDS) is 10 or more such cases per 100,000 individuals (as indicated by the number of such cases reported to and confirmed by the Centers for Disease Control and Prevention (CDC) for the most recent calendar year for which the data are available (See 45 CFR 96. 128(b)).

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

Next Steps in Addressing Unmet Service Needs

The DBH completed a comprehensive statewide needs assessment in 2020 which provided information on estimating burden of behavioral health in Nebraska, strengths and gaps in the system, the needs of special populations, the status of workforce, and a review of national and state level initiatives for integrated care. Key findings from the assessment, which included RBHA and other stakeholder input, guided the development of the DBH 2022-2024 Strategic Plan and work plan to address targeted needs. Progress in the work plan is and will be monitored and shared with key stakeholders. An important recommendation, and one that drives ongoing

assessment of service need, is DBH optimizing the use of the Nebraska Prevention Information Reporting System (NPIRS) and the Centralized Data System (CDS). The CDS supports service capacity assessment of both residential and outpatient settings, supports longitudinal follow up to assess outcomes and accommodates formal data sharing to coordinate and assess services and outcomes across systems. The DBH works with RBHAs to address unmet needs in a variety of ways. It should be noted that unmet needs may be based on lack of training for providers, lack of funding within the system, or lack of providers in the system with certain expertise.

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

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

The Behavioral Health Education Center of Nebraska (BHECN) provides training and incentives for professionals to practice in areas of provider healthcare shortage, to increase access for consumers in rural and frontier areas, or in professions with a severe shortage within the state (psychiatry). The DBH is also working cooperatively with BHECN and other entities to increase the peer workforce in the system.

Within the Prevention system, the DBH continues to work with RBHAs to support community coalitions in using funding for areas of need for Substance Abuse prevention. Using data from the NPIRS, in addition to a variety of surveys regarding alcohol and drug use, communities are

able to evaluate the effectiveness of current prevention efforts and redirect dollars to areas of need when appropriate.

Summary of System Needs and Priorities

Through a comprehensive review of data sources and reports, followed by discussion and review with stakeholder and advisory groups, the DBH has identified seven priority areas. Each identified priority area has been determined as necessary to best address priority and target population needs. Concentration on identified priority areas throughout FY24/FY25 is expected to bring about overall behavioral health system improvements to support the treatment and recovery needs of consumers while working to prevent harmful substance use behaviors. In summary, the DBH has selected the following eight priority areas for FY24/FY25:

1. Prevention of binge drinking among youth and young adults
2. Increase the use of Evidence-Based Strategies employed by prevention coalitions to reduce alcohol and substance use
3. Increase support for consumers to secure and maintain permanent housing
4. Increase support for consumers to sustain and acquire employment
5. Increased access to community-based services for priority populations
6. Increase the number of persons admitted into treatment for first-episode psychosis
7. Referral to services for persons with tuberculosis
8. Crisis Response Dashboard (988 & Mobile Crisis Response)

#END Plan Step 2.

[i] February 2019. “Behavioral Health in Your Community- A Health Department Review Summary”. Survey of Local Health Departments across Nebraska.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Alcohol Use among Youth and Young Adults

Priority Type: SUP

Population(s): PP, Other

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.

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: 27%

First-year target/outcome measurement: 27%

Second-year target/outcome measurement: 27%

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

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 of survey results through coordination with DPH and CDC.

Priority #: 2

Priority Area: Increase Use of Evidence-based Strategies

Priority Type: SUP

Population(s): PP, Other

Goal of the priority area:

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

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of Block Grant funded evidence-based strategies.

Baseline Measurement: 50%

First-year target/outcome measurement: 55%

Second-year target/outcome measurement: 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.

Priority #: 3

Priority Area: Consumers in Stable Living Arrangements

Priority Type: SUT, MHS

Population(s): SMI, SED, ESMI, PWWDC, PWID, EIS/HIV, TB, Other

Goal of the priority area:

Consumers have permanent and stable housing.

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of consumers in stable living arrangements at discharge from Residential Services.

Baseline Measurement: 80%

First-year target/outcome measurement: 83%

Second-year target/outcome measurement: 85%

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures:

Information is provided by consumer who may not wish to disclose they are or are at risk of experiencing homelessness. Residential services include: Dual Disorder Residential - MH + SUD, Halfway House - SUD, Intermediate Residential - SUD, Psychiatric Residential Rehabilitation - MH, Secure Residential - MH, Short Term Residential - SUD, and Therapeutic Community - SUD.

Priority #: 4

Priority Area: Consumer Employment

Priority Type: SUT, SUR, MHS

Population(s): SMI, SED, ESMI, PWWDC, PWID, EIS/HIV, TB, Other

Goal of the priority area:

Consumers in the labor market have employment.

Strategies to attain the goal:

Work with providers and community partners to understand local employment opportunities and help support efforts to connect consumers with employers.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of consumers in the labor market who are employed at discharge from any DBH funded service

Baseline Measurement: 58%

First-year target/outcome measurement: 58%

Second-year target/outcome measurement: 60%

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures:

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

Priority #: 5

Priority Area: Access for Priority Populations to Substance Use Disorder Services

Priority Type: SUT

Population(s): PWID, EIS/HIV, TB, Other

Goal of the priority area:

Priority populations are admitting into substance use disorder services in a timely manner.

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of persons reported as injecting drugs who are admitted into Short Term Residential services within 14 days of seeking treatment

Baseline Measurement: 80%

First-year target/outcome measurement: 85%

Second-year target/outcome measurement: 85%

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures:

The CDS access reporting function is monitored for completeness and accuracy on a regular basis.

Priority #: 6

Priority Area: First Episode Psychosis Coordinated Specialty Care

Priority Type: MHS, ESMI

Population(s): SMI, SED, ESMI

Goal of the priority area:

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

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of statewide admissions into FEP CSC programs

Baseline Measurement: 20 Admissions

First-year target/outcome measurement: 20 Admissions

Second-year target/outcome measurement: 20 Admissions

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures:

The CDS access reporting function is monitored for completeness and accuracy on a regular basis.

Priority #: 7

Priority Area: Priority Area: Tuberculosis

Priority Type: SUT

Population(s): TB, Other

Goal of the priority area:

Tuberculosis screening is provided to all persons entering substance abuse treatment service and meets federal requirements regarding screening for Tuberculosis.

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Tuberculosis (TB)

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

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

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

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures:

This contract requirement is connected to the Federal requirements under the Substance Abuse Prevention and Treatment Block Grant.

Priority #: 8

Priority Area: Crisis Response Dashboard

Priority Type: SUT, MHS, BHCS

Population(s): SMI, SED, ESMI, BHCS, PWWDC, PWID, EIS/HIV, TB, Other

Goal of the priority area:

Implement a working dashboard that summarizes and visualizes volume and metrics data for 988 and Mobile Crisis Response (MCR); to be updated monthly.

Strategies to attain the goal:

Maintain ongoing 988 data collection with Boys Town to develop a public-facing dashboard that will summarize and visualize Calls/Chats/Texts volume data for 988 and key metrics for MCR activations at statewide and regional levels.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Stand up a public-facing 988 dashboard (updated monthly)

Baseline Measurement: Project is in development

First-year target/outcome measurement: Report 988 Calls/Chats/Texts volume and metrics on a working Dashboard

Second-year target/outcome measurement: Report 988 Calls/Chats/Texts volume and Mobile Crisis Response activation metrics on a working Dashboard

Data Source:

988 data from Boys Town.

Description of Data:

Nebraska 988 calls chats, and texts volume and Mobile Crisis Response (MCR) activations volumes and metrics on statewide and regional levels.

Data issues/caveats that affect outcome measures:

None.

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SUPTRS]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2024/2025.
SUPTRS BG – ONLY include funds expended by the executive branch agency administering the SUPTRS BG.

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2025

Activity (See instructions for using Row 1.)	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) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SUPTRS BG)[a]	J. ARP Funds (SUPTRS BG)[b]
1. Substance Use Prevention[c] and Treatment	$15,159,147.45		$49,675,377.48	$8,607,868.00	$43,936,670.88	$0.00	$0.00		$1,184,568.00	$920,386.99
a. Pregnant Women and Women with Dependent Children[c]	$1,467,325.36				$1,430,810.26					
b. Recovery Support Services	$362,767.84				$4,127,712.50					
c. All Other	$13,329,054.25		$49,675,377.48	$8,607,868.00	$38,378,148.12				$1,184,568.00	$920,386.99
2. Primary Prevention[d]	$945,624.95		$0.00	$3,618,692.00	$437,792.46	$0.00	$0.00		$786,985.00	$1,716,993.01
a. Substance Use Primary Prevention	$945,624.95			$3,618,692.00	$437,792.46				$786,985.00	$1,716,993.01
b. Mental Health Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
4. Other Psychiatric Inpatient Care										
5. Tuberculosis Services										
6. Early Intervention Services for HIV										
7. State Hospital										
8. Other 24-Hour Care										
9. Ambulatory/Community Non-24 Hour Care										
10. Crisis Services (5 percent set-aside)										
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately	$847,619.60								$103,765.95	$138,809.47
12. Total	**$16,952,392.00**	**$0.00**	**$49,675,377.48**	**$12,226,560.00**	**$44,374,463.34**	**$0.00**	**$0.00**	**$0.00**	**$2,075,318.95**	**$2,776,189.47**

[a] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. Per the instructions, the planning period for standard MHBG/SUPTRS BG expenditures is July 1, 2023 – June 30, 2025. Please enter SUPTRS BG ARP planned expenditures for the period of July 1, 2023 through June 30, 2025

[c] Prevention other than primary prevention

[d] The 20 percent set-aside funds in the SUPTRS BG must be used for activities designed to prevent substance misuse.

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Footnotes:

1. Table 2 State Agency Planned Expenditures [SUPTRS] for Column I. COVID-19 Relief Funds (SUPTRS BG) is $2,075,318.95 for the state planned expenditure period of July 1, 2023 to March 12, 2024. Nebraska was awarded SUPTRS BG FY2021 COVID emergency funding of $7,162,196 for the 24-month expenditure period March 15, 2021 to March 14, 2023 and received a No Cost Extension until March 14, 2024 to expend the COVID-19 Relief funds.
>
2. Table 2 State Agency Planned Expenditures [SUPTRS] for Column J. ARP Funds (SUPTRS BG) is $2,776,189.47 for the state planned expenditure period of July 1, 2023 to June 30, 2025. Nebraska was awarded SABG FY2021 ARPA funding of $6,185,533 in federal funding for the Budget Period Start Date 09/01/2021 – End Date 09/30/2025.

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Table 2 addresses funds to be expended during the 24-month period of July 1, 2023 through June 30, 2025. Table 2 now includes columns to capture state expenditures for COVID-19 Relief Supplemental and ARP funds. Please use these columns to capture how much the state plans to expend over a 24-month period (July 1, 2023 - June 30, 2025). Please document the use of COVID-19 Relief Supplemental and ARP funds in the footnotes.

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2025

Activity (See instructions for using Row 1.)	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) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SUPTRS BG)[a]	J. ARP Funds (MHBG)[b]	K. BSCA Funds (MHBG)[c]
1. Substance Use Prevention and Treatment											
a. Pregnant Women and Women with Dependent Children											
b. Recovery Support Services											
c. All Other											
2. Primary Prevention											
a. Substance Use Primary Prevention											
b. Mental Health Prevention[d]											
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[e]		$897,811.50						$175,000.00		$300,000.00	
4. Other Psychiatric Inpatient Care											
5. Tuberculosis Services											
6. Early Intervention Services for HIV											
7. State Hospital				$4,744,266.00	$169,971,152.00						
8. Other 24-Hour Care		$40,000.00	$40,500,740.00		$17,887,018.32			$465,000.00		$2,001,569.00	
9. Ambulatory/Community Non-24 Hour Care		$7,142,487.25	$185,674,484.00	$576,000.00	$111,360,259.68			$275,000.00		$250,000.00	
10. Crisis Services (5 percent set-aside)[f]		$448,905.75		$1,066,666.00	$31,238,681.90						
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately[g]		$448,905.50						$48,157.89		$134,293.11	
12. Total	**$0.00**	**$8,978,110.00**	**$226,175,224.00**	**$6,386,932.00**	**$330,457,111.90**	**$0.00**	**$0.00**	**$963,157.89**	**$0.00**	**$2,685,862.11**	**$295,182.00**

[a]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states. Note: If your state has an approved no cost extension, you have until March 14, 2024, to expend the COVID-19 Relief supplemental funds.

[b]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

[c]The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is from **October 17, 2022 thru October 16, 2024** and the expenditure for the 2nd allocation of BSCA funding will be from September 30, 2023 thru September 29, 2025 which is different from the expenditure period for the "standard" MHBG. Column J should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

[d]While the state may use state or other funding for prevention services, the MHBG funds must be directed toward adults with SMI or children with SED.

[e]Column 3 should include Early Serious Mental Illness programs funded through MHBG set aside.

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

[g]Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.

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Footnotes:

1. Table 2 State Agency Planned Expenditures [MH] for Column H. COVID-19 Relief Funds (MHBG) is $963.157.89 for the state planned expenditure period of July 1, 2023 to March 12, 2024. Nebraska was awarded MHBG FY2021 COVID emergency funding of $3,795,400 for the 24-month expenditure period March 15, 2021 to March 14, 2023 and received a No Cost Extension until March 14, 2024 to expend the COVID-19 Relief funds.
>
2. Table 2 State Agency Planning Expenditures [MH] for Column J. ARP Funds (MHBG) is $2,685,862.11 for the state planned expenditure period of July 1, 2023 to June 30, 2025. Nebraska was awarded MHBG FY2021 ARPA funding of $6,555,690 in federal funding for the Budget Period Start Date 09/01/2021 – End Date 09/30/2025.
>
3. (Footnote #3 revised per RevReq102423) -Table 2 State Agency Planned Expenditures [MH] for Column K. BSCA Funds (MHBG) is $295,182.00 (amount reported revised per RevReq102423) for the state planned expenditure period of Year 2 Allocation with detail in Row 3

and Row 10. Nebraska was awarded $295,182 for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding with an expenditure period from October 17, 2022 thru October 16, 2024 and was awarded $295,182 for the 2nd allocation of BSCA funding with an expenditure period from September 30, 2023 thru September 29, 2025.

Planning Tables

Table 3 SUPTRS BG Persons in need/receipt of SUD treatment

To complete the Aggregate Number Estimated in Need column, please refer to the most recent edition of SAMHSA's 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, please refer to the most recent edition of the Treatment Episode Data Set (TEDS) data prepared and submitted to SAMHSA's Behavioral Health Services Information System (BHSIS).

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	2,840	18
2. Women with Dependent Children	10,000	217
3. Individuals with a co-occurring M/SUD	58,000	1,347
4. Persons who inject drugs	2,000	753
5. Persons experiencing homelessness	675	113

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

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%. 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." Source Row 3-Col 1 Individuals with a co-occurring M/SUD: SAMHSA/CBHSQ Data Tables in "ASC_AdHoc091-08-18-17" released to SABG Coordinators on August 24, 2017. Table used: Co-Occurring Need for Treatment at a Specialty Facility for a Substance Use Problem and Characteristic of Interest in the Past Year among Persons Aged 18 or Older, 2012-2014-Any Many Illness in the Past Year." Source Row 4-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."

Source Row 5-Col 1 Persons experiencing homelessness: Need estimated based on HUD 2022 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations with a chronic SUD 2022 Point-in-Time Count (PIT). The PIT Count is conducted on a single day across the state and SUD is self-reported. Counts in the second column of rows 1-4 are based on FY22 CDS anchor dataset of persons served during FY22. Data current as of 10/1/2022. Co-occurring MH/SUD counts based on SUD encounters with dual MH/SUD diagnoses or primary MH diagnosis while admitted in SUD service. Counts in the second column of row 5 is based on point in time of currently admitted consumers reporting living arrangements as homeless or homeless shelter. Count based on number of unique consumer IDs reporting homeless or homeless shelter. Data was pulled direct from CDS on 8/10/2023.
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Footnotes:

Planning Tables

Table 4 SUPTRS BG Planned Expenditures

States must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations, including the supplemental COVID-19 and ARP funds. Plan Table 4 must be completed for the FFY 2024 and FFY 2025 SUPTRS BG awards. The totals for each Fiscal Year should match the President's Budget Allotment for the state.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	FFY 2024		
Expenditure Category	**FFY 2024 SUPTRS BG Award**	**COVID-19 Award[1]**	**ARP Award[2]**
1 . Substance Use Disorder Prevention and Treatment[3]	$5,968,938.67	$1,184,568.00	$920,386.99
2 . Substance Use Primary Prevention	$2,083,447.53	$786,985.00	$1,716,993.01
3 . Early Intervention Services for HIV[4]			
4 . Tuberculosis Services			
5 . Recovery Support Services[5]			
6 . Administration (SSA Level Only)	$423,809.80	$103,765.95	$138,809.47
7. Total	**$8,476,196.00**	**$2,075,318.95**	**$2,776,189.47**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19

Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the FY 2024 "standard" SUPTRS BG, which is October 1, 2023 - September 30, 2024. The SUPTRS BG ARP planned expenditures for the period of October 1, 2023 - September 30, 2024 should be entered here in the first ARP column, and the SUPTRS BG ARP planned expenditures for the period of October 1, 2024, through September 30, 2025, should be entered in the second ARP column.

[3]Prevention other than Primary Prevention

[4]For the purpose of determining which states and jurisdictions are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance use disorder Prevention and Treatment Block Grant (SUPTRS BG); Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the AtlasPlus HIV data report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP). 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 services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a “designated state” in any of the three years prior to the year for which a state is applying for SUPTRS BG funds with the flexibility to obligate and expend SUPTRS BG funds for EIS/HIV even though the state’s AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SUPTRS BG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance will be allowed to obligate and expend SUPTRS BG funds for EIS/HIV if they chose to do so and may elect to do so by providing written notification to the CSAT SPO as a part of the SUPTRS BG Application.

[5]This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023.

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Footnotes:

Planning Tables

Table 5a SUPTRS BG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

A		B		
Strategy	IOM Target	FFY 2024		
		SUPTRS BG Award	COVID-19 Award[1]	ARP Award[2]
1. Information Dissemination	Universal	$188,204		$308,196
	Selected	$62		
	Indicated	$465		
	Unspecified			
	Total	**$188,731**	**$0**	**$308,196**
2. Education	Universal	$217,060	$406,985	$175,455
	Selected	$126,315		
	Indicated	$27,907		
	Unspecified			
	Total	**$371,282**	**$406,985**	**$175,455**
3. Alternatives	Universal	$42,346		$80,844
	Selected	$14,047		
	Indicated	$6,375		
	Unspecified			
	Total	**$62,768**	**$0**	**$80,844**
4. Problem Identification and Referral	Universal	$128,181		$141,623
	Selected	$12,115		$98,506
	Indicated	$121,000		
	Unspecified			
	Total	**$261,296**	**$0**	**$240,130**
	Universal	$395,301		$32,338

5. Community-Based Processes	Selected			
	Indicated			
	Unspecified			
	Total	**$395,301**	**$0**	**$32,338**
6. Environmental	Universal	$596,701		
	Selected			
	Indicated			
	Unspecified			
	Total	**$596,701**	**$0**	**$0**
7. Section 1926 (Synar)-Tobacco	Universal	$29,781		
	Selected			
	Indicated			
	Unspecified			
	Total	**$29,781**	**$0**	**$0**
8. Other	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
Total Prevention Expenditures		**$1,905,861**	**$406,985**	**$836,962**
Total SUPTRS BG Award[3]		**$8,476,196**	**$2,075,319**	**$2,776,189**
Planned Primary Prevention Percentage		**22.48 %**	**19.61 %**	**30.15 %**

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

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

[3]Total SUPTRS BG Award is populated from Table 4 - SUPTRS BG Planned Expenditures

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Footnotes:

1. For the FFY2024 SUPTRS Block Grant, the sum of the total amount reported on Table 5a SUPTRS BG Primary Prevention Planned Expenditures for SUPTRS BG Award ($1,905,860.53) plus the total amount of Primary Prevention set-aside funds reported on Table 6 Non-Direct-Services/System Development [SUPTRS] column B. SUPTRS BG Prevention ($177,587.00) should equal the amount reported on Table 4 SUPTRS BG Planned Expenditures , Row 2 Substance Use Primary Prevention, FFY 2024 SUPTRS BG Award ($2,083,447.53).
>
2. For the FFY2024 SUPTRS Block Grant, the sum of the total amount reported on Table 5a SUPTRS BG Primary Prevention Planned Expenditures for SUPTRS BG COVID-19 Award ($406,985) plus the total amount of Primary Prevention set-aside funds reported on Table 6 Non-Direct-Services/System Development [SUPTRS] column D. SUPTRS BG COVID-19 ($380,000.00) should equal the amount reported on Table 4 SUPTRS BG Planned Expenditures , Row 2 Substance Use Primary Prevention, FFY 2024 SUPTRS BG COVID-19 Award ($786,985.00).
>
3. For the FFY2024 SUPTRS Block Grant, the sum of the total amount reported on Table 5a SUPTRS BG Primary Prevention Planned Expenditures for SUPTRS BG ARP Award ($836,962.17) plus the total amount of Primary Prevention set-aside funds reported on Table 6 Non-Direct-Services/System Development [SUPTRS] column E. SUPTRS BG ARP ($880,030.84) should equal the amount reported on Table 4 SUPTRS BG Planned Expenditures , Row 2 Substance Use Primary Prevention, FFY 2024 SUPTRS BG ARP Award ($1,716,993.01).

Planning Tables

Table 5b SUPTRS BG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

Activity	FFY 2024 SUPTRS BG Award	FFY 2024 COVID-19 Award[1]	FFY 2024 ARP Award[2]
Universal Direct	$472,751		$381,429
Universal Indirect	$1,124,824	$406,985	$357,027
Selected	$152,539		$98,506
Indicated	$155,747		
Column Total	**$1,905,861**	**$406,985**	**$836,962**
Total SUPTRS BG Award[3]	**$8,476,196**	**$2,075,319**	**$2,776,189**
Planned Primary Prevention Percentage	**22.48 %**	**19.61 %**	**30.15 %**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

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

[3]Total SUPTRS BG Award is populated from Table 4 - SUPTRS BG Planned Expenditures

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Footnotes:

1. For the FFY2024 SUPTRS Block Grant, the sum of the total amount reported on Table 5b SUPTRS BG Primary Prevention Planned Expenditures by IOM Category ($1,905,860.53) plus the total amount of Primary Prevention set-aside funds reported on Table 6 Non-Direct-Services/System Development [SUPTRS] column B. SUPTRS BG Prevention ($177,587.00) should equal the amount reported on Table 4 SUPTRS BG Planned Expenditures , Row 2 Substance Use Primary Prevention, FFY 2024 SUPTRS BG Award ($2,083,447.53).
>
2. For the FFY2024 SUPTRS Block Grant, the sum of the total amount reported on Table 5b SUPTRS BG Primary Prevention Planned Expenditures by IOM Category for SUPTRS BG COVID-19 Award ($406,985) plus the total amount of Primary Prevention set-aside funds reported on Table 6 Non-Direct-Services/System Development [SUPTRS] column D. SUPTRS BG COVID-19 ($380,000.00) should equal the amount reported on Table 4 SUPTRS BG Planned Expenditures , Row 2 Substance Use Primary Prevention, FFY 2024 SUPTRS BG COVID-19 Award ($786,985.00).
>
3. For the FFY2024 SUPTRS Block Grant, the sum of the total amount reported on Table 5b SUPTRS BG Primary Prevention Planned Expenditures by IOM Category for SUPTRS BG ARP Award ($836,962.17) plus the total amount of Primary Prevention set-aside funds reported on Table 6 Non-Direct-Services/System Development [SUPTRS] column E. SUPTRS BG ARP ($880,030.84) should equal the amount reported on Table 4 SUPTRS BG Planned Expenditures , Row 2 Substance Use Primary Prevention, FFY 2024 SUPTRS BG ARP Award ($1,716,993.01).

Planning Tables

Table 5c SUPTRS BG Planned Primary Prevention Priorities (Required)

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2024 and FFY 2025 SUPTRS BG awards.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	SUPTRS BG Award	COVID-19 Award[1]	ARP Award[2]
Prioritized Substances			
Alcohol	☑	☑	☑
Tobacco	☑	☑	☑
Marijuana	☑	☑	☑
Prescription Drugs	☑	☑	☑
Cocaine	☑	☑	☑
Heroin	☐	☐	☐
Inhalants	☐	☐	☐
Methamphetamine	☑	☑	☑
Fentanyl	☑	☑	☑
Prioritized Populations			
Students in College	☑	☑	☑
Military Families	☑	☑	☑
LGBTQI+	☑	☑	☑
American Indians/Alaska Natives	☑	☑	☑
African American	☑	☑	☑

Hispanic	☑	☑	☑
Persons Experiencing Homelessness	☐	☐	☐
Native Hawaiian/Other Pacific Islanders	☐	☐	☐
Asian	☑	☑	☑
Rural	☑	☑	☑
Underserved Racial and Ethnic Minorities	☑	☑	☑

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

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

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Footnotes:

Planning Tables

Table 6 Non-Direct-Services/System Development [SUPTRS]

Please enter the total amount of the SUPTRS BG, COVID-19, or ARP funds expended for each activity.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

Expenditure Category	FFY 2024 A. SUPTRS BG Treatment	B. SUPTRS BG Prevention	C. SUPTRS BG Integrated[1]	D. COVID-19[2]	E. ARP[3]
1. Information Systems					$259,000.00
2. Infrastructure Support					
3. Partnerships, community outreach, and needs assessment		$23,698.00		$150,000.00	$133,830.84
4. Planning Council Activities (MHBG required, SUPTRS BG optional)					
5. Quality Assurance and Improvement					
6. Research and Evaluation		$88,889.00			
7. Training and Education	$134,200.00	$65,000.00		$230,000.00	$487,200.00
8. Total	**$134,200.00**	**$177,587.00**	**$0.00**	**$380,000.00**	**$880,030.84**

[1]Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.

[2]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[3]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the federal planned expenditure period of October 1, 2023 - September 30, 2025. Please list ARP planned expenditures for each standard FFY period.

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Footnotes:

1. For the FFY2024 SUPTRS Block Grant, the amount of SUD Prevention funds (Table 4, Row 2, FFY 2024 SUPTRS BG Planned Expenditures) to be used for Non-Direct Services/System Development Activities Column B SUPTRS BG Prevention and/or Column C SUPTRS BG Integrated = $177,587.00.
>
2. For the FFY2024 SUPTRS Block Grant, the amount of SUPTRS BG Administration funds (from Table 4, Row 6) to be used for Non-Direct Services/System Development Activities for SUPTRS BG Prevention Column B, and/or SUPTRS BG Integrated, Column C, = $0.
>
3. For the FFY2024 SUPTRS Block Grant, the amount of SUD COVID-19 (Table 4, Row 1, FFY 2024 SUPTRS BG Planned Expenditures) to be used for Non-Direct Services/System Development Activities Column D SUPTRS BG COVID-19 and/or Column C SUPTRS BG Integrated = $380,000.00.
>
4. For the FFY2024 SUPTRS Block Grant, the amount of SUD ARP (Table 4, Row 1, FFY 2024 SUPTRS BG Planned Expenditures) to be used for

Non-Direct Services/System Development Activities Column E SUPTRS BG ARP and/or Column C SUPTRS BG Integrated = $880,030.84.

Planning Tables

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

Please enter the total amount of the MHBG, COVID-19, ARP funds, and BSCA funds expended for each activity

MHBG Planning Period Start Date: 07/01/2023 MHBG Planning Period End Date: 06/30/2025

Activity	FY 2024 Block Grant	FY 2024[1] COVID Funds	FY 2024[2] ARP Funds	FY 2024[3] BSCA Funds	FY 2025 Block Grant	FY 2025[1] COVID Funds	FY 2025[2] ARP Funds	FY 2025[3] BSCA Funds
1. Information Systems			$223,673.80				$223,673.80	
2. Infrastructure Support			$185,000.00				$185,000.00	
3. Partnerships, community outreach, and needs assessment			$40,000.00	$90,000.00			$40,000.00	$90,000.00
4. Planning Council Activities (MHBG required, SUPTRS BG optional)								
5. Quality Assurance and Improvement								
6. Research and Evaluation			$75,000.00				$75,000.00	
7. Training and Education		$30,000.00	$70,000.00	$205,182.00			$60,000.00	$205,182.00
8. Total	**$0.00**	**$30,000.00**	**$593,673.80**	**$295,182.00**	**$0.00**	**$0.00**	**$583,673.80**	**$295,182.00**

[1] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for most states. Note: If your state has an approved no cost extension, you have until March 14, 2024 to expend the COVID-19 Relief supplemental funds.

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

[3] The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is **October 17, 2022** thru **October 16, 2024** and for the 2nd allocation will be **September 30, 2023** thru **September 29, 2025** which is different from the expenditure period for the "standard" MHBG. Column D should reflect the spending for the state reporting period. The total may reflect the BSCA allotment portion used during the state reporting period.

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Footnotes:

1. Nebraska does not use regular MHBG funding for Non-Direct Services/System Development activities.
>
2. For the FFY2024 MH Block Grant, the amount of MH COVID Relief Funds (Table 2, Column H, MHBG Planned Expenditures) to be used for Non-Direct Services/System Development Activities Column FY2024 COVID Funds = $30,000.00. And, the amount of MH ARP Funds (Table 2, Column J, MHBG Planned Expenditures) to be used for Non-Direct Services/System Development Activities Column FY2024 ARP Funds = $593,673.80. And, the amount of MH BSCA Funds (Table 2, Column K, MHBG Planned Expenditures) to be used for Non-Direct Services/System Development Activities Column FY2024 BSCA Funds = $295,182.00.
>
3. For the FFY2025 MH Block Grant, the amount of MH COVID Relief Funds (Table 2, Column H, MHBG Planned Expenditures) to be used for Non-Direct Services/System Development Activities Column FY2025 COVID Funds = Zero dollars. And, the amount of MH ARP Funds (Table 2, Column J, MHBG Planned Expenditures) to be used for Non-Direct Services/System Development Activities Column FY2025 ARP Funds = $583,673.80. And, the amount of MH BSCA Funds (Table 2, Column K, MHBG Planned Expenditures) to be used for Non-Direct Services/System Development Activities Column FY2025 BSCA Funds = $295,182.00.

Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required

Narrative Question

Across the United States, significant percentages of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not access needed behavioral health care. 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 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: **https://store.samhsa.gov/product/essential-aspects-of-parity-training-tool-for-policymakers/pep21-05-00-001**; **https://store.samhsa.gov/product/Approaches-in-Implementing-the-Mental-Health-Parity-and-Addiction-Equity-Act-Best-Practices-from-the-States/SMA16-4983**. 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 seriousness 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 detail on efforts to increase access to services for:

a) Adults with serious mental illness

b) Pregnant women with substance use disorders

c) Women with substance use disorders who have dependent children

d) Persons who inject drugs

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

f) Persons with substance use disorders in the justice system

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

h) Other adults with substance use disorders

i) Children and youth with serious emotional disturbances or substance use disorders

j) 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 SAPTBG and MHBG and provides leadership in funding for substance use disorder programs and mental health programs in the state. DBH provides substance use and mental health disorder services to non-Medicaid eligible consumers using a combination of SAPTBG and MHBG and state funding. DBH collaborates with other state agencies providing behavioral health services.

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

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

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.

System integration through managed care policy and practice includes improved health outcomes based on the social determinants of health, enhanced integration of services and quality of care, care management and preventive services, reduced costly and avoidable care, improved financial sustainability and a quality public system of primary and behavioral health care that is seamless and inclusive of all individuals eligible for services. The MLTC plans are financially and contractually incentivized to invest in prevention case management and care/treatment. At an administrative level, MLTC, the three Heritage Health Managed Care Organizations (MCOs) and DBH meet regularly.

MLTC 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

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

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

Services are provided by the SSA/SMHA to non-Medicaid eligible consumers in the state and are paid for with a combination of SAPTBG, MHBG and state funding. MLTC contracted plans provide the following services for behavioral health consumers, many of which are also contracted for by SSA/SMHA. Medicaid is in collaboration with DBH on a major project to update all mental health and substance use service definitions.
http://dhhs.ne.gov/Pages/Medicaid-Behavioral-Health-Definitions.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 are important components in systems of care surrounding each individual served. For example, other state agencies (e.g., State Probation through the Nebraska Supreme Court, the Nebraska Department of Correctional Services (NDCS), the Nebraska Department of Education Vocational Rehabilitation (NDE-VR), and the Veterans Administration) fund or support behavioral health services for specific populations. The DBH system integration collaborative activities include working with:
• the NDCS to ensure those individuals released from correctional facilities are connected with the services they need to meet their rehabilitation needs.
• the 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.

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. A 2020 National Alliance for Mental Illness Fact Sheet reported 7.9% of Nebraskan's are uninsured.

The Mental Health Parity and Addiction Equity 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 parity regulations and has an established working relationship with the Department of Insurance (DOI) to provide input and guidance on parity legislation as well as communication for consumers. A Parity 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. Four insurers offer plans in the exchange in 2023.

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 parity membership. Legislation related to health plans and the coverage of telehealth and telephonic service delivery for medical and behavioral services occurred in the most recent Legislative session.

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

The DBH, in partnership with the Behavioral Health Education Center of Nebraska (BHECN), promotes activities in research and education to improve the quality of services, recruitment and retention of behavioral health professionals and access to programs and services. The DBH and BHECN are engaged in shared workforce strategic planning focusing on access to healthcare data, integration efforts, and reciprocity in relationships, needs assessment, workforce plan and metrics and shared conferences. BHECN and the Mid-America Mental Health Technology Transfer Center (MHTTC) is working with the University of Nebraska Medical Center on a project to re-examine behavioral health worker recruitment and retention. As the contracted Region VII MHTTC this work will continue to build upon and enhance efforts in integration and workforce development. In October 2020, BHECN was awarded a multi-year grant from the Health Resources and Services Administration (HRSA) Rural Communities Opioid Response Program to connect people and resources in rural Nebraska and address barriers to access in rural communities related to substance use disorder, including opioid use disorder. The Nebraska Legislature allocated more than $25 million in American Rescue Plan Act (ARPA) funding to BHECN in 2022 to address the impacts of the pandemic and the shortage of behavioral health professional.

Through planning efforts and State Targeted Response / State Opioid Response grant funding, the DBH and the University of Nebraska Medical Center (UNMC) have implemented an intensive training and service delivery program approved for UNMC. The

program is located within Family Practice medicine which further supports integration initiatives.

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

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.

Nebraska has five operating Certified Community Behavioral Health Clinics (CCBHC) whose purpose is to provide integrated care and ensure 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.

DBH completed a needs and gaps assessment in 2020. The Strategic Plan 2022-2024 includes integration goals that drives strategies directed to impact mental health and substance use service delivery and practices, workforce development, and increased behavioral health services in primary care settings, including crisis services.

2. Describe 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 parity 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.

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The Division of Behavioral Health 2022-2024 Behavioral Health Strategic Plan identifies the simple and shared goal for Nebraskans is access to healthcare; our focus is on behavioral healthcare. The needs and gaps analysis recommended continued work to build a more comprehensive array of prevention, treatment, and recovery services that also addresses health equity through cross system engagement. The new plan comes at a time of continued challenges, but also great opportunity given the resources afforded including Medicaid expansion, Covid-19 emergency grants, state opioid response grants, and other resources that work to innovate, improve and integrate services to address the whole-health needs and well-being of Nebraskans.

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3. Describe how the state supports integrated behavioral health and primary health care, including services for individuals with mental disorders, substance use disorders, and co-occurring mental and substance use disorders. 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

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4. 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

b) Adults with substance use disorders

c) Children and youth with serious emotional disturbances or substance use disorders

The Nebraska Division of Behavioral Health (DBH) supports and promotes coordination and collaboration related to the provision of person-centered, person-directed and trauma-informed care. The use of person-centered service delivery and participant directed care within the state hospitals, regional and community-based provider systems. Nebraska's public behavioral health system governing regulations "Standards of Care" (NAC 206, Chapter 1 identifies the right of each consumer to receive behavioral health services in the most integrated setting appropriate based on an individualized and person-centered assessment, and actively and directly participate in decisions which incorporate independence, individuality, privacy, and dignity and to make decisions regarding care and treatment. This is evidenced by person-centered planning policies within the state hospitals (e.g. Regional Centers), regional and community based provider program fidelity audits, the work of the Office of Consumers Affairs related to 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, traumas, and cultural background.

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..

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

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

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

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

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

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

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

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

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

8. Provide developmentally appropriate behavioral health services and supports that promote protective factors, resiliency, trauma-

informed care, and optimal social-emotional outcomes for young children and their families in their homes and community settings.

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

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

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

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

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

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 an inclusive 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

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.

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.

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 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 committees and 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.

The OCA's Peoples Council is specifically designed to advise DBH on meaningful consumer involvement. The Council consists of members who represent the geographic, cultural, and racial diversity 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).

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 stigma reduction. 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 stigma reduction efforts, and provide feedback on DBH program and policy guidelines.

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.

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.

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. In Plan Year 2023, there are three MCOs are Nebraska Total Care, UnitedHealthcare Community Plan of Nebraska, and Healthy Blue. The Nebraska Department of Health and Human Services (DHHS) has selected Molina Healthcare of Nebraska, Nebraska Total Care, and UnitedHealthcare to provide health and dental services for Heritage Health beginning January 1, 2024.

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.

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, cultural, and racial diversity of the MCO's membership.

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.

NDE and DBH are partnering at the State level to collaborate with three Local Education Agencies (LEAs) to improve school-based mental health services. The LEAs of Chadron, Hastings, and South Sioux City are demographically and geographically diverse, with varying levels of poverty and scarcity of mental health resources. Two sites have higher free/reduced lunch rates, indicative of poverty and student mobility. Each differs in racial/ethnic composition, with higher proportions of Hispanic and Native American students. All three LEAs have strong, long-standing track records of successful collaborations with State and local partners, including mental health providers, community coalitions, civic organizations, the business and private sector, and stakeholders, including students and families.

This project is intended to build and expand the capacity of the NDE, in partnership with the DBH and the three LEA Site partners, to:
• Prevent the development of mental health and behavioral disorders among students by providing a positive, supportive, and trauma-informed learning environment.
• Increase awareness of mental health issues among school-aged youth and skills fostering resilience and pro-social behaviors through strength-based approaches and social-emotional learning.
• Increase the school-based mental health services available and connect students with mental health issues and their families to the appropriate services.
• Increase schools' capacity to identify and immediately respond to the mental health needs of students exhibiting behavioral or psychological signs requiring clinical intervention.
• Increase schools' capacity to identify and intervene in bullying and aggressive or violent behaviors of students that may contribute to school violence.

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

Services are provided by the SSA/SMHA to non-Medicaid eligible consumers in the state and are paid for with a combination of SAPTBG, MHBG and state funding. MLTC contracted health plans provide mental health and substance use disorder services for behavioral health consumers. MLTC and DBH share services and service definitions. Most providers contracted to provide services contract with MLTC and the SSA/SMHA.
http://dhhs.ne.gov/Pages/Medicaid-Behavioral-Health-Definitions.aspx
http://dhhs.ne.gov/Pages/Heritage-Health-Contacts.aspx

LB1173 (2022) requires 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 have been engaged in statewide meetings to develop a framework to transform and integrate systems. Information garnered from numerous stakeholder groups have been collated and are being prioritized by members. Priorities are intended to drive DHHS overarching strategic plan as well as impact Division plans going forward.

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

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, mental and emotional health needs among children and adolescents in Nebraska.

The Munroe-Meyer Institute is conducting a project to improve access to pediatric mental health services in Nebraska, working as a sub-recipient in a $2.2 million five-year grant awarded to the Nebraska DHHS Title V Maternal and Child Health program.

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 will utilize the information and recommendations to outline a vision and plan for how best to disseminate information to families; to develop a website as an online resource repository; to determine the needs for training and education of families; and to identify steps for addressing gaps in resources. By April 2025, the project will deliver a white paper and an action plan.

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

None at this time.

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Footnotes:

Environmental Factors and Plan

2. Health Disparities - Required

Narrative Question

In accordance with Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (Executive Order 13985), Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals (Executive Order 14075), the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[1], **Healthy People, 2030**[2], **National Stakeholder Strategy for Achieving Health Equity**[3], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual orientations, gender identities, races, and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (e.g., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the **Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care** (CLAS)[4].

Collecting appropriate data are a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[5]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[6]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQI+ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

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

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

[1] **https://www.minorityhealth.hhs.gov/assets/pdf/hhs/HHS_Plan_complete.pdf**

[2] **https://health.gov/healthypeople**

[3] **https://www.mih.ohio.gov/Portals/0/Documents/CompleteNSS.pdf**

[4] **https://thinkculturalhealth.hhs.gov/**

[5] **https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status**

[6] **https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf**

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?

a) Race — Yes / No

b) Ethnicity — Yes / No

c) Gender — Yes / No

d) Sexual orientation — Yes / No

e) Gender identity — Yes / No

f) Age — Yes / No

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

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

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

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

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

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

The Division of Behavioral Health will release its 2022-2024 Behavioral Health Strategic Plan in the summer of 2021. The simple and shared goal for Nebraskans is access to healthcare; our focus is on behavioral healthcare. The needs and gaps analysis recommended continued work to build a more comprehensive array of prevention, treatment, and recovery services that also addresses health equity through cross system engagement. The new plan comes at a time of continued challenges, but also great opportunity given the resources afforded including Medicaid expansion, Covid-19 emergency grants, state opioid response grants, and other resources that work to innovate, improve and integrate services to address the whole-health needs and well-being of Nebraskans.

As the chief behavioral health strategist for the state, DBH will serve as a catalyst for responsiveness to the needs of Nebraskans related to prevention, treatment and recovery of mental illness and substance use. For example, as the Latino population in Nebraska has risen, the DBH sought out the services of the Office of Health Equity and Disparity to help design, translate and disseminate a needs assessment survey in Spanish. As an identified planning objective moving forward, the 2022-2021 Behavioral Health Strategic Plan focuses on increasing behavioral health services/access in a variety of settings, setting targets and activities to address disparities in those served as well as workforce. This includes increasing diversity and health equity through cross system engagement, planning and ensuring culturally and linguistically appropriate services (CLAS). DBH also reviews data by race and ethnicity to identify disparity.

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

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

Please indicate areas of technical assistance needed related to this section

None at this time.

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Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

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

Health Care Value = Quality ÷ Cost, (**V = Q ÷ C**)

SAMHSA anticipates that the movement toward value-based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services. The **National Center of Excellence for Integrated Health Solutions**[1] offers technical assistance and resources on value-based purchasing models including capitation, shared-savings, bundled payments, pay for performance, and incentivizing outcomes.

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

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

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions used with individuals with mental illness and substance use disorders, including youth and adults with substance use disorders, adults with SMI, and children and youth with SED. The recommendations build on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[2], The New Freedom Commission on Mental Health[3], the IOM, NQF, and the **Interdepartmental Serious Mental Illness Coordinating Committee** (ISMICC)[4].

One activity of the EBPRC[5] was a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[6] SAMHSA and other HHS federal partners, including the Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many innovative and promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, evidence is collected to determine their efficacy and develop a more detailed understanding of for who and in what circumstances they are most effective.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[7] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[8] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. Each KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice

demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, for educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is interested with what additional information is needed by SMHAs and SSAs to support their and other purchasers' decisions regarding value-based purchase of M/SUD services.

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[1] **https://www.thenationalcouncil.org/program/center-of-excellence/**

[2] United States Public Health Service Office of the Surgeon General (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[3] The President's New Freedom Commission on Mental Health (July 2003). *Achieving the Promise: Transforming Mental Health Care in America*. Rockville, MD: Department of Health and Human Services, Substance use disorder and Mental Health Services Administration.

[4] National Quality Forum (2007). *National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices*. Washington, DC: National Quality Forum.

[5] **https://www.samhsa.gov/ebp-resource-center/about**

[6] **http://psychiatryonline.org/**

[7] **http://store.samhsa.gov**

[8] **https://store.samhsa.gov/?f%5B0%5D=series%3A5558**

Please respond to the following items:

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

2. Which value based purchasing strategies do you use in your state (check all that apply):

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

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

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

In 2017, the DBH implemented an Electronic Billing System (EBS). The EBS is a DHHS hosted web-based system developed to streamline the billing processes by moving billing for recovery, treatment, and prevention efforts from paper to electronic

submission. The system provides system-wide consistency in tracking and reporting all DBH funded community-based mental health and substance abuse services.

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

The EBS and CDS are the primary evaluation tools for service utilization at the State, Region and provider level. They allow DBH to make data informed decisions about management and quality assurance initiatives. Standard reports for individual providers and RBHAs can be used for planning, controlling, and monitoring operations, including cost comparisons between providers of the same services across the state. Statewide reports allow DBH oversight at aggregated and granular levels. The result will be more data informed decisions to ensure overall efficiency and cost effectiveness.

Nebraska continues exploring approaches to design and develop value-based reimbursement models with a focus on performance metrics in key areas such as cost of service unit per consumer. Education regarding different types of models and the benefits/challenges of each model was presented to DBH senior leadership and sister agency leadership, the MCOs, the Administrative Office of Probation and the Courts and RBHA Partners. Recommendations will drive enhancements to the CDS and EBS systems.

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

None needed at this time.

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Footnotes:

Environmental Factors and Plan

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

Narrative Question

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

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

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

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

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

Please respond to the following items:

1. Please name the model(s) that the state implemented including the number of programs for each model for those with ESMI using MHBG funds.

Model(s)/EBP(s) for ESMI/FEP	Number of programs
NAVIGATE (FEP)	2

2. Please provide the total budget/planned expenditure for ESMI/FEP for FY 24 and FY 25 (only include MHBG funds).

FY2024	FY2025
448906	448906

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

At this time, all funding for the FEP model are being provided through block grant funds. DBH provides these services through a service called “Coordinated Specialty Care” which adheres to the NAVIGATE model. Medicaid reimburses for components of this service.

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

In addition to the state appropriation for Mental Health First Aid (MHFA), DBH is a key partner on Nebraska’s 2 Project AWARE grants. This grant, awarded to the Nebraska Department of Education, aims to improve prevention, early identification and treatment response for students with or at risk of having behavioral health conditions. As a result, Nebraska has added 55 new certified Youth Mental Health First Aid instructors who trained over 1,200 individuals across the state over the past 4 years.

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

The goals of the FEP CSC Program continue to be to develop and implement an individualized, person-centered plan that will help the consumer manage symptoms, identify any co-morbid conditions that should be treated, provide for on-going risk assessment, provide education so clients and families can learn to manage the illness and develop coping skills, and focus on consumer goals and recovery. Nebraska uses block grant funds for targeted investments to build core capacities and regional collaborations to develop FEP expertise as the programs reform.

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

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

5. Does the state monitor fidelity of the chosen EBP(s)?

(●) Yes ( ) No

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

(●) Yes ( ) No

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

The NAVIGATE model of FEP treatment aims to successfully transition the individual to a less intensive level of care and establish safety planning in the event of a crisis. The program promotes Active and ongoing engagement in educational or volunteer activities or is competitively employed and maintaining a job of choice. The team approach to treatment promotes opportunities for the individual to be referred to other helpful services that may improve the individual’s outcomes or provide support to their family.

Since implementation the providers have revamped their orientation and intake process to have the person and their family meet the team at orientation and get an initial appointment set up with every member of the team. This has resulted in better engagement in all services, including family members; Utilizing peer support to engage clients has been vital to help individuals increase their level of insight and begin to make progress as they move towards the acceptance stage of the illness. It appears that one prominent need for the people that we serve is case management- while not everyone may be ready to consider school or work- each person and their family have seemed to need additional support to navigate the mental health system and get connected to resources in the community.

In 2020, the DBH sponsored training on the evidence based practice of cognitive behavioral therapy for psychosis delivered by Dr. Laura Tulley from the UC Davis Early Psychosis Program. As the training was available across the state, the goal was to support providers treating FEP individuals regardless of their affiliation with an FEP CSC team. In 2022, DBH initiated a study in partnership with the University of Nebraska Medical Center to assess prevalence rates of FEP conditions across the state and collect qualitative interview data from experts who encounter individuals experiencing FEP in their professional practice and this study is in the process of being published as a

manuscript for distribution.

Furthermore, DBH maintains active contracts with regional authorities and the University of Nebraska public policy center to provide trainings for workforce development and continuing education credits. Topics having included DBT certification, Dual Disorder treatment, youth crisis intervention and incorporating data collection into clinical practice.

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

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

Nebraska has five Certified Community Behavioral Health Clinics credentialed through SAMSHA. These additions to the integrated care continuum will strengthen the care coordination available to people, including families affected by ESMI. With the recent passage of LB276 through the state's legislature, DBH will be partnering with the divisions of Medicaid and Public Health to develop standards, payment models and credentialing methods to implement CCBHCs statewide, with a target go-live date of January 2026.

8. Please describe the planned activities for FY 2024 and FY 2025 for your state's ESMI/FEP programs.

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

The Nebraska FEP CSC Programs have been reporting as requested on outcomes measures and fidelity measures to answer key questions around program implementation. Fidelity and outcome information includes CSC components of team structure and functioning, psychopharmacology, individual psychotherapy, family intervention, and supported employment/education.

The teams have been using the Columbia Suicide Severity Rating Scale, the MIRECC-GAF, the OnTrack NY Modified Colorado Symptom Index, the OnTrackNY Quality of Life, and OnTrackNY Experience scales. With the change in models, Nebraska intends to revise outcome reporting and data collection to focus on quality care and evaluate the clinical and organizational changes related to the switch in EBP models. Metrics and tools supported by the NIMH EPINET project have been selected and include the Brief Adherence to Medication Rating Scale and the RAISE Illness and Management Recovery tool.

9. Please list the diagnostic categories identified for your state's ESMI/FEP programs.

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

a. Age: Male/Female age 14 through 35

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

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

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

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

With the technical training received over the last year we plan to review and expand the service definition and service provision to remain consistent with recent literature in the development of the program.

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

Table: The first episode psychosis admission rate per 100,000 population among Nebraska residents 14-35 years of age: 2021

Variable	Unique Patients	Nebraska Population Estimate	Rate per 100,000
Total	675	584,182	116
Sex			
Male	438	300,073	146
Female	235	284,109	83
Unknown	2	--	--
Age Groups			
14-18	60	138,009	43
19-25	243	187,539	130
26-35	372	258,634	144
Behavioral Health Region (PUMAs and Counties)			
1 (Part of NC&NW)	20	21,007	95
2 (Part of SW)	29	26,150	111
3 (All of SC and CEN, part of SW)	55	65,143	84
4 (All of NE, part of NC&NW)	56	56,817	99
5 (All of SE, part of DCSW, Lancaster)	133	152,536	87
6 (Part of DCSW, Douglas, Sarpy)	382	262,529	146

Notes:
1. Limited to first observation in 2021 for patients who did not appear in previous 4 years of data and who were 14-35 at first observation in 2021
2. See appendix for specific diagnoses for this group by sex, age, and region
3. PUMAs and Counties: NC&NW – North Central & Northwest Nebraska Public Use Microdata Area (PUMA); SW – Southwest Nebraska PUMA; SC – South Central Nebraska PUMA; CEN – Central Nebraska PUMA; NE – Northeast Nebraska PUMA; SE – Southeast Nebraska PUMA; DCSW – Dodge, Cass, Saunders & Washington Counties PUMA

11. What is the state's plan to outreach and engage those with a first episode psychosis who need support from the public mental health system?

Through the state’s penetration study, we have identified a number of potential entry points into our system for individuals experiencing FEP, such as hospitals, emergency rooms and crisis centers. We will continue to promote outreach and education to these organizations and guide enrollment into FEP programming in regions that offer this service.

Providers continue to meet with hospital discharge planners, school counselors, outpatient clinics, and agency staff to ensure they are aware of the FEP program and admission criteria and refer as appropriate. They are continually talking about the FEP program and admission criteria when presenting in the community; educating students and residents that intern at the provider about the FEP program and referral process in hopes to spread the awareness of the program as they move into their human services role in the community.

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

None at this time.

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Footnotes:

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required for MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to 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. Resources for assessing and developing PCP systems can be found at the National Center on Advancing Person-Centered Practices and Systems **https://ncapps.acl.gov/home.html** with a systems assessment at **https://ncapps.acl.gov/docs/NCAPPS_SelfAssessment_201030.pdf**

1. Does your state have policies related to person centered planning? (●) Yes ( ) No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

Not Applicable

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

The Nebraska Division of Behavioral Health (DBH) supports and promotes the use of person-centered service delivery and participant directed care within the state hospitals, regional and community-based provider systems. Nebraska's public behavioral health system governing regulations "Standards of Care" (NAC 206, Chapter 1 identifies the right of each consumer to receive behavioral health services in the most integrated setting appropriate based on an individualized and person-centered assessment, and actively and directly participate in decisions which incorporate independence, individuality, privacy, and dignity and to make decisions regarding care and treatment. This is evidenced by person-centered planning policies within the state hospitals (e.g. Regional Centers), regional and community based provider program fidelity audits, the work of the Office of Consumers Affairs related to 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, traumas, and cultural background.

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..

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

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

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

2. Ensure availability and access to a broad, flexible array of effective, community-based services and supports for children and their families that address their emotional, social, educational, and physical needs, including traditional and nontraditional

services that build on the family's natural and informal supports system.

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

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

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

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

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

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

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

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

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

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

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

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 an inclusive 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

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.

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.

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.

The OCA's Peoples Council is specifically designed to advise DBH on meaningful consumer involvement. The Council consists of members who represent the geographic, cultural, and racial diversity 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).

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.

The DBH OCA administrator collaborates with 6 Regional Consumer Specialists (RCSs) throughout the state to coordinate strategies and activities related to consumer advocacy, education, and stigma reduction. 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 stigma reduction efforts, and provide feedback on DBH program and policy guidelines.

The OCA and its various committees and 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.

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 102 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. Link to site:
https://dhhs.ne.gov/Behavioral%20Health%20Documents/Advanced%20Mental%20Health%20Directive%20FAQ.pdf

The DBH OCA is currently exploring opportunities to bring a Recovery Friendly Workplace initiative (RFWI) to the state. The RFWI objectives include providing business owners 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 decrease stigma and normalize the conversation around behavioral health challenges; and create sustainable organizational change in providing support to employees and their families.

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. In Plan Year 2023, there are three MCOs are Nebraska Total Care, UnitedHealthcare Community Plan of Nebraska, and Healthy Blue. The Nebraska Department of Health and Human Services (DHHS) has selected Molina Healthcare of Nebraska, Nebraska Total Care, and UnitedHealthcare to provide health and dental services for Heritage Health beginning January 1, 2024.

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.

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, cultural, and racial diversity of the MCO's membership.

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

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

DBH OCA continues to collaborate with Regional Consumer Specialists to provide Wellness Recovery Action Planning (WRAP) is an important step in supporting individuals utilizing behavioral health services. WRAP is an evidence-based curriculum that allows individuals to create a personalized plan that includes various elements such as a wellness toolbox, daily maintenance plan, identifying triggers and actions to avoid them, crisis management, and post-crisis planning. Having these sessions available both in state hospitals and community-based services across the state ensures that individuals have access to the support they need in different settings.

The DBH OCA utilizes a comprehensive approach to addressing behavioral health challenges. By working collaboratively with Regional Consumer Specialists, the DBH OCA can identify areas for improvement in services, advocate for necessary policy changes, and promote awareness and understanding through community events and social media. This holistic approach helps reduce stigma and create a supportive environment for individuals facing behavioral health challenges.

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

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 SAMHSA's **A Practical Guide to Psychiatric Advance Directives**)?"

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.

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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. Link to site: https://dhhs.ne.gov/Behavioral%20Health%20Documents/Advanced%20Mental%20Health%20Directive%20FAQ.pdf

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

None at this time.

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Footnotes:

Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

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

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x–5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and 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. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. 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 the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SUPTRS BG funds are allocated to support evidence-based, culturally competent programs, 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 M/SUD 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 M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following:

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 for new services or capacity needed in the network. RBHA staff, DBH staff, and consumers evaluate proposals for quality based on bid requirements and best practices.

DBH relays its standards of care through service definitions, 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 trauma informed services, consumer eligibility and payments for services, records content, access, and retention, clinical documentation requirements, discharge planning, and requirements for individualized treatment, rehabilitation, and recovery planning with consumers. 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.

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 quarterly 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.

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.

Please indicate areas of technical assistance needed related to this section

None at this time.

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Footnotes:

Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[56] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

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

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

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

[56] **https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf**

Please respond to the following items:

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

Post pandemic has allowed for more active re-engagement with the four federally recognized tribes in Nebraska. In 2022-23, the Divisions of Public Health and Behavioral Health reached out to all Tribes of Nebraska and held a Tribal Health listening session. DBH recognizes the sovereignty of our Nebraska Tribal Nations and plans to use the listening session information to better align program and services to the health, including behavioral health, priorities of the Nations. The first Tribal Health Listening Session took place on April 25-26, 2023. This session was intended for tribal council persons, healthcare leadership and program staff to meet and work with DHHS, including DBH, leadership to share and discuss Tribal health priorities and align efforts to support Tribal health priorities.

The DBH participated in the Winnebago Healthy Promotions and Education Annual Health Fair on June 28, 2023. DHHS liaisons were available for meet and greet, communication, and consultation. Additional re-engagement consultations are being scheduled with each of the Tribes. DBH has refilled a long vacant Tribal Program Specialist position to build relationships with each of the Tribes.

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

billed is still completed.

During these consultations, DBH reviews the Tribe's MH/SUD program plan and verifies that the services are being provided to Nebraskan Tribal members. Conversations and findings from the review are discussed with Tribal Program Directors and Clinical Directors and provide a further opportunity to meet with Tribal representatives about other items needing discussion.

2. What specific concerns were raised during the consultation session(s) noted above?

Overarching goal is to achieve relationship building and collaboration; characteristics and areas to strengthen.
• Top five activities:
o Develop Tribal directories/resource mapping to include DHHS resources,
o Conduct meet and greets on regular basis (on site visits),
o Identify a state liaison from each Tribe and the Council,
o Conduct cross training to learn about and understand Tribal structure and limitations, and
o Develop Tribal unit/divisions within DHHS (Office of Health Equity and Disparity role).
• Areas of concern for the DBH:
o Suicide rate for Native Americans; prevention work,
o Sovereignty and challenges with emergency protective custody statutes; authority, transportation, on/off reservation.

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

The State of Nebraska recognizes that the four federally recognized Tribes headquartered in Nebraska have a unique status that sets them apart from other groups and interests in Nebraska. The DBH provides state funding directly to those four tribes – the Omaha Tribe of Nebraska, the Ponca Tribe of Nebraska, the Santee Sioux Nation, and the Winnebago Tribe of Nebraska.

The four federally recognized tribes with whom the DBH allocates $1.2 million of state general funds in contracts, are invited to participate in advisory committees, local and statewide meetings regarding services, trainings on behavioral health topics, and other state activities and initiatives.

The DBH is in active discussion with other DHHS Divisions including the Division of Public Health, Division of Medicaid and Long-Term care and the three contracted MCOs and the Division of Children and Family Services, all of whom have contractual relationships with the Tribes. Efforts are needed to understand what, if any, contract management, meeting or other communication efficiencies should be considered to reduce administrative burden on Tribal partners. DHHS Tribal Liaison's, from each Division will, continue to meet monthly and work on identified activities from the Tribal Health listening session. The DBH will continue its efforts to engage Tribal representatives in planning, trainings, and initiatives, as well as support the culturally appropriate provision of services to their tribal members.

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

None at this time.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

8. Primary Prevention - Required SUPTRS BG

Narrative Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use 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 target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based 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 abuse of alcohol, tobacco and other drugs used in the general population.

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

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) (●) Yes ( ) No

- **a)** [x] Data on consequences of substance-using behaviors
- **b)** [x] Substance-using behaviors
- **c)** [x] Intervening variables (including risk and protective factors)
- **d)** [x] Other (please list)

  Adult and Youth perceptions about underage substance use and abuse.

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)** [x] Youth (ages 12-17)

c) [x] Young adults/college age (ages 18-26)

d) [x] Adults (ages 27-54)

e) [x] Older adults (age 55 and above)

f) [x] Cultural/ethnic minorities

g) [ ] Sexual/gender minorities

h) [x] Rural communities

i) [ ] Others (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) [x] National survey on Drug Use and Health (NSDUH)

c) [x] Behavioral Risk Factor Surveillance System (BRFSS)

d) [x] Youth Risk Behavioral Surveillance System (YRBS)

e) [ ] Monitoring the Future

f) [ ] Communities that Care

g) [x] State - developed survey instrument

h) [x] Others (please list)

- Nebraska Young Adult Alcohol Opinion Survey (NYAAOS)
- Nebraska Risk and Protective Factor Student Survey (NRPFSS)
- Youth Tobacco Survey (YTS)
- Adult Tobacco Survey (ATS)
- Nebraska Community Alcohol Opinion Survey (NCAOS)
- MH/SA Treatment
- Vital Statistics

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), serve as the prevention evidence-based program (EBP) workgroup for the State of Nebraska. A decision making process has been developed to review and select appropriate programming. This involves completion of an assessment of available evidence of effectiveness, consideration of the overarching state and local level prevention strategy, and an understanding of the local level climate and capacity

to implement. Nebraska has a small paid prevention workforce statewide that would overlap substantially with the PAC if an additional committee were to be formed. We have found that the process of reviewing concerns related to evidence-based prevention is best done in conjunction with other advisory efforts. This process has proven to be successful in monitoring the effectiveness of evidence-based prevention programs, policies, and strategies selected. Our Nebraska Prevention Information Reporting System (NPIRS) collects data on these strategies and monitors fidelity. For the Nebraska FY24/25 SABG, one of our priority areas focused on increasing the use of evidenced-based strategies supported by block grant funding. These outcomes are supported by the work of our PAC and EBP Workgroups.

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

6. Does your state integrate the National CLAS standards into the assessment step? (●) Yes ( ) No

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

RPCs are to utilize CLAS standards to the assessment steps to ensure service/programs and materials are sensitive to age, ethnicity, gender, sexual orientation, religion, creed, socio-economic status, cultural and geographic backgrounds.

b) If no, please explain in the box below.

7. Does your state integrate sustainability into the assessment step? (●) Yes ( ) No

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

RPCs continue to build on existing success by further providing extensive community-based training and technical assistance to assess community readiness, identify outcomes and prioritize the most effective interventions in the development of local sustainability plans.

b) If no, please explain in the box below.

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use 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 target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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

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

Capacity Planning

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.

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

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

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. Individualized reports with quantitative and qualitative data are made available to regional behavioral health authorities and community coalitions.

4. Does your state integrate the National CLAS Standards into the capacity building step? ◉ Yes ○ No

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

RPCs are to utilize CLAS standards when assessing capacity building to ensure service/programs and materials are sensitive to age, ethnicity, gender, sexual orientation, religion, creed, socio-economic status, cultural and geographic backgrounds.

5. Does your state integrate sustainability into the capacity building step? (●) Yes ( ) No

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

RPCs continue to build on existing success by further providing extensive community-based training and technical assistance to assess community readiness, identify outcomes and prioritize the most effective interventions in the development of local sustainability plans.

b) If no, please explain in the box below.

Narratve Question

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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 BGAS by going to the **Attachments Page** and upload the plan.

1. The Nebraska DHHS Division of Behavioral Health 2022-2024 Strategic Plan is uploaded and available at URL: https://dhhs.ne.gov/Behavioral%20Health%20Documents/DBH%20Strategic%20Plan%202022-2024.pdf
2. The Division of Behavioral Health Strategic Plan 2017-2020 End of Plan documents, including carry-over strategies and metrics, along with prioritized needs resulting from the new needs and gaps analysis drove the identification of key objectives and prioritized strategies for the 2022-2024 strategic plan. This plan is uploaded and available at URL: https://dhhs.ne.gov/Reports/Behavioral%20Health%20Strategic%20Plan%20Final%20Report%20-%202017-2020.pdf

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

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)** [x] Process indicators
- **e)** [x] Outcome indicators
- **f)** [x] Cultural competence component (i.e., National CLAS Standards)

g) ☐ Sustainability component

h) ☐ Other (please list):

i) ☐ Not applicable/no prevention strategic plan

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

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with 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), serve as the prevention evidence-based program (EBP) workgroup for the State of Nebraska. A decision-making process has been developed to review and select appropriate programming. This involves completion of an assessment of available evidence of effectiveness, consideration of the overarching state and local level prevention strategy, and an understanding of the local level climate and capacity to implement. Nebraska has a small paid prevention workforce statewide that would overlap substantially with the PAC if an additional committee were to be formed. We have found that the process of reviewing concerns related to evidence-based prevention is best done in conjunction with other advisory efforts. This process has proven to be successful in monitoring the effectiveness of evidence-based prevention programs, policies, and strategies selected. Our Nebraska Prevention Information Reporting System (NPIRS) collects data on these strategies and monitors fidelity. For the Nebraska FY24/25 SABG, one of our priority areas focused on increasing the use of evidenced-based strategies supported by block grant funding. These outcomes are supported by the work of our PAC and EBP Workgroups.

6. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? ◉ Yes ○ No

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8. Does your state integrate the National CLAS Standards into the planning step? ◉ Yes ○ No

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

RPCs are to utilize CLAS standards to the planning process to ensure service/programs and materials are sensitive to age, ethnicity, gender, sexual orientation, religion, creed, socio-economic status, cultural and geographic backgrounds.

b) If no, please explain in the box below.

Not Applicable (BGAS required a response be entered.)

9. Does your state integrate sustainability into the planning step? ◉ Yes ○ No

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

RPCs continue to build on existing success by further providing extensive community-based training and technical assistance to assess community readiness, identify outcomes and prioritize the most effective interventions in the development of local sustainability plans.

b) If no, please explain in the box below.

Not Applicable (BGAS required a response be entered.)

Narratve Question

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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, abuse, and addiction on individual's families and communities. Many of our community coalitions showcase their products via brochures, flyers, public service (radio) announcements, billboards, newspapers inserts and during speaking engagements, public health fairs, and parent teacher conferences. Visibility and reach of social norming campaigns have also expanded by use of numerous social media platforms as well as screen messaging at movie theaters and signage at sports arenas.

b) Education:

DBH funds educational programs and curriculums aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities. State staff, Regional Prevention Coordinators and coalition leaders present to various advisory committees, board groups, schools, youth groups, community and public interest groups upon request. Examples of these primary prevention programs include but are not limited to the following:

- 3rd Millennium
- Across Ages
- Alcohol Literacy Challenge
- 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 SABG is dedicated to the support of community-based processes that include organizing, planning, evaluating and enhancing the effectiveness of funded programs, policies, and 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 lifestyle 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 lifestyle 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) If yes, please describe.

DBH updates and provides annual budgetary guidance for use of SABG dollars through a number of methods. The first has been to ensure the language within our State to RBHA contract is consistent with the federal register and SABG application instructions. Thus, it is a standard contractual requirement that SABG dollars can only be used to fund primary substance abuse prevention services. These requirements are also outlined in the RBHA Budget Guidelines published each year as part of the community RFP process. Additionally, DBH performs a variety of audits with their providers, including a Programmatic Activity Review for an entity receiving SABG dollars for prevention. The programmatic review is required for all community coalitions funded by the SABG and is conducted annually in partnership with Regional Prevention Coordinators.

4. Does your state integrate National CLAS Standards into the implementation step? (●) Yes ( ) No

a) If yes, please describe in the box below.

RPCs are to utilize CLAS standards to the implementation phase to ensure service/programs and materials are sensitive to age, ethnicity, gender, sexual orientation, religion, creed, socio-economic status, cultural and geographic backgrounds.

b) If no, please explain in the box below.

5. Does your state integrate sustainability into the implementation step? (●) Yes ( ) No

a) If yes, please describe in the box below.

RPCs continue to build on existing success by further providing extensive community-based training and technical assistance to assess community readiness, identify outcomes and prioritize the most effective interventions in the development of local sustainability plans.

b) If no, please explain in the box below

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use 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 target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based 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 abuse of alcohol, tobacco and other drugs used in the general population.

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

Evaluation

1. Does your state have an evaluation plan for substance use primary prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan.

Please following plan(s) are uploaded :
Nebraska Strategic Prevention Framework - Partnerships for Success Evaluation Plan

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

- **a)** [x] Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- **b)** [x] Includes evaluation information from sub-recipients
- **c)** [x] Includes SAMHSA National Outcome Measurement (NOMs) requirements
- **d)** [x] Establishes a process for providing timely evaluation information to stakeholders
- **e)** [x] Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- **f)** [ ] Other (please list:)
- **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)** [x] 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 use

c) ☑ Binge 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).

5. Does your state integrate the National CLAS Standards into the evaluation step? ◉ Yes ○ No

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

RPCs are to utilize CLAS standards to the evaluation steps to ensure service/programs and materials are sensitive to age, ethnicity, gender, sexual orientation, religion, creed, socio-economic status, cultural and geographic backgrounds.

b) If no, please explain in the box below.

6. Does your state integrate sustainability into the evaluation step? ◉ Yes ○ No

a) If yes, please describe in the box below.

RPCs continue to build on existing success by further providing extensive community-based training and technical assistance to assess community readiness, identify outcomes and prioritize the most effective interventions in the development of local sustainability plans.

b) If no, please explain in the box below.

Footnotes:

DHHS Behavioral Health

Strategic Plan

2022-2024

Influence
Integration
Inclusion
Innovation
Value








NEBRASKA
Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

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Message from the Director, Division of Behavioral Health

Dear Nebraskans:

The Nebraska Behavioral Health System (NBHS) has grown and changed significantly over the last decades. The result is an array of services and supports that promotes community living for those we serve. Our lives as citizens and community members have been enriched by changes made over time. Over the last few years, there are successes focused on the recovery tenants, home, health, community, and purpose. The accomplishments are the result of strong collaborations with partners dedicated to improving the lives of individuals and families experiencing behavioral health challenges.

As the Division of Behavioral Health closed out fiscal year 2020, COVID-19 significantly altered the lives of the people we serve and those providing service. The impact of COVID-19 has generated unprecedented challenges that have required resiliency, innovation and openness to change. Nebraskans once again faced uncertainty with resolve. Consumers and providers adapted to alternate service delivery such as telehealth and telephone. The situation promoted new ways to engage. Services have remained open and continue to address the needs of Nebraskans with mental illness and substance use disorders. As we sunset the DBH 2017-2020 Strategic Plan and move forward with a new Plan, I sincerely applaud the responsiveness of the people we serve, teammates and partners.

I am pleased to present you with the 2022-2024 Behavioral Health Strategic Plan. I appreciate the many stakeholders that gave voice to the vision and plan. You participated virtually, by survey, by interview, or sending in your ideas. As we move forward, it is important to build upon the successes and acknowledge the lessons and challenges experienced over the last years. The simple and shared goal we have for Nebraskans is access to healthcare, our focus is on behavioral healthcare. We are driven by how we want our families and ourselves to experience the behavioral health system. Together, we must continue to build a more comprehensive array of prevention, treatment, and recovery services.

Consumer and system partners developed a strategic vision to guide the work of the Nebraska behavioral system. The new plan includes purposeful objectives and unique strategies that address a set of five distinct areas of focus setting a clear path forward for the continued delivery of behavioral health services with excellence.

Transformation pillars within the plan:

1. **Enhance Behavioral Health *INFLUENCE***
2. **Implement an *INTEGRATION* Strategy**
3. **Promote Stakeholder *INCLUSION***
4. **Drive *INNOVATION* and Improve Outcomes**
5. **Demonstrate and Drive *VALUE***

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The new plan comes at a time of continued challenges but also great opportunity given the resources afforded to us including Medicaid expansion, Covid-19 emergency grants, state opioid response grants, and other resources that work to innovate, improve and integrate services to address the whole-health needs and well-being of Nebraskans. As the chief behavioral health strategist for the state, we will serve as a catalyst for responsiveness to the needs of Nebraskans with mental illness and substance use disorders. Keeping the goals and aspirations of those we serve as the highest priority, Nebraska is uniquely situated to transform the behavioral health care experience through the pillars.

Today's challenge is to recognize that this work is a difficult journey. From certain vantage points it may be hard to identify that the journey, to this point, has much to celebrate. We also must recognize that at varying times, the journey is difficult, fearful, and exhilarating. As a system, we must continue to change and evolve. We must continue to boldly initiate and debate, even when it leads to an unsettling phase before the next moment of transformation. We can't avoid the trickier challenges of building systems of care, integrated managed care, data informed planning, and outcome or value based contracting.

As a healthcare leader, I am grateful and humbled to be in this position and to work alongside of you at this moment. Connecting and communicating with you as system partners is a priority. Transformation is difficult, necessary and provides opportunity. We will continue our work together on behalf of Nebraskans. Our future, our work.

Sincerely,

Sheri Dawson

Sheri Dawson, Director
Division of Behavioral Health
Department of Health and Human Services

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Department of Health & Human Services Behavioral Health Executive Summary

As the chief behavioral health strategist for the state, the Nebraska Department of Health and Human Services, Division of Behavioral Health (NDHHS-DBH) and a variety of Nebraskans developed a strategic plan to be a catalyst for responding to the needs of Nebraskans related to prevention, treatment and recovery of mental illness and substance use.

NDHHS-DBH engaged OPEN MINDS, a nationally recognized consulting firm, to conduct a Needs Assessment, provide a Gap Analysis and facilitate a Strategic Planning Process. Prioritized needs resulting from the needs and gaps assessment drive the identification of key objectives and prioritized strategies for the 2022-2024 strategic plan.

System partners developed a strategic VISION "to become a leader or gold standard for behavioral healthcare quality and health improvement" to guide the work of the Nebraska behavioral health system through the following five transformational pillars:

1. **Enhance Behavioral Health *INFLUENCE***
2. **Implement an *INTEGRATION* Strategy**
3. **Promote Stakeholder *INCLUSION***
4. **Drive *INNOVATION* and Improve Outcomes**
5. **Demonstrate and Drive *VALUE***

Behavioral Health Strategic Plan Transformation Pillars/Goals and Prioritized Objectives

FY 2022-2024

Pillar 1 – Enhance Behavioral Health *INFLUENCE*

Goal: Behavioral health influences systems and impacts people in positive ways.

- Align system partners and agencies in developing a more robust cross system behavioral health continuum of prevention, treatment and recovery services and supports.
- Increase activities to reduce behavioral health stigma.
- Increase integration of Behavioral Healthcare with community resources so there is a front door for people to connect to services.

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Pillar 2 – Implement an *INTEGRATION* Strategy

Goal: Behavioral health is integrated across public and private systems.

- Increase integration between substance use treatment providers and mental health treatment providers.
- Increase behavioral health services/access in a variety of settings including crisis services.

Pillar 3 – Promote Stakeholder *INCLUSION*

Goal: Stakeholders are included and contribute to the planning and development of the Behavioral Health System.

- Improve consumer and family input for service evaluation and service needs.
- Address disparities, increase diversity and health equity through cross system engagement, planning and ensuring culturally and linguistically appropriate services (CLAS).
- Increase engagement between NDHHS, DBH and other partners in serving justice populations.

Pillar 4 – Drive *INNOVATION* and Improve Outcomes

Goal: The Behavioral Health System advances effective outcomes through innovation.

- Improve competencies of behavioral health providers through partnerships and training with academic institutions
- Expand evidence-based practices through cross system engagement and planning.
- Expand use of technology for improved behavioral health outcomes.

Pillar 5 – Demonstrate and Drive *VALUE*

Goal: The public Behavioral Health System demonstrates and drives value.

- Improve interagency data sharing.
- Establish system wide BH outcomes.

What is the Vision and What is Different?

INFLUENCE

- The behavioral health system of care has strengthened and additional partnerships that propels Nebraskans through their health and wellness journey.
- Reshaping the behavioral health system by collaborating with partners, and aligning funding, services, and supports.
- Helping all Nebraskans connect to a seamless and cross system continuum of care that meets their needs whenever they need help.
- Adult and youth continuums of care are inventoried, assessed, aligned and drive future state cross system planning and funding.
- Stigma of substance use and mental illness is eliminated and a culture of no health without behavioral health is the norm.
- Every community and every Nebraskan talks about behavioral health as an essential part of overall health.

- No matter where you live, no matter your race, age, gender, all Nebraskans have equity of access to trusted services.
- Healthcare is integrated into the places people most commonly go in their daily lives.
- Access is simplified and available to all Nebraskans through developed resource connection.

INTEGRATION

- Nebraskans can access the array of needed services wherever a consumer is served.
- Working with Nebraskans, system partners, adult partners and youth and family partners, we develop a more diverse workforce that is trained, competent and accessible to meet the needs and refer individuals to helpful resources.

INCLUSION

- The voice of the people we serve is sought, diverse, meaningful and valued. We build trust and comfortable environments where voices are shared.
- We intentionally build a diverse workforce delivering equitable and equal behavioral health services across Nebraska and the role of culture in engagement and outcomes is affected.
- The system of care for adults and youth across prevention, treatment, and recovery includes early interventions and all intercepts for justice behavioral health.

INNOVATION

- Nebraskans with behavioral health challenges are served by individuals that are recruited, educated, developed and trained to be culturally responsive.
- Nebraskans receive services that are supported through evidence and make a difference to individual engagement in their own health.
- Consumers receive services and treatment that has evidence of effectiveness in their recovery journeys.
- Consumers have access to virtual, just in time or urgent care services to achieve positive health outcomes.
- Providers continue to innovate service delivery that is engaging, convenient, and effective in improving access and health outcomes.

VALUE

- Infrastructure and policies support inter and intra agency sharing of behavioral health key outcomes and datasets.
- Nebraska has a core set of standardized client outcomes that includes measuring and promoting health equity.
- The collecting and sharing of outcomes information related to health is not limited to one determinant; one agency or one fund source.

Goal 1: Behavioral health influences systems and impacts people in positive ways.		
	Objectives	**Strategies**
INFLUENCE	**1.1** Align system partners and agencies in developing a cross system behavioral health continuum of prevention, treatment and recovery services and supports.	• Create DHHS cross agency behavioral health infrastructure/system of care framework for youth and adult services and supports, outcomes, and blended funding models. • Develop an implementation plan to address assessed needs and gaps that will grow the behavioral health continuum of care for youth and adults including inpatient/ residential/detention and community based services. • Establish admission and discharge process and criteria for Lincoln Regional Center • Develop a cross system capacity and waitlist process, a cross system bed registry, same day services, and crisis system best practices, alternatives to the emergency department. • BH partners review 30 day and 180 day readmission rates by provider and service and develop a cross system familiar faces data review process. • A plan to maximize facility and community based services capacity to decrease wait times and improve access.
INFLUENCE	**1.2** Increase activities to reduce behavioral health stigma.	• Develop a Recovery Friendly Workplace Initiative. • Develop a cross agency and cross system multilingual stigma campaign. • Expand virtual trainings, with an emphasis on community education (Mental Health First Aid, Question Persuade Refer and Assessing and Managing Suicide Risk). • Increase utilization of the Certified Peer Support Specialist (CPSS) workforce. • Explore ways to incentivize CPSS certification, CPSS utilization/employment, increasing peer trainers, and increase diversity of the CPSS workforce.

INFLUENCE	**1.3** Increase integration of behavioral health with community resources so there is a front door for people to connect to services.	• Crisis response mapping and 988 mapping to connect with state resources and implement 988 by July 2022. • Inventory and consolidate resource lines for behavioral health clients. • Crosswalk resource lines and databases. Identify efficiencies in maintaining real time accurate resources and referrals.

Goal 2: Behavioral health is integrated across public and private systems.		
	Objectives	**Strategies**
INTEGRATION	**2.1** Increase behavioral health services/ access in health care settings including behavioral/physical health crisis services best practices.	• Complete an assessment of integrated practices and services, noting strengths, barriers and outcomes. • Develop more rapid responses for behavioral health consultations (crisis and primary care settings). • Develop training program specific to targeted provider types to improve provider knowledge base in behavioral health engagement techniques; assign CEUs. • Expand virtual access to care consultation with emphasis on rural areas and hospital emergency rooms (ER). • Develop plan to reduce high ER utilization. • Engage state Medicaid and private payers to create cost sharing strategy that incentivizes (alternative payment strategy/Value - Based reimbursement) ED avoidance based on care management and community tenure of the identified population. • Provide leadership to statewide opioid coalition and settlement workgroup.
INTEGRATION	**2.2** Increase integration between mental health and substance use treatment providers.	• Determine best practices for co-occurring capability and establish guidance and explore incentives for using behavioral health screening/evaluation tools. • Review system policies and practices to address barriers and reduce administrative burden re: dual credentials, coding, integration, funding, and service definitions across behavioral health system. • Provide training on dual diagnosis EBP- Integrated Dual Diagnosis Treatment (IDDT).

Goal 3: Stakeholders are included and contribute to the planning and development of the Behavioral Health System.		
	Objectives	**Strategies**
INCLUSION	**3.1** Improve engagement between DHHS, DBH, and Justice partners in addressing Justice Behavioral Health needs and gaps, access to services, sequential intercepts, and Justice/ Behavioral Health outcomes.	• Identify specific/targeted interventions for justice involved behavioral health consumers. • Establish DHHS/DBH/Justice workgroups to conduct a needs analysis, identify service gaps and develop appropriate services; develop shared system goals and quality outcome measures.
INCLUSION	**3.2** Improve consumer and family voice in planning and evaluation of services.	• Conduct gap/barrier analysis of current community organizations engagement practices by groups and demographics. • Inventory of communication platforms, including social media, being utilized to reach consumers and families; determine best practices; consolidation or expansion to promote participation. • Create an infrastructure for consumer and family voice. • Increase survey utilization for engaging broader and diverse voices.
INCLUSION	**3.3** Increase diversity and health equity through cross system engagement, planning and ensuring culturally and linguistically appropriate services (CLAS).	• Align goals with the Office of Equity and Disparity; create overarching holistic plan. • Complete a systemic CLAS need assessment and baseline data for culturally and linguistically appropriate services. • Create cross-agency infrastructure to carry out plan. • Develop strategies to strengthen a competent behavioral health workforce which is racially, ethnically/culturally and linguistically diverse. • Develop strategies to increase bi-lingual/ bi-cultural behavioral health workforce.

Goal 4: The Behavioral Health System advances effective outcomes through innovation.		
	Objectives	**Strategies**
INNOVATION	**4.1** Improve the competencies of behavioral health providers through partnerships and training with academic institutions.	• Assess needs and develop training plan across the behavioral health system. • Partner with academic institutions to assure workforce competency training is aligned with emerging consumer needs and treatment continuum needs and gaps. • Assure trainings are being promoted to providers across the state and virtual/on-line access is available.
INNOVATION	**4.2** Expand use of technology for improved behavioral health outcomes.	• Survey state providers/organization to determine current capacity and needs. • Develop technology trainings for providers; including use of surveys for patient engagement, satisfaction and outcomes via telehealth. • Explore incentives and payer sources for technology solutions for providers and consumers. • Identify and implement technology solutions to address consumers with complex needs (improve community tenure and provide success in servicing; support transitions between levels of care). • Expand competency and training in digital technology/telehealth.
INNOVATION	**4.3** Expand evidence-based practices through cross system engagement and planning.	• Inventory of cross-system evidence-based practices and identify need for additional EBPs. Create cross-system workgroup to conduct a needs assessment, determine appropriate EBPs and develop an implementation/expansion plan. • Create baseline of EBP data, determine best source of EBP data collection, and explore incentives for the use of evidenced-based practices (consider Value-Based Reimbursements (VBR).

Goal 5: The public Behavioral Health System demonstrates and drives value.		
	Objectives	**Strategies**
VALUE	**5.1** Improve interagency data sharing for system planning.	• Crosswalk behavioral health system partner metrics, dashboards, and data sources. • Prioritize and identify year 1, 2, and 3 metrics which must include health disparities and consumer experience. • Regularly scheduled interagency-meeting to review data and develop strategies for quality improvement on selected metrics. • Develop detailed and accessible DHHS behavioral health dashboards. • Develop cross system dashboards for implementation.
VALUE	**5.2** Establish system wide BH outcomes.	• Identify outcomes and indicators for cross division behavioral health providers. • Build upon outcomes developed with DBH partners to begin value based contracting across DHHS divisions.

Although Some Flowers Are Struggling, All Flowers Deserve Love! #MentalHealth IS Important

NDHHS-DBH Strategic Plan
&
System Optimization Road Map

December 16, 2020

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NDHHS-DBH Strategic Plan & System Optimization Road Map

I. Executive Summary

Executive Summary

Statement Of Purpose

As the chief behavioral health strategist for the state, the Nebraska Department of Health and Human Services, Division of Behavioral Health (NDHHS-DBH) and a variety of stakeholders, have developed a strategic plan to be a catalyst for responding to the needs of Nebraskans with mental illness and substance use disorders. Central to this strategic plan is dedication and commitment to serving impacted individuals and families. NDHHS-DBH engaged *OPEN MINDS* to conduct a Needs Assessment, provide a Gap Analysis and facilitate a Strategic Planning Process which aligned with the quadruple aims of 1) improving the patient experience of care, 2) improving the provider experience of care, 3) improving the health of populations, and 4) the per capita cost of health care. System partners developed a strategic vision to guide the work of the Nebraska behavioral system. There are five transformation pillars:

1. Enhance Behavioral Health Influence
2. Implement an Integration Strategy
3. Promote Stakeholder Inclusion
4. Drive Innovation and Improve Outcomes
5. Demonstrate and Drive Value

Keeping the goals and aspirations of those we serve as the highest priority, Nebraska is uniquely situated to transform the behavioral health care experience through quality, innovation and service excellence. Our future work together will strengthen our regional and national positions in becoming the leader or gold standard for healthcare quality and health improvement. Through enhanced and expanded partnerships with other agencies and stakeholders throughout the State, the prevention, treatment and recovery of individuals with mental illness and substance use is elevated in status and focused on improved behavioral health outcomes.

Executive Summary

Overall Findings

After collaborating with multiple stakeholder groups including consumers, family members, community members, partner agencies, tribal entities, NDHHS and DBH staff and other interested citizens to collect and analyze data, several system wide concerns and needs became evident:

1. Behavioral health stigma is seen as the single most difficult barrier to overcome for consumers.
2. Integrating physical health and behavioral health is a primary need for consumers and their families.
3. Lack of integrating and sharing data across systems is a barrier to providing integrated and "whole person" care.
4. There is a consistent need to expand the ability to use technology to both provide and receive services across Nebraska, especially in rural and frontier communities.
5. Developing alternate reimbursement models, such as Value-Based Reimbursement, is needed in the changing marketplace.
6. NDHHS and DBH must continue to address cultural diversity throughout the system.

To find the right outcomes for the citizens of Nebraska, multiple meetings and discussions with NDHHS and DBH leadership and team members were held from which this Strategic Plan was developed. The Strategic Plan includes:

1. 29 Strategic Objectives
2. 39 Specific Tactics
   A. 23 DBH tactics
   B. 16 NDHHS tactics
3. Over 60 Key Performance Indicators
4. Three-year goal planning window
5. Optimization Roadmap

While ambitious, we feel confident that NDHHS and DBH teams have both the commitment and determination to accomplish the strategies and tactics detailed in this report.

II. Overview Of Nebraska Department Of Health & Human Services Department Of Behavioral Health

Overview Of DHHS/DBH

Framework

State Agency responsible for uninsured citizens and delivery system model

- The Nebraska Division of Behavioral Health (DBH) is responsible for comprehensive statewide planning for all community-based behavioral health services (Mental Health and Substance Use Disorder treatment) and the continuum of care including oversight and coordination with regional Behavioral Health authorities and Tribal entities. Additionally, DBH oversees the administration and management of the Division, Lincoln Regional Center, Norfolk Regional Center, and all other facilities and programs operated by the Division.

Overview Of DHHS/DBH

National Comparison

Nationally, DBH has proven itself to be an innovator and a leader in social determinants of health, utilization of evidenced based practices, and grant implementation as demonstrated by:

- **Supported Employment – Exceeded National Average:** 36% of Nebraskans with a mental health diagnosis have employment which is nearly twice the national average. DBH continues to utilized Supported Employment to continue this trend.
- **Supported Housing – Exceeded National Standard:** DBH provided housing assistance to over 900 Nebraskans in 2019, meeting or exceeding the national standard in five out of six regions for consumers in private residence.
- **Medication Management – Exceeded National Average:** DBH was able to reach 46% of DBH consumers for medication management which is far in excess of the national average of 31%

Overview Of DHHS/DBH

DBH Leadership In Innovation

DBH demonstrates leadership in supporting innovation across the state by:

1. Promulgating new regulations for the certification, training, and testing of Certified Peer Support Specialists (CPSS)
2. Centralizing and integrating data systems
3. Meeting the needs of children and families through the Nebraska Behavioral Health System of Care (NeSOC) grant which provides funding to community-based services for youth who are at risk for or experiencing a serious emotional disturbance. In 2018 over 900 children and families received care under this grant
4. Providing funding for prevention, treatment, and recovery activities related to the opioid crisis through the State Targeted Response (STR) grant

Overview of DHHS/DBH

Current Strategic Plan Goal Accomplishment

The Nebraska Department of Behavioral Health exceeds their current strategic plan goals on several measures. Highlights include:

1. Medication Assisted Treatment (MAT) Prescribers:
   - Goal FY 2020: 32 prescribers
   - **Exceeded:** 93 prescribers (FY 2020)
2. Providers using EBPs:
   - Goal FY 2020: 50
   - **Exceeded:** 80 providers using EBPs (FY2020)
3. BH providers in integrated settings:
   - Goal FY 2019: 32%
   - **Exceeded**: 33% (FY 2019)
4. Diversity population receiving CLAS services:
   - Goal FY 2019: 18%
   - **Exceeded:** 18.5% (FY 2019)

Overview of DHHS/DBH

Current Strategic Plan Goal Accomplishment (cont)

DBH continues to meet their strategic plan goals in the areas of:

1. Stable housing, all services at discharge
2. Consumer Satisfaction
3. Short Term Residential Services Average Capacity
4. Medication Management Wait and Capacity
5. Employment Initiatives
6. Tobacco Sales Compliance
7. Underage Alcohol Use
8. Reduction of Binge Drinking
9. Non-Medical use of pain relievers
10. Promulgating new regulations for the certification, training, and testing of Certified Peer Support Specialists

Strategic Plan areas for improvement for DBH include:

- Decreasing Suicide rates for all target population
- Decreasing Short Term Residential Services Wait

III. Needs Assessment & Gap Analysis

Needs Assessment & Gap Analysis

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

- Visioning Sessions
- Key Stakeholder Interviews
- Electronic Surveys in both English and Spanish

The data and information from these three sources were synthesized to create the Gap Analysis.

1. Visioning Sessions

OPEN MINDS conducted visioning exercises with:

A. NDHHS-DBH Leadership

B. NDHHS-DBH System Partners

C. Key Community Partners

The meetings were centered around the Five Pillars and identify goals, needs, gaps and strategies for systemic improvement. The information was also used as the groundwork for a statewide survey designed to assure input from voices of providers, consumers, families, community partners, and other system partners.

2. Key Stakeholder Interviews

OPEN MINDS conducted 10 interviews with key stake holders in Nebraska. The groups represented leaders in Community Behavioral Health, Housing, Justice, Provider Development, Tribal Nations, Minority Needs, Rural Health, and Education.

These findings were combined with the visioning sessions findings to further inform the survey questions.

3. Electronic Survey

- The survey, in English and Spanish, was developed from information gathered during the visioning sessions and key stakeholder interviews.
- The survey was distributed statewide via NDHHS ListServs to behavioral health providers, systems partners, consumers, families, and Tribal Nations.*
- The survey was designed to prioritize the needs identified under each of the Five Pillars. The survey also offered each respondent the opportunity to provide feedback on needs, gaps, and strategies as related to the Five Pillars of Transformation.

*Approximately 750 individuals responded. Demographics include:

A. 42% of respondents were behavioral health providers
B. 26% of respondents were affiliated with state agencies or system partners
C. 18% of respondents were consumers and families
D. <1% of respondents represented Tribal Nations

Gap Analysis

Prioritizing Needs, Creating Strategies

The *OPEN MINDS* team compared data from the Needs Assessment to current services to develop the Gap Analysis.

Through reviewing the Gap Analysis with NDHHS-DBH Leadership, and NDHHS-DBH System Partners, a list of the top 15 priorities were identified (three priorities for each pillar), as well as Strategic Objectives for each priority.

The *OPEN MINDS* team then worked with DBH staff to establish Key Performance Indicators (KPIs), timelines, and resources needed to make this plan feasible.

Prioritized Needs

Pillar 1: Enhance Behavioral Health Influence

1. Increase activities to reduce behavioral health stigma.
2. Improve integration of behavioral health care with community resources
3. Align system partners and agencies in developing a cross system behavioral health continuum of prevention, treatment and recovery. (physical health, mental health, substance use treatment, intellectual and developmental disabilities, public health, child welfare, and justice)

Pillar 2: Implement an Integration Strategy

1. Increase behavioral health services in primary care settings.
2 Increase integration of behavioral health and physical health crisis services best practices across the state.
3. Increase integration between substance use treatment providers and mental health treatment providers.

Pillar 3: Promote Stakeholder Inclusion

1. Improve engagement between NDHHS, DBH, and Justice Partners in planning Justice Behavioral Health goals, service gap and need analysis, access to services, sequential intercepts, and quality outcomes for justice/behavioral health consumers.
2. Improve consumer and family input for service evaluation and service needs.
3. Improve engagement between NDHHS-DBH and behavioral health system stake holders in planning processes.
4. Increase health equity through cross system engagement, planning and ensuring culturally and linguistically appropriate services (CLAS)

Pillar 4: Drive Innovation and Better Outcomes

1. Improve competencies of behavioral health providers through partnerships and training with academic institutions.
2. Expand use of technology for improved behavioral health outcomes.
3. Expand evidence-based practices through cross system engagement and planning.

Pillar 5: Demonstrate and Drive Value

1. Improve interagency data sharing
2. Establish system wide behavioral health outcomes.
3. Compare Nebraska behavioral health outcomes data to national benchmarks.

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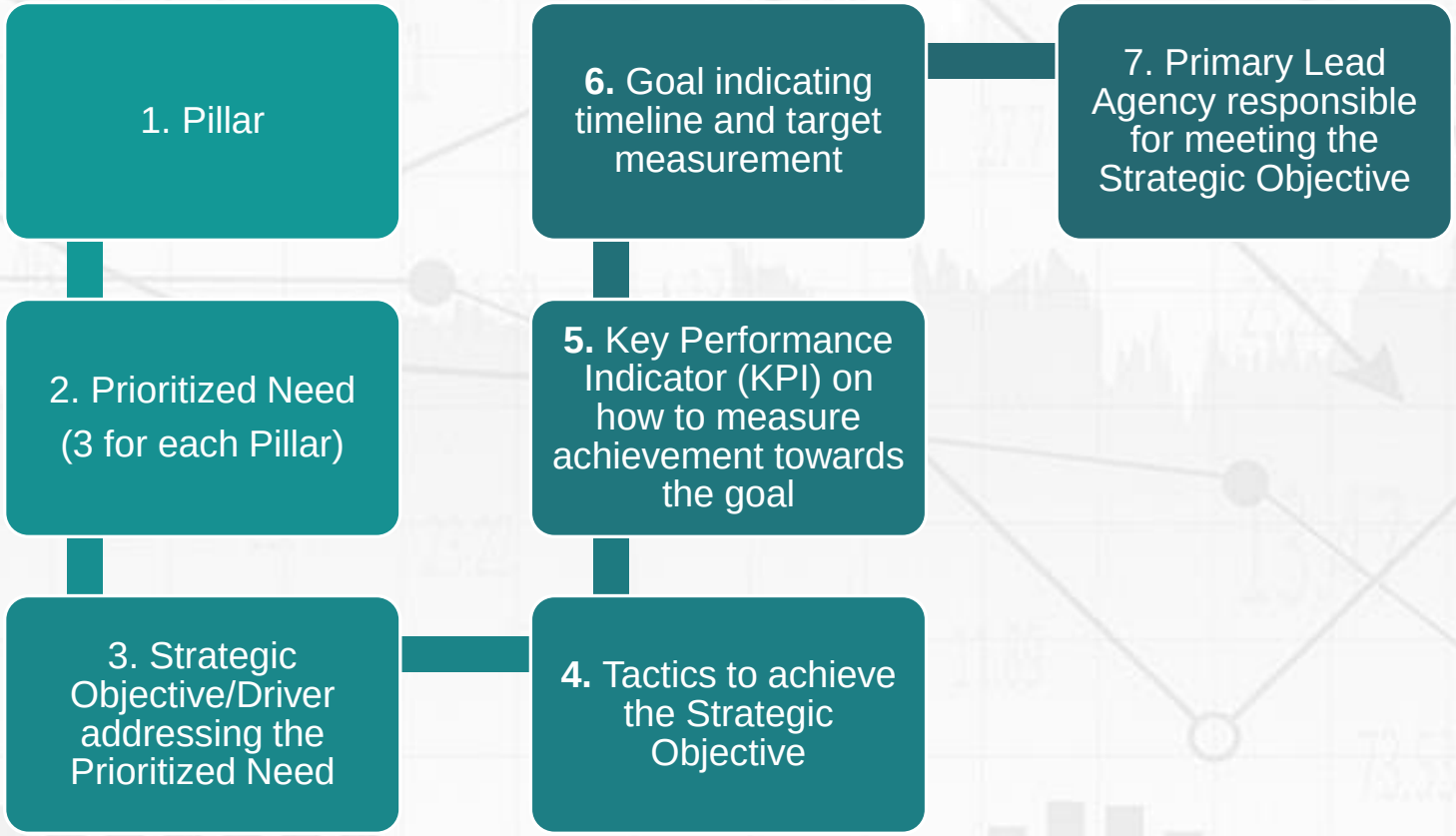
IV. Strategic Plan & Optimization Roadmap: Strategic Objectives, Tactics, KPIs, & Goals

Strategic Objectives, Tactics, Key Performance Indicators & Goals

To address all factors in the Needs Assessment and Gap Analysis while working within the Five Pillars framework, the Strategic Plan is structured as follows:



Pillar 1: Enhance Behavioral Health Influence

Prioritized Need 1.1: Increase activities to reduce behavioral health stigma

Strategic Objective/Driver	Tactic	KPI(s)	Goals	Primary Lead
1. Increase utilization of Certified Peer Support Specialist (CPSS).	1A. Explore ways to incentivize CPSS certification, CPSS utilization/employment, peers in workforce and increasing peer trainers/vendors.	Increase: ▪ # units of CPSS provided service ▪ # served in peer support/peer services by type ▪ # CPSS certified by type ▪ # of CPSS becoming trainers ▪ # of peers employed	▪ CY 2021: 5% Increase over 2020 baseline. ▪ CY 2022: 10% increase over 2021. ▪ CY 2023: 10% increase over 2022.	DBH
	1B. Increase public awareness of value of persons with lived experience via social media and other communication platforms..	▪ Increase # of peers completing CPSS trainings. ▪ Increase # of trainings to employers regarding employing persons with lived experience	▪ CY 2021: 5% Increase over 2020 baseline. ▪ CY 2022: 10% increase over 2021. ▪ CY 2023: 10% increase over 2022.	
2. Increase use of person-centered language in State publications/communications.	2A. Integrate person-centered language into state publications.	Create educational material/trainings for communication staff, so that all new publications utilize person-centered language (PCL).	▪ CY 2021: Create training. ▪ CY 2022: All new publications are reviewed for PCL.	DBH

Pillar 1: Enhance Behavioral Health Influence

Prioritized Need 1.1: Increase activities to reduce behavioral health stigma *(continued)*

Strategic Objective/Driver	Tactic	KPI(s)	Goals	Primary Lead
3. Improve cultural awareness and competency across State agencies for NDHHS staff.	3A. Provide Cultural Linguistic Training program for NDHHS.	Create a NDHHS mandatory CLAS training.	▪ CY 2021: Create training. ▪ CY 2022: Implement training. ▪ CY 2023: Update training as needed.	DBH
4. Expand virtual trainings, with an emphasis on community education (like Mental Health First Aid and Assessing and Managing Suicide Risk).	4A. Inventory of number and types of trainings available for providers in smaller/rural communities; Promote or develop trainings as needed for smaller/rural communities.	Increase: ▪ # of trainings. ▪ # of participants by predetermined demographic categories to describe populations in attendance.	▪ CY 2021: 5% Increase over 2020 baseline. ▪ CY 2022: 10% increase over 2021. ▪ CY 2023: 10% increase over 2022.	NDHHS

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Pillar 1: Enhance Behavioral Health Influence

Prioritized Need 1.2: Improve integration of behavioral health care with community resources

Strategic Objective/Driver	Tactic	KPI(s)	Goals	Primary Lead
1. Expand the use of resource lines for behavioral health clients.	1A. Expand promotion of community resource lines (Family HelpLine and Nebraska 211) for behavioral health clients.	Increase: ▪ #of calls. ▪ #of referrals made and types services.	▪ CY 2021: 5% Increase over 2020 baseline. ▪ CY 2022: 10% increase over 2021. ▪ CY 2023: 10% increase over 2022.	DBH
2 Centralize database of community resources.	2A. Develop an on-line resource site for all providers to identify, by region, community agencies for support services linked to SDoHs.	Launch on-line resource.	▪ CY 2021: Internal planning. ▪ CY 2022: Build tool. ▪ CY 2023: Implement tool.	NDHHS

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Pillar 1: Enhance Behavioral Health Influence

Prioritized Need 1.3: Align system partners and agencies in developing a cross system behavioral health continuum of prevention, treatment and recovery, including physical health, mental health, substance use treatment, intellectual and developmental disabilities, public health, child welfare, and justice

Strategic Objective/Driver	Tactic	KPI(s)	Goals	Primary Lead
1. Align with the goal of creating and integrating a behavioral health continuum of prevention, treatment and recovery across other NDHHS partners and agencies, including physical health, mental health, substance use treatment, intellectual and developmental disabilities, public health, child welfare, and justice.	1A. Create NDHHS cross agency meetings to identify shared system goals and establish outcome measures.	Track: ▪ # of meetings. ▪ # of participants. ▪ # of agencies represented.	▪ CY 2021: Create meeting format/Implement. ▪ CY 2022: Include metrics to be utilized, systemic goals, and QIP process. ▪ CY 2023: Continue with QIP process.	NDHHS

Pillar 2: Implement an Integration Strategy

Prioritized Need 2.1: Increase behavioral health services in primary care settings

Strategic Objective/Driver	Tactic	KPI(s)	Goals	Primary Lead
1. Increase use of behavioral health screening/evaluation tools, especially in primary care settings.	1A. Establish guidance and incentives for using behavioral health screening/evaluation tools, align to emergent needs (i.e. Suicide Prevention and/or alcohol usage).	Increase utilization of specified tool(s) per year after baseline established. Measure: ▪ # screenings. ▪ # referrals.	▪ CY 2021: Determine best screenings and utilization tracking system, implement and create baseline. ▪ CY 2022:Increase screening usage 20% over baseline. ▪ CY 2023: Increase utilization 20% over 2022.	NDHHS
2. Educate primary care providers and physician extenders such as APRNs on techniques to engage patients in behavioral health.	2A. Develop a training program specific to targeted provider types to improve provider knowledge base in behavior health engagement techniques; Assign CEUs.	Monitor: ▪ #of trainings. ▪ # of attendees. ▪ # of attendees by provider types.	▪ CY 2021: Define target audience(s) and training. ▪ CY 2022: Deploy tool. ▪ CY 2023: Implement tool.	NDHHS

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Pillar 2: Implement an Integration Strategy

Prioritized Need 2.2: Increase integration of behavioral health and physical health crisis services best practices across the state.

Strategic Objective/Driver	Tactic	KPI(s)	Goals	Primary Lead
1. Develop more rapid responses in crisis situations for behavioral health consultations.	1A. Expand virtual access to specialty care (consultation and 24/7 availability) with emphasis on rural areas and hospital ERs.	Evaluate: ▪ # of people receiving services via telehealth. ▪ # of units of service. ▪ # of telehealth capable providers.	▪ CY 2021: Inventory of ERs and define best practices. ▪ CY 2022: Develop strategy. ▪ CY 2023: Implement strategy.	NDHHS
		Increase seven day follow up for SUD/MH after ED visit (National Medicaid average is 12%).	▪ CY 2021: Determine data needs. ▪ CY 2022: Establish measurement baseline. ▪ CY 2023: Increase rate to %15.	NDHHS
2. Decrease ER utilization by identified population (i.e. SMI/SED).	2A. Engage state Medicaid and private payers to create a cost sharing strategy that incentivizes (alternative payment strategy/Value-Based Reimbursement) ED avoidance based on care management of the identified population.	Decrease of ER utilization by population: ▪ # of SMI/SED. ▪ # of Emergency protective custody (EPC). ▪ # of involuntary and/or voluntary.	▪ CY 2021: Determine population, targets, baseline and alternative payment strategy. ▪ CY 2022: Track results toward a 15% reduction goal. ▪ CY 2023: Reach %15.	NDHHS

Pillar 2: Implement an Integration Strategy

Prioritized Need 2.3: Increase integration between substance use treatment providers and mental health treatment providers

Strategic Objective/Driver		KPI(s)	Goals	Primary Lead
1. Improving outcomes by integration between substance use treatment providers and mental health treatment providers.	1A. Determine best practices for screenings. Establish guidance and incentives for using behavioral health screening/evaluation tools.	Increase: ▪ # of screenings. ▪ # of referrals.	▪ CY 2021: Determine best screenings and utilization tracking system, implement and create baseline. ▪ CY 2022: Increase screenings and referrals 20% over baseline. ▪ CY 2023: Increase screenings and referrals 20% over 2022.	DBH
2. Reduce policy barriers to SUD and MH integration.	2A. Review system policies re: dual credentials, coding, service definitions across behavioral health system.	Update policies and/or create clarification of policies that enhance integration: ▪ # of policies reviewed. ▪ # of policy updates. ▪ # of policy clarifications.	▪ CY 2021: Complete assessment. ▪ CY 2022: Policy dates and/or policy clarifications in place. ▪ CY 2023: Monitor for additional needs.	DBH
	2B. Provide training on dual diagnosis EBP-Integrated Dual Diagnosis Treatment (IDDT).	Increase dual diagnosis EBP-Integrated Dual Diagnosis Treatment (IDDT) utilization.	▪ CY 2021: 5% Increase over 2020 baseline. ▪ CY 2022: 10% increase over 2021. ▪ CY 2023: 10% increase over 2022.	DBH

Pillar 3: Promote Stakeholder Inclusion

Prioritized Need 3.1: Improve engagement between NDHHS, DBH, and Justice Partners in planning Justice Behavioral Health goals, service gap and need analysis, access to services, sequential intercepts, and quality outcomes for justice/behavioral health consumers.

Strategic Objective/Driver	Tactic	KPI(s)	Goals	Primary Lead
1. Work with Justice Partners to create a comprehensive behavioral health system for justice/behavioral health consumers.	Create DBH/Justice workgroups to conduct a needs analysis, identify service gaps, develop appropriate behavioral health services and shared system goals and establish quality outcome measures.	Track: ▪ # and frequency of meetings per workgroup created ▪ # of deliverables completed per workgroup	▪ CY 2021: Create meeting format/Implement. ▪ CY 2022: Include metrics to be utilized, systemic goals, and QIP process. ▪ CY 2023: Continue with QIP process.	NDHHS

Pillar 3: Promote Stakeholder Inclusion

Prioritized Need 3.2: Improve consumer and family input around services

Strategic Objective/Driver	Tactic	KPI(s)	Goals	Primary Lead
1. Expand communication platforms used to reach consumers and families.	1A. Explore and various communication platforms, including social media, as best practices to reach different consumer populations and increase inclusion in planning processes.	Increase # of likes or hits by demographic and media platform.	▪ CY 2021: Conduct assessment and baseline social media utilization. ▪ CY 2022: 25% increase in hits over 2021. ▪ CY 2023: 25% increase over 2022.	DBH
		Increase # of minorities and/or specific demographic populations in planning groups.	▪ CY 2021: Conduct assessment and baseline of specified populations. ▪ CY 2022: 10% increase over 2021. ▪ CY 2023: 10% increase over 2022.	DBH
2. Increase survey utilization for input on DBH initiatives and programming as an assessment for program effectiveness.	2A. Use social media to promote consumer survey participation.	Increase # of survey responses by demographic groups.	▪ CY 2021: Baseline on 2020 data and implement with a 10% increase over 2020. ▪ CY 2022: 10% increase over 2021. ▪ CY 2023: 10% increase over 2022.	DBH
	2B. Create minority specific surveys.	Increase # of languages surveys are offered.	▪ CY 2021: Minimum English/Spanish ▪ CY 2022: Add new languages as needed. ▪ CY 2023: Add new languages as needed.	DBH

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Pillar 3: Promote Stakeholder Inclusion

Prioritized Need 3.3: Improve engagement between NDHHS-DBH and behavioral health community-based organizations in planning processes

Strategic Objective/Driver	Tactic	KPI(s)	Goals	Primary Lead
1. Intentionally identity community organizations and assure ongoing engagement.	1A.Conduct Gap/Barrier analysis of current community organizations engagement practices by groups and demographics.	Increase # of community organizations involved in planning processes.	▪ CY 2021: Complete assessment and identify key community organizations. ▪ CY 2022: 10% increase over 2021. ▪ CY 2023: 10% increase over 2022.	DBH
2. DBH will take leadership in creating actionable agendas that reflect system planning and provide follow-up and feed back to stakeholders.	2A. Create a process planning agenda for all meetings, and assure follow-up on actionable items.	Increase % of agendas items with timely follow up (30 days or less) after meetings.	▪ CY 2021: Develop process planning agenda with a 90% follow-up rate. ▪ CY 2022: 90% follow-up rate. ▪ CY 2023: 90% follow-up rate.	DBH

Pillar 3: Promote Stakeholder Inclusion

Prioritized Need 3.4: Increase use of culturally and linguistically appropriate services (CLAS)

Strategic Objective/Driver	Tactic	KPI(s)	Goals	Primary Lead
1. Identify areas of need for CLAS services.	1A. Complete a CLAS need assessment and baseline data for culturally and linguistically appropriate services.	Increase: ▪ # of services deemed CLAS. ▪ # of staff trained in CLAS trainings.	▪ CY 2021: Complete CLAS assessment and establish baseline (Consider external reviewer due to complexity). ▪ CY 2022: Implement planning and with a 10% increase of services and trained staff over baseline. ▪ CY 2023: 10% increase of services and trained staff over 2022.	NDHHS
2. Increase bi-lingual/bi-cultural behavioral health staff.	2A. Explore promoting and/or expanding bi-lingual/bi-cultural staff retention programs currently utilized in Nebraska.	Increase # of students retained in state by demographic category and with language insight.	▪ CY 2021: Evaluation of current programs and establish baselines. ▪ CY 2022: 5% increase of target demographic populations. ▪ CY 2023: 10% increase of target demographics over 2022.	NDHHS
3. Align DBH goals with the Office of Equity and Disparity.	3A. Create cross-agency meetings.	Increase: ▪ # of meetings. ▪ # of shared goals.	▪ CY 2021: Establish meeting and create charter of shared goals. ▪ CY 2022: Establish and meet goal metrics. ▪ CY 2023: Establish and meet goal metrics.	DBH

Pillar 4: Drive Innovation & Better Outcomes

Prioritized Need 4.1: Improve competencies of behavioral health providers through partnerships and training with academic institutions.

Strategic Objective/Driver	Tactic	KPI(s)	Goals	Primary Lead
1. Improve competencies of behavioral health providers.	1A. Determine best method to determine accepted EBP practices and how to track EBP utilization by frequency and type.	Increase: ▪ # of units of services. ▪ # of individuals served.	▪ CY 2021: Evaluate for best method of EBP data collection. Determine EBPs to be tracked. Create baseline. ▪ CY 2022: 10% increase of services and consumers served over 2021 baseline. ▪ CY 2023: 10% increase of services and consumers server over 2022.	DBH
	1B. Work with academic institutions to assure training is aligned with emerging consumer needs.	Regular meetings with academic institutions to discuss training needs. Track: ▪ # of university programs working with. ▪ # of academic professionals involved in planning efforts and follow up.	▪ CY 2021-2023 Quarterly meetings with updates to planning and outcomes.	DBH

Prioritized Need 4.1: Improve competencies of behavioral health providers *(continued)*

Strategic Objective/Driver	Tactic	KPI(s)	Goals	Primary Lead
1. Improve competencies of behavioral health providers.	1C. Assure trainings are being promoted to providers across the state and virtual/on-line access is available.	Increase: ▪ # of trainings with virtual setting. ▪ # of training participants by geographical area. ▪ # of trainings by provider type.	▪ CY 2021: Evaluation of availability of virtual trainings and types of trainings. Establish target participants/provider types. ▪ CY 2022: Implement tracking of target participants/provider types and baseline. ▪ CY 2023: 20% increase of target participants/provider types over 2022.	DBH
	1D. Assess needs and develop training across the entire justice system (forensic/law enforcement/corrections) system for behavioral health needs and prevention strategies.	Increase: ▪ # of trainings by identified need. ▪ # of participants from corrections/justice, etc.	▪ CY 2021: Evaluate areas of need and establish baseline of current trainings (consider external reviewer due to complexity). ▪ CY 2022: 10% increase of trainings over 2021 baseline. ▪ CY 2023: 20% increase of training over 2022	NDHHS

Pillar 4: Drive Innovation & Better Outcomes

Prioritized Need 4.2: Expand use of technology for improved behavioral health outcomes

Strategic Objective/Driver	Tactic	KPI(s)	Goals	Primary Lead
1. Expand competency and training in digital technology/ telehealth.	1A. Develop technology trainings for providers. Develop survey for patient engagement, satisfaction, and outcomes with telehealth.	Increase: ▪ # of trainings with digital tech/telehealth focus. ▪ # of participants. ▪ % of patients satisfied with outcomes.	▪ CY 2021: Evaluate areas of need and establish baseline of current training. ▪ CY 2022: 10% increase of trainings over 2021 baseline. Evaluate patient outcome satisfaction rate. ▪ CY 2023: 20% increase of training over 2022. 10% improvement patient outcome satisfaction rates.	DBH
2. Increase technical capabilities: equipment/hardware, software, and access (internet/Wi-Fi).	2A. Survey state providers/ provider organizations to determine current capacity and needs.	Increase # of providers/ provider organizations with full telehealth capacity.	▪ CY 2021: Survey state technology baseline capacity. ▪ CY 2022: Implement strategy. ▪ CY 2023: 20% increase in technology enabled providers.	DBH
	2B. Explore incentives and payer sources to pay for tech solutions for providers and consumers (i.e. Medicaid managed care, grants, and other funding sources).	Coordinating with rural taskforce team, track: ▪ # of payer sources. ▪ # of dollars from other funding sources vs states.	▪ CY 2021: Evaluation of payer sources and coordination with rural taskforce. ▪ CY 2022: Create and implement a strategy and baseline. ▪ CY 2023: Track increase in technology enabled providers.	NDHHS

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Prioritized Need 4.3: Expand evidence-based practices through cross system engagement and planning

Strategic Objective/Driver	Tactic	KPI(s)	Goals	Primary Lead
1. Inventory of all evidence-based practices and need for additional EBPs.	1A. Create baseline of EBP data, determine best source of EBP data collection, and develop incentives for the use of evidenced-based practices (consider Value-Based Reimbursements (VBR)).	Assess: ▪ # of EBPs in use ▪ #/% of providers with EBPs in use. ▪ # of units / dollars paid for services with EBPs. ▪ # of units / dollars paid for non-EBP services.	▪ CY 2021: Create evaluation and develop a baseline of EBP to cost saving ratio. ▪ CY 2022: Create and implement a VBR strategy. ▪ CY 2023: Track improvement	NDHHS
2. Work with system partners to assess need and expand use of EBPs across the NDHHS system	Create cross-system workgroup to conduct a needs assessment, determine appropriate EBPs and develop an implementation/expansion plan as needed	Track: ▪ # of meetings ▪ # of deliverables completed	▪ CY 2021: Create meeting format/Implement. ▪ CY 2021: Complete needs assessment and determine EBPs. ▪ CY 2022: Implement EBP expansion plan.	NDHHS

Pillar 5: Demonstrate & Drive Value

Prioritized Need 5.1: Improve interagency data sharing

Strategic Objective/Driver	Tactic	KPI(s)	Goals	Primary Lead
1. Improve interagency data sharing.	1A. Determines best metrics to demonstrate programming processes and outcomes.	Determine: ▪ # of DBH metrics that matter. ▪ # of measures on regular schedule for review. ▪ # of metrics with cross-agency value.	▪ CY 2021: Inventory measures and determine best measures. ▪ CY 2022: Update and add measures as needed. ▪ CY 2023: Update and add measures as needed.	DBH
	1B. Regularly scheduled interagency-meeting to review data and develop strategies for improvement.	Determine: ▪ # of agencies involved. ▪ # of measures on regular schedule for review.	▪ CY 2021: Create meeting format, data/KPIs, stakeholders. ▪ CY 2022: Implement a QIP process for KPIs. ▪ CY 2023: Evolve programming to meet emerging needs.	NDHHS
	1C. Develop interagency MOU for data sharing.	Determine: ▪ # of current MOUs. ▪ # of MOUs needed. ▪ # records shared.	▪ CY 2021: Inventory current MOUs and needed MOUs. ▪ CY 2022: Complete all MOUs. ▪ CY 2023: Track data being shared.	NDHHS
2. Develop more detailed and accessible dashboards that reflect the impact of programming.	2A. Develop interagency accessible dashboards. Evaluate efficacy of a dually utilized dashboard, inward and outward facing.	Inventory: ▪ # of dashboards in use. ▪ # of shared measures in use and to develop. ▪ # persons accessing dashboards.	▪ CY 2021: Inventory current dashboards and determine best data for future use. ▪ CY 2022: Determine best platform and implement development. ▪ CY 2023: Roll out dashboards (inward facing first then outward facing).	NDHHS

Prioritized Need 5.2: Need for system wide behavioral health outcomes

Strategic Objective/Driver	Tactic	KPI(s)	Goals	Primary Lead
1. Establish system wide behavioral health outcomes.	1A. Develop Strategic Plan.	Establish KPIs.	▪ CY 2021: Establish KPIs and Strategic Plan to reach goals. ▪ CY 2022: Review Strategic Plan for completion and reevaluation as needed. ▪ CY 2023: Review Strategic Plan for completion and reevaluation as needed.	DBH

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Prioritized Need 5.3 Compare Nebraska behavioral health outcomes data to national benchmarks

Strategic Objective/Driver	Tactic	KPI(s)	Goals	Primary Lead
1. Compare Nebraska outcome goals to national benchmarks.	1A. Review Behavioral Health HEDIS measures that reflects program goals.	Determine HEDIS measure(s).	▪ CY 2021: Choose one HEDIS measure and determine best methodology to gather metric data. Baseline the measure. ▪ CY 2022: Implement QIP strategy for the measure.. Determine system goals. ▪ CY 2023: Continue monitor and update to improve measurement outcomes.	NDHHS

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Strategic Plan & Optimization Roadmap

Working Together To Fulfill The Vision

Optimizing the strategic plan will involve new ways of doing business such that DBH, NDHHS divisions, justice partners, public and private constituencies are working toward:

1. Enhancing and Expanding the behavioral health system continuum of services and supports
2. Enhancing Integration of Behavior Health into an array of healthcare settings, across NDHHS and justice providers

A summary of both enhancing the strategic system role for DBH and enhancing the integration of behavioral health across the system are in the following slides.

1. Enhance & Expand The DBH Scope Of Work

Areas Of Optimization

To achieve maximum optimization of the Strategic Plan, the scope of BH should be enhanced and expanded in the following areas:

1. Training and Education Logistics - .5 FTE (DHHS Staff Development)
2. Grants Application & Management – 1 FTE
3. Planning, Policy and Legislation – 1 FTE
4. Cross Division Clinical Consultation/Managed Care including Complex Case Management – 1 FTE
   A. Re-establish the Chief Clinical Officer that has cross system knowledge – Contract or 1 FTE
5. Community Engagement and Communication Manager – 1 FTE
6. Consumer Engagement – 1 FTE
7. Tribal Manager, CLAS Equity & Disparity – 1 FTE
8. Cross System Cost Benefit Analysis, cost models, value-based contracting – 1 FTE (shared across divisions)
9. Population Health Management – 1 FTE
10. Workforce Planning/ Health Integration/Provider Relations – 1 FTE
11. Cross System BH Liaison (Justice, Veterans) – 1 FTE

DBH HR need: 11.5 FTEs plus .5 DHHS Staff Development (Subject to DHHS Classification)

2. Enhance Integration Of Behavioral Health Into NDHHS

Areas Of Optimization

To further optimize the Strategic Plan, behavioral health should be fully integrated into all Divisions of NDHHS and the justice system through building organizational cross system infrastructure as follows:

1. Cross System Training and Workforce development
2. Cross System Policy and Regulation review / development
3. Cross System Service development that maximizes and braids or blends funding
4. Cross System Grants management to drive innovation
5. Cross System Data Analysis and Reporting functionality
   A. System capacity and waiting lists, outcomes, etc.
   B. Enterprise level inward and outward facing dashboard platform
6. Cross System IS&T integration: robust data analytics tools and knowledgeable staff
7. Establishment of cross system protocols for consumer engagement and involvement in planning (outside of formal Release of Information)
8. Cross system development of public/private partnerships for communication and campaigns
9. Cross system public/private partnerships with academia for research and development of best practices and centers of excellence

NDHHS HR need: Organizational changes and/or work assignments will ultimately determine the number of FTEs. Coordination estimate is up to 5 FTEs (subject to DHHS and System Partner classifications)

Support for optimization to carry out the Plan are contained throughout the Strategic Plan.

2. Enhance Integration Of Behavioral Health Into NDHHS

Areas Of Optimization (continued)

To further optimize the Strategic Plan, behavioral health should be fully integrated into all divisions of NDHHS as follows:

1. Cross Division Training and Operational Knowledge
2. Cross Division Policy review / development
3. Cross Division Service review and system development
4. Cross Division Grants management and expertise
5. Cross Division Data Analysis and Reporting functionality
6. Cross Division IS&T integration
7. Determination of program vs. legal role (policy development, regulation re-write, MOU development, etc.)
8. Establishment of protocols for consumer planning across divisions (outside of formal Release of Information)

NDHHS HR need: 5.25 FTEs

Details for optimization are contained throughout the Strategic Plan

Appendix A: Key Stakeholder Interviews Summary

Interview #1- Community Partner

1. Needs/Gaps
   A. No reimbursement for 'warm hand off model‘
   B. No payable codes for prevention education
   C. Lack of Psychiatric services.
   D. Cultural Competency.
   E. Lack of care coordination with ER visits related to BH need.
   F. Enhanced school intervention with trained therapists.
   G. Improved relationship with FQHC to better align services.
   H. Better public health data such as HEDIS measures and community tenure.
   I. Closer alignment with BH community groups and coalitions including state representation. Need to have goals.
2. Barriers
   A. Diverse population
   B. Language barrier - large Hispanic population growing Asian Population
   C. Nonresponsive Regional Authority
3. Strengths
   A. Primary Care Integration - Ames Model -Long wait list

Interview #2 – Community Partner

1. Needs/Gaps
   A. Case Management for Housing Support.
   B. Peer support services for housing.
   C. Not enough intensive case management (ICM).
   D. Medication Adherence
   E. Availability of 24/7 services to assist in housing success.
   F. 1115 Waiver for braided funding for housing.
   G. Community based housing organizations and DBH are too siloed.
   H. Lack of communication between HUD, SAMSHA and DBH.
   I. Rural regions do not have enough BH services to support housing.
   J. Coordinate housing between DOC and DBH.
2. Barriers
   A. Access to ICM and other intensive case services.
   B. Landlords hesitant to take on SMI individuals.
3. Strengths
   A. Incentivized case management for housing tenure
   B. Intensive Case Management (ICM)-"Johnny on the spot"- assuage landlords-MH association and U of N partnered on SAMSHA housing grant for housing and employment
   C. ACT teams are also effective
   D. Long lasting injectables very effective

Interview #3 – Law Enforcement Partner

1. Needs/Gaps
   A. Transportation for western region.
   B. High substance abuse rate and disconnect with services.
   C. Need for more certified BH providers with forensic training.
2. Barriers
   A. None Identified
3. Strengths
   A. Use of telehealth interventions, Lutheran Services.
   B. Did have behavioral health services embedded in the police station.
   C. Diversion for first time offenders.
   D. Emergency Protective Custody allows for a period of time to detox from substance abuse w/o arrest.

Interview #4 – Justice Partner

1. Needs/Gaps
   A. Lack of available services for competency evaluations and restorations. Can take 3-4 months for services.
   B. Lack of SUD treatment for juveniles.
   C. Lack of treatment for sex offenders.
   D. Lack of progress on improving utilization of the Lincoln Regional Center.
   E. Lack of service in rural regions.
   F. Overutilization of out of expensive out state services for restoration.
2. Barriers
   A. Lack of trained staff for BH needs.
3. Strengths
   A. Data on recidivism rates is plentiful.
   B. Data for access is solid.
   C. Increased utilization of EBPs.

Interview #5 – Justice Partner

1. Needs/Gaps
   A. Need for better support competency and restoration - Up to 12 weeks to gain access to LRC.
   B. Transition for individuals from not guilty by reason of insanity from treatment to the community.
   C. Lack of Quality Assurance processes for individuals diverted from Problem Solving Court to treatment. Need more accountability. No outcome measures. Minimal data.
   D. Need for leadership in best practices in forensic BH interventions, providers are not staying current.
   E. Lack of Inpatient BH services in Western Nebraska.
   F. Lack of Psychiatry in Western Nebraska.
   G. Poor oversight in Halfway House system especially Oxford House level of care.
   H. GREATEST NEED: DBH should review marijuana policy before legalization especially with lessons learned from Colorado and Oregon. Need for closer regulation and enhanced education on the public and legislative side.
   I. Need for Medication Assisted Treatment for opioid treatment.
2. Barriers
   A. None Identified
3. Strengths
   A. Court is very motivated toward diversion practices.

Interview #6 – Community Partner

1. Needs/Gaps
   A. Need for more culturally appropriate treatment in African American community
   B. Lack of focus on prevention
   C. Lack of education to address BH Stigma-Would like DBH to lead with better marketing effort
   D. Feels a lack of focus, organization, and listening from DBH
   E. Lack of funding for administrative processes especially in juvenile services
   F. Lack of BH support for those with psychotropic medication needs.
   G. More BH/PH connections
2. Barriers
   A. Lack of BH providers in PCP
   B. High copay and deductibles
3. Strengths
   A. KidSquad programming to increase preschool retention.

Interview #7 – Education Partner

1. Needs/Gaps
   A. Need to continue to develop psychiatric services, psychiatrists. 50% of psychiatrists are over 50
   B. More engagement in rural areas and pan handle
   C. Increase BH rotation in medical training
   D. Downward trend in licensed SUD counselors
   E. Continue to develop telehealth, need for more internet access and hardware to deliver services
   F. Beginning to develop Spanish brochures for BH services
   G. Need for improve cultural competency
   H. Need for increased BH literacy
2. Barriers
   A. None Identified
3. Strengths
   A. Works well with DBH
   B. 17% growth in BH work force over two years especially Psychiatric Nurse Practitioners
   C. Provides free CEUs for BH providers-
   D. Some workforce data available
   E. Regularly engaged with 17 academic institutions
   F. Developing rural fellowships

Interview #8 – Tribal Partner

1. Needs/Gaps
   A. Lack of trust or confidence in NDHHS-DHS. One tribal leader said, "The state is beyond doing anything positive. I see no hope for improvement in any area.“
   B. Were excluded from CARES Act by NDHHS, eventually Winnebagos were able to secure funding
   C. Poor healthcare support, COVID has hit tribes hard, especially for those associated with meatpacking
   D. Poor representation of Native Americans in government and healthcare
   E. No presence on reservation of permanent BH providers
   F. Need for onsite visits from state
   G. Need for cultural competency mandate from DBH
2. Barriers
   A. Distant location means little interaction with state and difficulty finding health care
3. Strengths
   A. NDHHS task for to deal with rash of suicides on reservations was effective.

Interview #9 – Health Partner

1. Needs/Gaps
   A. Need to raise profile and status of BH.
   B. Stigma of BH especially clear in rural region
   C. Inability to sustain BH in Primary care setting
   D. Lack of enforcement of Parity Law
   E. Need for BH in ER critical and not addressed
   F. Lack of funding for BH in general and particularly in Medicaid
   G. Prison crowding by those that need BH treatment
   H. Lack of utilization of HIE and restrictive nature of state laws
   I. Need to address the digital divide
   J. Address improving BH education for non psychiatric physicians
   K. Need for Geriatric BH services
   L. Growing need for pediatric BH care
   M. Need for improved care in Indian Health Services
2. Barriers
   A. Privacy in rural regions is very low
3. Strengths
   A. Working to integrate BH into Primary Care
   B. Psychiatric Nurse Practioners
   C. Telehealth development has been a boon

Interview #10 – Spanish Community Partner

1. Needs/Gaps
   A. Education that is culturally competent for the Hispanic population on the benefits of BH
   B. NDHHS has been non-responsive in meeting with Latino based community/advocacy groups
   C. Increase Hispanics going into Human Service field via colleges/university
2. Barriers
   A. Language and culture of the Hispanic population
3. Strengths
   A. Hispanic population heavily uses Facebook
   B. Use faith-based organizations to reach population
   C. Latino Commission and other community/Advocacy organizations are open to working with NDHHS
   D. Has Spanish educational material

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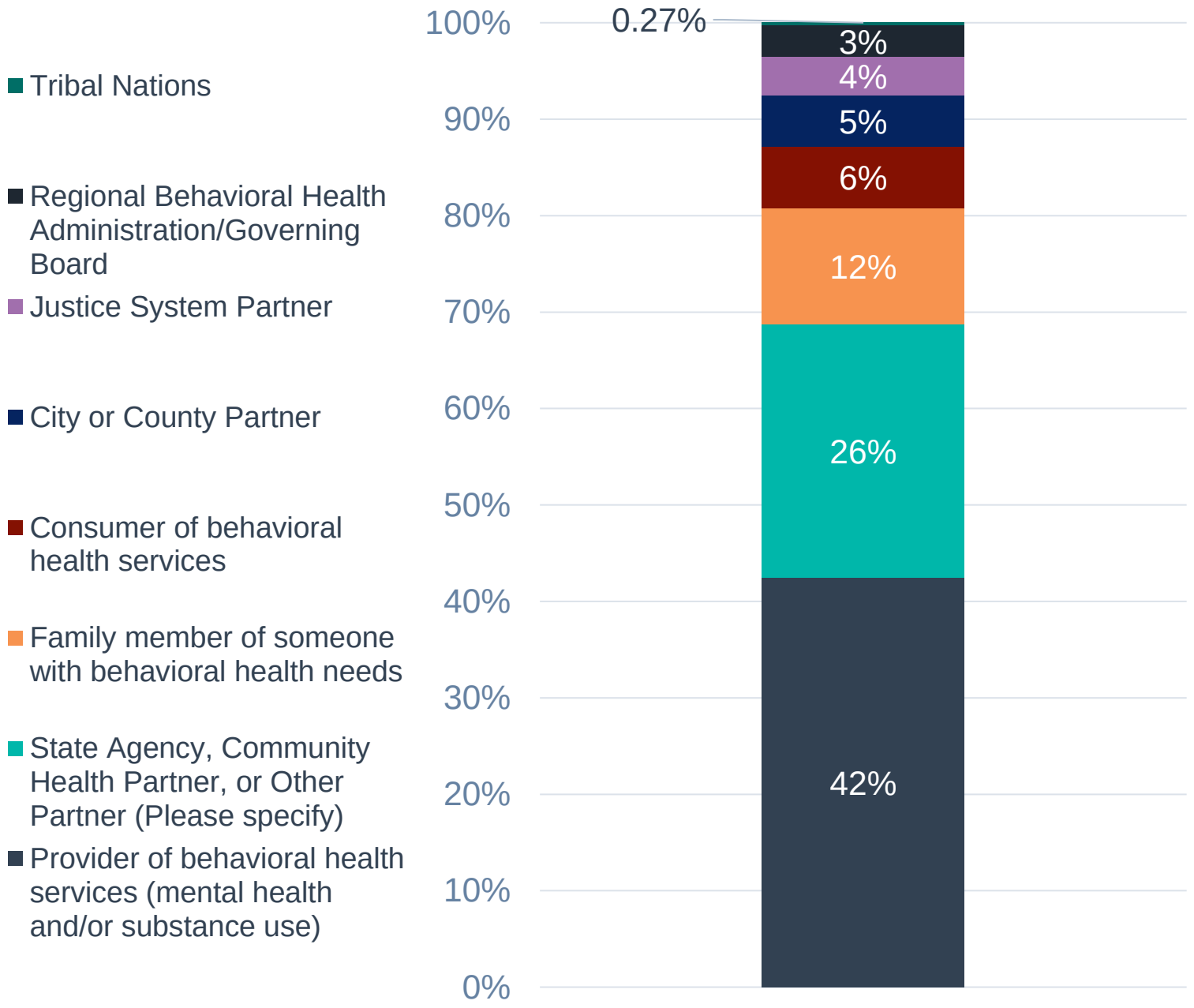
Appendix B: Survey Results

Q1: What is your primary affiliation with the behavioral health system in Nebraska?

Answered: 733

Skipped: 5



Q1: What is your primary affiliation with the behavioral health system in Nebraska?

Answered: 733

Skipped: 5

Answer Choice	Responses (Percent & Number)	
Provider of behavioral health services (mental health and/or substance use)	42.43%	311
State Agency, Community Health Partner, or Other Partner (Please specify)	26.33%	193
Family member of someone with behavioral health needs	12.01%	88
Consumer of behavioral health services	6.41%	47
City or County Partner	5.32%	39
Justice System Partner	3.96%	29
Regional Behavioral Health Administration/Governing Board	3.27%	24
Tribal Nations	0.27%	2
Total	**100%**	**733**

Q2/Q3: Please identify the primary county/zip code that you represent

Answered: 703
Skipped: 35

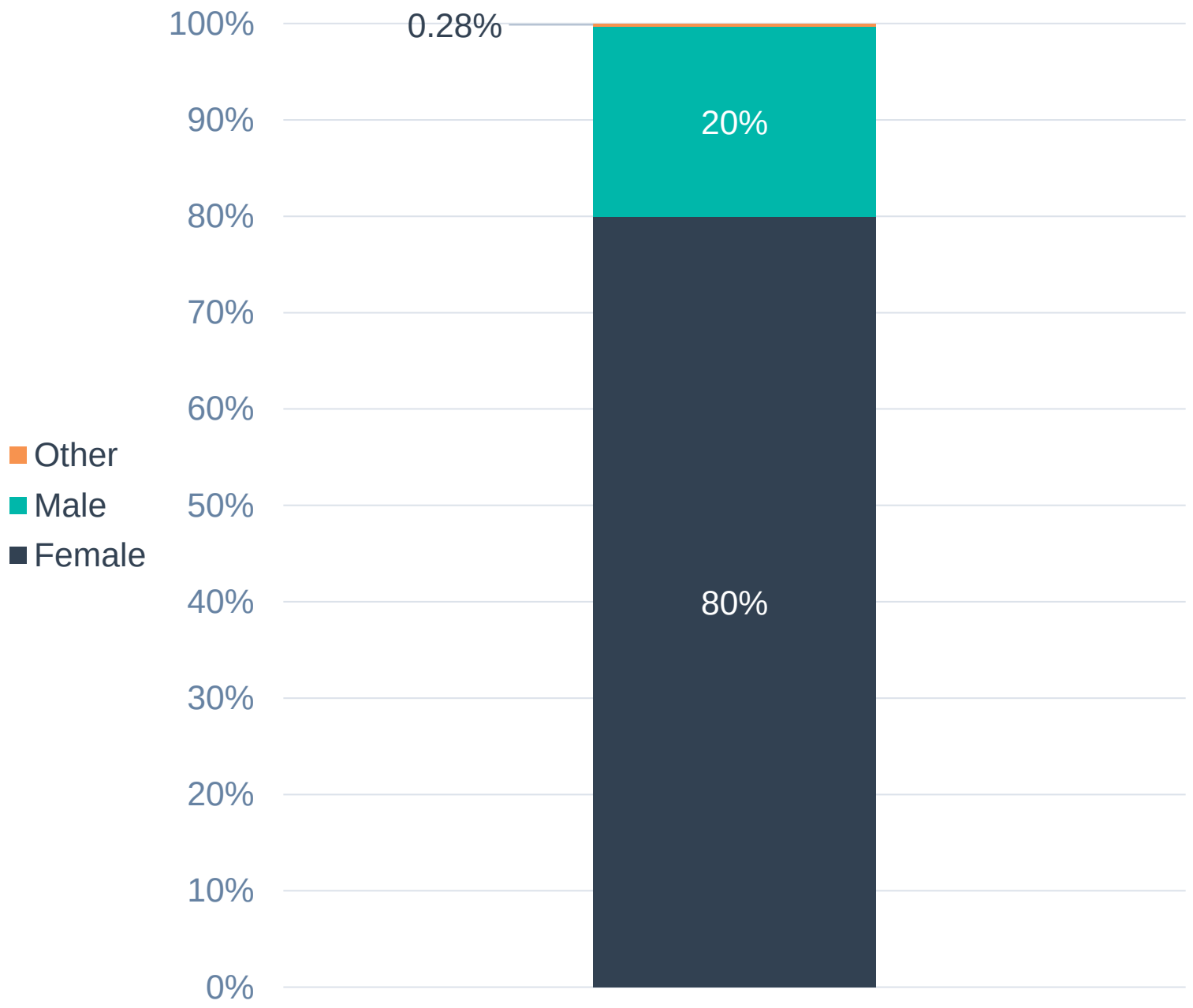
Note: Zip code data used to identify respondent county

Lancaster	22.8%	160
Douglas	21.7%	152
Madison	6.4%	45
Buffalo	4.4%	31
Hall	3.8%	27
Sarpy	3.0%	21
Lincoln	2.8%	20
Scotts Bluff	2.6%	18
Dakota	2.4%	17
Adams	1.9%	13
Gage	1.6%	11
Platte	1.3%	9
Dodge	0.9%	6
Otoe	0.9%	6
Thurston	0.9%	6
Dawson	0.7%	5
Holt	0.7%	5
Nuckolls	0.7%	5
Saunders	0.7%	5
York	0.7%	5
Box Butte	0.6%	4
Keith	0.6%	4
Knox	0.6%	4
Richardson	0.6%	4
Seward	0.6%	4
Cass	0.4%	3
Fillmore	0.4%	3
Johnson	0.4%	3
Nemaha	0.4%	3
Red Willow	0.4%	3
Saline	0.4%	3
Thayer	0.4%	3
[illegible]	[illegible]	2

Butler	0.3%	2
Cherry	0.3%	2
Cuming	0.3%	2
Dawes	0.3%	2
Jefferson	0.3%	2
Pawnee	0.3%	2
Phelps	0.3%	2
Sherman	0.3%	2
Antelope	0.1%	1
Banner	0.1%	1
Cheyenne	0.1%	1
Colfax	0.1%	1
Custer	0.1%	1
Dixon	0.1%	1
Franklin	0.1%	1
Furnas	0.1%	1
Garden	0.1%	1
Grant	0.1%	1
Hamilton	0.1%	1
Nance	0.1%	1
Perkins	0.1%	1
Pierce	0.1%	1
Polk	0.1%	1
Sheridan	0.1%	1
#N/A	8.5%	60

Q4: Gender

Answered: 717
Skipped: 21



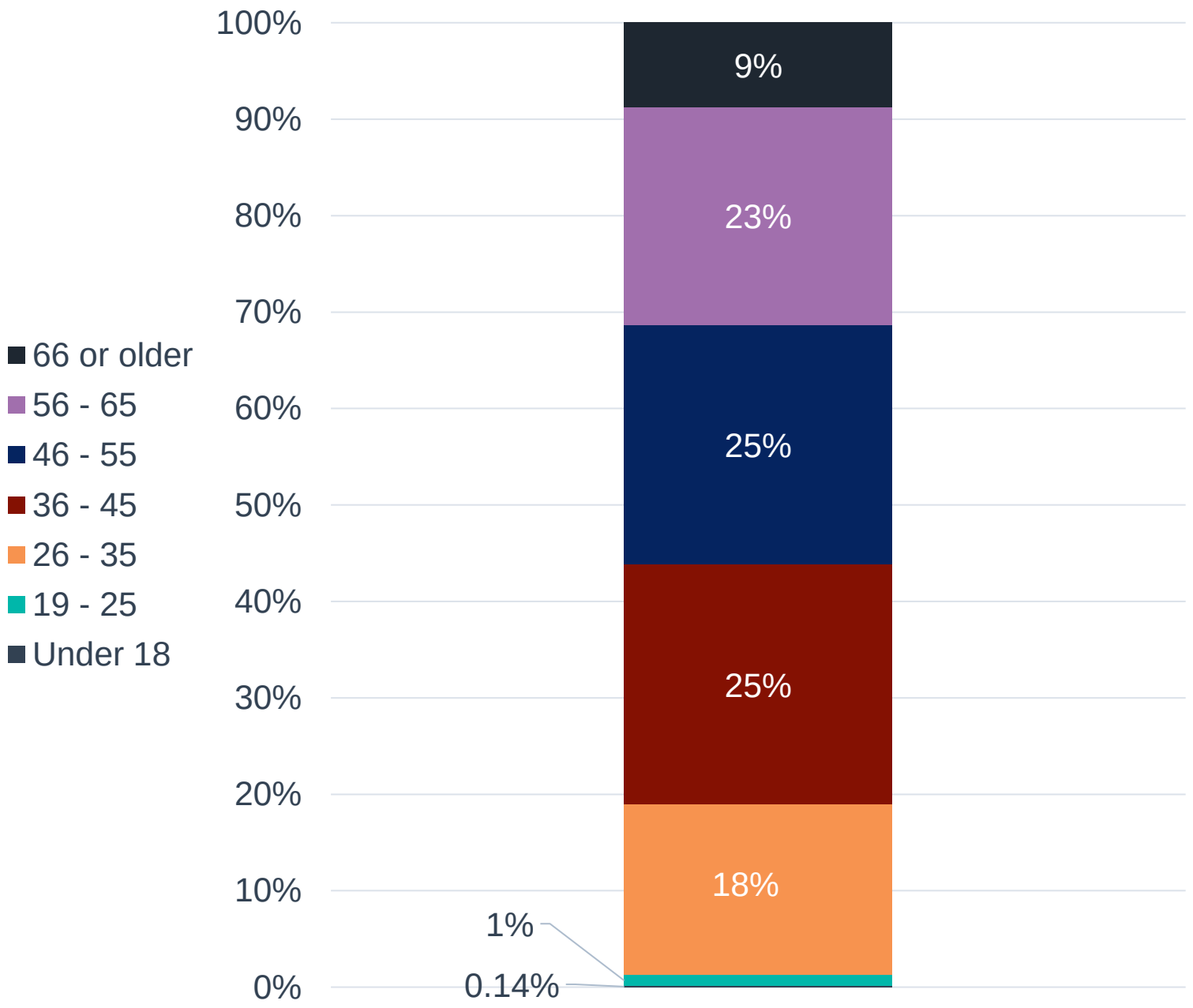
Q4: Gender

Answered: 717
Skipped: 21

Answer Choice	Responses (Percent & Number)	
Female	79.92%	573
Male	19.80%	142
Other	0.28%	2
Total	**100%**	**717**

Q5: Age

Answered: 718
Skipped: 20



Q5: Age

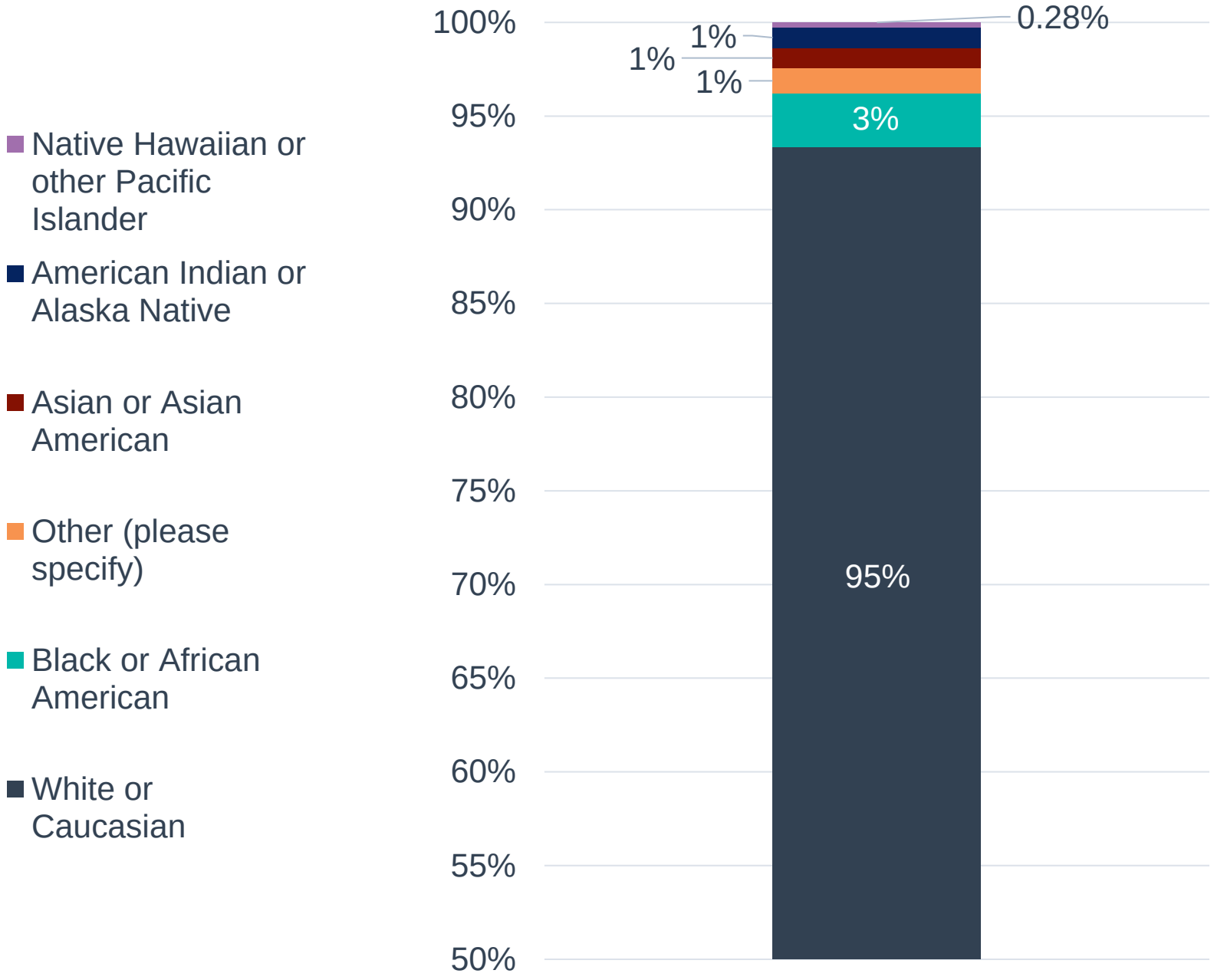
Answered: 718
Skipped: 20

Answer Choice	Responses (Percent & Number)	
36 - 45	25%	179
46 - 55	25%	178
56 - 65	23%	162
26 - 35	18%	127
66 or older	9%	63
19 - 25	1%	8
Under 18	0.14%	1
Total	**100%**	**718**

Q6: What is your race? (Mark all that apply)

Answered: 723

Skipped: 15



Q6: What is your race? (Mark all that apply)

Answered: 723

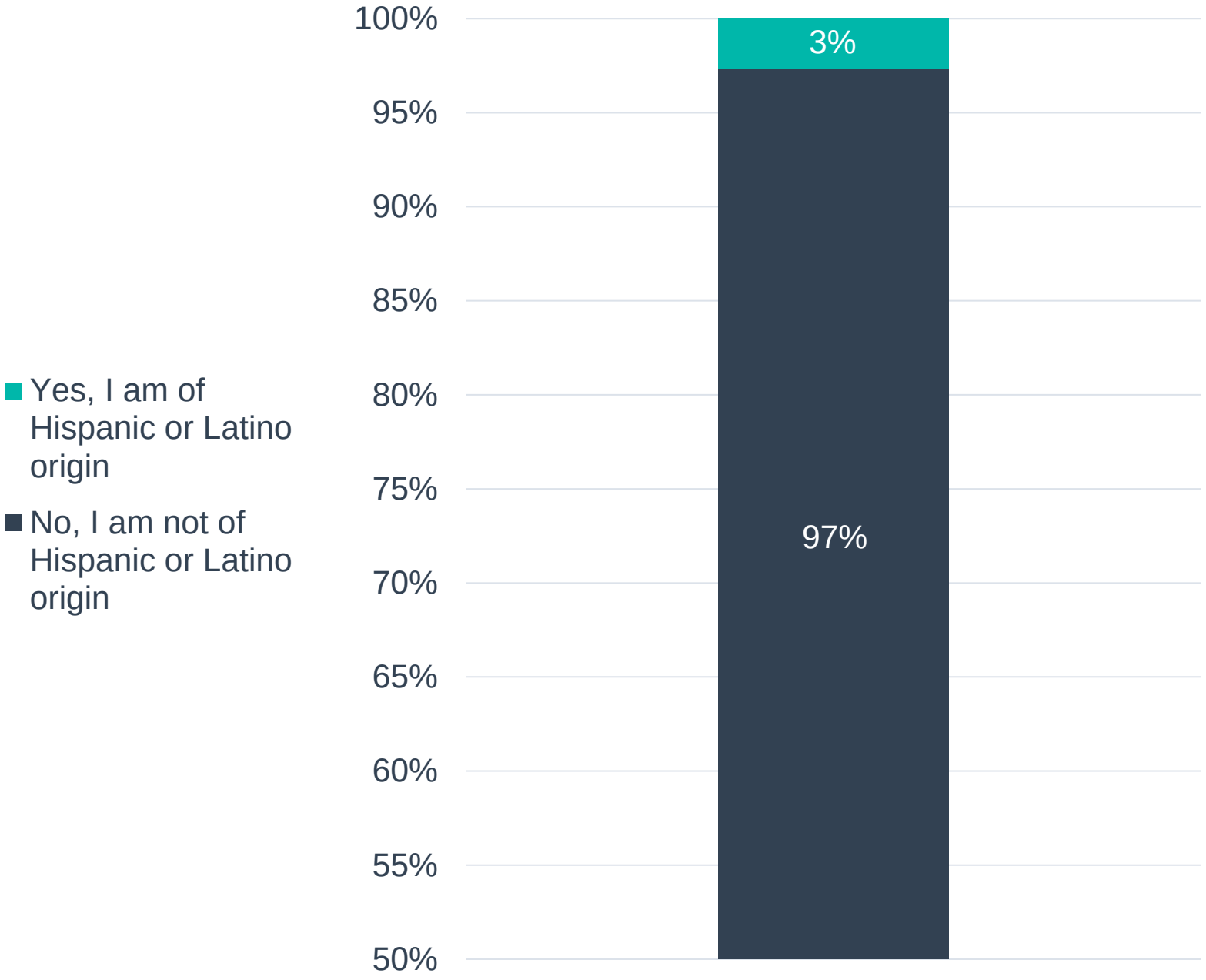
Skipped: 15

Answer Choice	Responses (Percent & Number)	
White or Caucasian	95.44%	690
Black or African American	2.90%	21
Other (please specify)	1.38%	10
Asian or Asian American	1.11%	8
American Indian or Alaska Native	1.11%	8
Native Hawaiian or other Pacific Islander	0.28%	2
Total	**100%**	**723**

Q7: Are you of Hispanic or Latino origin?

Answered: 719

Skipped: 19



Q7: Are you of Hispanic or Latino origin?

Answered: 719

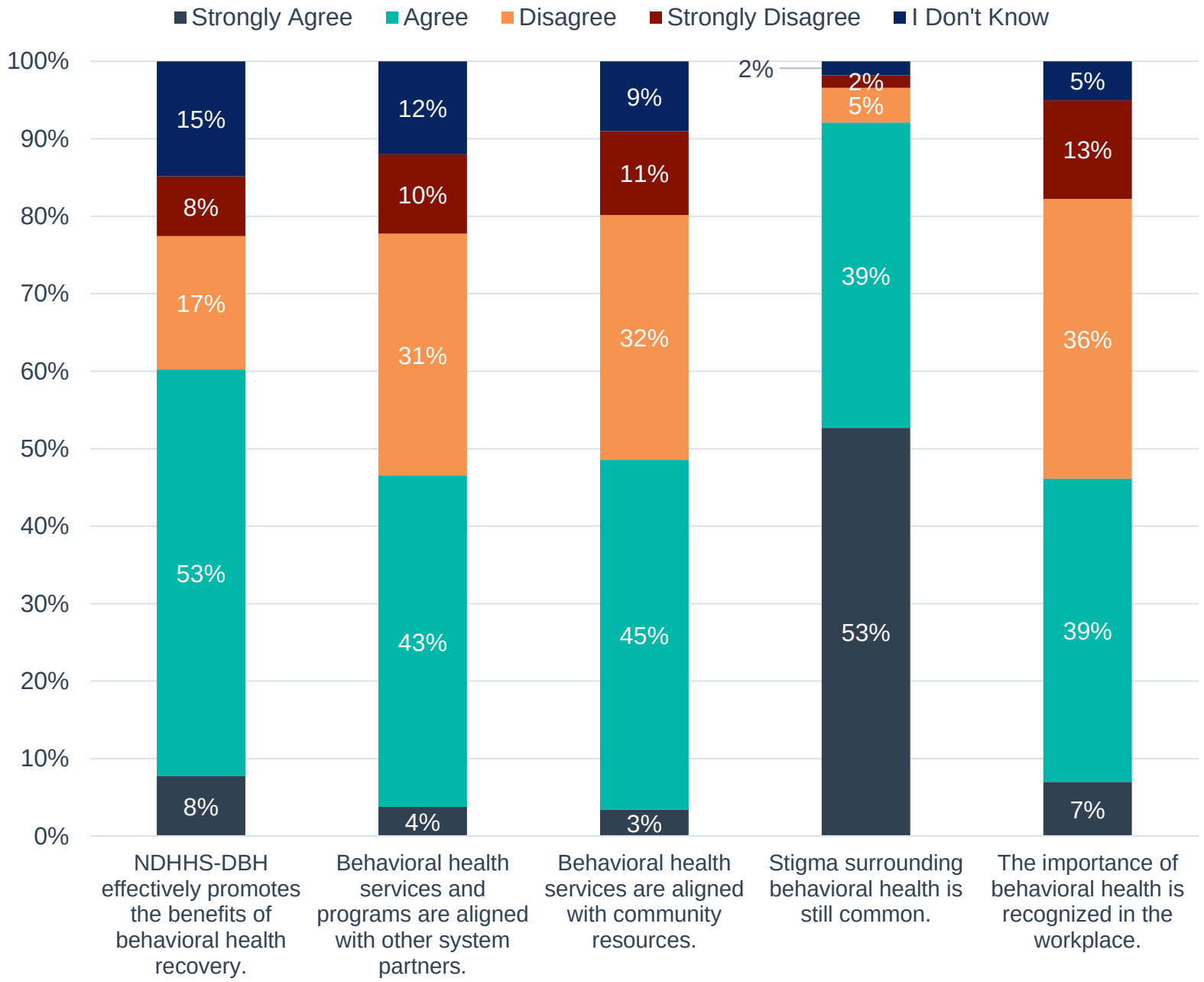
Skipped: 19

Answer Choice	Responses (Percent & Number)	
No, I am not of Hispanic or Latino origin	97.36%	700
Yes, I am of Hispanic or Latino origin	2.64%	19
Total	**100%**	**719**

Enhance Statewide Behavioral Health Influence

Q12: Please identify how much you agree or disagree with the following statements:

Answered: 558
Skipped: 180



Enhance Statewide Behavioral Health Influence

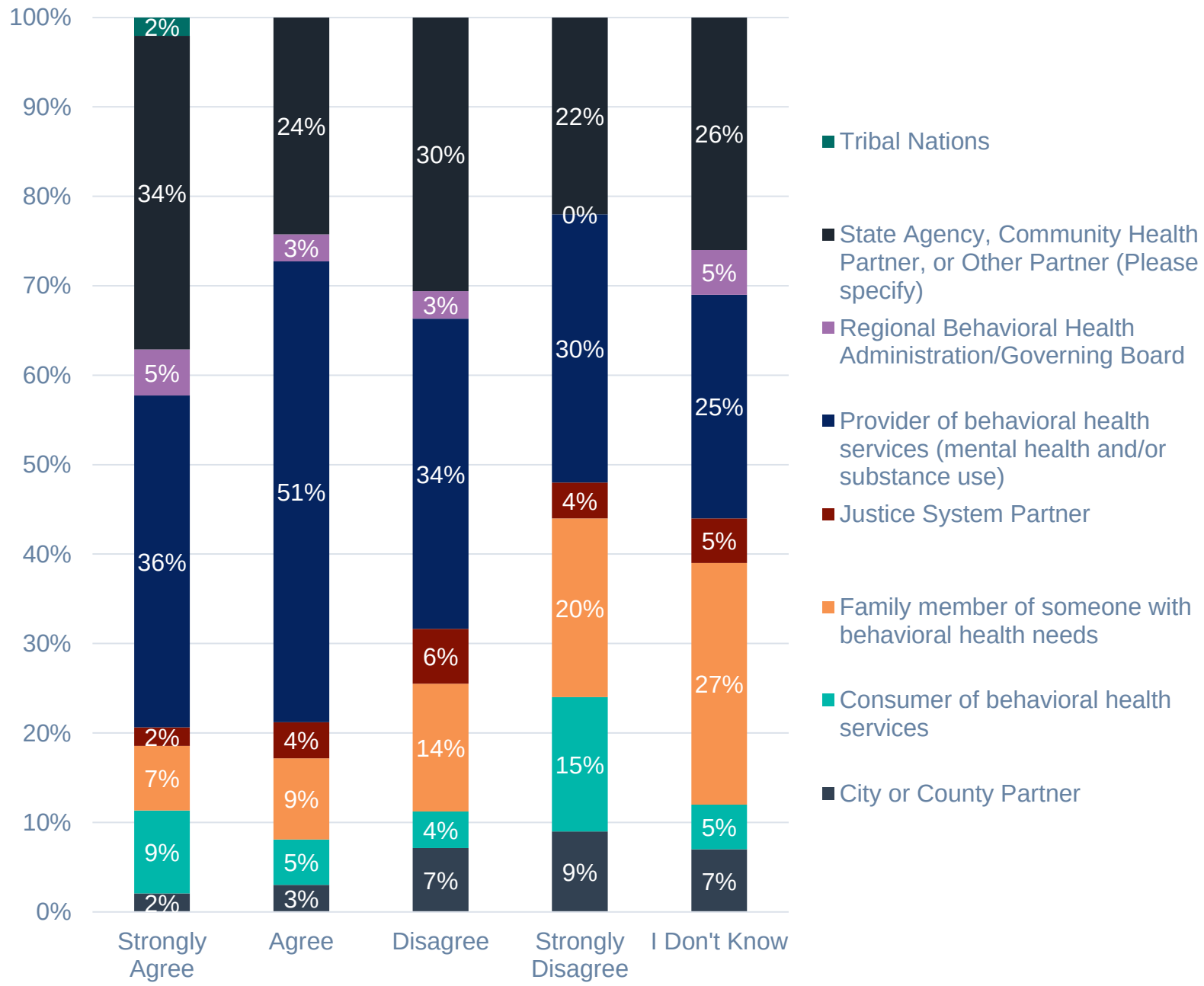
Q12: Please identify how much you agree or disagree with the following statements:

Answered: 558
Skipped: 180

Answer Choice	Strongly Agree		Agree		Disagree		Strongly Disagree		I Don't Know	
NDHHS-DBH effectively promotes the benefits of behavioral health recovery.	7.71%	43	52.51%	293	17.20%	96	7.71%	43	14.87%	83
Behavioral health services and programs are aligned with other system partners.	3.77%	21	42.73%	238	31.24%	174	10.23%	57	12.03%	67
Behavioral health services are aligned with community resources.	3.43%	19	45.13%	250	31.59%	175	10.83%	60	9.03%	50
Stigma surrounding behavioral health is still common.	52.70%	293	39.39%	219	4.50%	25	1.62%	9	1.80%	10
The importance of behavioral health is recognized in the workplace.	7.00%	39	39.14%	218	36.09%	201	12.75%	71	5.03%	28

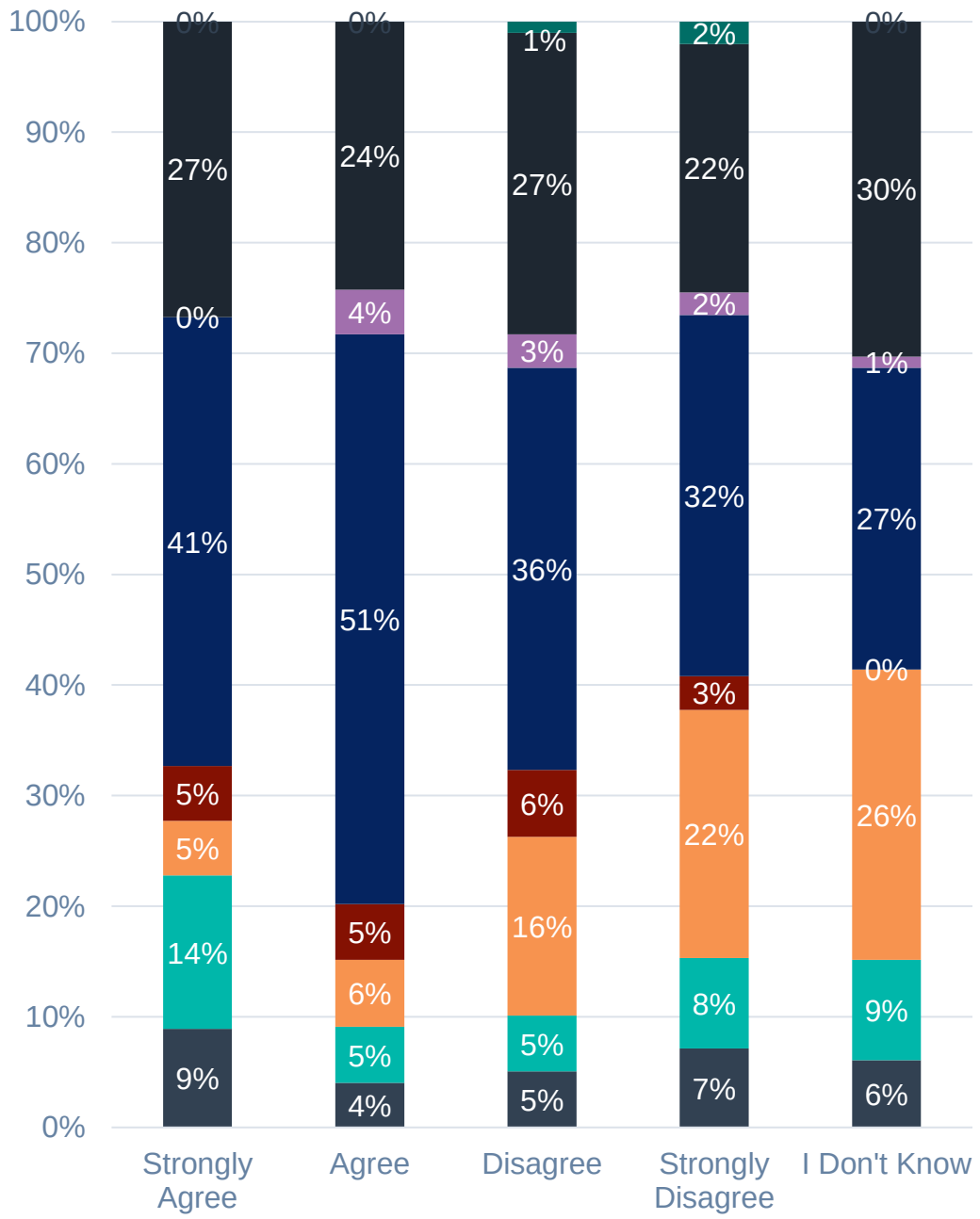
Enhance Statewide Behavioral Health Influence

Q12 Statement Results By Group: NDHHS-DBH effectively promotes the benefits of behavioral health recovery.



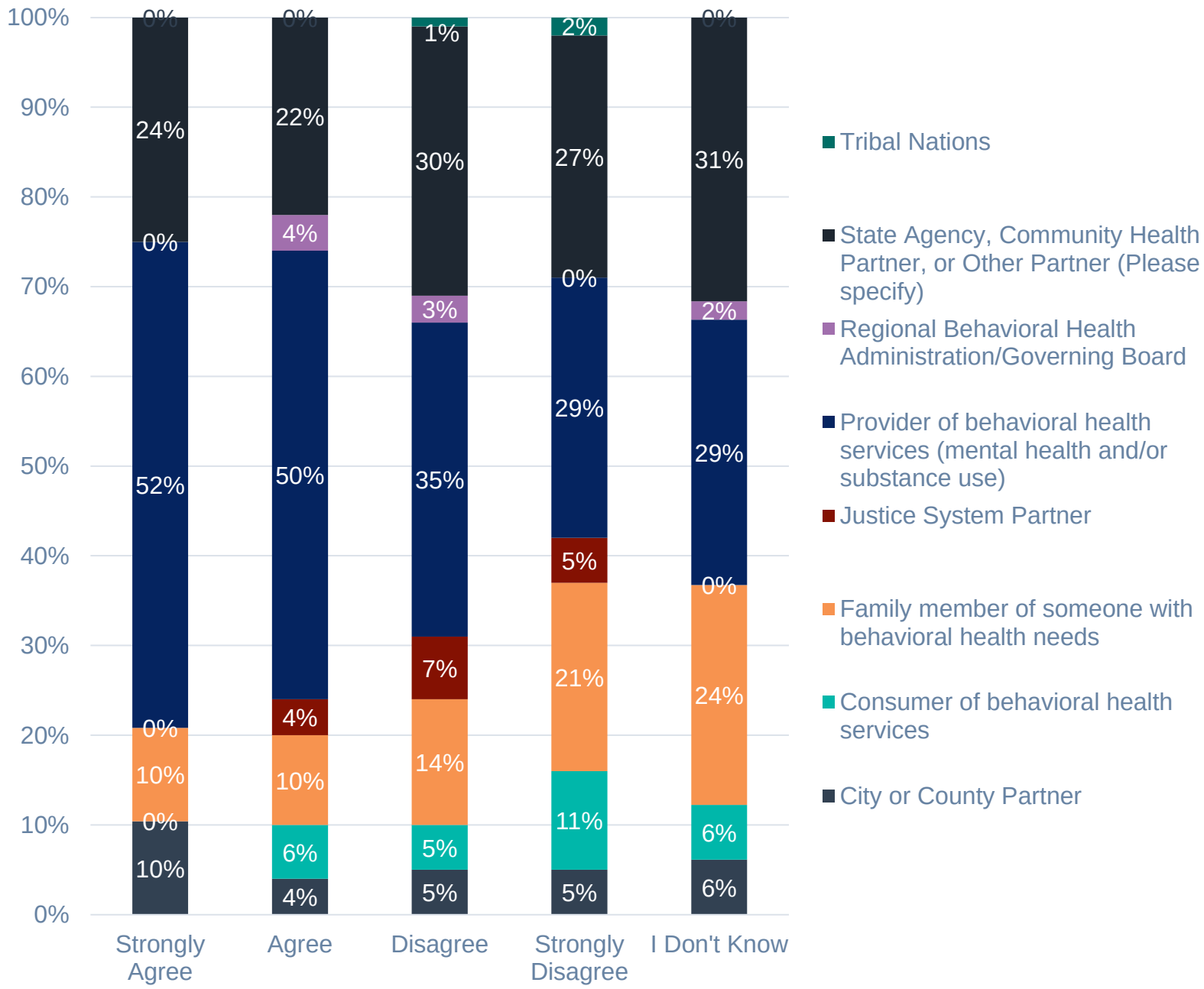
Enhance Statewide Behavioral Health Influence

Q12 Statement Results By Group: Behavioral health services and programs are aligned with other system partners.



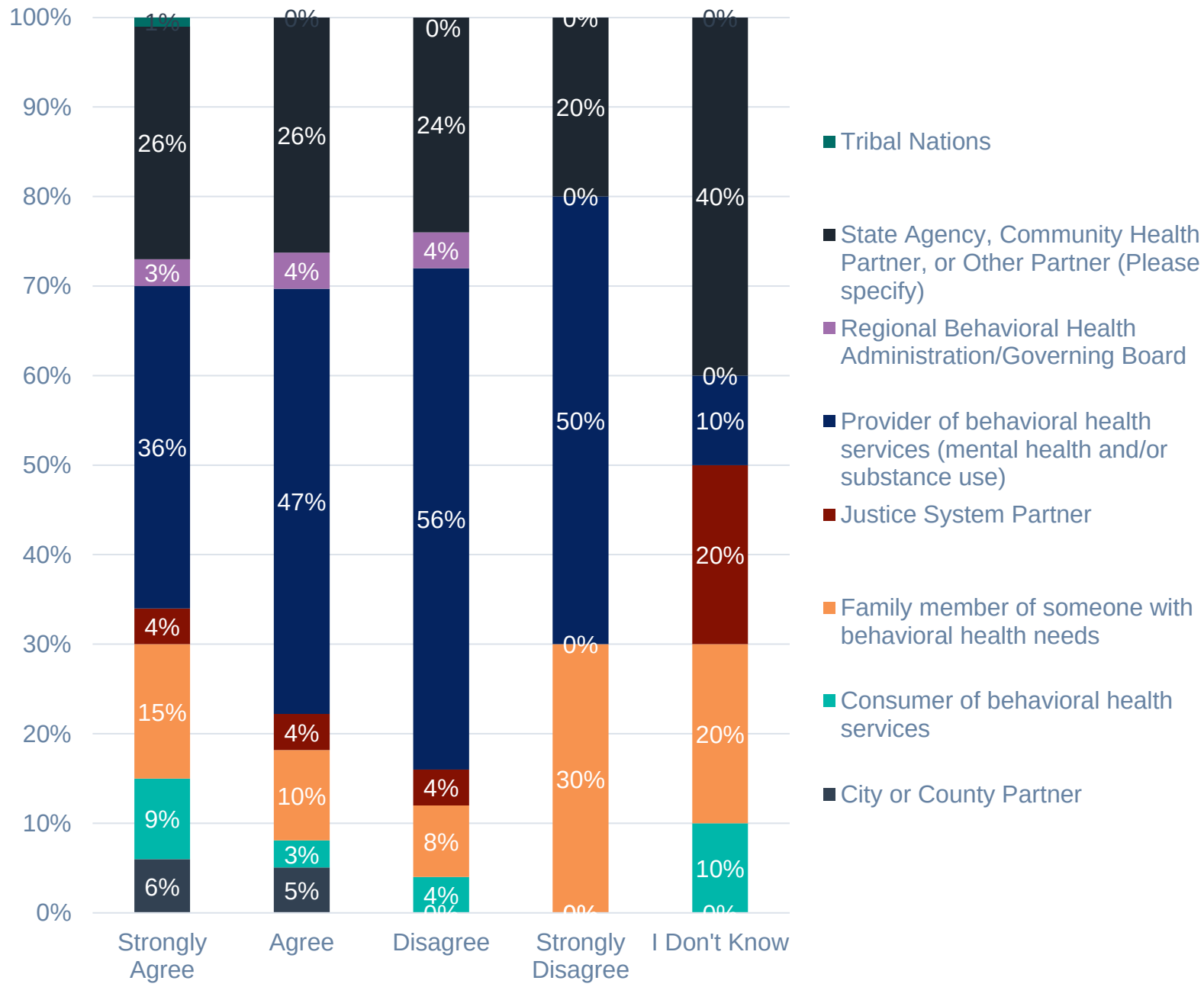
Enhance Statewide Behavioral Health Influence

Q12 Statement Results By Group: Behavioral health services and programs are aligned with community resources.



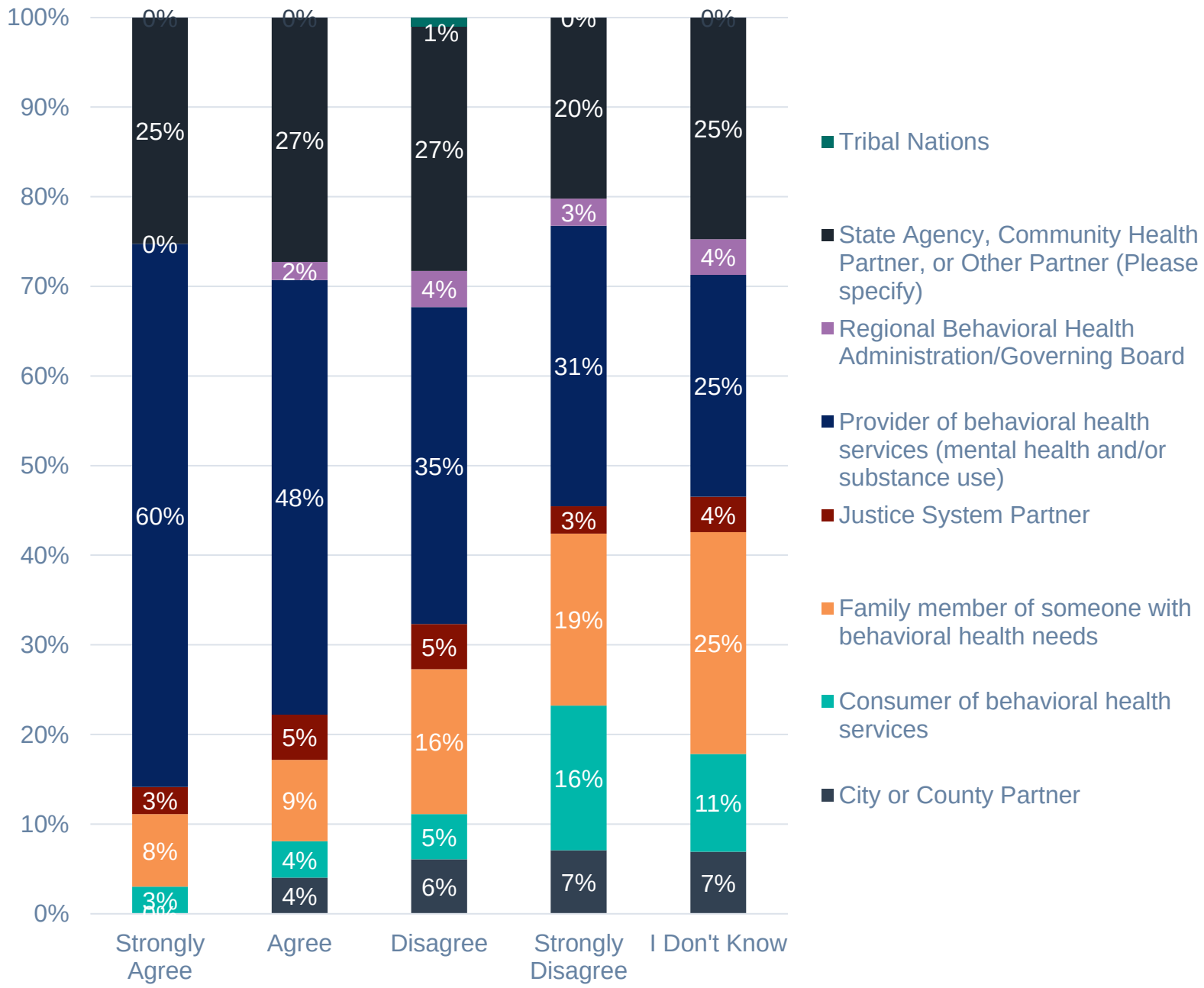
Enhance Statewide Behavioral Health Influence

Q12 Statement Results By Group: Stigma surrounding behavioral health is still common.



Enhance Statewide Behavioral Health Influence

Q12 Statement Results By Group: The importance of behavioral health is recognized in the workplace.



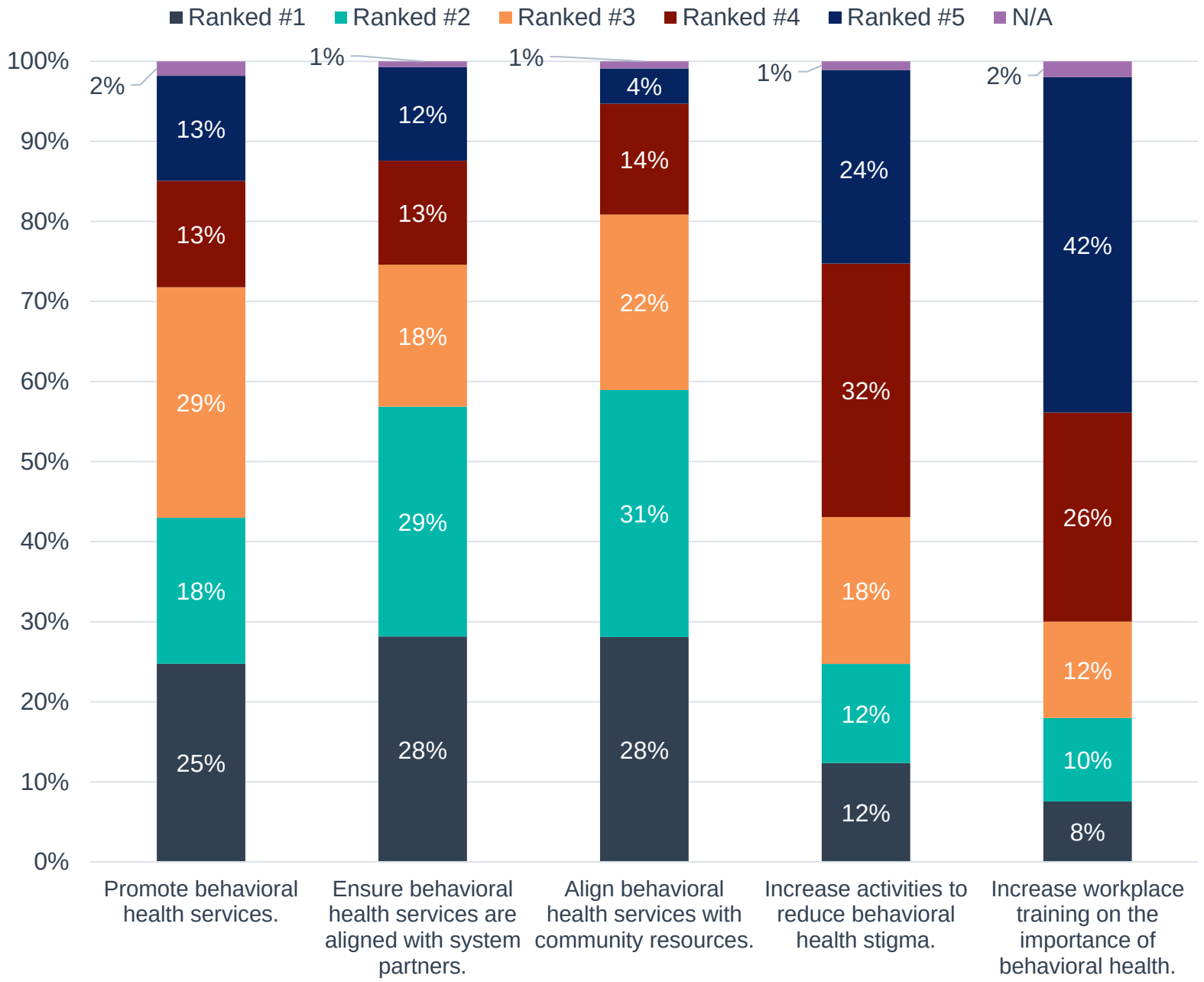
Enhance Statewide Behavioral Health Influence

Q13: Greatest Need Rankings

Answered: 557
Skipped: 181

Ranking Instruction:

Please rank...by putting "1" for the item you think is the greatest need, a "2" for the item you think is the second greatest need, and so on. Each ranking number may only be used once. Mark "N/A" for items that are not considered a need.



Enhance Statewide Behavioral Health Influence

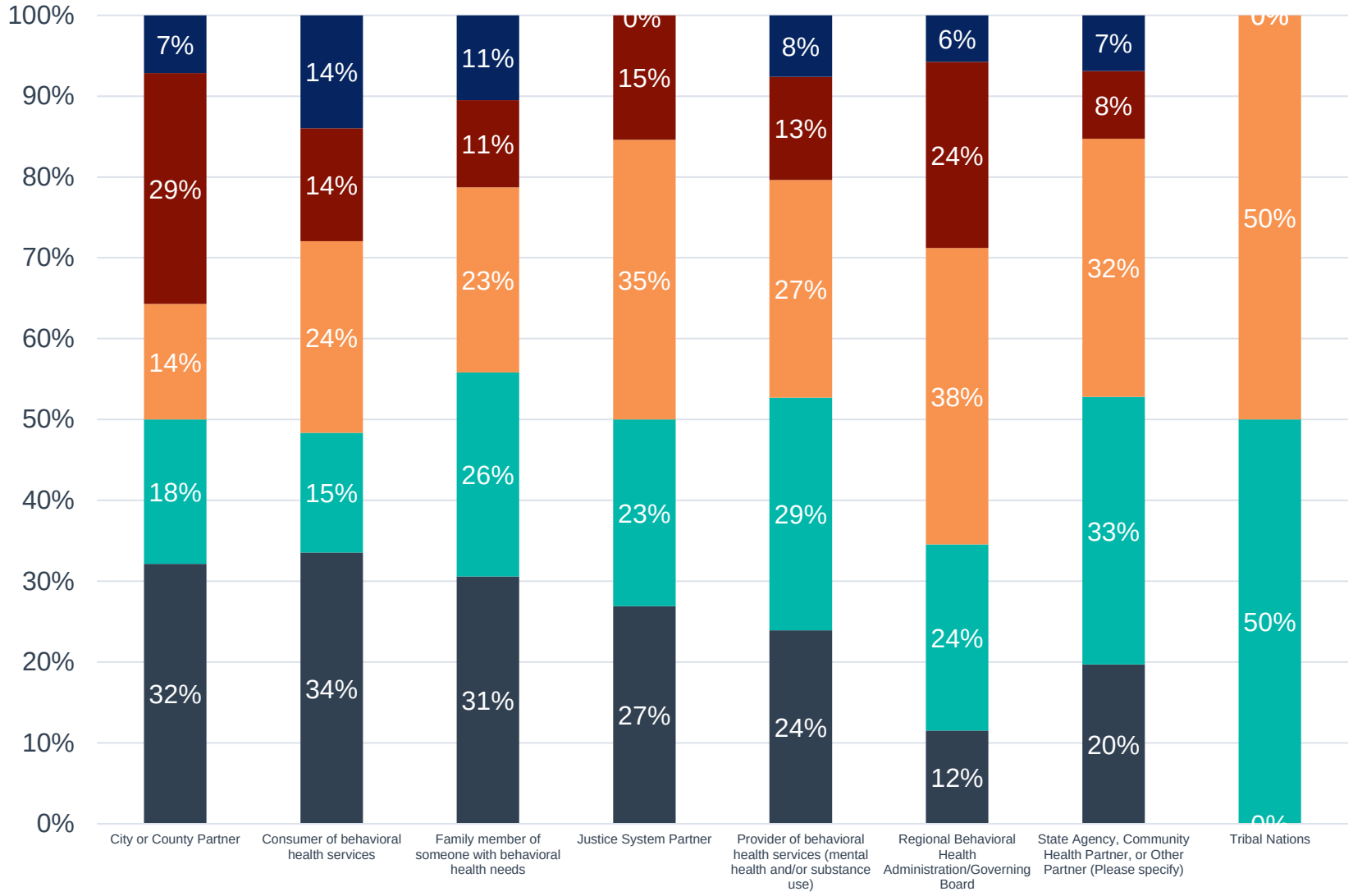
Q13: Greatest Needs Rankings

Answered: 557
Skipped: 181

Answer Choice	1		2		3		4		5		N/A	
Promote behavioral health services.	24.77%	136	18.21%	100	28.78%	158	13.30%	73	13.11%	72	1.82%	10
Ensure behavioral health services are aligned with system partners.	28.15%	154	28.70%	157	17.73%	97	12.98%	71	11.70%	64	0.73%	4
Align behavioral health services with community resources.	28.10%	154	30.84%	169	21.90%	120	13.87%	76	4.38%	24	0.91%	5
Increase activities to reduce behavioral health stigma.	12.36%	68	12.36%	68	18.36%	101	31.64%	174	24.18%	133	1.09%	6
Increase workplace training on the importance of behavioral health.	7.55%	42	10.43%	58	12.05%	67	26.08%	145	41.91%	233	1.98%	11

Enhance Statewide Behavioral Health Influence

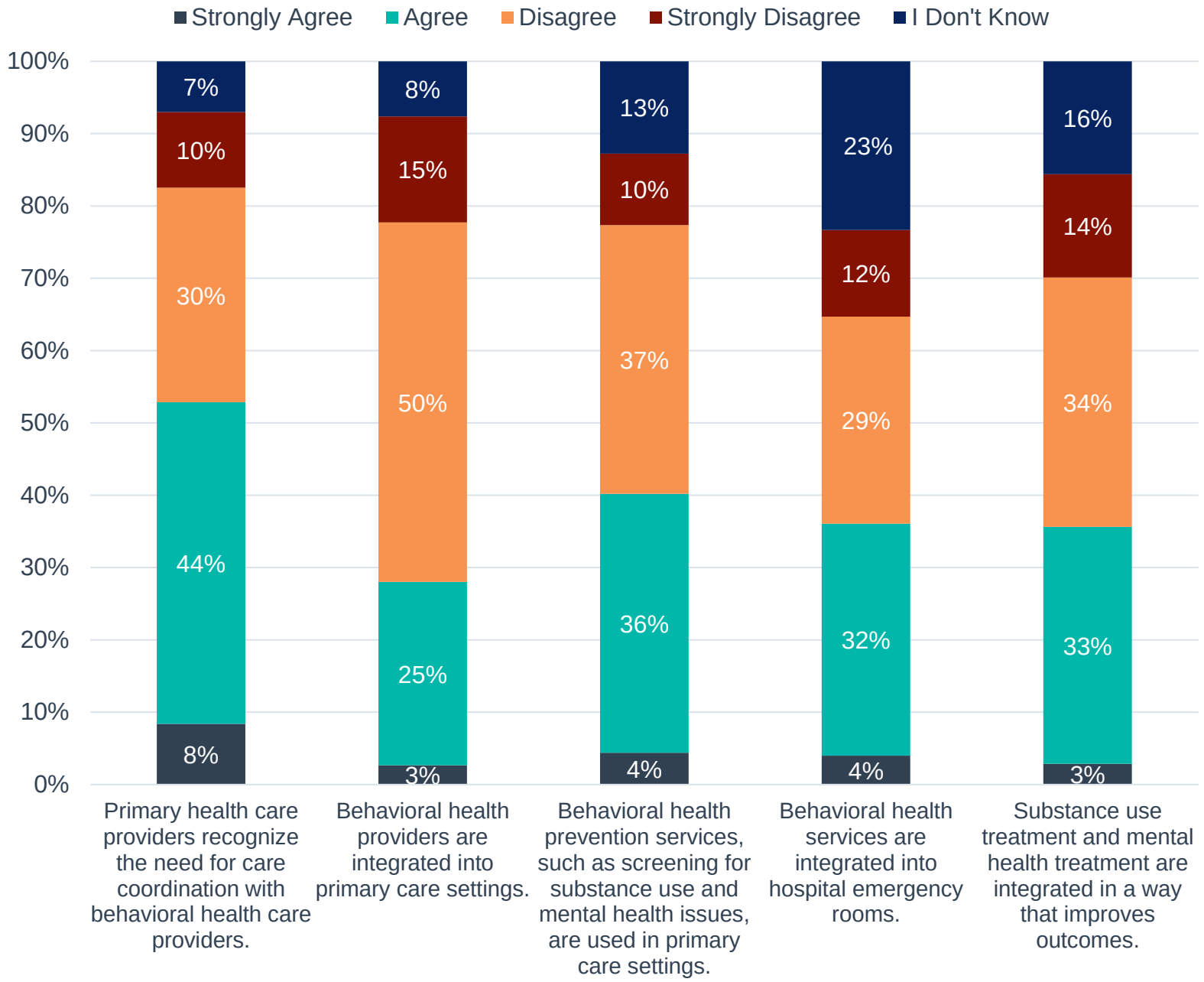
Q13 Greatest Needs Ranking By Group



Implement An Integration Strategy

Q15: Please identify how much you agree or disagree with the following statements:

Answered: 527
Skipped: 211



Implement An Integration Strategy

Q15: Please identify how much you agree or disagree with the following statements:

Answered: 527
Skipped: 211

Answer Choice	Strongly Agree		Agree		Disagree		Strongly Disagree		I Don't Know	
Primary health care providers recognize the need for care coordination with behavioral health care providers.	8.37%	44	44.49%	234	29.66%	156	10.46%	55	7.03%	37
Behavioral health providers are integrated into primary care settings.	2.67%	14	25.33%	133	49.71%	261	14.67%	77	7.62%	40
Behavioral health prevention services, such as screening for substance use and mental health issues, are used in primary care settings.	4.38%	23	35.81%	188	37.14%	195	9.90%	52	12.76%	67
Behavioral health services are integrated into hospital emergency rooms.	3.98%	21	32.07%	169	28.65%	151	11.95%	63	23.34%	123
Substance use treatment and mental health treatment are integrated in a way that improves outcomes.	2.86%	15	32.76%	172	34.48%	181	14.29%	75	15.62%	82

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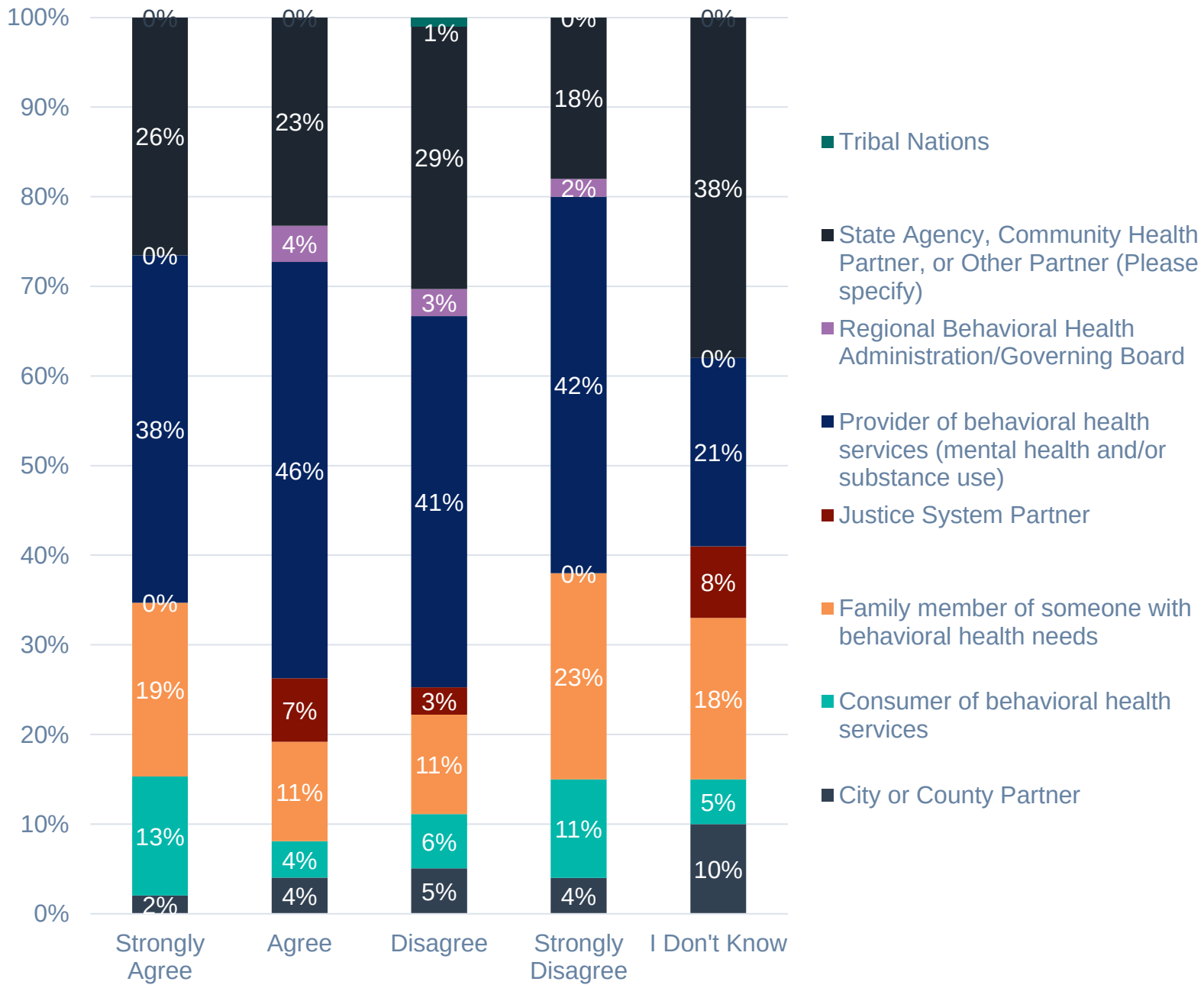
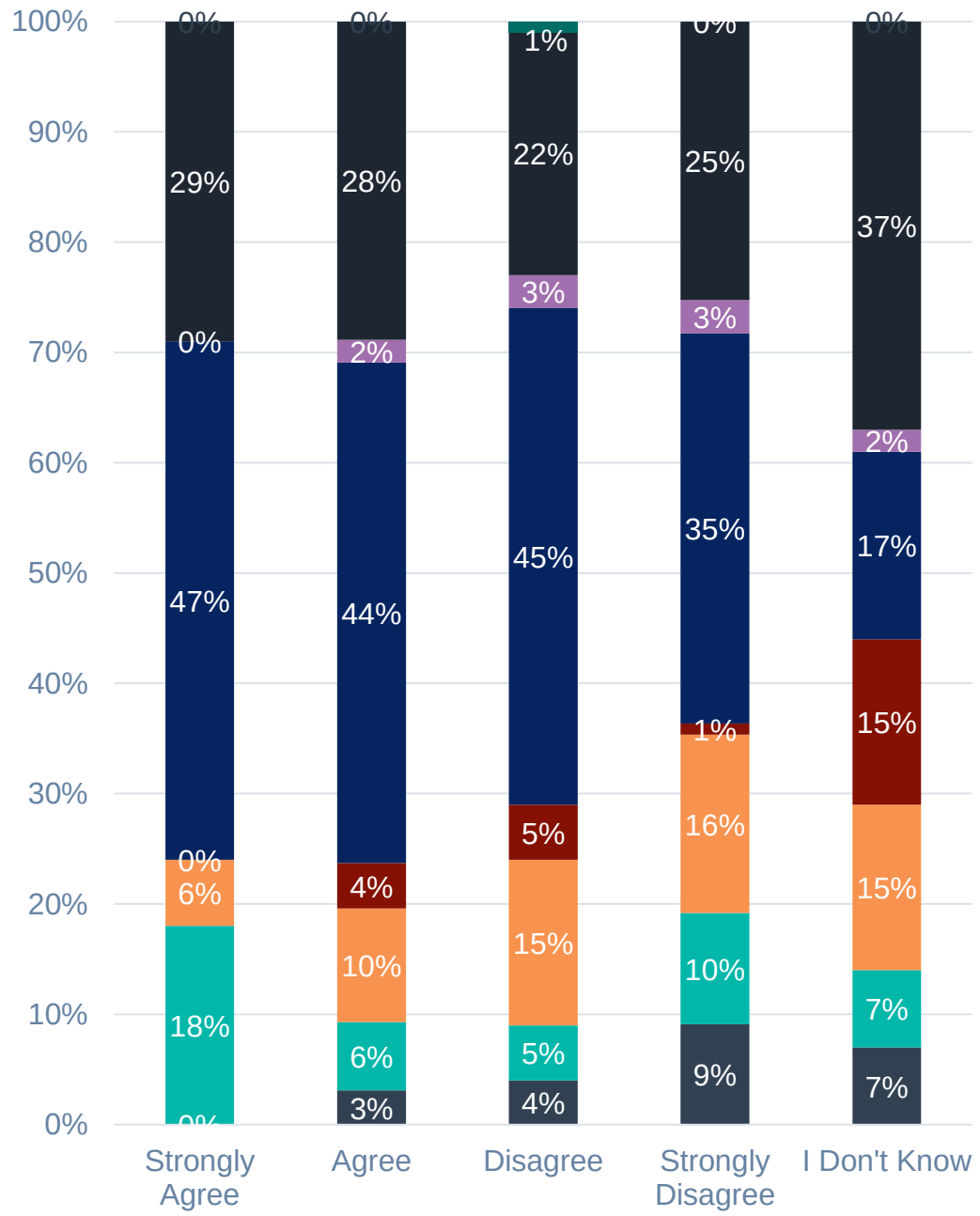
Implement An Integration Strategy

Q15 Statement Results By Group: Primary health care providers recognize the need for care coordination with behavioral health care providers



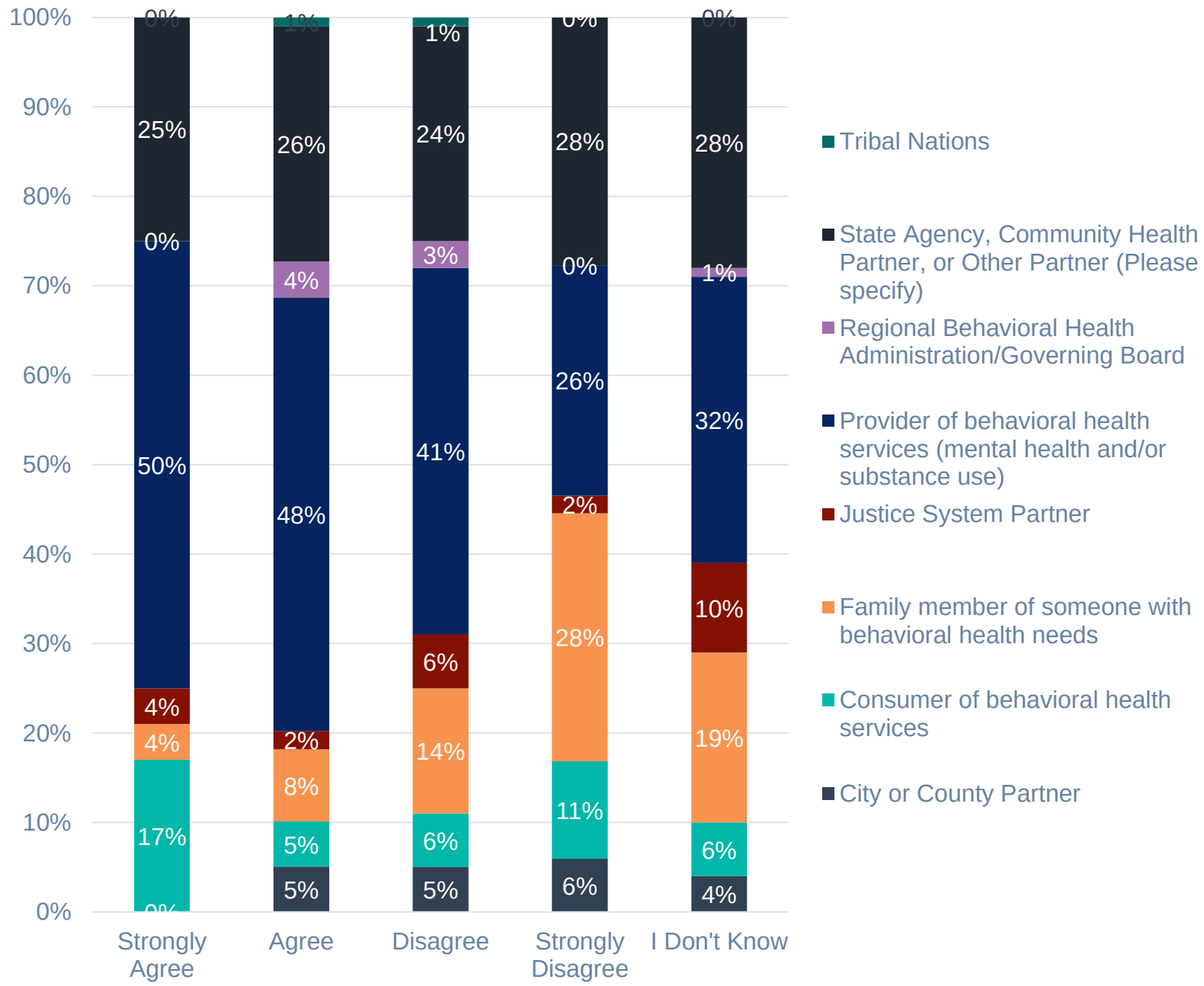
Implement An Integration Strategy

Q15 Statement Results By Group: Behavioral health providers are integrated into primary care settings.



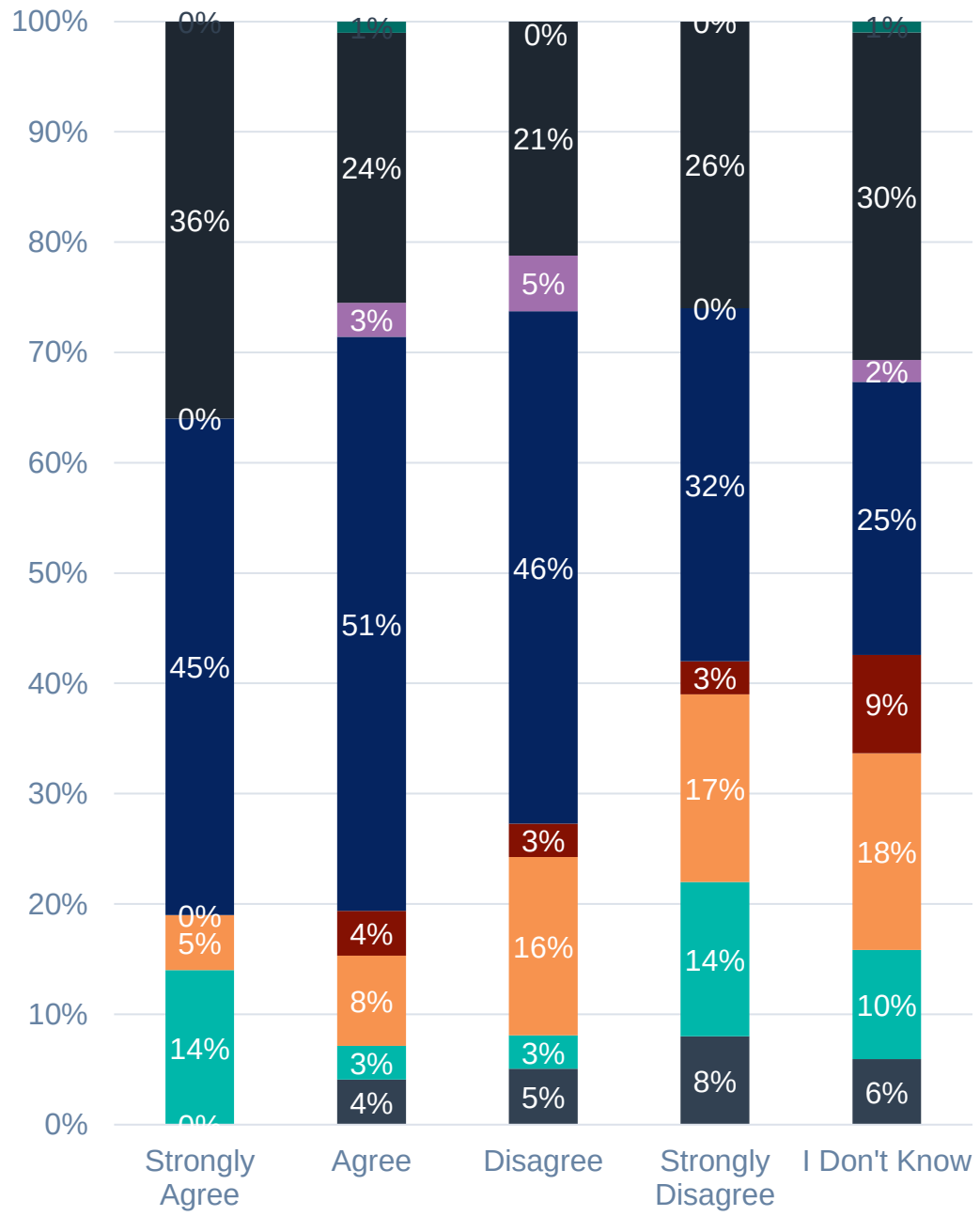
Implement An Integration Strategy

Q15 Statement Results By Group: Behavioral health prevention services, such as screening for substance use and mental health issues, are used in primary care settings.



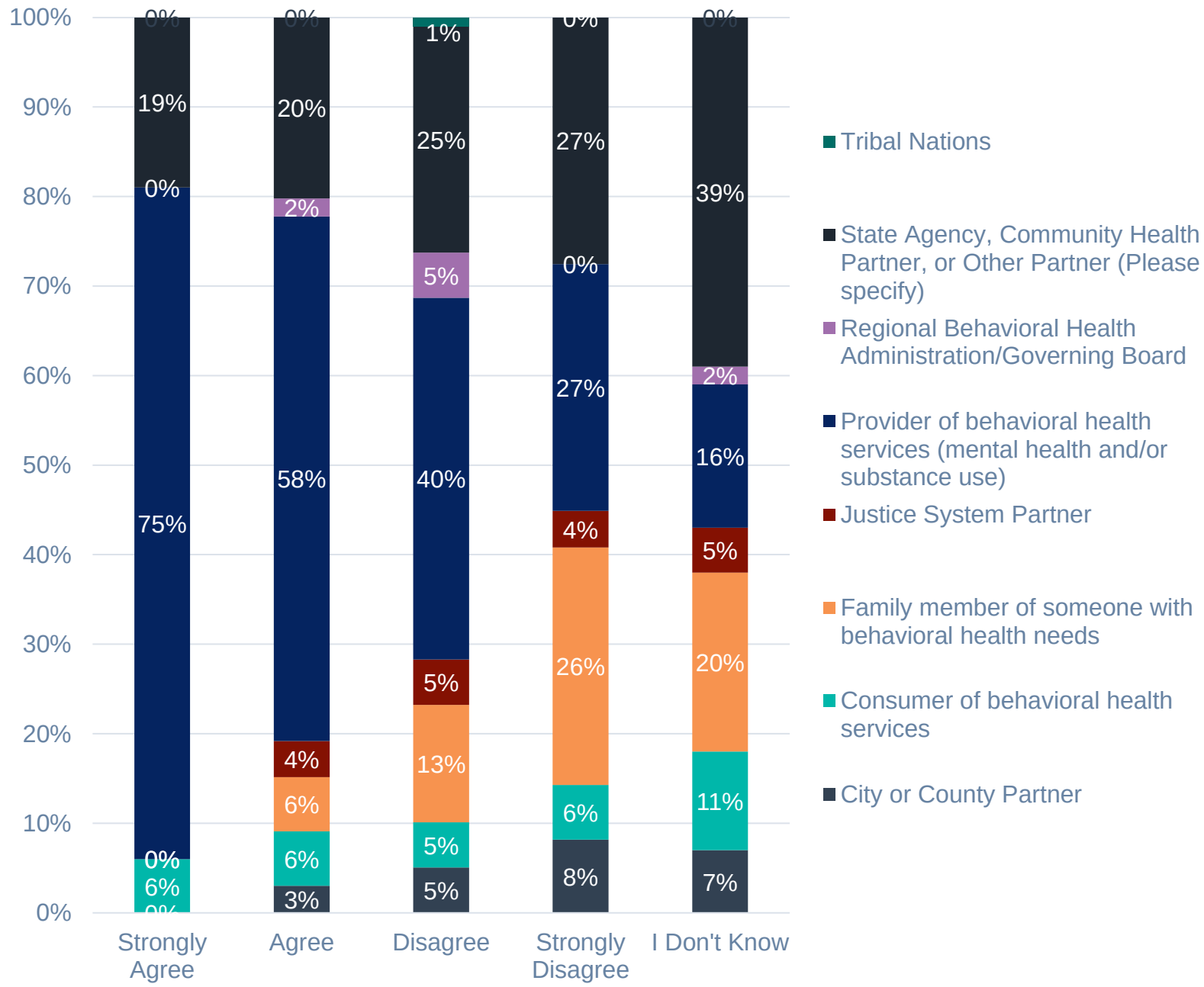
Implement An Integration Strategy

Q15 Statement Results By Group: Behavioral health services are integrated into hospital emergency rooms.



Implement An Integration Strategy

Q15 Statement Results By Group: Substance use treatment and mental health treatment are integrated in a way that improves outcomes.



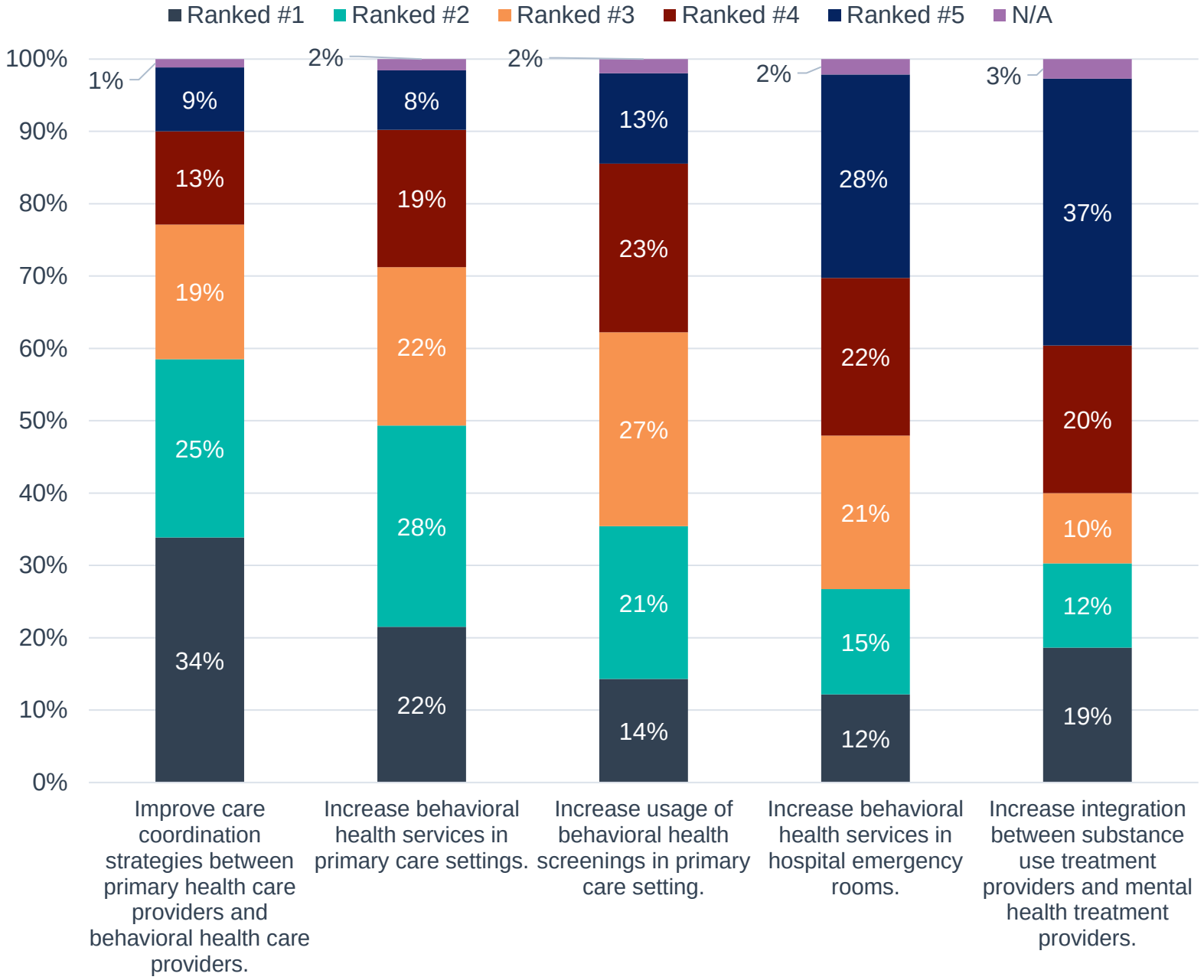
Implement An Integration Strategy

Q16: Greatest Need Rankings

Answered: 520
Skipped: 218

Ranking Instruction:

Please rank...by putting "1" for the item you think is the greatest need, a "2" for the item you think is the second greatest need, and so on. Each ranking number may only be used once. Mark "N/A" for items that are not considered a need.



Implement An Integration Strategy

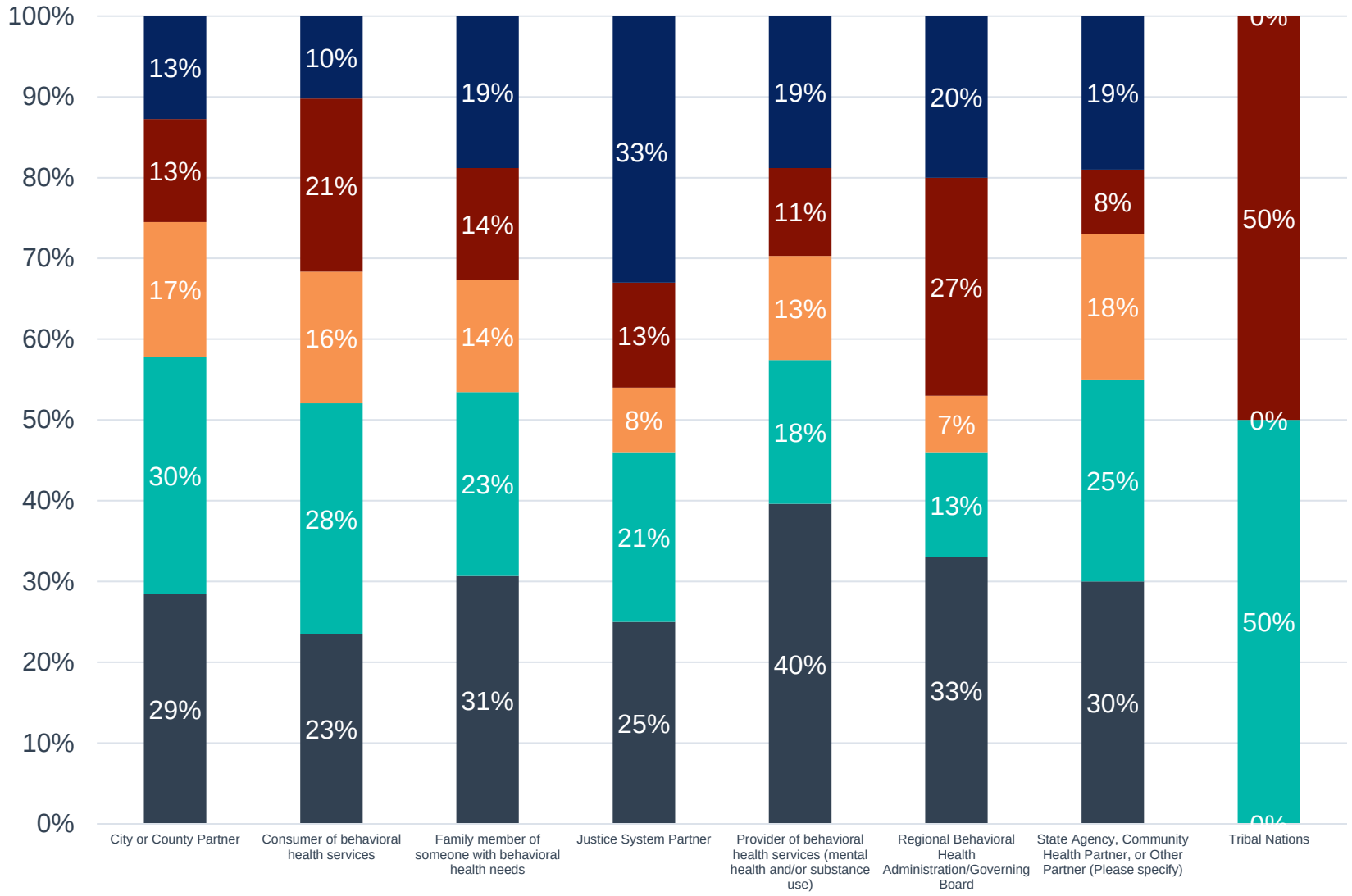
Q16: Greatest Needs Rankings

Answered: 520
Skipped: 218

Answer Choice	1		2		3		4		5		N/A	
Improve care coordination strategies between primary health care providers and behavioral health care providers.	33.86%	173	24.66%	126	18.59%	95	12.92%	66	8.81%	45	1.17%	6
Increase behavioral health services in primary care settings.	21.53%	110	27.79%	142	21.92%	112	18.98%	97	8.22%	42	1.57%	8
Increase usage of behavioral health screenings in primary care setting.	14.29%	73	21.14%	108	26.81%	137	23.29%	119	12.52%	64	1.96%	10
Increase behavioral health services in hospital emergency rooms.	12.18%	62	14.54%	74	21.22%	108	21.81%	111	28.09%	143	2.16%	11
Increase integration between substance use treatment providers and mental health treatment providers.	18.64%	96	11.65%	60	9.71%	50	20.39%	105	36.89%	190	2.72%	14

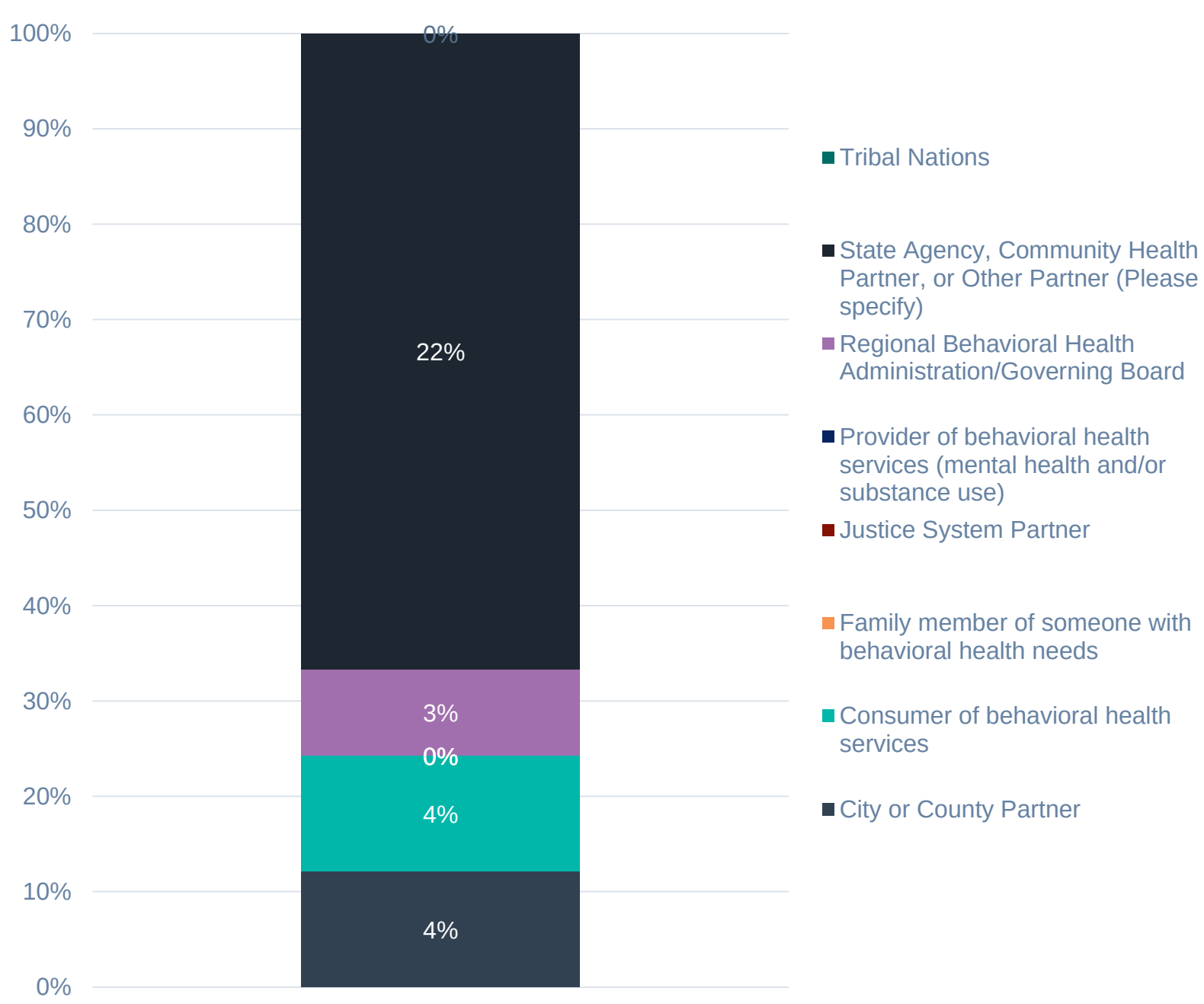
Enhance Statewide Behavioral Health Influence

Q16 Greatest Needs Ranking By Group



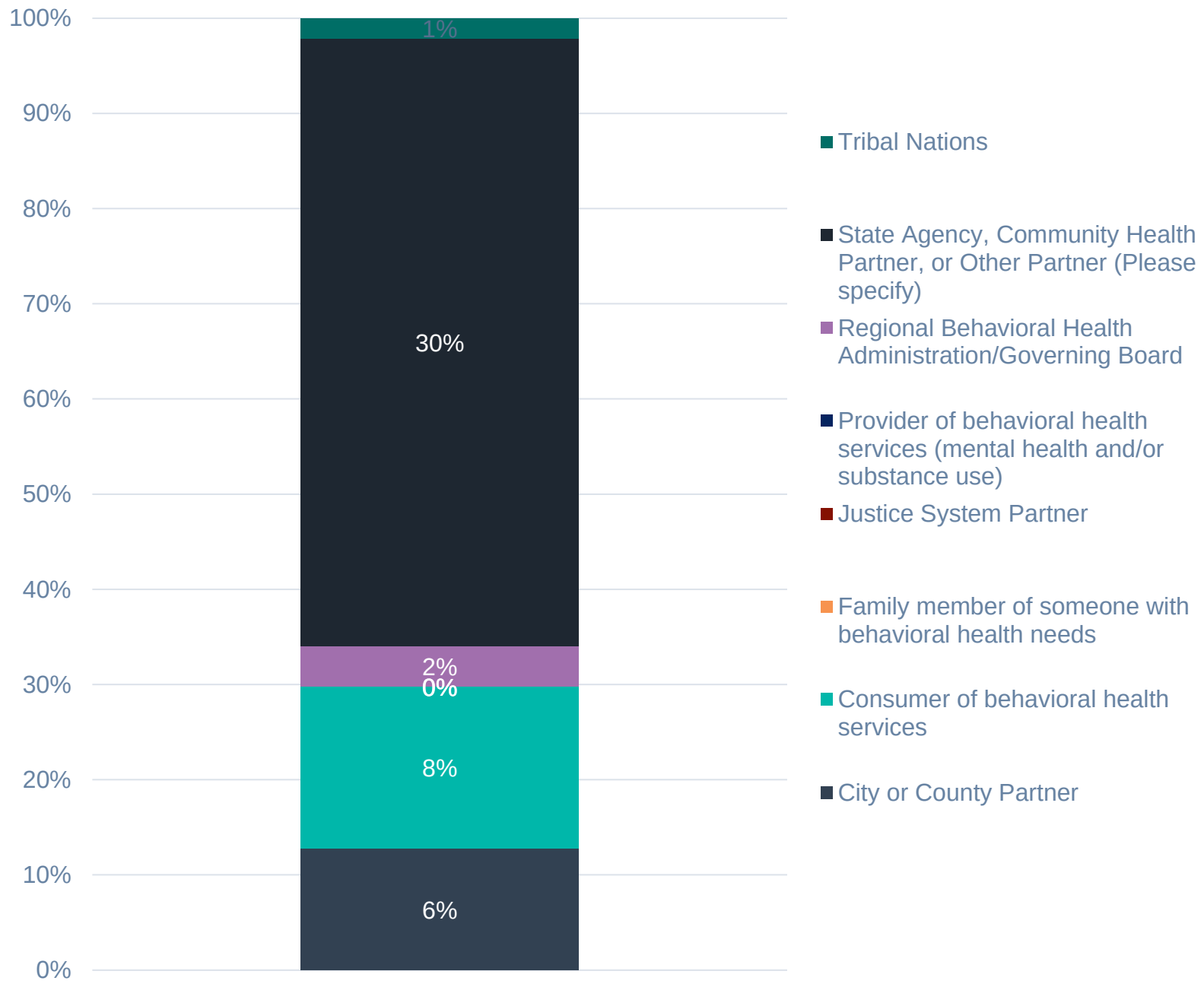
Implement An Integration Strategy

Q16 Greatest Needs #1 Rank By Group: Improve care coordination strategies between primary health care providers and behavioral health care providers.



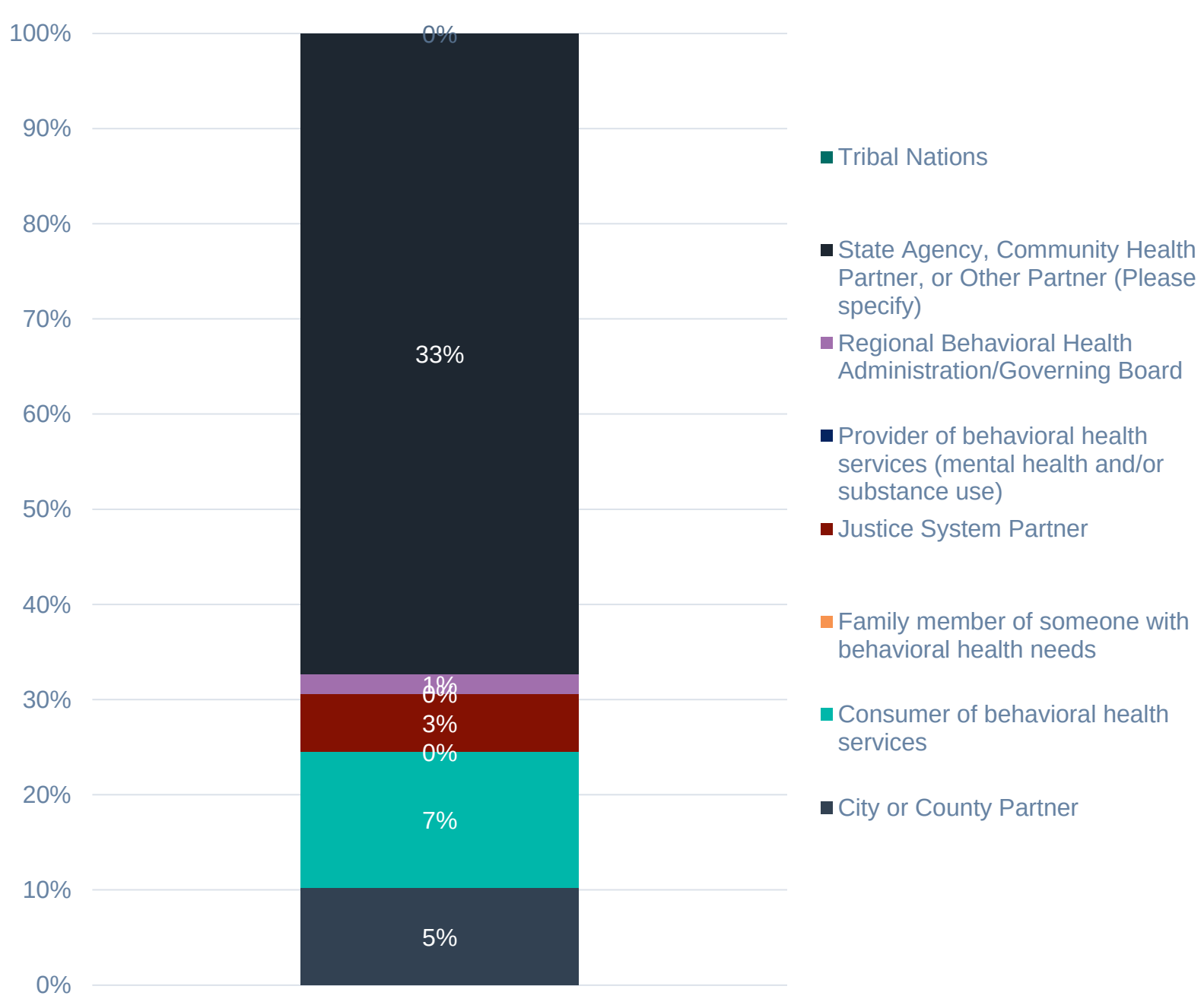
Implement An Integration Strategy

Q16 Greatest Needs #1 Rank By Group: Increase behavioral health services in primary care settings.



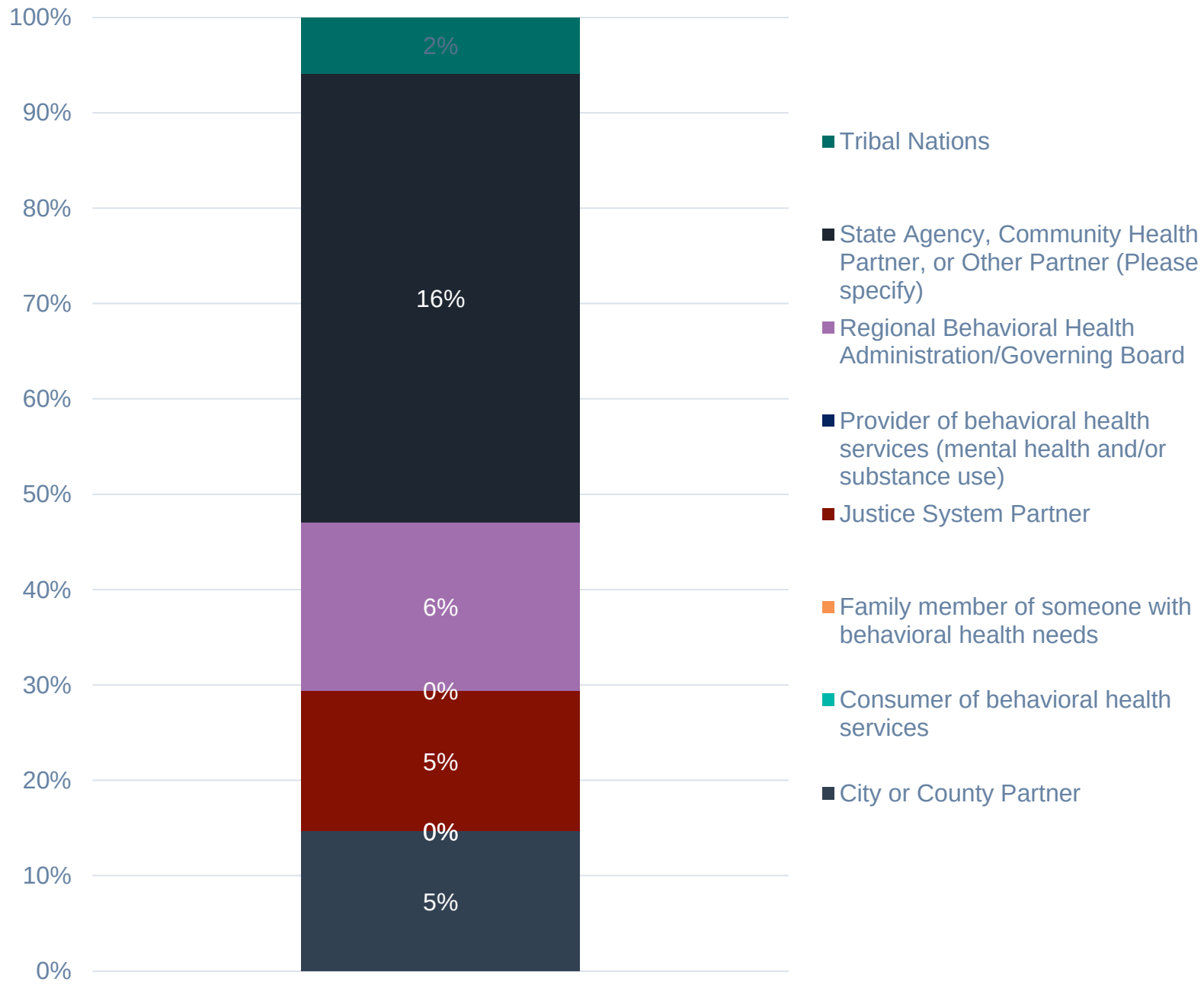
Implement An Integration Strategy

Q16 Greatest Needs #1 Rank By Group: Increase usage of behavioral health screenings in primary care setting.



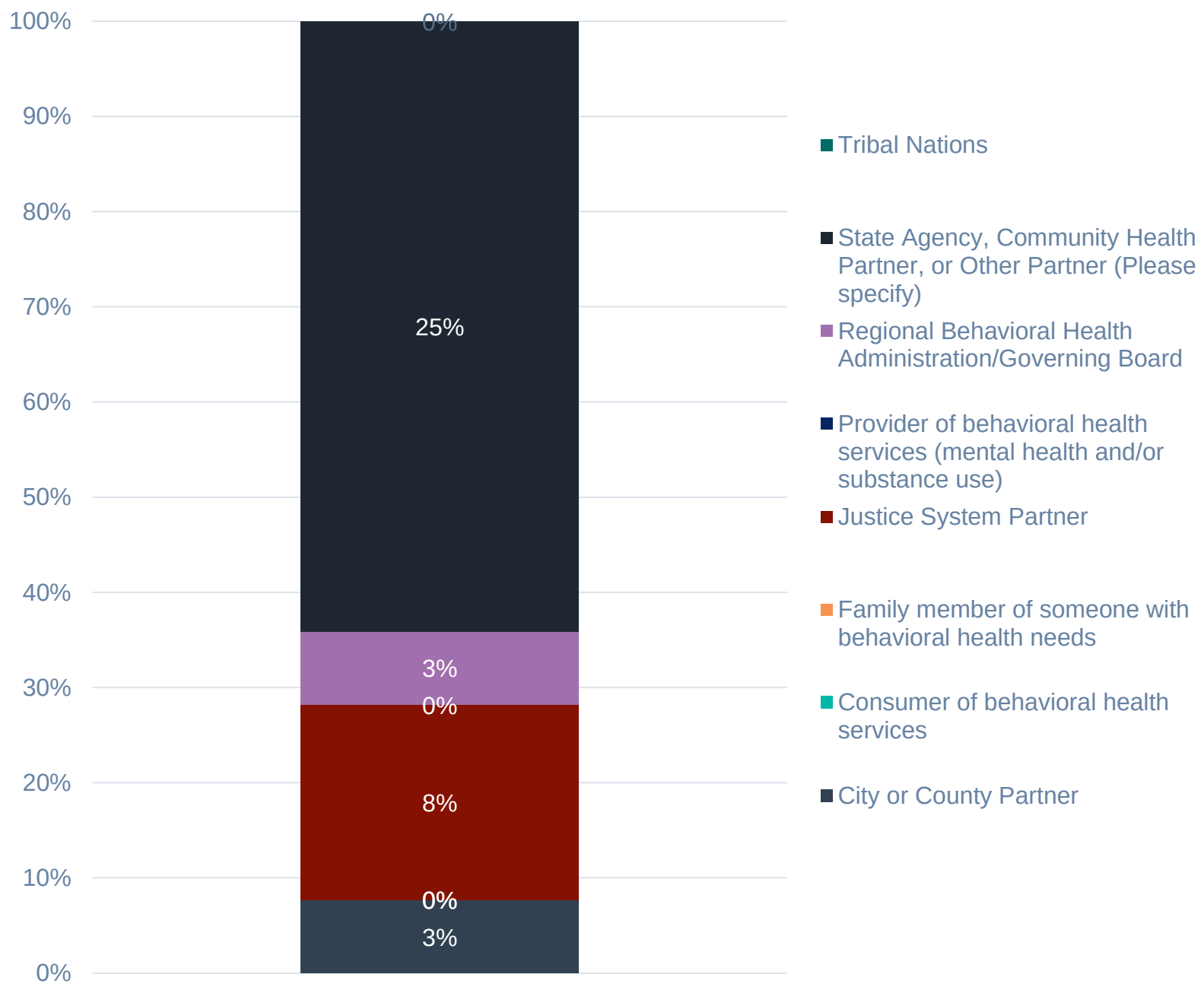
Implement An Integration Strategy

Q16 Greatest Needs #1 Rank By Group: Increase behavioral health services in hospital emergency rooms.



Implement An Integration Strategy

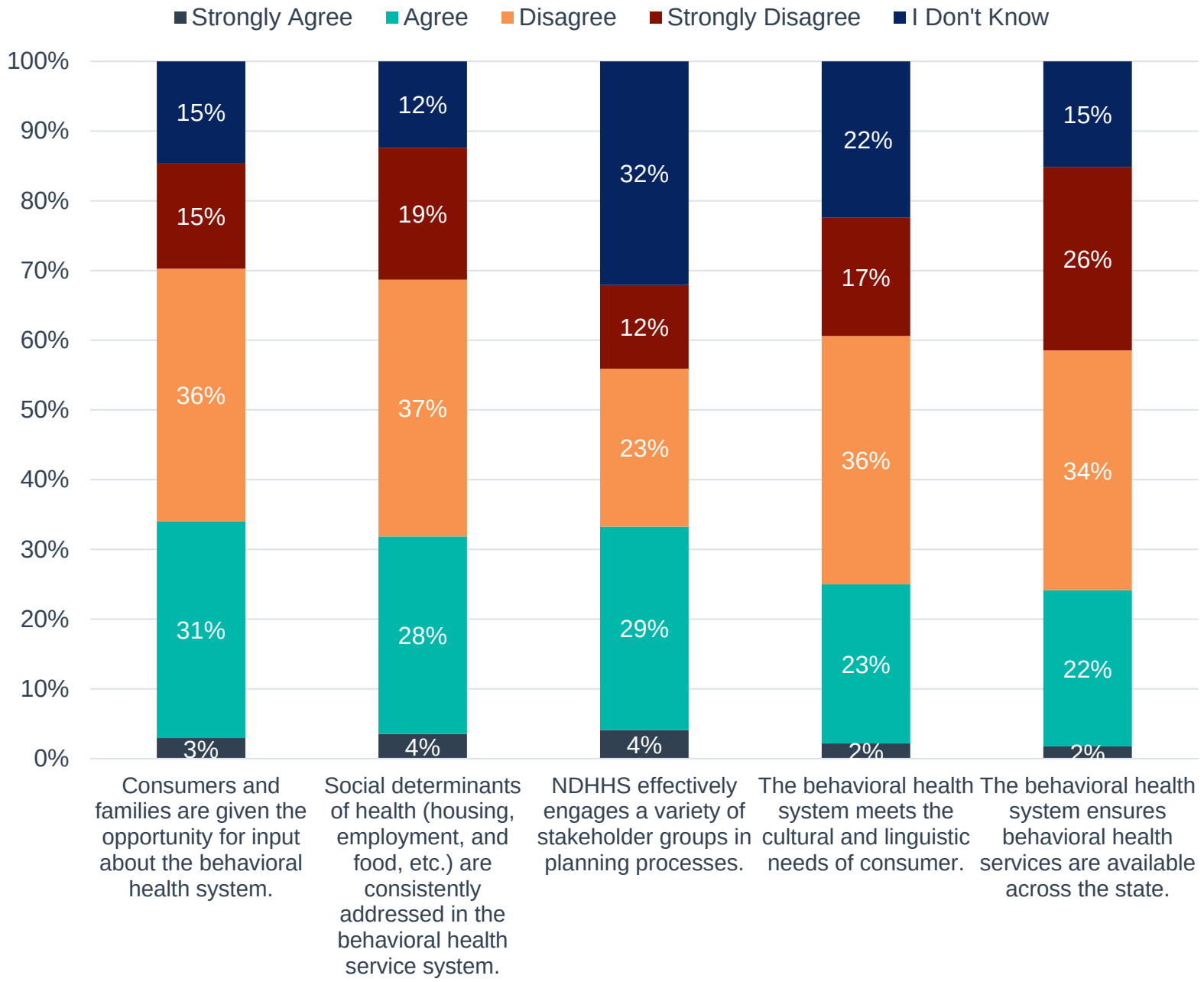
Q16 Greatest Needs #1 Rank By Group: Increase integration between substance use treatment providers and mental health treatment providers.



Promote Inclusion

Q18: Please identify how much you agree or disagree with the following statements:

Answered: 508
Skipped: 230



Promote Inclusion

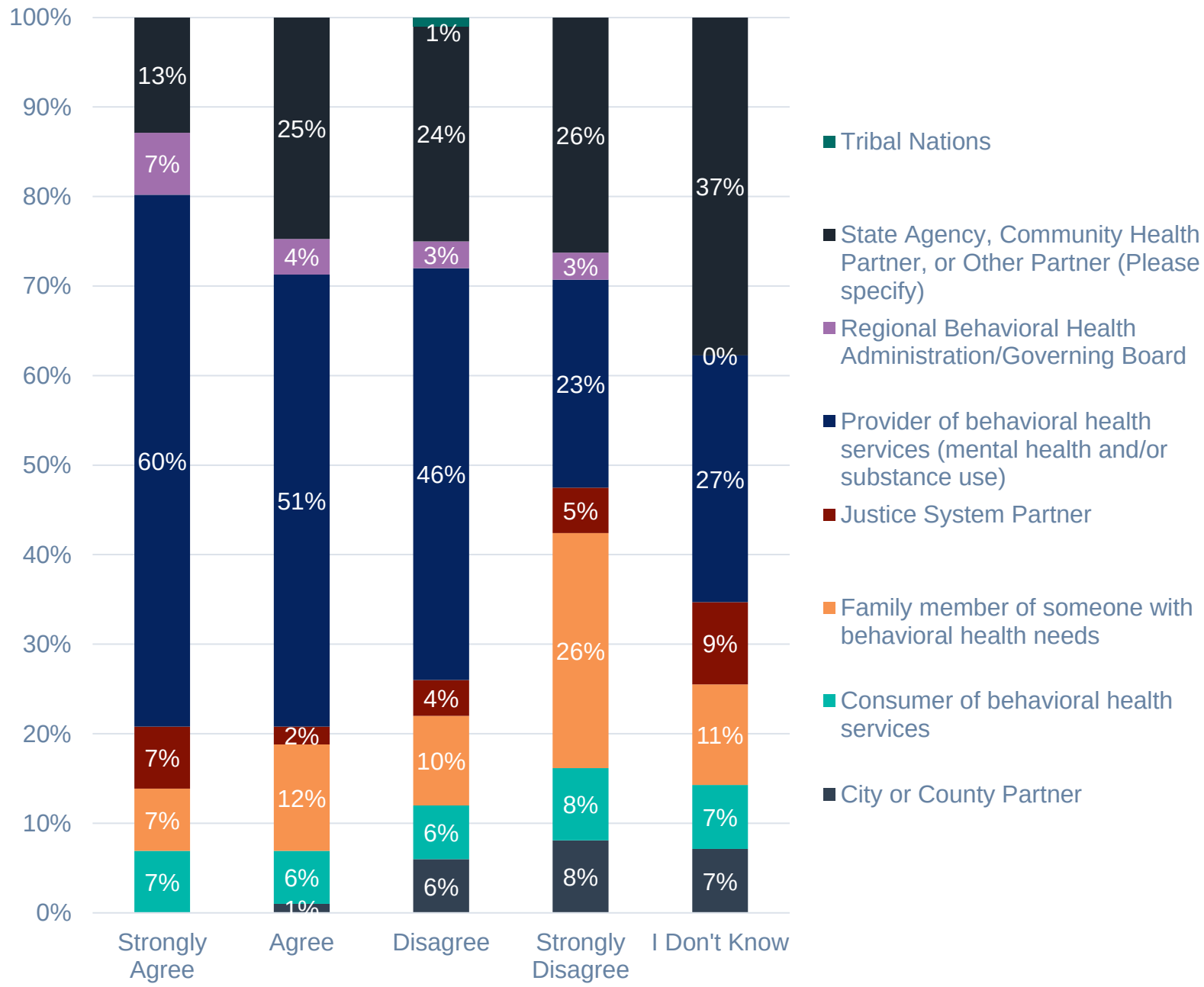
Q18: Please identify how much you agree or disagree with the following statements:

Answered: 508
Skipped: 230

Answer Choice	Strongly Agree		Agree		Disagree		Strongly Disagree		I Don't Know	
Consumers and families are given the opportunity for input about the behavioral health system.	2.95%	15	31.10%	158	36.22%	184	15.16%	77	14.57%	74
Social determinants of health (housing, employment, and food, etc.) are consistently addressed in the behavioral health service system.	3.54%	18	28.35%	144	36.81%	187	18.90%	96	12.40%	63
NDHHS effectively engages a variety of stakeholder groups in planning processes.	4.13%	21	29.13%	148	22.64%	115	12.01%	61	32.09%	163
The behavioral health system meets the cultural and linguistic needs of consumer.	2.17%	11	22.83%	116	35.63%	181	16.93%	86	22.44%	114
The behavioral health system ensures behavioral health services are available across the state.	1.77%	9	22.40%	114	34.38%	175	26.33%	134	15.13%	77

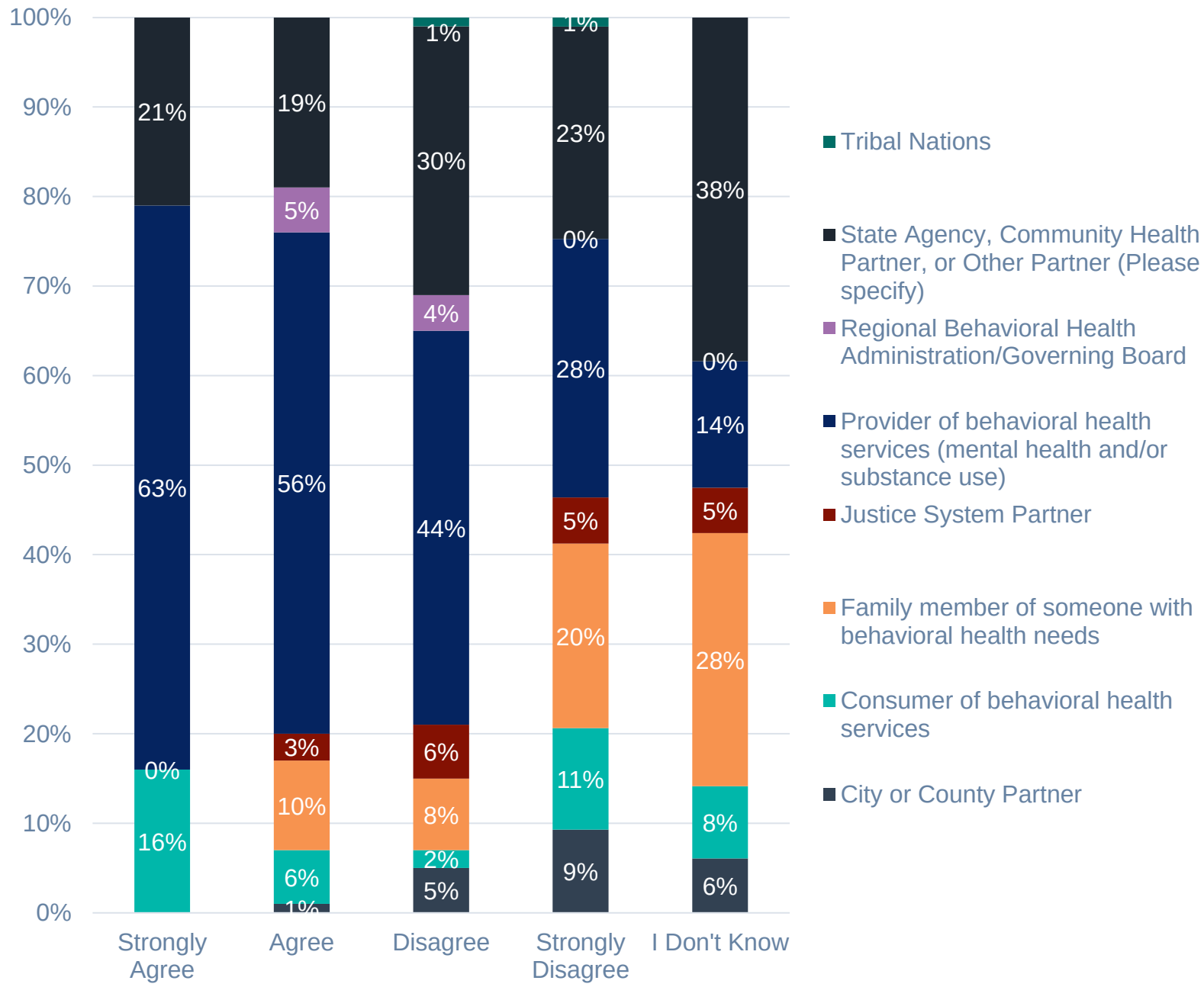
Promote Inclusion

Q18 Statement Results By Group: Consumers and families are given the opportunity for input about the behavioral health system.



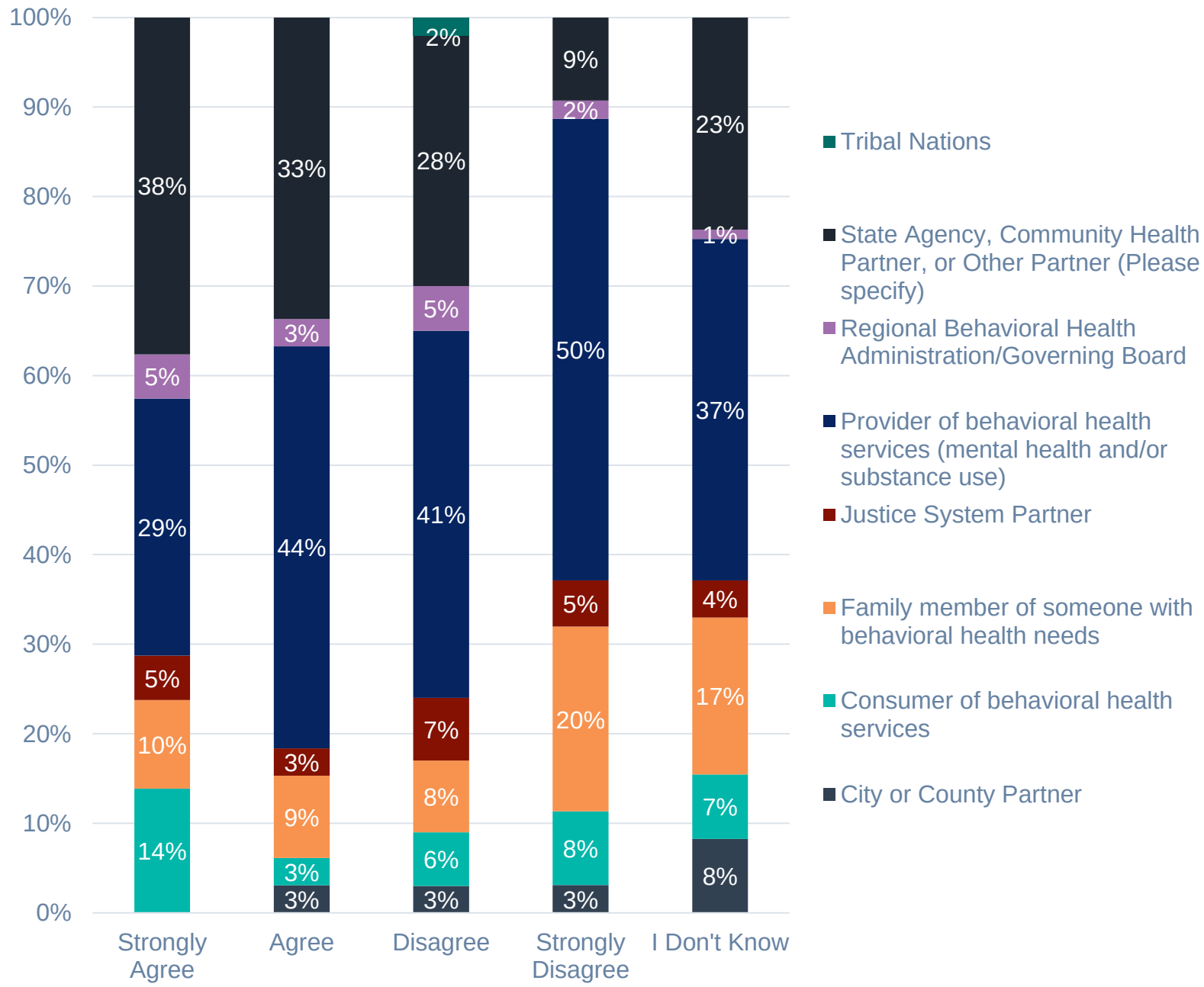
Promote Inclusion

Q18 Statement Results By Group: Social determinants of health (housing, employment, and food, etc.) are consistently addressed in the behavioral health service system.



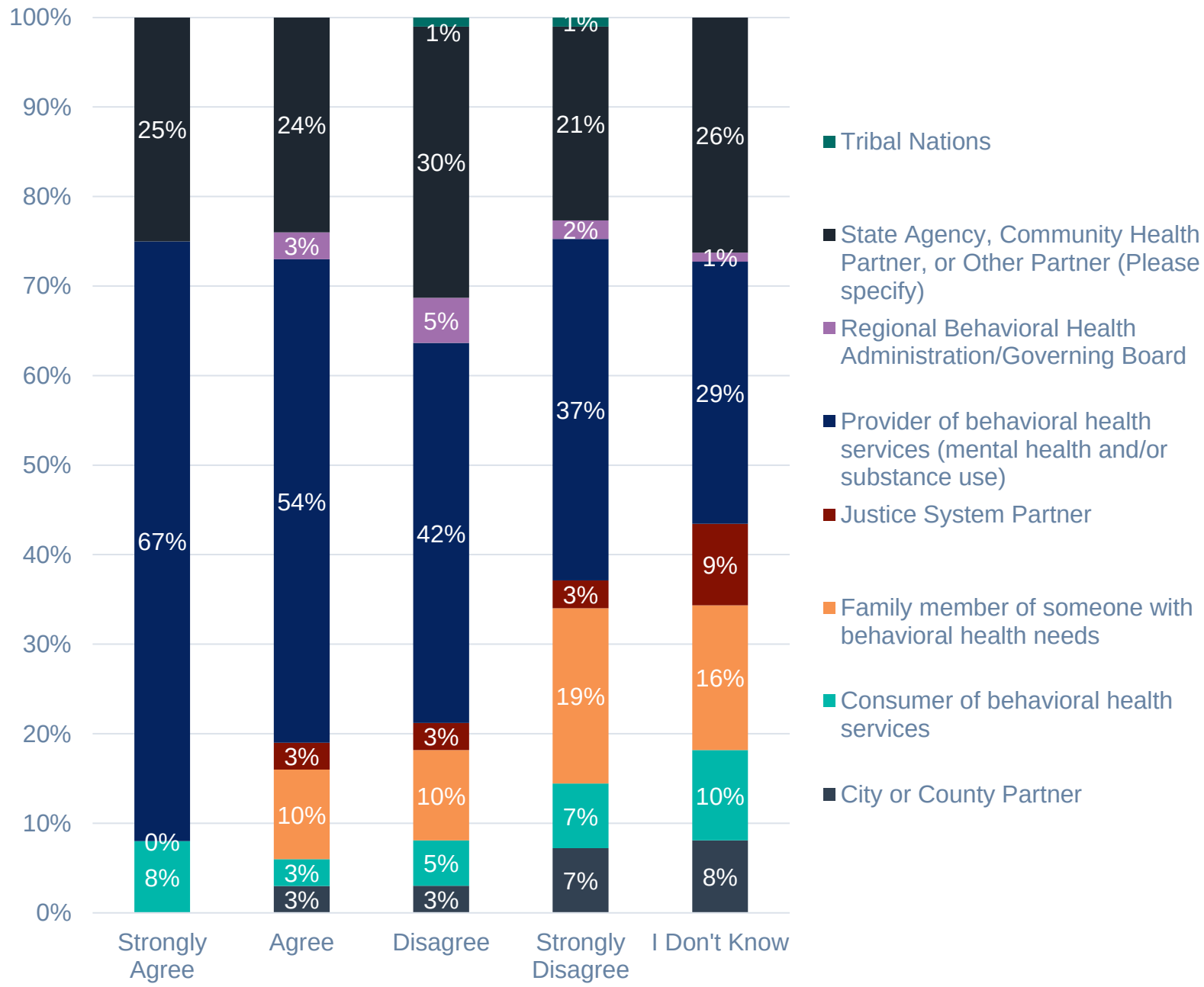
Promote Inclusion

Q18 Statement Results By Group: NDHHS effectively engages a variety of stakeholder groups in planning processes.



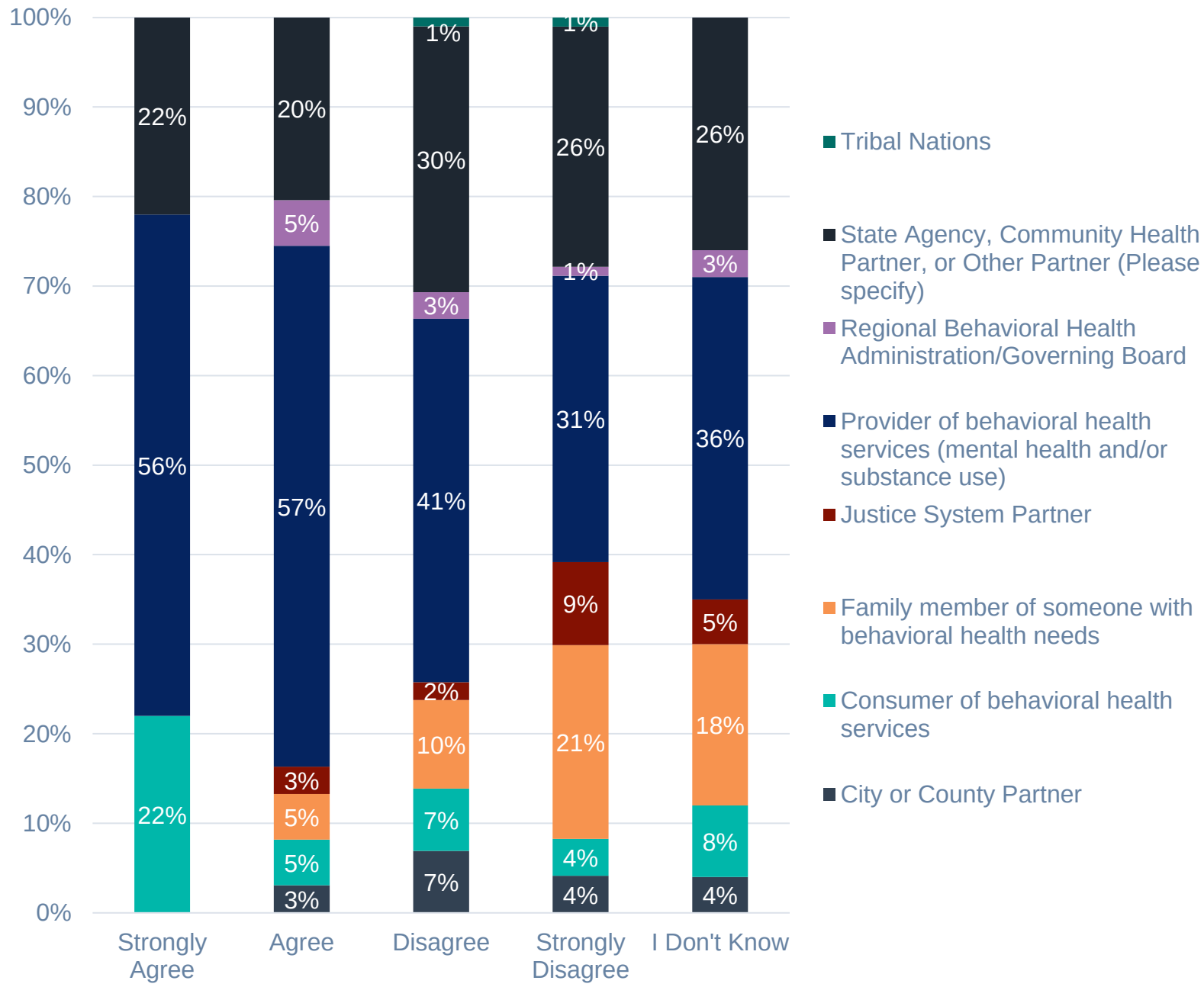
Promote Inclusion

Q18 Statement Results By Group: The behavioral health system meets the cultural and linguistic needs of consumer.



Promote Inclusion

Q18 Statement Results By Group: The behavioral health system ensures behavioral health services are available across the state.



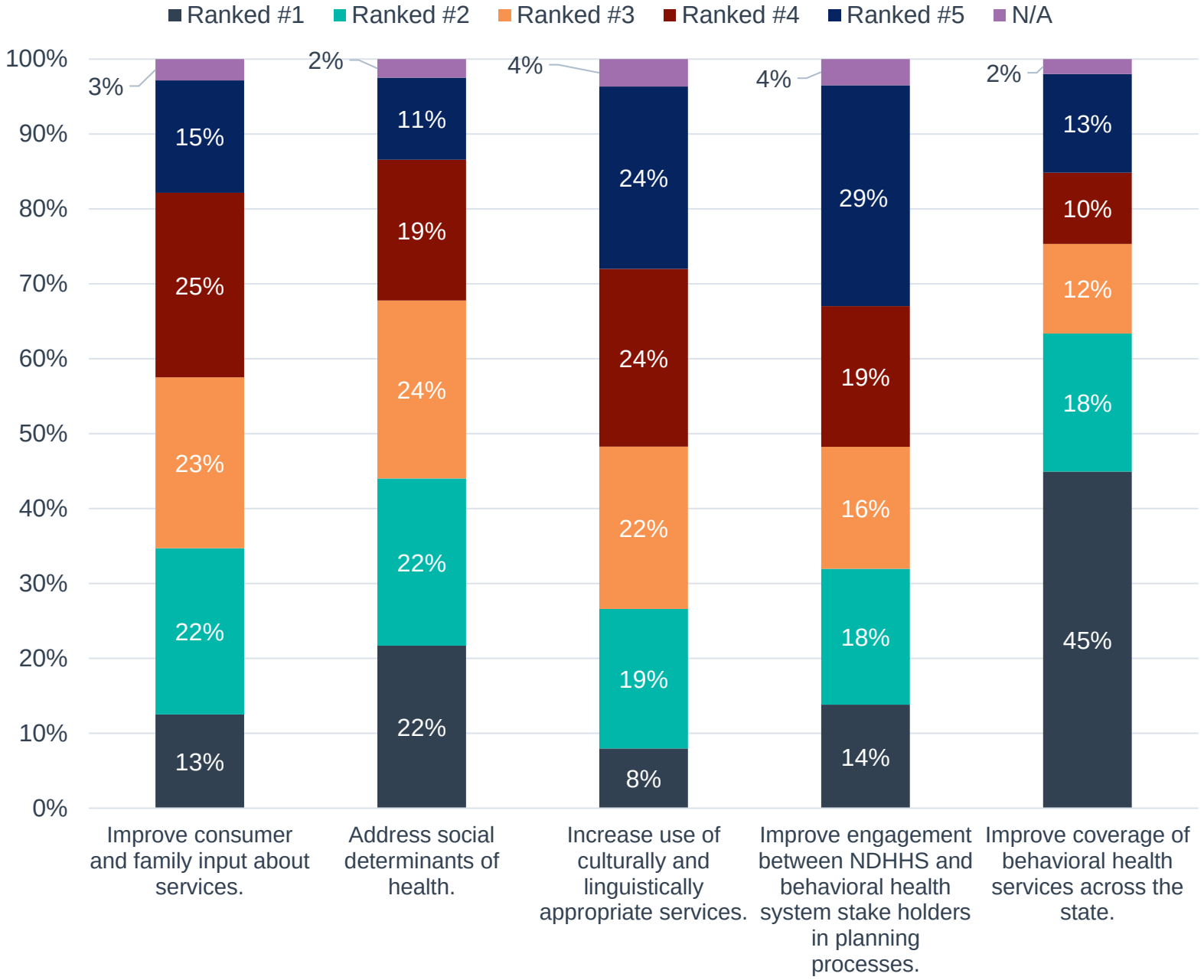
Promote Inclusion

Q19: Greatest Need Rankings

Answered: 520
Skipped: 218

Ranking Instruction:

Please rank...by putting "1" for the item you think is the greatest need, a "2" for the item you think is the second greatest need, and so on. Each ranking number may only be used once. Mark "N/A" for items that are not considered a need.



Promote Inclusion

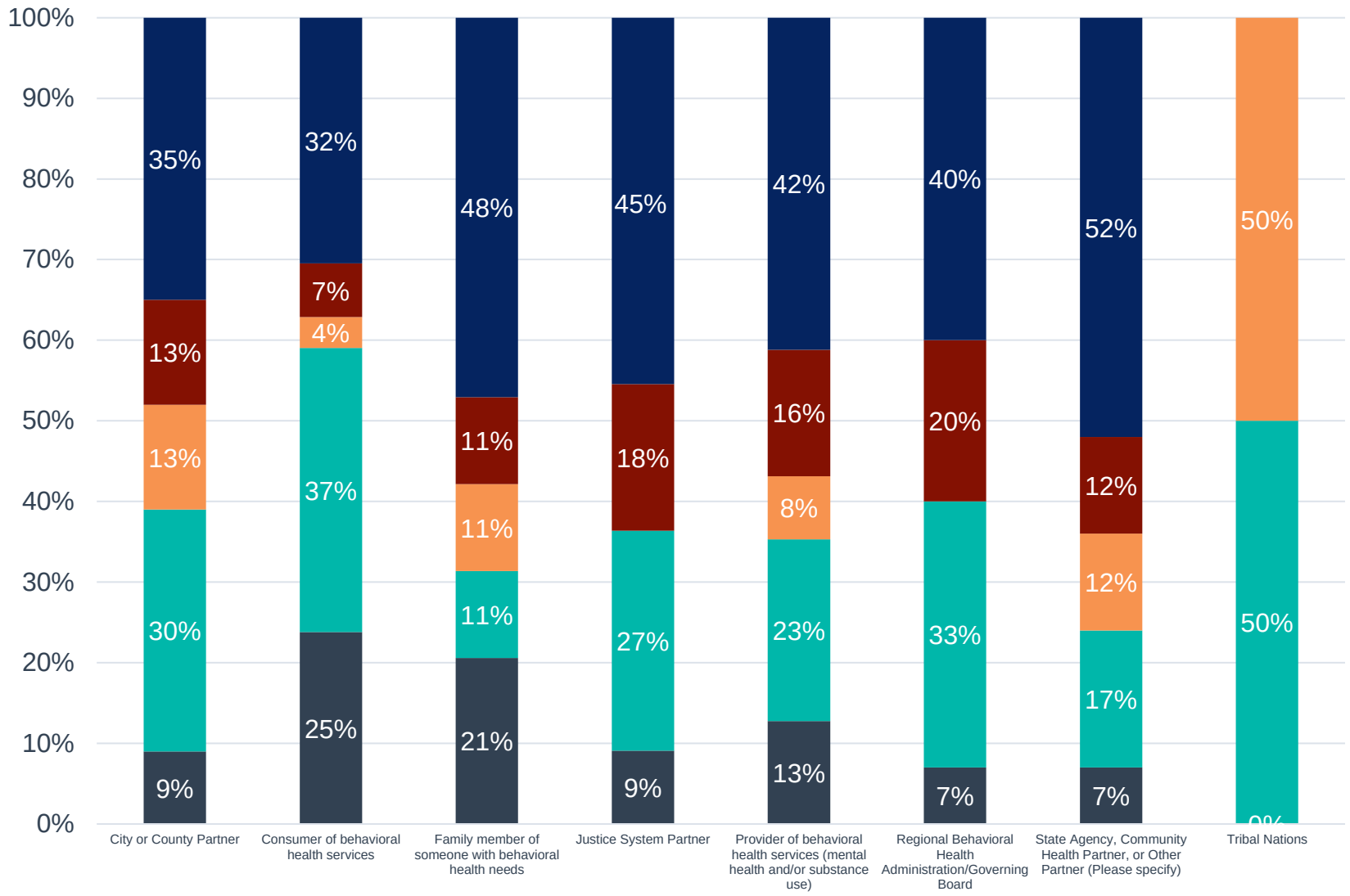
Q19: Greatest Needs Rankings

Answered: 520
Skipped: 218

Answer Choice	1		2		3		4		5		N/A	
Improve consumer and family input about services.	12.53%	61	22.18%	108	22.79%	111	24.64%	120	14.99%	73	2.87%	14
Address social determinants of health.	21.69%	105	22.31%	108	23.76%	115	18.80%	91	10.95%	53	2.48%	12
Increase use of culturally and linguistically appropriate services.	7.98%	39	18.61%	91	21.68%	106	23.72%	116	24.34%	119	3.68%	18
Improve engagement between NDHHS and behavioral health system stake holders in planning processes.	13.81%	67	18.14%	88	16.29%	79	18.76%	91	29.48%	143	3.51%	17
Improve coverage of behavioral health services across the state.	44.94%	222	18.42%	91	11.94%	59	9.51%	47	13.16%	65	2.02%	10

Promote Inclusion

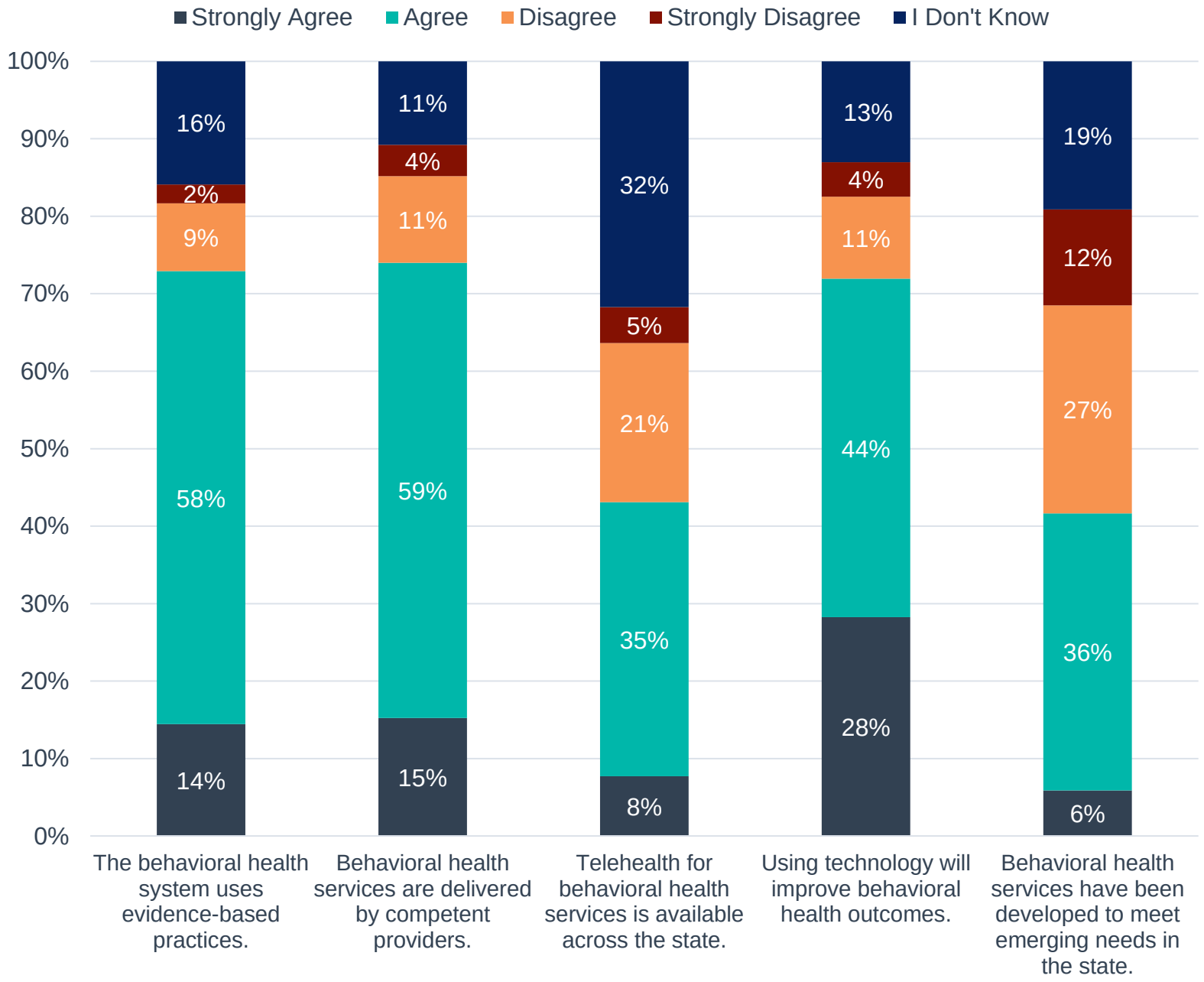
Q19 Greatest Needs Ranking By Group



Drive Innovation & Improve Outcomes

Q21: Please identify how much you agree or disagree with the following statements:

Answered: 492
Skipped: 246



Drive Innovation & Improve Outcomes

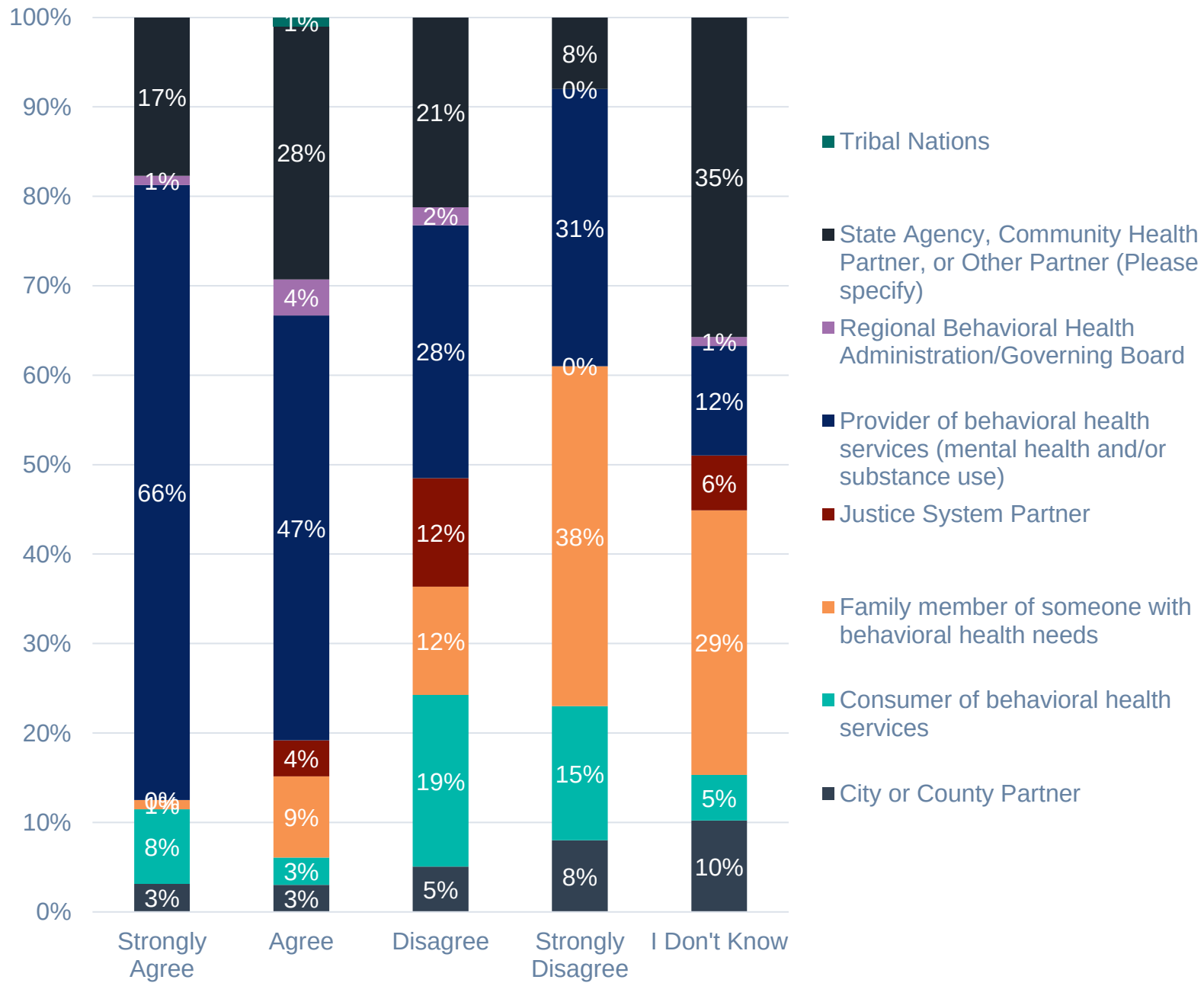
Q21: Please identify how much you agree or disagree with the following statements:

Answered: 492
Skipped: 246

Answer Choice	Strongly Agree		Agree		Disagree		Strongly Disagree		I Don't Know	
The behavioral health system uses evidence-based practices.	14.46%	71	58.45%	287	8.76%	43	2.44%	12	15.89%	78
Behavioral health services are delivered by competent providers.	15.24%	75	58.74%	289	11.18%	55	4.07%	20	10.77%	53
Telehealth for behavioral health services is available across the state.	7.72%	38	35.37%	174	20.53%	101	4.67%	23	31.71%	156
Using technology will improve behavioral health outcomes.	28.25%	139	43.70%	215	10.57%	52	4.47%	22	13.01%	64
Behavioral health services have been developed to meet emerging needs in the state.	5.89%	29	35.77%	176	26.83%	132	12.40%	61	19.11%	94

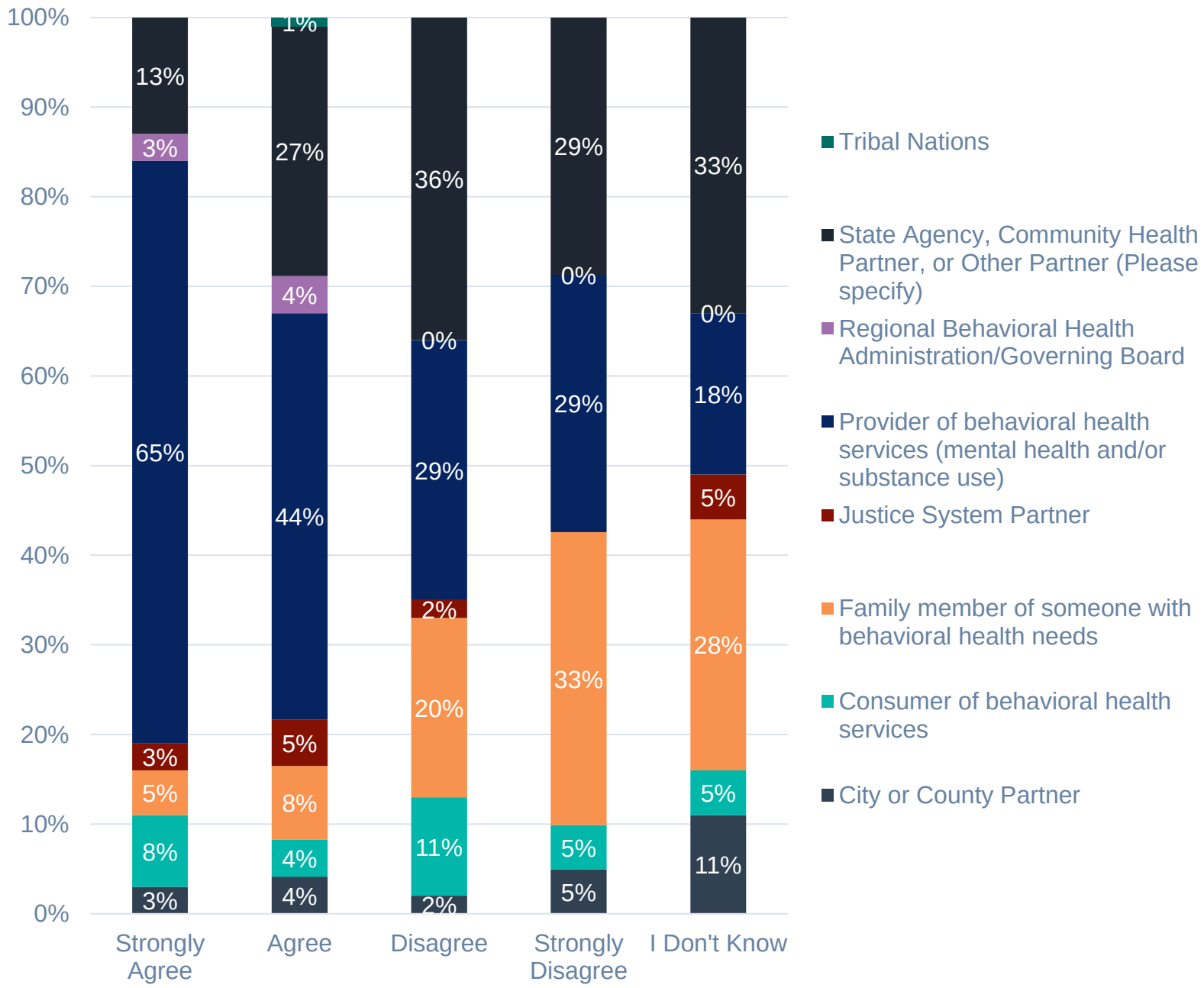
Drive Innovation & Improve Outcomes

Q21 Statement Results By Group: The behavioral health system uses evidence-based practices.



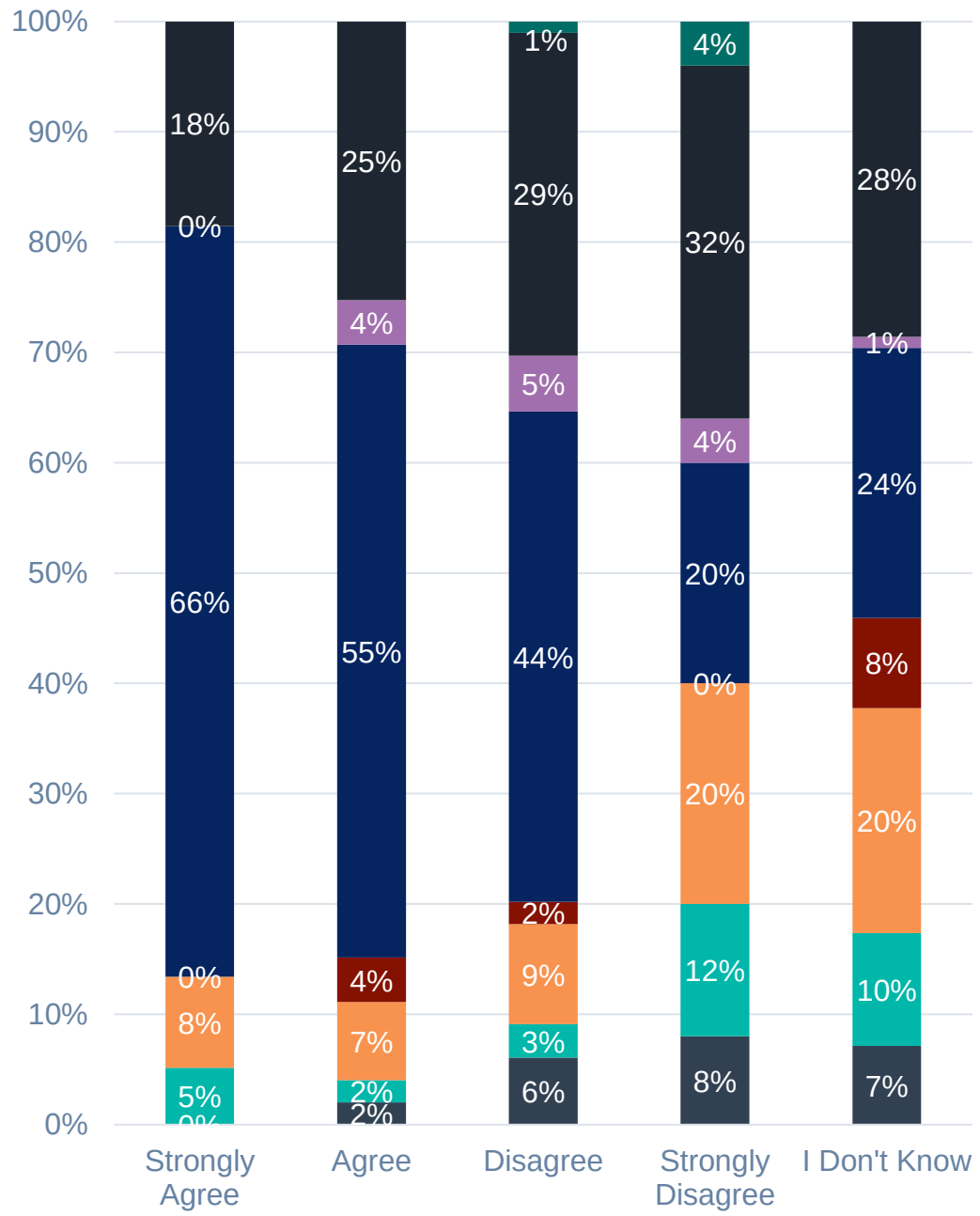
Drive Innovation & Improve Outcomes

Q21 Statement Results By Group: Behavioral health services are delivered by competent providers.



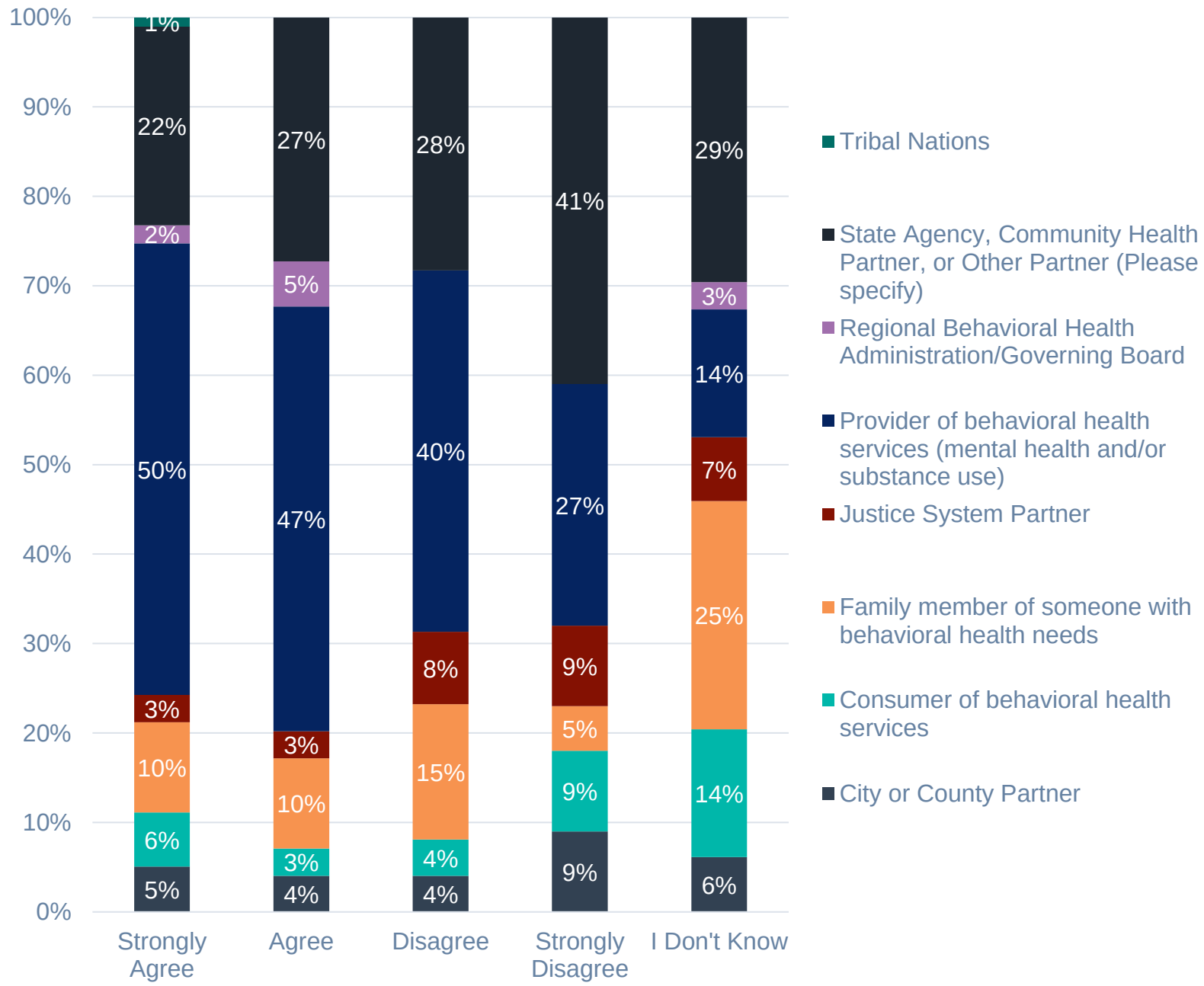
Drive Innovation & Improve Outcomes

Q21 Statement Results By Group: Telehealth for behavioral health services is available across the state.



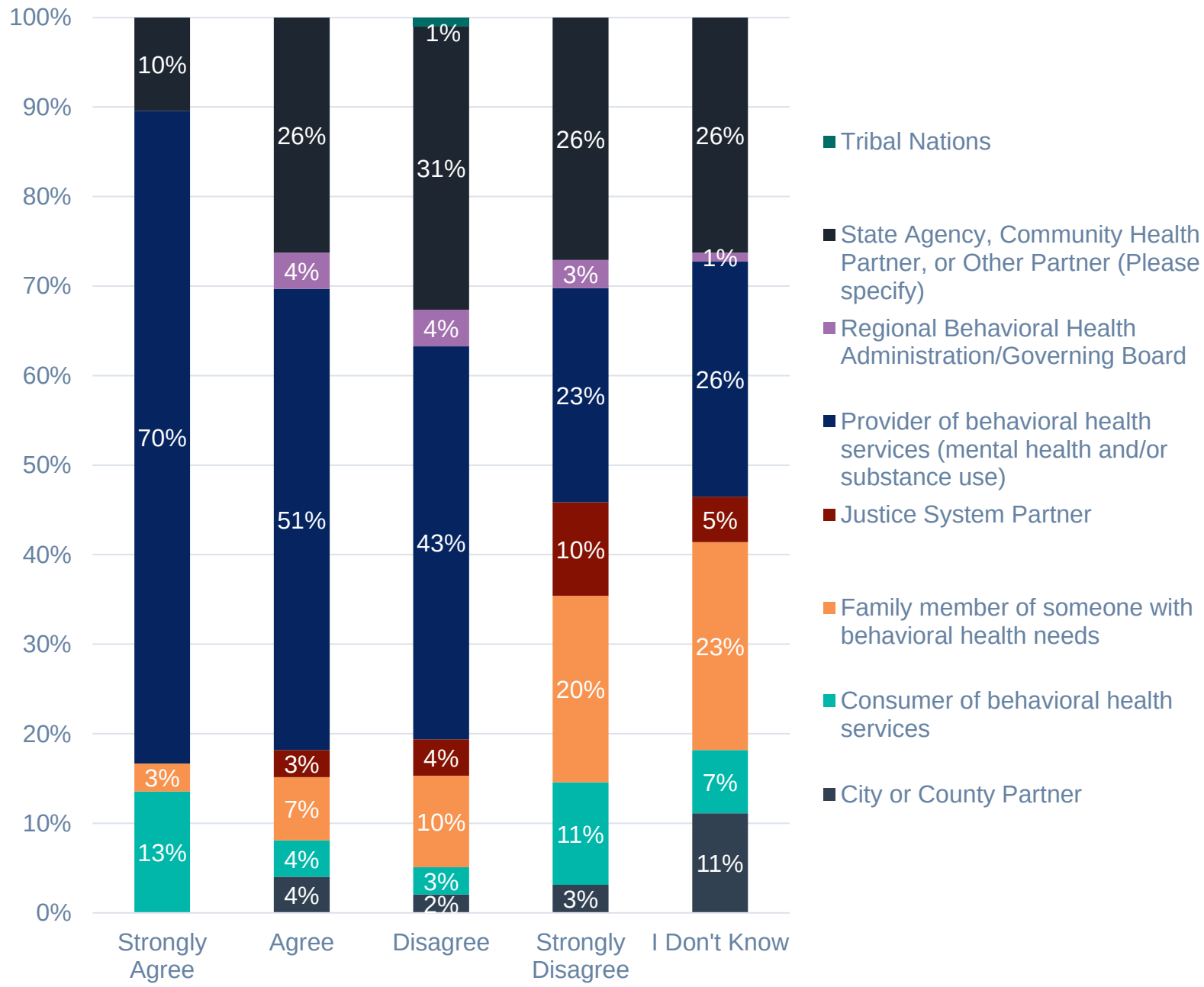
Drive Innovation & Improve Outcomes

Q21 Statement Results By Group: Using technology will improve behavioral health outcomes.



Drive Innovation & Improve Outcomes

Q21 Statement Results By Group: Behavioral health services have been developed to meet emerging needs in the state.



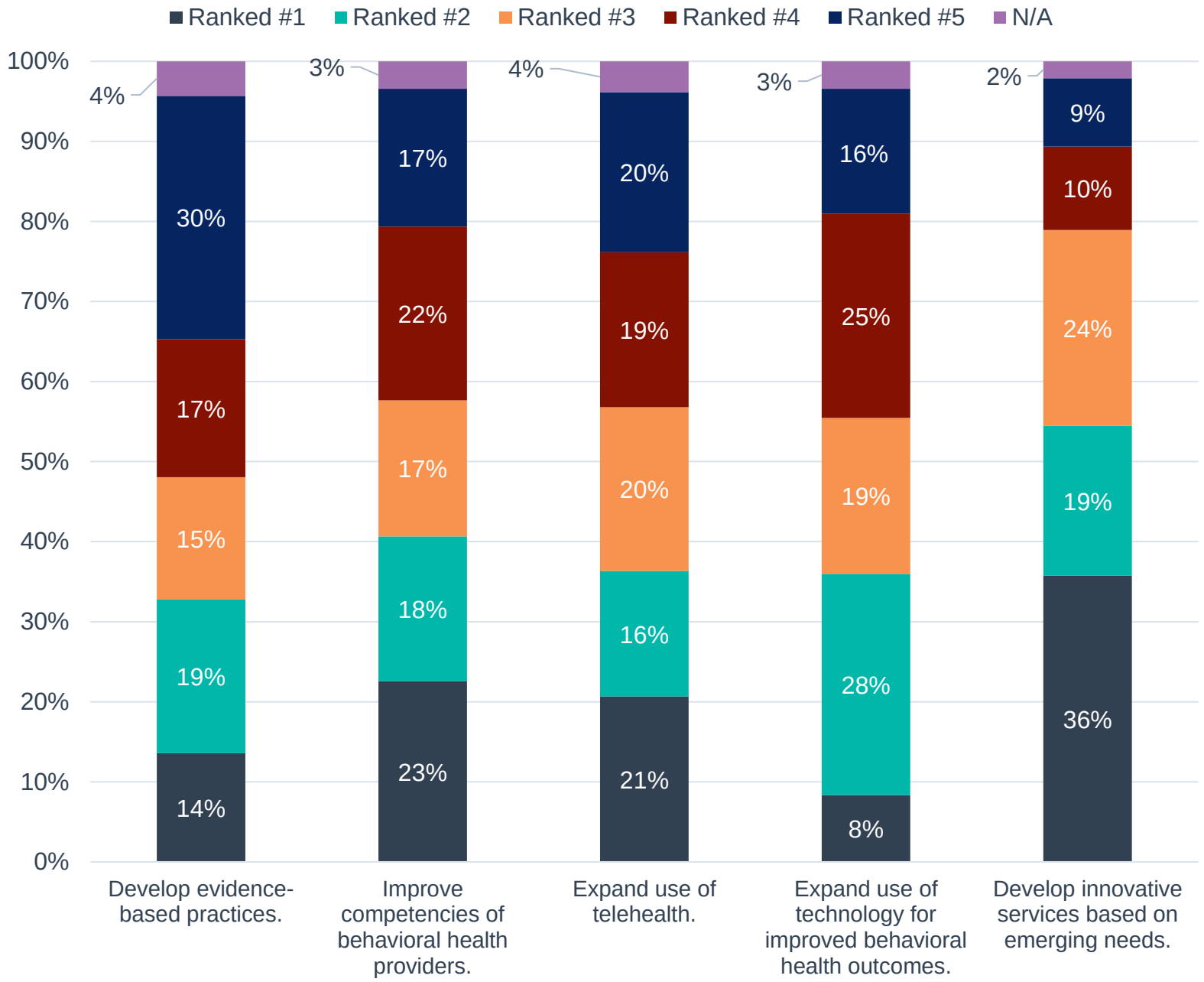
Drive Innovation & Improve Outcomes

Q22: Greatest Need Rankings

Answered: 478
Skipped: 260

Ranking Instruction:

Please rank...by putting "1" for the item you think is the greatest need, a "2" for the item you think is the second greatest need, and so on. Each ranking number may only be used once. Mark "N/A" for items that are not considered a need.



Drive Innovation & Improve Outcomes

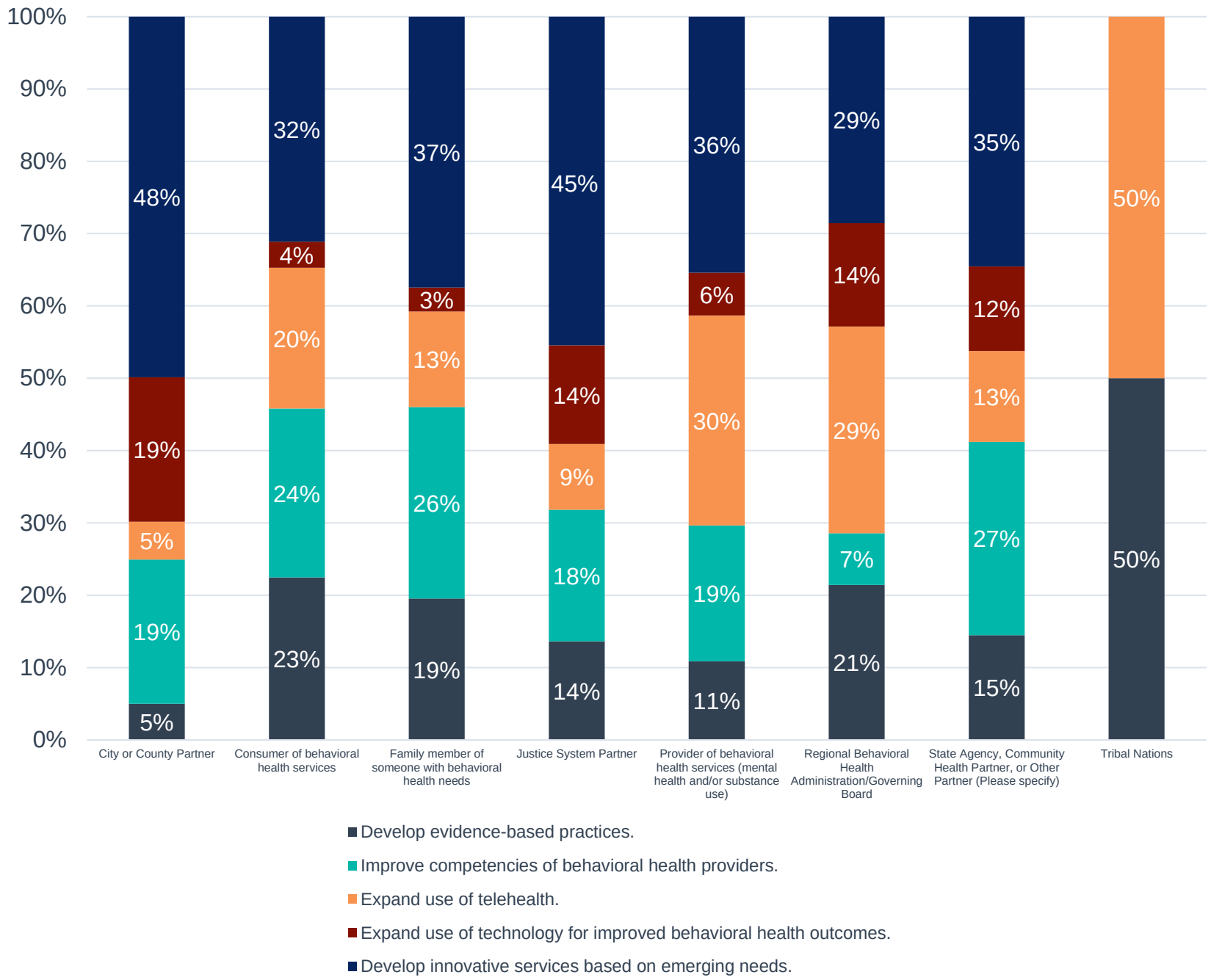
Q22: Greatest Needs Rankings

Answered: 478
Skipped: 260

Answer Choice	1		2		3		4		5		N/A	
Develop evidence-based practices.	13.58%	63	19.18%	89	15.30%	71	17.24%	80	30.39%	141	4.31%	20
Improve competencies of behavioral health providers.	22.58%	105	18.06%	84	16.99%	79	21.72%	101	17.20%	80	3.44%	16
Expand use of telehealth.	20.65%	96	15.70%	73	20.43%	95	19.35%	90	20.00%	93	3.87%	18
Expand use of technology for improved behavioral health outcomes.	8.35%	39	27.62%	129	19.49%	91	25.48%	119	15.63%	73	3.43%	16
Develop innovative services based on emerging needs.	35.74%	168	18.72%	88	24.47%	115	10.43%	49	8.51%	40	2.13%	10

Drive Innovation & Improve Outcomes

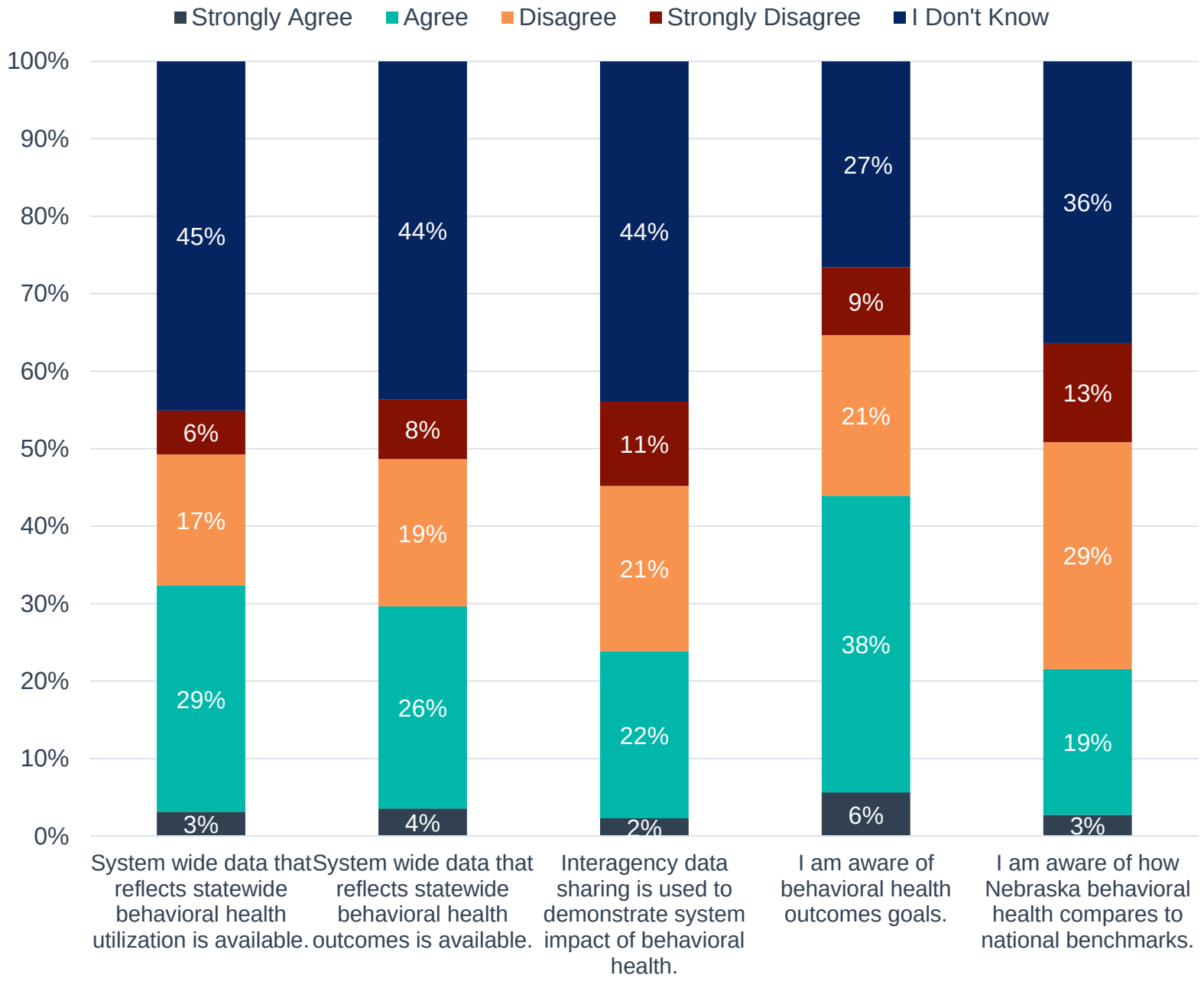
Q22 Greatest Needs Ranking By Group



Demonstrate & Drive Value

Q24: Please identify how much you agree or disagree with the following statements:

Answered: 479
Skipped: 259



Demonstrate & Drive Value

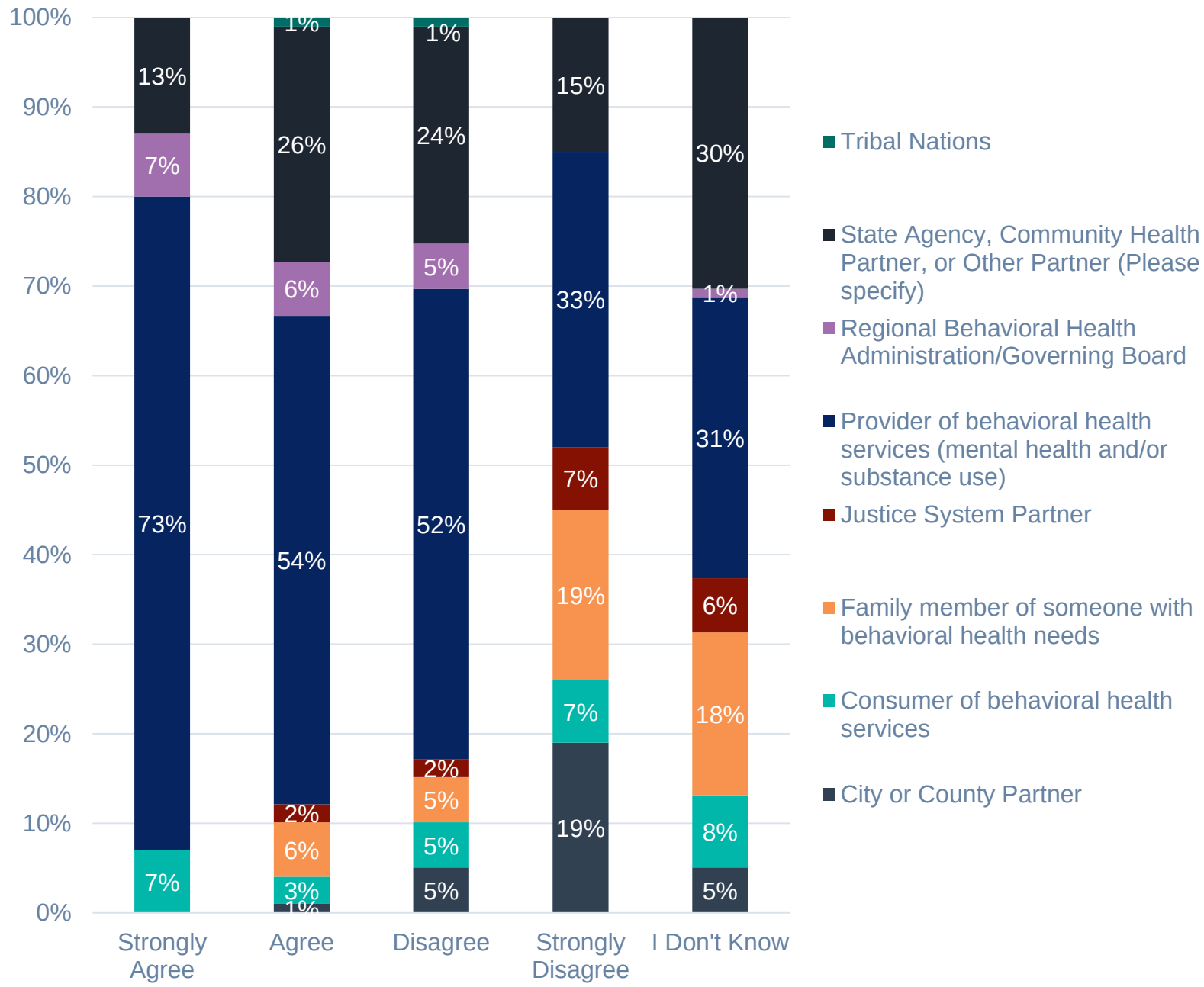
Q24: Please identify how much you agree or disagree with the following statements:

Answered: 479
Skipped: 259

Answer Choice	Strongly Agree		Agree		Disagree		Strongly Disagree		I Don't Know	
System wide data that reflects statewide behavioral health utilization is available.	3.14%	15	29.14%	139	16.98%	81	5.66%	27	45.07%	215
System wide data that reflects statewide behavioral health outcomes is available.	3.55%	17	26.10%	125	19.00%	91	7.72%	37	43.63%	209
Interagency data sharing is used to demonstrate system impact of behavioral health.	2.30%	11	21.55%	103	21.34%	102	10.88%	52	43.93%	210
I am aware of behavioral health outcomes goals.	5.65%	27	38.28%	183	20.71%	99	8.79%	42	26.57%	127
I am aware of how Nebraska behavioral health compares to national benchmarks.	2.72%	13	18.83%	90	29.29%	140	12.76%	61	36.40%	174

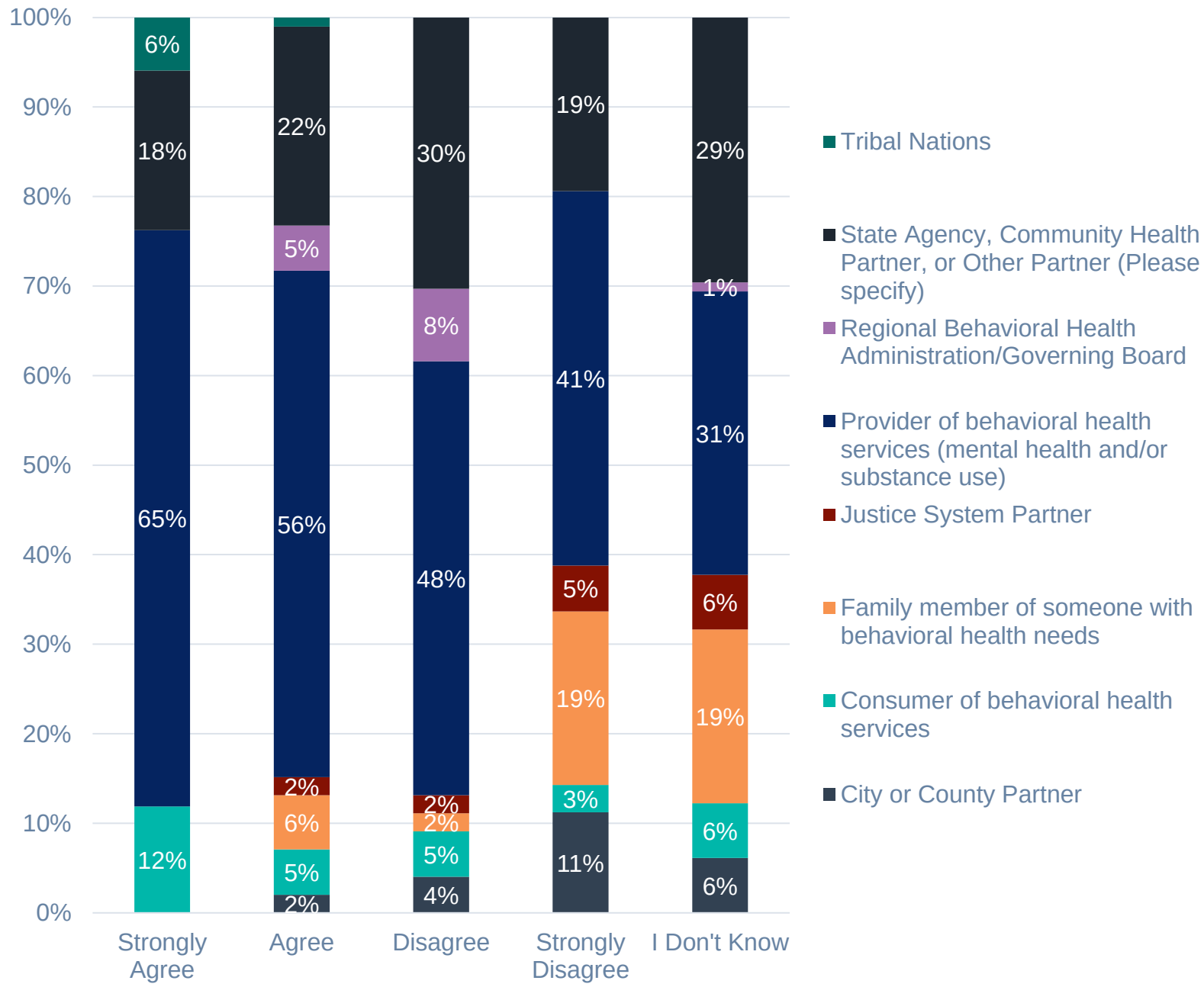
Demonstrate & Drive Value

Q24 Statement Results By Group: System wide data that reflects statewide behavioral health utilization is available.



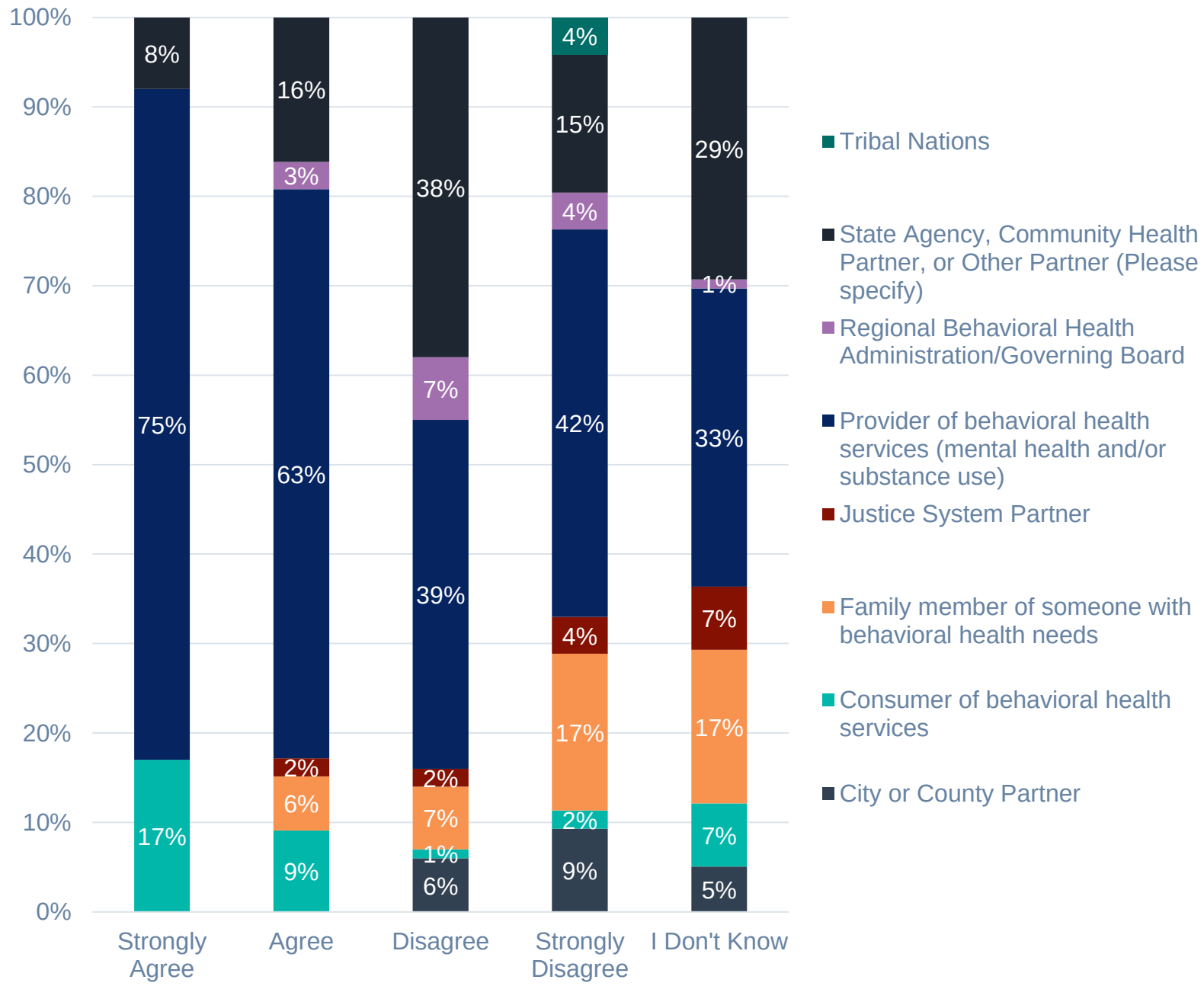
Demonstrate & Drive Value

Q24 Statement Results By Group: System wide data that reflects statewide behavioral health outcomes is available.



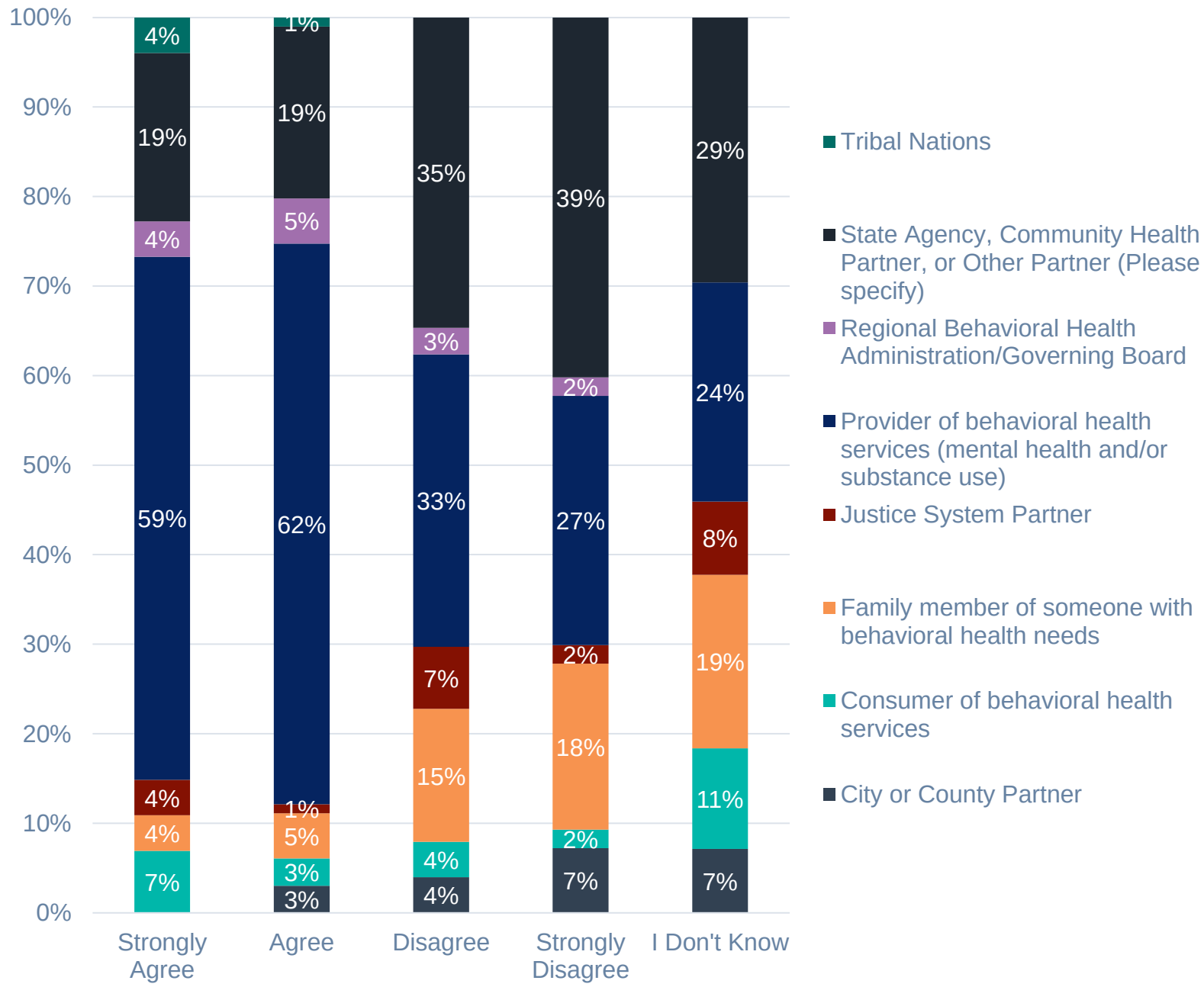
Demonstrate & Drive Value

Q24 Statement Results By Group: Interagency data sharing is used to demonstrate system impact of behavioral health.



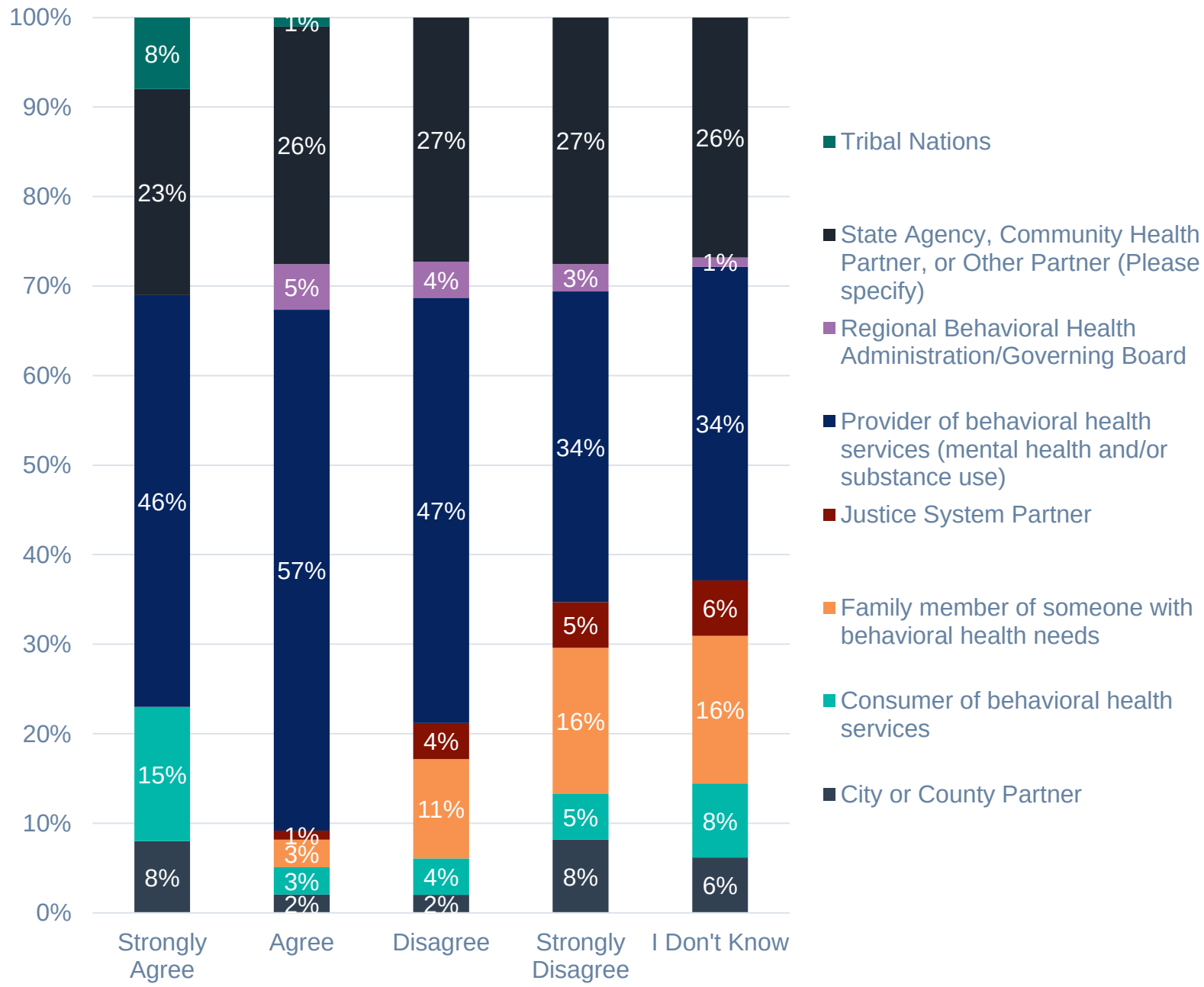
Demonstrate & Drive Value

Q24 Statement Results By Group: I am aware of behavioral health outcomes goals.



Demonstrate & Drive Value

Q24 Statement Results By Group: I am aware of how Nebraska behavioral health compares to national benchmarks.



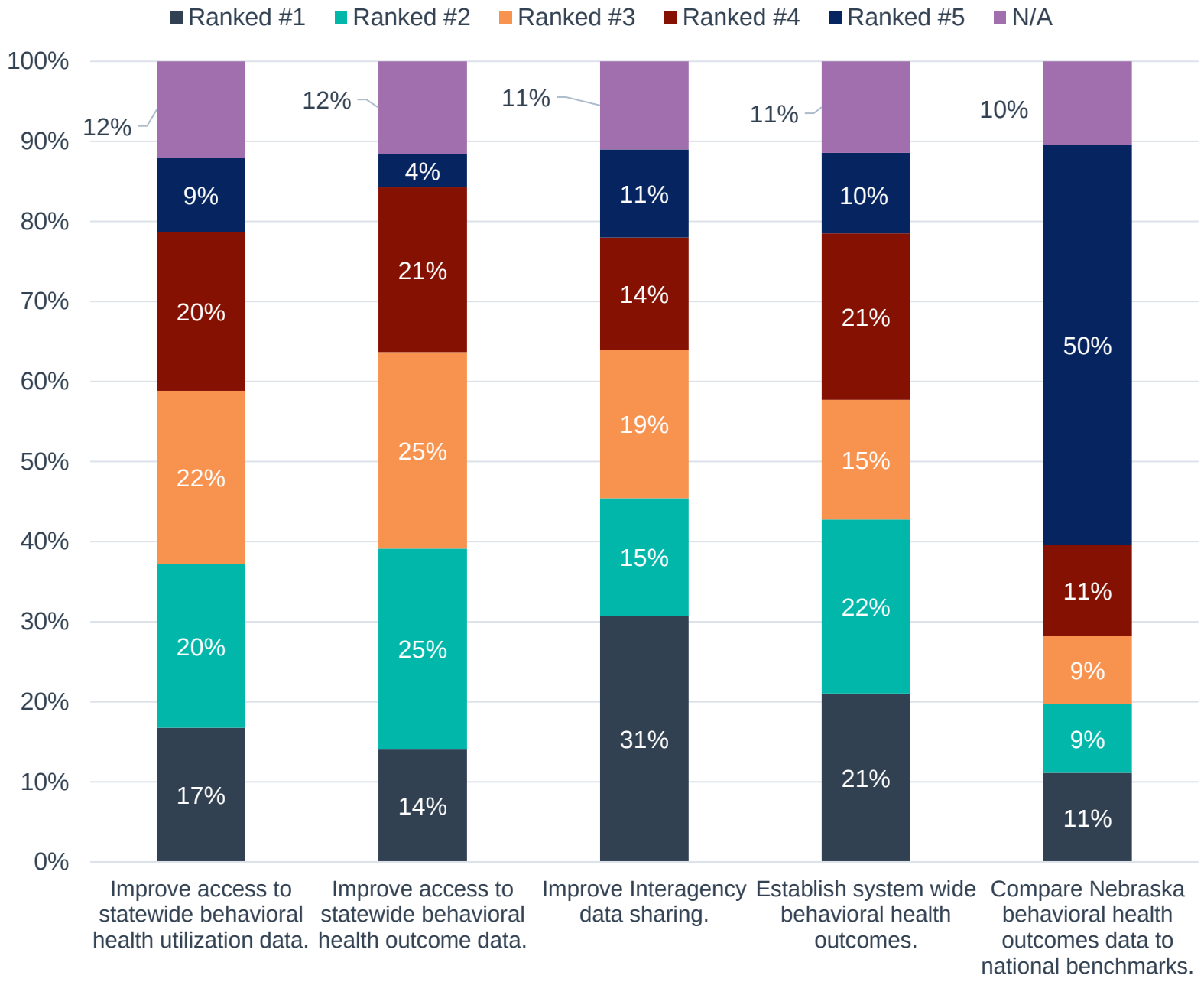
Demonstrate & Drive Value

Q25: Greatest Need Rankings

Answered: 444
Skipped: 294

Ranking Instruction:

Please rank...by putting "1" for the item you think is the greatest need, a "2" for the item you think is the second greatest need, and so on. Each ranking number may only be used once. Mark "N/A" for items that are not considered a need.



Demonstrate & Drive Value

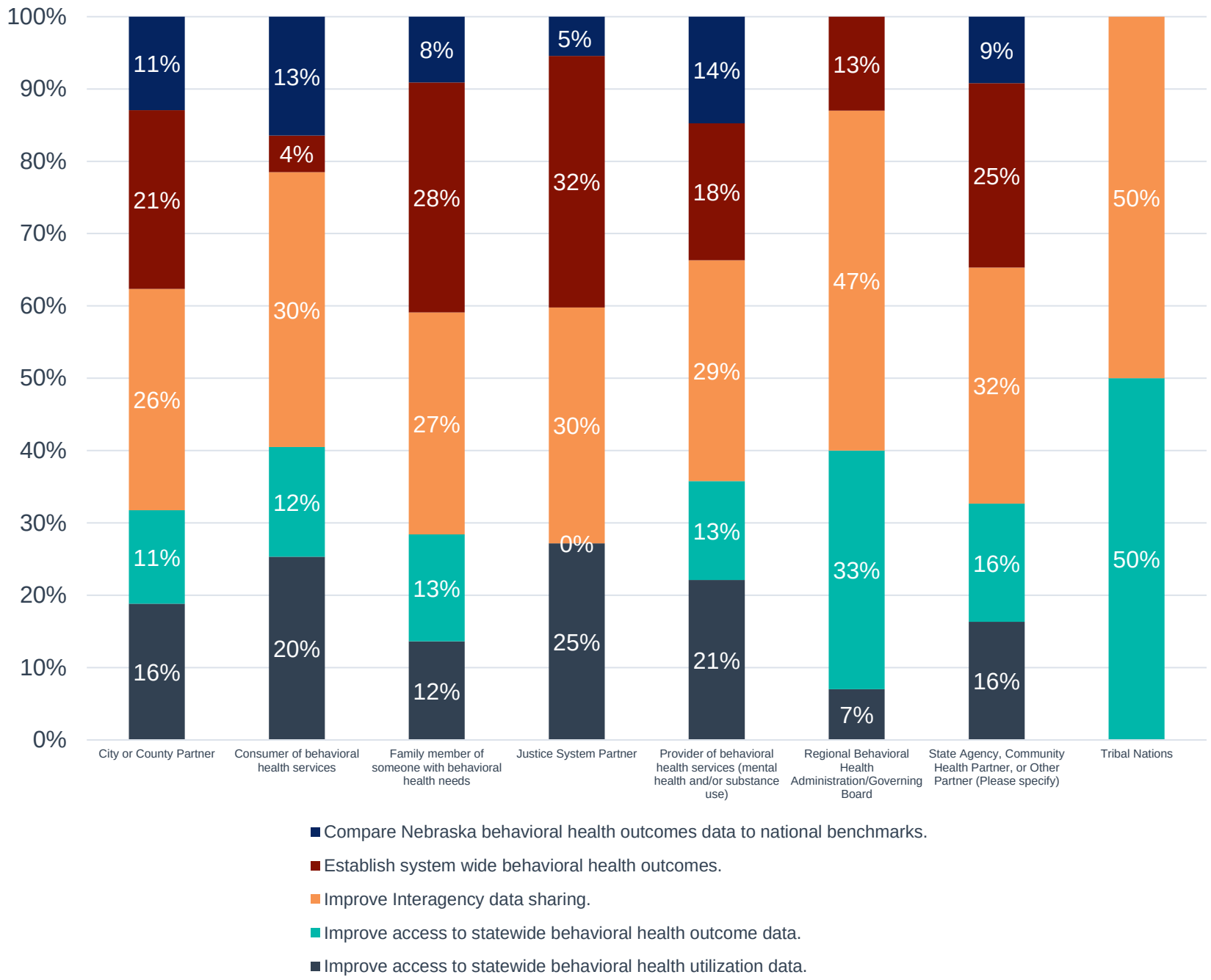
Q25: Greatest Needs Rankings

Answered: 444
Skipped: 294

Answer Choice	1		2		3		4		5		N/A	
Improve access to statewide behavioral health utilization data.	16.74%	72	20.47%	88	21.63%	93	19.77%	85	9.30%	40	12.09 %	52
Improve access to statewide behavioral health outcome data.	14.12%	61	25.00%	108	24.54%	106	20.60%	89	4.17%	18	11.57 %	50
Improve Interagency data sharing.	30.73%	134	14.68%	64	18.58%	81	13.99%	61	11.01%	48	11.01 %	48
Establish system wide behavioral health outcomes.	21.03%	90	21.73%	93	14.95%	64	20.79%	89	10.05%	43	11.45 %	49
Compare Nebraska behavioral health outcomes data to national benchmarks.	11.11%	48	8.56%	37	8.56%	37	11.34%	49	50.00%	216	10.42 %	45

Demonstrate & Drive Value

Q25 Greatest Needs Ranking By Group



Appendix C: Visioning Session Summary

Pillar 1: Enhance BH Health Influence

1. Drive the system of care by exerting greater authority in facilitating Nebraska being the Gold Standard in the nation for behavioral health (e.g., greater influence over managed care contracts).
2. Set the expectations and targets for system-wide performance with the capacity to intervene to assure consumer outcomes are a focus.
3. Change statutes that weaken BH Division or DHHS authority to achieve our mission of helping people live better lives.
4. Develop structures that increase BH Division's impact on the system (e.g., regional authority).

Pillar 2: Implement An Integration Strategy

1. Make Behavioral Health the cornerstone and a driving influence in every part of the system (IDD, CFS, Public Health, Law Enforcement, Dept of Education)
2. Align all health system components (hospitals, independent clinicians, non-profits, regional authority, DHHS, etc.) on mission, vision and values and to be working together with a singular focus of improving consumer health and wellness.
3. Demonstrate the impact of behavioral health on the total health and wellness of Nebraskans in order to encourage a wholistic approach in all parts of the healthcare system to help consumers live better lives

Pillar 3: Promote Stakeholder Inclusion

1. Develop channels for individuals who have not previously had a voice in improving the system of care and behavioral health to have greater influence in both the identification of gaps in care and the solutions to address those gaps.
2. Ensure that previously under-represented constituents (e.g., Tribes, farmers, persons of color, and individuals with a primary language other than English) become part of the solution to improve the system of care.
3. Develop a welcoming and inclusive environment for all previously under-represented constituents by individuals who have historically had the most influence in designing and enhancing the system of care.
4. Include specific interventions to address those previously under-represented constituents in the state's strategic plan to enhance the system of care with a focus on improved outcomes for those constituents.

Pillar 4: Drive Innovations & Better Outcomes

1. Continually look for new ways to deliver and promote better outcomes in the transformation of the Nebraskan system of care (e.g., telehealth, message-based therapy, mobile services).
2. Regularly set specific targets for improvement that reflect helping Nebraskans to a healthier future.
3. Boldly seek guidance and best practices from outside Nebraska, outside of healthcare and outside of the traditional comfort zone to invent new approaches and improve health outcomes.

Pillar 5: Demonstrate & Drive Value

1. Measure and monitor services and service delivery to assure we are driving value to our constituents; a clear return on investment will guide our priorities.
2. Identify targeted achievements (consumer outcomes) that include clear interventions and buy-in from our partners (hospitals, clinicians, regional authority, etc.) to support the change/improvements being sought.
3. Develop measures and targets that address the most critical gaps in care

Appendix D: Key Performance Measure Inventory

Most Commonly Used Performance Measures Of Specialty Provider Organizations, 2016-2018

Follow-up after hospitalization for mental illness	Emergency room utilization	Readmission rates	Patient or consumer satisfaction
PCP Engagement	Access to care measures	Diabetes screening for people with Schizophrenia using an antipsychotic	Antidepressant medication management
Community Tenure	Depression monitoring via PHQ-9	Patient Reported Outcomes	Involvement of family/significant other
Initiation/ engagement of alcohol and other drugs	Diabetes care – blood sugar controlled	Adherence to antipsychotic medication for people with schizophrenia	Use of depression screening and follow-up

Risk adjusted ALOS

Key Metrics For Probation

SAMPLE

Access & Engagement	Percentage
Consumers with a presenting BH diagnosis who had a visit with a provider within 10 calendar days of release	
Consumers engaged in education/vocational programs within 30 days of release from criminal justice system	
Consumers diagnosed with opioid addiction who receive Medical Assisted Treatment (MAT) within 10 days of diagnosis	
Consumers who receive MAT with smoking and tobacco use	
Consumers diagnosed with HIV who receive MAT within 10 days of diagnosis	

Quality & Accountability	Percentage
Consumers with stable housing	
Consumers free of domestic violence in any given year	
Consumers who completed job/vocational training programs in any given year	
Consumers who stayed out of prison as a result of program efforts	
Consumers reporting that their services and supports are helping them lead better lives	
Consumers reporting NPS in 9-10 range	

Integration	Percentage
Consumers participating in community activities, i.e. church, social, volunteer in any given year	
Consumers with a PCP and had (1) PCP visit annually	
Consumers with diabetic and cardiovascular screenings annually	
Consumers with BMI assessments annually	

Key Metrics For Medicaid

SAMPLE

Access & Engagement	Percentage
Network adequacy for consumers with access to BH prescribers within 10 calendar days	
Consumers with access to cultural/linguistically appropriate providers	
Consumers diagnosed with opioid addiction who receive MAT within 10 days	

Quality & Accountability	Percentage
ROI dollars established to provide stale housing for consumers	
Screenings for SUD and MH	
Screenings for diabetes for people with schizophrenia and bipolar and using psychotropic meds	
Follow-up after ED visit for MH and SUD	
Consumers with adherence to anti-psychotic medications for individuals with schizophrenia	

Integration	Percentage
Amount of dollars allocated to address social determinants of health	
Amount of dollars allocated to understand geographical characteristics and behaviors of communities related to social, economic, and environmental factors to improve health outcomes	
# of community partnerships established to support social networks and supports for consumers in geographic areas	

Key Metrics For MCOs

SAMPLE

Access & Engagement	Percentage
Network adequacy for consumers with access to BH prescribers within 10 calendar days	
Consumers with access to cultural/linguistically appropriate providers	
Network adequacy of providers to provide MAT to consumers diagnosed with opioid addiction within 10 days of diagnosis	

Quality & Accountability	Percentage
ROI dollars established to provide stable housing for consumers	
Screenings for SUD and MH	
Screening for diabetes for people with schizophrenia and Bipolar who are using psychotropic meds	
Follow-up after ED visits for MH or SUD	
Consumers adherent to anti-psychotropic meds for individuals with schizophrenia	
Older adults with in-person contact or phone at least weekly	

Integration	Percentage
Amount of dollars allocated to address social determinants of health	
Amount of dollars allocated to understand geographic characteristics and behaviors of communities related to social, economic, and environmental factors to improve health outcome	
# of community partnerships established to support social networks and supports for consumers in geographic areas	

Key Metrics For I/DD

SAMPLE

Access & Engagement	Percentage
Consumers with access to BH prescribers within 10 calendar days	
Consumers with access to cultural/linguistically appropriately providers	

Quality & Accountability	Percentage
Consumers who had choice about where and with whom they live	
Consumers in stable housing in any given year	
Consumers who had jobs that they had a choice in getting	
Consumers taking apart in community activities with people who are not DD	
Consumers free of sexual abuse	
Consumers screened for obesity	
Consumers with transportation	
Consumers earning a livable wage	
Consumers reporting satisfaction with social supports and services	

Integration	Percentage
Consumers with PCP and had (1) PCP visit annually	
Consumers with food security	
Consumers involved in community activities	

Key Metrics For CFS

SAMPLE

Access & Engagement	Percentage
Consumers with access to BH prescribers within 10 days	
Consumers with access to cultural/linguistically appropriate providers	
Adult consumers diagnosed with opioid addiction who receive MAT within 10 days of diagnosis	

Quality & Accountability	Percentage
Children/adults receiving prevention screenings annually	
Children with ADHD diagnosis who receive follow-up care at least every 90 days	
Adults who have been free of domestic violence in any given year	
Children who have been free of child neglect within any given year	
Consumers with stable housing	
Consumers with transportation	
Consumers with food security	
Adult consumers with jobs within given year	
Children completed high school/GED	
Consumers reporting satisfaction with balance of work and leisure	
Consumers receiving ambulatory follow-up within 7 days of hospitalization	
Consumers receiving follow-up after ED visit	
Adult consumers with a livable wage	

Integration	Percentage
Consumers participating in community activities	
Consumers with PCP and have (1) PCP visit annually	
Consumers reporting satisfaction with social supports and services to meet their daily needs	
Consumers reporting satisfaction with safety of their neighborhoods	

Key Metrics For DBH/Regions

SAMPLE

Access & Engagement	Percentage
Improve access and utilization of behavioral health prescribers	
Improve access and utilization of Medication Assisted Treatment	

Quality & Accountability	Percentage
Increase the percentage of consumers in stable housing	
Increase the percentage of consumers in integrated employment	
Increase community tenure	
Improve consumer-reported outcome results	
Improve NPS (I would recommend this agency to a friend or family member)	
Improve 7-day HEDIS measure	

Integration/Social Determinants of Health	Percentage
Improve PCP /Pediatrician coordination (enrolled members have 1 PCP/Ped.1 visit annually)	
Improve screening for diabetes and adherence to treatment plan	
Improve screening for obesity and access to nutritional options	

Appendix E: National Trends Impacting Behavioral Health

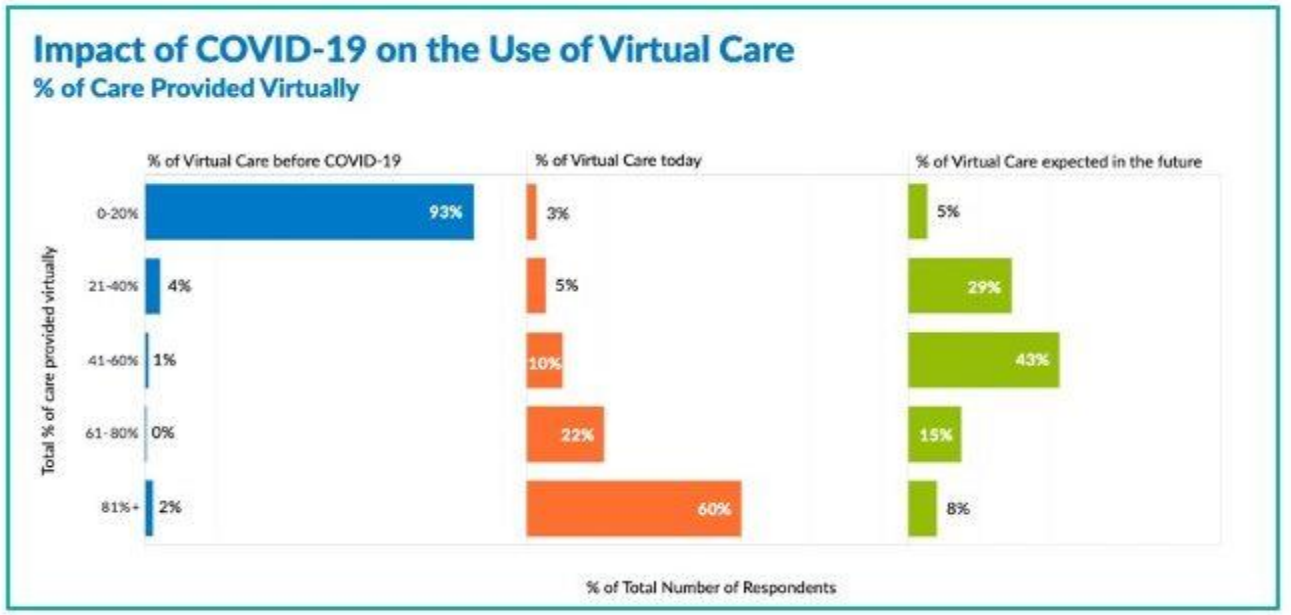
National Trends Impacting Behavioral Health

1. Expansion of Telehealth and other Technologies
2. Continued Shift To Alternative Payment Arrangements (APM)*
   - *APMs include pay-for-performance and value-based contracting
3. Increased Funding & Utilization Of Integrated Care Models
4. Growing Demand For Mental Health & Addiction Treatment Services
5. Behavioral Health Trends in Medicaid
6. Impacts of COVID on Care Planning and service provision

Trend #1: Expansion Of Telehealth & Other Technologies

Increased Use Of Technology Impacting Service Delivery

1. Pre-pandemic, telehealth utilization in behavioral health care was relatively low, only 2% of organizations were providing 80% or more of their care virtually
2. Policy changes during the COVID-19 pandemic have reduced barriers to telehealth. Now, 60% of behavioral health organizations are providing 80% or more virtual care.
3. Behavioral health care executives expect the higher utilization of virtual services to continue, with a majority believing 40 % to 60% of their overall services will be provide in virtual platforms.



Trend #2: Continued Shift To Value-Base Contracting

APMs are on the rise in Medicaid Managed Care

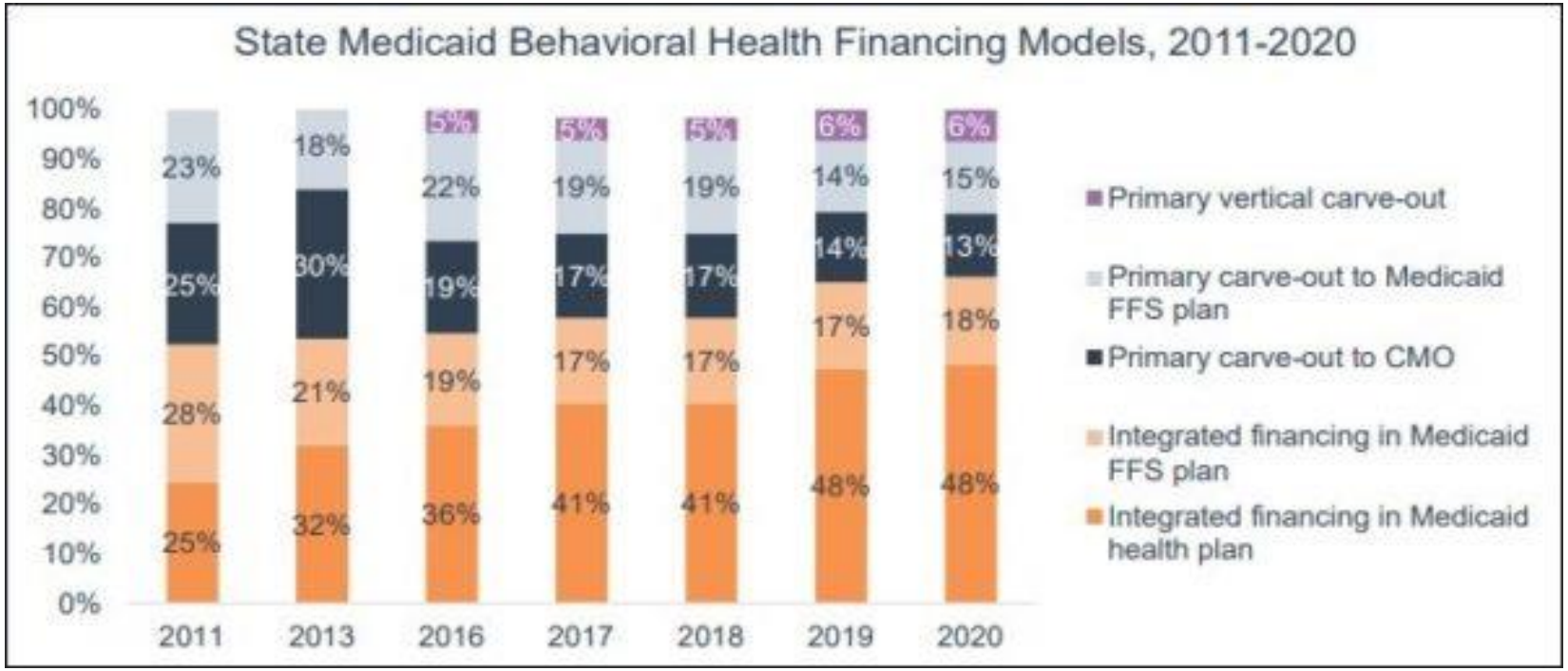
1. The 2019 State-By-State Update found that 28 of the 40 states with Medicaid managed care require health plans to implement alternative payment arrangements (APMs) with provider organizations
   A. This is up from 22 states out of 39 states in 2017.

2. With the growth of APM utilization the need for data analytics and technologies to effectively manage clinical information, monitor patient outcomes, track quality metrics, and assess financial impacts has grown as well.

Trend #3: Increased Funding & Utilization Of Integrated Care

Funding Drives Integration

1. Approximately 34.9 million (48%) of the 72.8 million Medicaid beneficiaries are enrolled in Medicaid health plans with integrated behavioral health financing.



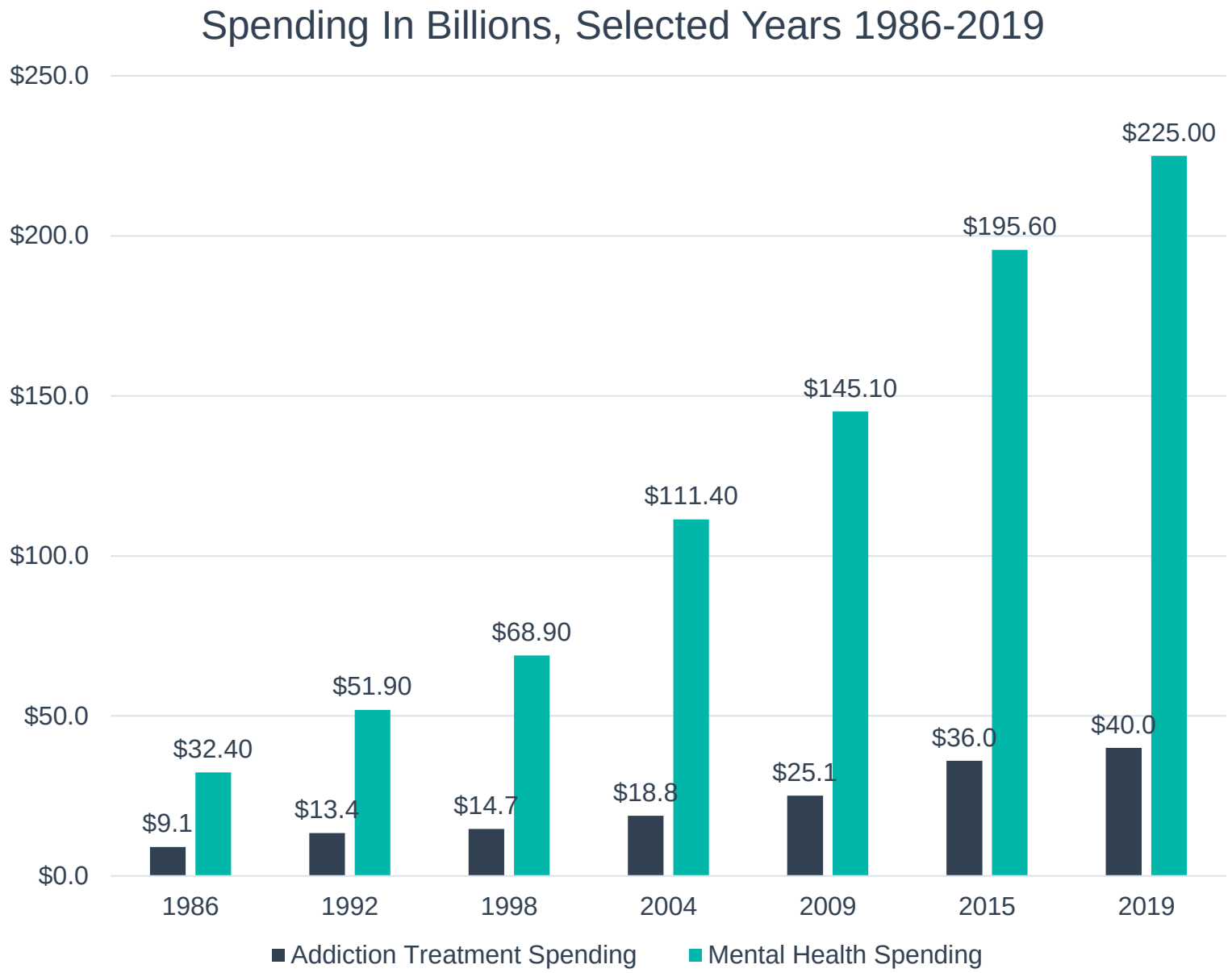
Trend #3: Increased Funding & Utilization Of Integrated Care

Federal and State Funding Trending Toward Integration

1. Certified Community Behavioral Health Clinics (CCBHC) have expanded from 66 in 2015 to 166 in 2020. Congress has acted five times to extend the demonstration project and has allocated $450 million to date for CCBHC expansion grants.
2. Recently, Ohio submitted a request for proposal to expand mental health and early intervention services to children (see Ohio Expanding Child Mental Health Capacity With Whole Child Matters RFP and Ohio Seeks Early Childhood Mental Health and Early Intervention Capacity Expansion Services).
3. 47 states have adopted policies and programs to advance the use of integrated care medical homes – Initiatives involving 90 commercial insurance plans, multiple employers,42 state Medicaid programs, numerous federal agencies, the Department of Defense, hundreds of safety net clinics, and thousands of small and large clinical practices nationwide.

Trend #4: Growing Demand For Behavioral Health & Addiction Treatment Services

Mental Health & Addiction Treatment Spending On The Rise



Trend #4: Growing Demand For Behavioral Health & Addiction Treatment Services

Expanding Payment For Addiction Treatment

Addiction treatment industry was $31 billion in 2014 and is projected to be $42 billion 2020.

1. Parity Act 2008
2. Affordable Care Act 2010
3. Opioid Crisis Response Act
4. Opioid State Targeted Response Grants
5. Centers Of Excellence For Care Coordination
6. Addiction Treatment Demonstration Waiver
7. Integrated Care Of Kids Model (CMS Innovation Center)

Trend #5 Medicaid Based Trends

National Trends In Medicaid

- Supporting reciprocity between states for Medicaid provider enrollment and professional licenses.
- Enhancing access to psychiatric medication with expanded Nurse Practitioner prescribing privileges.
- Extending programming through specialized training and certification efforts for peer and other certified staff
- Leveraging pharmacies and retail drop-in clinics for screening, assessment and referrals needs.

Trend #6 Impacts of COVID on Care Planning

New Challenges In The COVID-19 Era

Rise in Mental Illness

- Increases in levels of trauma, depression, and anxiety are occurring as a result of the pandemic. In April 2020 Johns Hopkins COVID-19 Civic Life and Public Health Survey1 demonstrated a 10% increase in adults reporting serious psychological distress over 2019 reports. These results showed an exacerbation for adults with household income of less than $35,000 per year, 19% of whom reported serious psychological distress.

Suicide and Unemployment

- Unemployment is highly correlated with deaths by suicide, which has led experts to speculate that suicides will increase in 2020/2021. One model, based upon previous suicide and unemployment data, projects 3,235 to 8,164 additional deaths by suicide in the United States in 2020/20212

Opioid Use

- Due to increased opioid usage during COVID, mortality rates are expected to climb due opioid-related deaths. The American Medical Association (AMA) recently released a statement of concern about reports of increased levels of addiction and opioid-related mortality.

Provider Concerns

- Many behavioral health providers have experienced significant decreases in utilization and revenue streams due to COVID-19, which greatly impacts their financial viability due to the increased unemployment from COVID-19.

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Nebraska Strategic Prevention Framework – Partnerships for Success (SPF-PFS)

Evaluation Plan

2019

Prepared for:
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SPF-PFS Director
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Division of Behavioral Health

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SPF-PFS Evaluator
Schmeeckle Research

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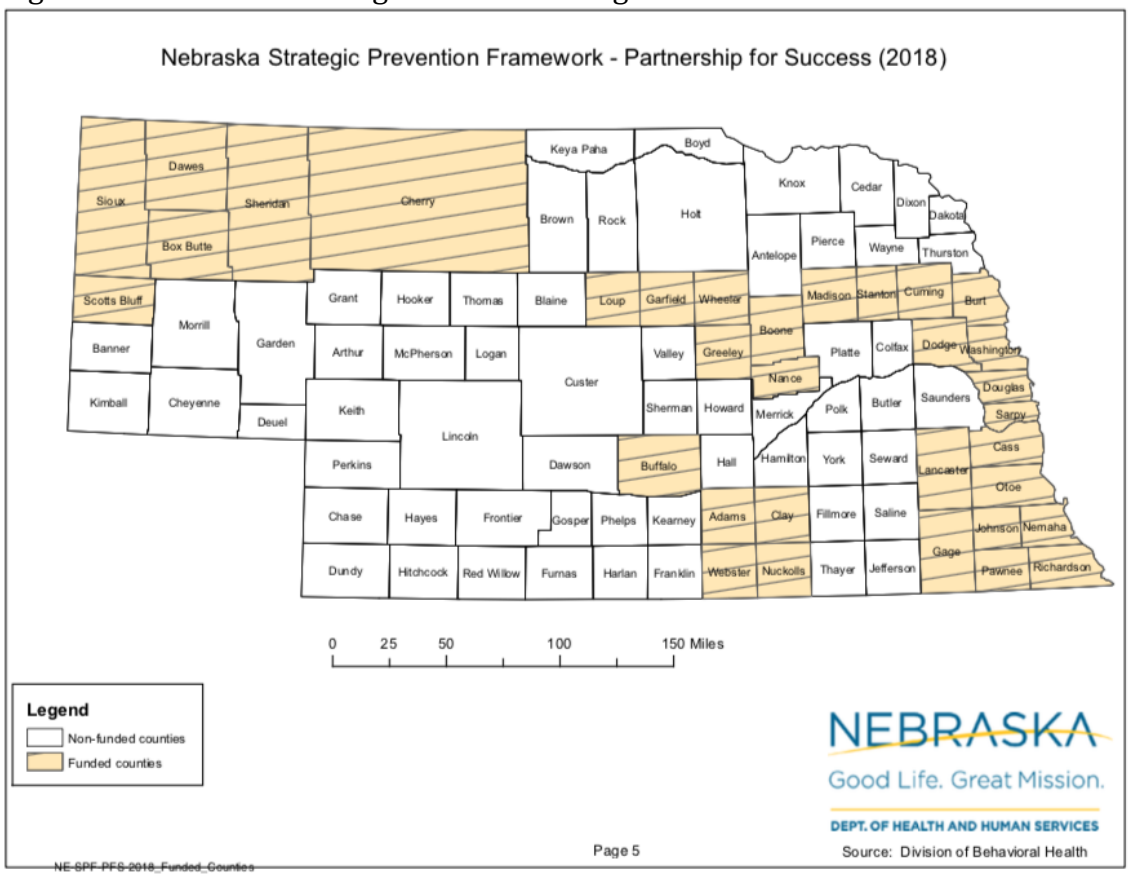
Introduction

Persistently higher rates of alcohol use are found among Nebraska youth than the national average. This places the reduction of underage drinking as a high priority at the statewide level and in communities across Nebraska. Alcohol use is both a product of and contributing factor in major community problems. Based on various protective and risk factors within communities, some counties and regions are in more immediate need of assistance to address alcohol use and abuse than others, particularly among youth. Given the complex and intertwined nature of underlying community conditions, an integrated and extensive plan is necessary to address the issues. In order to achieve the goal of implementing an effective prevention plan and promote sustainable systems change, the Strategic Prevention Framework is utilized.

The Strategic Prevention Framework Partnership for Success (SPF-PFS) project seeks to reduce problems related to underage drinking by preventing the onset and reducing underage drinking among Nebraskans aged 9 to 20. The focus is on targeted sub-populations based on need, established through protective and risk factor indicators.

Through the use of a risk-and-protective-factor framework, the Division of Behavioral Health chose to fund communities identified with personal, family, and/or community characteristics that increase the likelihood of a substance abuse problem developing. Targeted counties were selected based on their problematic binge drinking behavior and increased acceptability for binge and underage drinking. These counties were selected as a result of comparing demographic, survey and health profiles of the State's 93 counties and ranking each county against the statewide average of the selected indicators. A detailed description of these indicators can be found in Nebraska's SPF-PFS 2018 application. Thirty-three counties were identified as targeted counties to receive SPF-PFS funding (see Table 1).

Figure 1. Counties Receiving SPF-PFS Funding



Nebraska is divided into six (sub state) Regional Behavioral Health Authorities or "Regions" serving as quasi-governmental agencies with which the state contracts for community based treatment and prevention services. The Nebraska Department of Health and Human Services Division of Behavioral Health has chosen to sub grant SPF-PFS funding through five of the six Regions and allocate their awards based on the number of targeted counties in that Region. The Regions in turn are subcontracting the SPF-PFS dollars to eligible community coalitions (sub-recipients). The behavioral health regions contracted with 18 community coalitions to implement SPF-PFS in the 33 targeted counties.

The Division of Behavioral Health requires SPF planning by any coalition regardless of funding source. The influence of the SPF has multiplied through the work of the Regional Prevention Coordinators, which now provide SPF-based training and technical assistance to all area coalitions. Community coalitions benefit from this hands-on, face-to-face training and technical assistance that takes them through every step of the prevention planning process and allows them to network and strategize with their peers. Bolstered by the provision of specific techniques and tools designed for each stage of the SPF process, communities have demonstrated significant increases in their capacity to engage in effective planning. The Regional

Prevention Coordination System, in partnership with the State and community coalitions, will continue to build on existing success by further providing extensive community-based training and technical assistance on all stages of the Strategic Prevention Framework.

Schmeeckle Research and the University of Nebraska-Lincoln's Methodology and Evaluation Research Core Facility will be utilized to conduct the evaluation. Mindy Anderson-Knott, a certified evaluator and the former onsite evaluation coordinator for the Strategic Prevention Framework-State Incentive Grant (SPF-SIG) and lead evaluator for the 2013 Strategic Prevention Framework-Partnerships for Success (SPF-PFS) Grant, will be leading the evaluation. The evaluation will assess outcomes of Nebraska's Strategic Prevention Framework Partnership for Success project to assess the project in meeting its goals and objectives:

- Prevent the onset and reduce the prevalence of underage alcohol use, including binge drinking, among individuals 9 to 20 years old.
- Prevent the onset and reduce the prevalence of marijuana use among individuals 9 to 20 years old.
- Increase the use of Evidence-Based Strategies employed by prevention coalitions to reduce alcohol and substance use among individuals 9 to 20 years old.
- Strengthen capacity and infrastructure at the state and community levels in support of prevention efforts.
- Leverage, redirect, and realign local funding streams for prevention related to underage drinking, and target the increased marijuana use among this population.

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

Evaluation Approach

The purpose of the SPF-PFS evaluation is to assess the impact on the state- and community level outcomes, as well as to identify and describe strengths and limitations associated with the administration of the grant. The SPF-PFS will be assessed utilizing both process and outcome evaluations. The process evaluation will inform the administration of the SPF-PFS by providing information needed to most effectively meet the proposed goals and objectives and to explain variation in outcomes. The impact of SPF-PFS efforts relative to their stated goals and objectives will be assessed in the outcome evaluation.

This report outlines the statewide evaluation plan. Additionally, individual evaluation plans have been developed in coordination with sub-recipients to establish the most effective community level evaluation design.

Evaluation Questions

To frame the evaluation, a series of evaluation questions were developed to assess the implementation and impact of the SPF-PFS. First, the process evaluation questions are provided, followed by the outcome evaluation questions. To further clarify the scope of the questions, they are separated by state and community level. Table 1 lists the evaluation questions, organized by the grant's five goals. The data sources that will be used to assess each evaluation question are also provided.

Table 1. Evaluation Questions and Data Sources

Evaluation Question	Evaluation Data Sources
Goal 1: Prevent the onset and reduce the prevalence of underage alcohol use, including binge drinking, among individuals 9 to 20 years old.	
Objective 1.1: By 2023 decrease prevalence of twelfth graders past month alcohol use, in funded geographic regions, to 33% or less as measured by the Nebraska Risk and Protective Factor Student Survey.	
Objective 1.2: By 2023 decrease the prevalence of twelfth graders past month binge drinking, in funded geographic regions, to 16% or less as measured by the Nebraska Risk and Protective Factor Student Survey.	
Objective 1.3: By 2023 decrease the prevalence of youth under 21 years old committing alcohol-related crimes, in funded regions, to a rate of 86.0 arrests per 10,000 population as measured through Uniform Crime Reports data.	
State Level Process:	
1.1. How did intervention type and combinations of interventions impact implementation and outcomes?	Workplans, PLI's, NRPFSS, NYAAOS
1.2. How did contextual factors and community characteristics impact implementation and outcomes?	Site visits (Civ1), Quarterly reports, PLI's, NRPFSS, NYAAOS
1.3. How did facilitators and barriers affect implementation?	Site visits (Civ1&2), Quarterly reports
Community Level Process:	
1.1. Were selected strategies implemented with fidelity?	NPIRS
1.2. How did facilitators and barriers affect implementation?	Site visits (Civ1&2), Quarterly reports
State Level Outcome:	

	1.1. Did the implementation of SPF-PFS prevent the onset and reduce the prevalence of underage alcohol use, including binge drinking, among individuals 9 to 20 years old?	YRBS, NRPFSS, NYAAOS, PLI's
	1.1a. Did the prevalence of twelfth graders past month alcohol use, in funded geographic regions, decrease to 33% or less as measured by the Nebraska Risk and Protective Factor Student Survey by 2023?	NRPFSS
	1.1b. Did the prevalence of twelfth graders past month binge drinking, in funded geographic regions, decrease to 16% or less as measured by the Nebraska Risk and Protective Factor Student Survey by 2023?	NRPFSS
	1.1c. Did the prevalence of youth under 21 years old committing alcohol-related crimes, in funded regions, decrease to a rate of 86.0 arrests per 10,000 population as measured through Uniform Crime Reports data by 2023?	Crime Commission
	Community Level Outcome:	
	1.1. Did the implementation of SPF-PFS prevent the onset and reduce the prevalence of underage alcohol use, including binge drinking, among individuals 9 to 20 years old in the targeted county/ies?	NRPFSS, NYAAOS, PLI's, College surveys
Goal 2: Prevent the onset and reduce the prevalence of marijuana use among individuals 9 to 20 years old.		
Objective 2.1: By 2023 decrease the prevalence of twelfth graders past month marijuana use, in funded geographic regions, to 14% or less as measured by the Nebraska Risk and Protective Factor Student Survey.		
	State Level Process:	
	2.1. How did intervention type and combinations of interventions impact implementation and outcomes?	Workplans, PLI's, NRPFSS, NYAAOS
	2.2. How did contextual factors and community characteristics impact implementation and outcomes?	Site visits (Civ1), Quarterly reports, PLI's, NRPFSS, NYAAOS

	2.3. How did facilitators and barriers affect implementation?	Site visits (Civ1&2), Quarterly reports
	Community Level Process:	
	2.1. Were selected strategies implemented with fidelity?	NPIRS
	2.2. How did facilitators and barriers affect implementation?	Site visits (Civ1&2), Quarterly reports
	State Level Outcome:	
	2.1. Did the implementation of SPF-PFS prevent the onset and reduce the prevalence of marijuana use among individuals 9 to 20 years old?	YRBS, NRPFSS, NYAAOS, PLI's
	2.1a. Did the prevalence of twelfth graders past month marijuana use, in funded geographic regions, decrease to 14% or less as measured by the Nebraska Risk and Protective Factor Student Survey by 2023?	NRPFSS
	Community Level Outcome:	
	2.2. Did the implementation of SPF-PFS prevent the onset and reduce the prevalence of marijuana use among individuals 9 to 20 years old in the targeted county/ies?	NRPFSS, NYAAOS, PLI's, College surveys
Goal 3: Increase the use of Evidence-Based Strategies employed by prevention coalitions to reduce alcohol and substance use among individuals 9 to 20 years old.		
Objective 3.1: Create an Approved Nebraska Evidence Based Program (EBP) Listing for communities to use for the prevention of alcohol use by the end of Year one.		
Objective 3.2: Increase the use of Evidence Based Programs used by coalitions for alcohol prevention to at least 60% of strategies used in each region as measured by the Nebraska Prevention Information Reporting System by 2019. By 2023 the use of Evidence Based Programs used should be at least 70%.		
	State Level Process:	

	3.1. Who was involved in the development of the Approved Nebraska Evidence Based Program (EBP) Listing?	EBP Listing Documentation
	3.2. How did facilitators and barriers affect the development of the Approved Nebraska Evidence Based Program (EBP) Listing?	PAC/SEOW FG (Q7), RPC FG (Q4)
	3.3. Did the State and Region provide support to community coalitions in identifying and selecting EBP's?	Site visits (Ciii7&8), Quarterly reports
	3.4. How did the SPF process affect the selection of strategies?	Site visits (Ciii4&6), Quarterly reports
	Community Level Process:	
	3.1. How was the Approved Nebraska Evidence Based Program (EBP) Listing used by coalitions?	Site visits (Ciii9), Quarterly reports
	3.2. How did the SPF process affect the selection of strategies?	Site visits (Ciii4&6), Quarterly reports
	3.3. How did facilitators and barriers affect the selection of strategies?	Site visits (Ciii4), Quarterly reports
	State Level Outcome:	
	3.1. Did the use of Evidence-Based Strategies employed by prevention coalitions to reduce alcohol and substance use among individuals 9 to 20 years old increase?	Workplans
	3.1a. Was an Approved Nebraska Evidence Based Program (EBP) Listing for communities to use for the prevention of alcohol use created by the end of Year one?	EBP Listing Documentation
	3.1b. Were at least 60% of PFS funds from all PFS subgrantees used on EBP's, as measured by the Nebraska Prevention Information Reporting System by September 30, 2019?	Workplans and Budgets
	3.1c. Were at least 70% of PFS funds from all PFS subgrantees used on EBP's, as measured by the Nebraska Prevention Information Reporting System by 2023?	Workplans and Budgets

	Community Level Outcome:	
	3.1. Did the use of Evidence-Based Strategies employed by prevention coalitions to reduce alcohol and substance use among individuals 9 to 20 years old increase?	Workplans
	3.1a. Were at least 60% of PFS funds used on EBP's, as measured by the Nebraska Prevention Information Reporting System by September 30, 2019?	Workplans and Budgets
	3.1b. Were at least 70% of PFS funds used on EBP's, as measured by the Nebraska Prevention Information Reporting System by 2023?	Workplans and Budgets
Goal 4: Strengthen capacity and infrastructure at the state and community levels in support of prevention efforts.		
	State Level Process:	
	4.1. Did the State and Region provide support to community coalitions in developing data driven workplans?	Site visits (Ciii7-8), RPC FG (Q2)
	4.2. Did the State and Region provide training and technical assistance to strengthen capacity and infrastructure at the community level in support of prevention efforts?	Site visits (F1&2), Coalition coordinator survey, Quarterly reports, T/TA tracking form, NPIRS
	4.3. How did the quantity and quality of training and technical assistance impact implementation?	Site visits (F4), Coalition coordinator survey, RPC FG (Q6), Quarterly reports
	4.4. Were Cultural and Linguistically Appropriate Standards (CLAS) used to improve capacity at the state level?	Site visits (E1), SEOW/PAC FG (Q9), RPC FG (Q7)
	4.5. How was coalition capacity and functioning related to implementation and outcomes?	Capacity survey, Site visits (Civ2), NRPFSS, NYAAOS, PLI's
	4.6. How did facilitators and barriers affect capacity and infrastructure at the state and region level?	Site visits (Cii4-7), SEOW/PAC FG (Q8), RPC FG (Q3)
	Community Level Process:	

	4.1. Did sub-recipients implement each SPF step with fidelity?	Site visits (SPF Rubrics)
	4.2. Were Cultural and Linguistically Appropriate Standards (CLAS) used to improve capacity at the community level?	Capacity survey, Site visits (E2), Quarterly reports
	4.3. How did facilitators and barriers affect capacity and infrastructure at the community level?	Site visits (Cii2), Quarterly reports
	State Level Outcome:	
	4.1. Were prevention capacity and infrastructure strengthened at the state level?	Coalition coordinator survey, Site visits (Cii6&7), SEOW/PAC FG (Q8), RPC FG (Q3)
	Community Level Outcome:	
	4.1. Were prevention capacity and infrastructure strengthened at the community level?	Coalition capacity survey, Site visits (capacity rubric and Cii2&3)
Goal 5: Leverage, redirect, and realign local funding streams for prevention related to underage drinking, and target the increased marijuana use among this population.		
	State Level Process:	
	5.1. How did facilitators and barriers affect sub-recipients' ability to leverage, redirect, and realign funding streams for prevention related to underage drinking, and target the increased marijuana use among this population?	Site visits (D1&2), RPC FG (Q8), Quarterly reports
	Community Level Process:	
	5.1. How did facilitators and barriers affect sub-recipients' ability to leverage, redirect, and realign funding streams for prevention related to underage drinking, and target the increased marijuana use among this population?	Site visits (D1&2), Quarterly reports

	State Level Outcome:	
	5.1. Were funding streams leveraged, redirected, and realigned to prioritize and fund prevention practices that produce improved results at the state level?	Site Visits (D1&2), NRPFSS, NYAAOS, Crime Commission, Hospital Discharge, Highway Safety
	Community Level Outcome:	
	5.1. Were funding streams leveraged, redirected, and realigned to prioritize and fund prevention practices that produce improved results at the community level?	Site Visits (D1&2), NRPFSS, NYAAOS, Crime Commission, Hospital Discharge, Highway Safety
Other Outcomes		
	State Level Outcomes:	
	O1. Did the implementation of SPF-PFS reduce alcohol-related consequences among youth ages 9-20 at the state level?	Crime Commission, Hospital Discharge, Highway Safety
	O2. Did the implementation of SPF-PFS impact alcohol-related perceptions and attitudes in the targeted communities?	NRPFSS, NYAAOS, NASIS
	O3. Did the implementation of SPF-PFS reduce racial/ethnic behavioral health disparities among youth ages 9-20 at the state level?	YRBS, NRPFSS, NYAAOS, Crime Commission, Hospital Discharge, Highway Safety
	Community Level Outcomes:	
	O1. Did the implementation of SPF-PFS reduce alcohol-related consequences among youth ages 9-20 in the targeted communities?	Crime Commission, Hospital Discharge, Highway Safety
	O2. Did the implementation of SPF-PFS impact alcohol-related perceptions and attitudes in the targeted communities?	NRPFSS, NYAAOS, NCAOS, College surveys
	O3. Did the implementation of SPF-PFS reduce racial/ethnic behavioral health disparities among youth ages 9-20 in the targeted communities?	NRPFSS, NYAAOS, Crime Commission, Hospital Discharge, Highway Safety

Evaluation Methods

Process Evaluation

Multiple evaluation methods will be employed to gather process evaluation data. The evaluation will use existing information whenever possible to reduce burden, including NPIRS, quarterly reports and other documentation. Table 2 summarizes measures and corresponding data sources for the state and community level process evaluation, while the text below describes each data source in more detail.

Workplans and Quarterly Reports

All sub-recipients are required to submit to the Division of Behavioral Health an annual workplan with budget, which will provide details on the strategies to be implemented. Funded sub-recipients will also provide quarterly reports, which will include an update on accomplishments and barriers for each of the SPF steps. The Division of Behavioral Health will share these reports with the evaluation team for review. Together, this information will be used to assess adherence to the SPF steps, implementation of selected strategies, training and technical assistance received, and to identify successes and barriers.

State Level Key Stakeholder Focus Groups

Two focus groups will be conducted with state level key stakeholders. One focus group will be conducted with representatives from the Prevention Advisory Council (PAC) and the State Epidemiological Outcomes Workgroup (SEOW) Executive Committee, while the other will be conducted with the Regional Prevention Coordinators. The focus groups will gather information regarding their perceptions of the overall SPF-PFS, as well as specific aspects including the development of the EBP Listing, training and technical assistance provided, assistance provided to sub-recipients in developing data driven workplans, incorporation of CLAS standards and perceptions of capacity at the state, regional, and local levels. The focus groups will be conducted in the first and final years of the grant. The focus groups conducted in the first year will provide a baseline assessment of state and regional infrastructure, while the final year focus groups will provide process data to explain outcomes and describe perceived impacts.

Sub-recipient Site Visits

The evaluator will conduct annual site visits with each funded community coalition. The site visits conducted in the first year will provide a baseline assessment of SPF adherence, community readiness, capacity, leveraging of resources, incorporation of CLAS standards, and facilitators and barriers experienced in the first year. The visits taking place during years 2- will provide insightful process evaluation information to guide modifications to further improve implementation and administration. The final site visit in the last year will elicit information to further explain final outcomes and describe the impact on underage drinking, state and

community level capacity, prevention infrastructure, and changes in the leveraging of resources. In addition to collecting in-depth qualitative feedback, the SPF Model Fidelity Rubric designed by a national workgroup of SPF SIG project directors and evaluators will be utilized during the visits to assess fidelity to the SPF Model.

Nebraska Prevention Information Reporting System (NPIRS)

The Nebraska Prevention Information Reporting System (NPIRS) will be utilized to provide process data regarding strategy implementation. Regional staff and sub-recipients enter all PFS activities into the NPIRS system on a monthly basis to track progress. The system will provide data on the number of participants served/reached, as well as their demographics. In addition, the system will provide fidelity data to describe how the strategy was implemented. The NPIRS system will be accessible to the evaluator.

Coalition Capacity Member Survey and Coalition Coordinator Survey

During the first, third, and final years of the grant, a survey will be administered to all coalition members to measure coalition capacity. In addition, the coalition coordinators will receive additional items as part of the coalition coordinator survey, which will measure state and regional capacity, as well as provide additional information about the coalition. The survey will assess coalition members' perceptions of several prevention system qualities, including the SPF steps, leadership, collaboration, communication, structure, membership, and impact. The evaluation team will work with coalition coordinators to establish the sample frame of coalition members. The survey will be administered as a web survey, with options of administering the survey in person at coalition meetings, and also mailing paper surveys to non-respondents to achieve a representative response.

Training/Technical Assistance Tracking Form

Regional prevention staff, DBH staff, and the evaluator will report all training and technical assistance provided to sub-recipients through a training and technical assistance form. The information may be submitted at any time, but must be submitted at least quarterly, and can be submitted through an online form or through the use of a paper form. The evaluator will review the information on a quarterly basis and share it with DBH for entry into SPARS.

Evidence-Based Program (EBP) Listing Documentation

The process of developing the EBP Listing will be documented by the evaluator. This documentation will include tracking who is involved in the development of the listing, meetings, and the product(s) delivered and the dissemination process.

Table 2. Process Evaluation Measures and Sources

Measure(s)	Data Sources	How Collected	Who will be collecting?	When will it be collected?
T/TA activities	NPIRS	Online reporting system	DBH	Monthly
	TA tracking form	Web or paper form	Evaluator	Ongoing
Strategy Selections	Workplans and Budgets	Electronic submission using template	DBH	Annually
EBP Listing Participation and Development	EBP Listing Documentation	Documentation of process	Evaluator	Ongoing
Number and demographics of people served/reached through selected strategies	NPIRS	Online Reporting System	DBH	Monthly
Fidelity	NPIRS	Online Reporting System	DBH	Monthly
Contextual Factors, Community Characteristics, Facilitators and Barriers	Quarterly Reports	Electronic submission using template	DBH	Quarterly
	Site Visits	In-person interviews during on-site visit	Evaluator	Annually
Coalition Capacity	Coalition Capacity Survey	Online survey	Evaluator	1st, 3rd, and 5th year
State/Region and Community Capacity: resources, assets, readiness, SPF adherence, use of CLAS	Coalition Coordinator Survey	Online survey	Evaluator	1st, 3rd, and 5th year
	State Stakeholder Focus Groups	In-person focus groups	Evaluator	1st and 5th year
	Site Visits	In-person interviews during on-site visit	Evaluator	Annually

Outcome Evaluation

In addition to the measures described above, a variety of other data sources will be used to further assess the impact of SPF-PFS on underage drinking behaviors, intervening variables and consequences, which are described in detail below. Data sources using sampling techniques designed to allow statewide estimates will be used to evaluate the impact on the state as a whole. In contrast, community level impacts will be assessed by analyzing data collected from a census or sample drawn with the intent of providing local level estimates. As the SPF-PFS is not targeted as a statewide effort, community level analysis will be the primary focus and comparisons between targeted and non-targeted counties will be made whenever data is available at the county level. Table 3 shows the data sources and specific measures that will be used to analyze statewide and community level impacts. In all cases, national outcome measures are primarily used. In some instances, these measures are supplemented with additional measures that have been tested and used longitudinally in ongoing surveys (e.g., NRPFSS and NYAAOS).

Youth Risk Behavior Survey

The Youth Risk and Behavior Survey (YRBS), a part of the Student Health and Risk Prevention (SHARP) Surveillance System, provides state level data on past and current use of alcohol, as well as addressing excessive use and riding with an impaired driver. The YRBS instruments have undergone laboratory and field testing on reliability by the CDC, and the data is collected from a random sample of high school students in Nebraska in grades 9 through 12 and is collected by the BOSR. The survey is administered in classrooms through a two-stage cluster design, whereby a random sample of public high schools is drawn by the CDC, then a random sample of classrooms is sampled within the selected and participating schools. The YRBS is conducted biennially by the BOSR in the fall of even years.

Nebraska Risk & Protective Factor Student Survey

The Nebraska Risk & Protective Factor Student Survey (NRPFSS), also a part of the SHARP Surveillance System, consists of community level data on lifetime use of alcohol, the age of onset, and past 30 day use. Similar to the YRBS, the NRPFSS is conducted biennially during even years in-person in Nebraska schools and is collected by the BOSR. The NRPFSS is designed and implemented as a census of students in grades 8, 10, and 12 where every public and non-public school with an eligible grade can choose to participate. Risk and protective factors found in the NRPFSS have been used from the Communities that Care (CTC) survey, the foundation of reliable and valid risk and protective factor information. In the 2016 administration of the NRPFSS, the overall participation statewide was 37.6% (N=28,710).

Nebraska Young Adult Alcohol Opinion Survey

The Nebraska Young Adult Alcohol Opinion Survey (NYAAOS) is administered by the BOSR to a sample of young adults ages 19 to 25 generated by the Nebraska Department of Motor Vehicles Driver Record Database. In the most recent

administration, conducted in 2018, the sample was stratified first by county to represent each of the SPF-PFS counties, and second by the six Nebraska behavioral health regions so that an approximately equal number of respondents was sampled in each region. The mail survey, which also utilized a $1 cash incentive, provides statewide data on lifetime and current use of alcohol, attitudes towards alcohol-related law enforcement, as well as community perceptions. In the 2018 administration of the NYAAOS, when adjusted for known ineligibles and undeliverable returns, the survey had response rate of 18.7% (N=1,967). Since the sample included information about the respondents, non-response analyses were conducted and found that respondents were well representative of the sample; thus non-response bias is not a significant concern. The NYAAOS will be administered at two time points during the funding period. The SEOW will discuss mechanisms to improve response rates, including gaining feedback on survey layout and cover letter wording, exploring ways to obtain email addresses and to market the survey, and identifying partnerships and/or grant opportunities to provide additional sponsorship or funding to incorporate additional methods, such as upfront incentives and additional contacts.

Nebraska Annual Social Indicators Survey/Nebraska Community Alcohol Opinion Survey

The Nebraska Annual Social Indicators Survey (NASIS) is an annual omnibus mail survey administered by the BOSR to residents of the state of Nebraska age 19 or over. The sample is a simple random sample drawn from a postal delivery sequence of household addresses to provide a representative statewide sample of Nebraska households. The last birthday method is used to randomly select an adult in the household to complete the survey. The 2018 survey utilized four mailings. The survey will be administered in the first, third, and final year of the grant with intervening variable and community perception measures to provide statewide and community level estimates. In the 2018 administration of the NASIS, the response rate was 26.1%. The NASIS typically yields approximately 900 completed surveys, so the 2019 administration will be used to provide statewide baseline estimates. The SPF-PFS relevant questions will be included as one page of the survey, which will also include items on other topics since it is an omnibus survey. In addition, a brief subsection of the NASIS survey, the Nebraska Community Alcohol Opinion Survey (NCAOS) will be used for an oversample in the SPF-PFS targeted counties (using the same random sampling design as NASIS, but after removing NASIS selected households). The two-page NCAOS survey will include demographics and SPF-PFS relevant questions only. In total, combining NASIS and NCAOS, it is expected that 200 surveys will be completed for each of the targeted coalitions.

College Alcohol Surveys

Multiple colleges across the state will implement various college climate surveys, which will measure alcohol and marijuana use. Some colleges will be using existing surveys, such as the American College Health Assessment, while others will be using locally developed surveys.

Program Level Survey

Sub-recipients implementing individual level strategies will collect pre- and post-test surveys (or retrospective). The surveys will be administered to all participants receiving the programming. Participants will be matched over time through the use of an identification number generated from multiple survey items that remain stable over time, such as birthdate and gender. The evaluation team will work in tandem with coalition coordinators to ensure program level surveys are completed by a minimum of 70% of participants. If response rates are below that threshold, technical assistance will be sought to develop strategies for increasing response.

Other Data Sources

In addition to the surveys discussed above, other sources of data will be obtained from the Nebraska Crime Commission, Nebraska Hospital Discharge Data, and the Nebraska Office of Highway Safety. These resources will provide information on alcohol related motor vehicle accidents, corrections, and hospitalizations. These data will be available at the county level. Other additional data sources may also be pursued to provide further insight into underage drinking, such as campus violation data.

Behavioral Health Disparities

Nebraska is experiencing dramatic demographic changes with regard to race/ethnicity. According to the U.S. Census Bureau, between 2000 and 2010, the minority population in Nebraska increased by 51%. Given the growing minority population, it is vital to investigate health disparities related to underage drinking. Moreover, Nebraska DHHS Vital Statistics show a disparity in alcohol-related deaths, with more American Indians, African Americans, and Hispanics dying due to alcohol from 2006-2010 compared to Whites. All survey data, and administrative data that includes race/ethnicity and/or gender, will be used to identify health disparities and to observe changes in these disparities over time. Currently, gender, race, and age are variables available for all survey data. Consequence data typically provides information by gender, and occasionally by race when the number of cases is sufficient, and data is available.

Table 3. Outcome Evaluation Measures and Sources

Construct	Measure(s)	Data Sources	Targeted Population	How Collected	Who will collect?	When collected?
Lifetime Use	During your life, on how many days have you had at least one drink of alcohol?	YRBS	Students in grades 9-12	In-school Survey	BOSR	2018, 2020, 2022
Age of onset	How old were you when you had your first drink of alcohol other than a few sips?					
Past 30 day alcohol use	During the past 30 days, on how many days did you have at least one drink of alcohol?					
Binge Drinking	During the past 30 days, on how many days did you have 5 or more drinks of alcohol in a row, that is, within a couple of hours?					
Past 30 day marijuana use	During the past 30 days, how many times did you use marijuana?					
Alcohol Lifetime Use	In your life, how many times have you had alcoholic beverages to drink - more than a few sips?	NRPFSS	Students in grades 8, 10, 12	In-school survey	BOSR	2018, 2020, 2022
Alcohol age of onset	How old were you when you first had more than a sip or two of beer, wine, or hard liquor (for example, vodka, whiskey, or gin)?					
Alcohol Past 30 day use	During the past 30 days, how many times have you had beer, wine, or hard liquor to drink?					
Binge Drinking	Have you had five or more drinks of alcohol in a row, that is, within a couple of hours during the past 30 days?					

Construct	Measure(s)	Data Sources	Targeted Population	How Collected	Who will collect?	When collected?
Marijuana Lifetime Use	In your life, how many times have you used marijuana?	NRPFSS	Students in grades 8, 10, 12	In-school survey	BOSR	2018, 2020, 2022
Marijuana age of onset	How old were you when you first smoked marijuana?					
Marijuana Past 30 day use	During the past 30 days, how many times have you used marijuana?					
Attitudes toward alcohol/marijuana use	How wrong do you think it is for someone your age to drink beer, wine or hard liquor regularly, that is, at least once or twice a month?					
	How wrong do you think it is for someone your age to smoke marijuana?					
Perception of risk from drinking/marijuana	How much do you think people risk harming themselves physically or in other ways if they take one or two drinks of an alcoholic beverage nearly every day?					
	How much do you think people risk harming themselves physically or in other ways if they have five or more drinks of an alcoholic beverage once or twice a week?					
	How much do you think people risk harming themselves physically or in other ways if they smoke marijuana once or twice a week?					
Perception of peer use	Thinking about all the students in your grade at your school, how many do you think drank beer, wine, or hard liquor during the past 30 days?					
	Thinking about all the students in your grade at your school, how many do you think smoked marijuana during the past 30 days					

Construct	Measure(s)	Data Sources	Targeted Population	How Collected	Who will collect?	When collected?
Access	If you wanted to, how easy would it be for you to get some beer, wine, or hard liquor?	NRPFSS	Students in grades 8, 10, 12	In-school survey	BOSR	2018, 2020, 2022
	If you wanted to, how easy would it be for you to get some marijuana?					
Parent/Community/Peer perceptions	How wrong do your parents or caregivers feel it would be for you to have one or two drinks of an alcoholic beverage nearly every day?					
	How wrong do your parents or caregivers feel it would be for you to smoke marijuana?					
	How wrong would most adults (over 21) in your neighborhood, or the area around where you live, think it is for kids your age to drink alcohol?					
	How wrong would most adults (over 21) in your neighborhood, or the area around where you live, think it is for kids your age to use marijuana?					
	How wrong do your friends feel it would be for you to have one or two drinks of an alcoholic beverage nearly every day?					
	How wrong do your friends feel it would be for you to smoke marijuana?					
Talk about alcohol	During the past 12 months, have you talked with at least one of your parents or caregivers about the dangers of alcohol?					
Prevention messaging	In the past 12 months, have you seen or heard any anti-alcohol or anti-drug messages on TV, the internet, the radio, or in newspapers or magazines?					

Construct	Measure(s)	Data Sources	Targeted Population	How Collected	Who will collect?	When collected?
Attitudes toward alcohol use and marijuana	How wrong… Individuals under the age of 18 to have one or two drinks	NASIS/ NCAOS	Adults	Mail Survey	BOSR	2019, 2021, 2023
	Individuals under the age of 18 to have five or more drinks at one setting					
	Individuals 18 to 20 years old to have one or two drinks					
	Individuals 18 to 20 years old to have five or more drinks at one setting					
	Individuals 21 and older to provide alcohol for people under 21 years old					
	Individuals under the age of 18 to use marijuana or cannabis					
	Individuals 18-20 years old to use marijuana or cannabis					
	Individuals 21 and older to use marijuana or cannabis					
Perception of community	How wrong would most adults in your community think it is for individuals under the age of 21 to drink alcohol?					
Perception of risk of alcohol	How much do you think people risk harming themselves physically or in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?					
Perception of risk of marijuana	How much do you think people risk harming themselves physically or in other ways if they use marijuana or cannabis once or twice a week?					
Access to alcohol	During the past 12 months, have you allowed individuals under the age of 21 to drink alcohol on your property?					

Construct	Measure(s)	Data Sources	Targeted Population	How Collected	Who will collect?	When collected?
Lifetime Use	Have you ever had a drink of an alcoholic beverage?	NYAAOS	19-25 year olds	Mail Survey	BOSR	2020, 2022
Past 30 day alcohol use	When was the last time you had at least one drink of any alcoholic beverage such as beer, wine, wine coolers, malt beverages, or liquor?					
Binge Drinking	During the past 30 days, on how many days did you have 4/5 or more drinks of alcohol in a row, that is, within a couple of hours?					
Past 30 day marijuana use	During the past 30 days, on how many days did you use marijuana or cannabis?					
Perception of risk of alcohol	How much do you think people risk harming themselves physically or in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?					
Perception of risk of marijuana	How much do you think people risk harming themselves physically or in other ways if they use marijuana or cannabis once or twice a week?					
Perception of peer use	What percentage of people your age do you think… have had at least one drink of alcohol?					
	What percentage of people your age do you think… have had five or more drinks of alcohol?					
	What percentage of people your age do you think… have used marijuana or cannabis?					

Construct	Measure(s)	Data Sources	Targeted Population	How Collected	Who will collect?	When collected?
Attitudes toward alcohol use and marijuana	How wrong… Individuals under the age of 18 to have one or two drinks	NYAAOS	19-25 year olds	Mail Survey	BOSR	2020, 2022
	Individuals under the age of 18 to have five or more drinks at one setting					
	Individuals 18 to 20 years old to have one or two drinks					
	Individuals 18 to 20 years old to have five or more drinks at one setting					
	Individuals 21 and older to provide alcohol for people under 21 years old					
	Individuals under the age of 18 to use marijuana or cannabis					
	Individuals 18-20 years old to use marijuana or cannabis					
	Individuals 21 and older to use marijuana or cannabis					
Past 30 day alcohol use	During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?	Program Level Instrument	Program Participants	Self-Admin Paper Survey	Evaluator /Program Staff	Before/After Program
Binge Drinking	During the past 30 days, on how many days did you have 5 or more alcoholic beverages in a row, that is, within a couple of hours?					
Past 30 day marijuana use	During the past 30 days, on how many days did you use marijuana?					

Construct	Measure(s)	Data Sources	Targeted Population	How Collected	Who will collect?	When collected?
Perception of risk of harm of alcohol	How much do you think people risk harming themselves (physically and in other ways) if they have 5 or more drinks of an alcoholic beverage once or twice a week?	Program Level Instrument	Program Participants	Self-Admin Paper Survey	Evaluator /Program Staff	Before/After Program
	How much do you think people risk harming themselves (physically and in other ways) if they take one or two drinks of an alcoholic beverage (beer, wine, or hard liquor) nearly every day?					
Perception of risk of harm of marijuana	How much do people risk harming themselves physically and in other ways when they smoke marijuana once a month?					
	How much do you think people risk harming themselves (physically and in other ways) if they smoke marijuana once or twice a week?					
Perception of wrongness	How wrong do you think it is for someone your age to drink beer, wine or hard liquor (for example vodka, whiskey or gin) regularly, that is at least once or twice a month?					
	How wrong do you think it is for someone your age to smoke marijuana?					
Perception of peer use	Thinking about all the students in your grade at your school, how many do you think drank beer, wine, or hard liquor during the past 30 days?					
	Thinking about all the students in your grade at your school, how many do you think smoked marijuana during the past 30 days					
Talk to parent	During the past 12 months, have you talked with at least one of your parents about the dangers of tobacco, alcohol, or drug use?					

Construct	Measure(s)	Data Sources	Targeted Population	How Collected	Who will collect?	When collected?
T/TA	How would you rate the Training and Technical Assistance (T/TA) you've received regarding PFS from DHHS Division of Behavioral Health?	Coalition Coordinator survey	Coalition Coordinators	Online survey	Evaluator	1st, 3rd, and 5th year
	How would you rate the Training and Technical Assistance (T/TA) you've received regarding PFS from Regional Behavioral Health Prevention staff?					
	How would you rate the performance of the DHHS Division of Behavioral Health staff in… Providing solutions when problems arise					
	How would you rate the performance of the DHHS Division of Behavioral Health staff in… Response time and quality of feedback					
	How would you rate the performance of the DHHS Division of Behavioral Health staff in… Promotion of evidence based practices					
Capacity/ Infrastructure	How would you rate the performance of the DHHS Division of Behavioral Health staff in… Coordination with Regional Behavioral Health Prevention Staff					
	How would you rate the performance of the DHHS Division of Behavioral Health staff in… Data collection and report management					
	How would you rate the performance of the DHHS Division of Behavioral Health staff in… Clear and effective communication					
	The PAC contributes to statewide prevention system development efforts					
	The PAC effectively advises PFS efforts					
	The Statewide Epidemiological Outcomes Workgroup (SEOW) contributes to statewide prevention system development efforts					
	The Statewide Epidemiological Outcomes Workgroup (SEOW) effectively contributes to PFS efforts					
	Our coalition benefits from interacting with other PFS-funded coalitions					
	Our coalition has enough staff with the right skills					

Construct	Measure(s)	Data Sources	Targeted Population	How Collected	Who will collect?	When collected?
Capacity	Assessment scale (3 items)	Coalition Capacity Survey	Coalition Members	Online survey	Evaluator	1st, 3rd, and 5th year
	Planning scale (3 items)					
	Implementation scale (3 items)					
	Evaluation scale (3 items)					
	Cultural competency scale (3 items)					
	Sustainability scale (3 items)					
	Structure/membership scale (5 items)					
	Leadership scae (5 items)					
	Involvement scale (3 items)					
	Communication scale (4 items)					
	Who do you feel your coalition/community group is currently lacking representation from that would help your coalition/community group in accomplishing your goals?					
	Rate the strength of your coalition's/community group's collaboration with each of the following organizations (schools, faith based orgs, law enforcement, city govt, business, media, community orgs)					
T/TA	To what extent do you agree or disagree that training is provided to coalition/community group members on relevant topics?					

Construct	Measure(s)	Data Sources	Targeted Population	How Collected	Who will collect?	When collected?
Alcohol and drug enforcement	Liquor law violations of those 9-20	Crime Commission	9-20 year olds	Administrative Data	Evaluator/Epidemiologist	Annually
	DUI arrests of those 9-20					
	Drug arrests of those 9-20					
ER visits due to alcohol and marijuana	Number of hospitalizations due to alcohol and marijuana among 9-20 year olds	Hospital Discharge Data	9-20 year olds	Administrative Data	Evaluator/Epidemiologist	Annually
Impaired driving consequences	Alcohol-related or marijuana-related motor vehicle accidents involving those 9-20	Office of Highway Safety	9-20 year olds	Administrative Data	Evaluator/Epidemiologist	Annually

Analysis

In year one, descriptive analyses will be employed to establish a baseline describing the targeted communities in comparison to non-targeted communities. The baseline assessment will include both process and outcome measures and will identify any existing racial/ethnic health disparities relevant to underage drinking. Quantitative data will provide baseline benchmarks, which impacts will be measured against. Sample sizes are expected to be sufficient, which are estimated below:

YRBS: N= 1,900 representing the state
NRPFSS: N=20,000 with variation by county to provide county level data (it is anticipated that coalition level estimates will be released for each targeted coalition, which represents either a single county or multiple counties)
NYAAOS: N=3,500 representing the state (it is anticipated that coalition level estimates will be released for each targeted coalition, which represents either a single county or multiple counties)
NASIS: N=900 representing the state
NCAOS: N=200 per targeted coalition

Qualitative data collected through interviews, focus groups, and document review will be analyzed using a thematic analytic approach. Themes will be identified after data collection is complete, but will include descriptions of implementation and areas identified as barriers and successes. To supplement the qualitative descriptions of implementation, quantitative comparisons will be utilized to assess dosage and the extent to which they were implemented with fidelity. After implementation begins, trend data will be analyzed to assess impacts; trend data for the previous five years will also be included when available to determine changes in trends. Due to oversampling and/or the use of a census, sample sizes (provided for each data source in the previous section) will provide sufficient power to conduct the necessary analyses. As the SPF-PFS is not targeted as a statewide effort, community level analysis will be the primary focus and comparisons between racial/ethnic minority groups and between targeted and non-targeted counties will be made when feasible. In addition to analyzing cross-sectional survey and administrative data, paired-sample t-tests will be conducted with program level pre- and post-tests to assess individual level programming. Finally, process data, including fidelity rubric scores and dosage, will be used throughout the funding period to guide modifications and as part of the outcome evaluation to explain differences in outcomes.

Reporting

The evaluation team will communicate regularly with state agency program staff and will participate in project-related meetings. Regular evaluation updates will be

provided to the SEOW and/or PAC at their quarterly meetings. The evaluation team will submit an annual statewide report to the Division of Behavioral Health summarizing evaluation data collected to date. In addition to statewide reporting, annual reports will be provided to each sub-recipient. These progress reports will assist sub-recipients in determining whether their goals, objectives, and outcomes are achieved, and will provide information to guide program modifications. A final summative report will also be provided to each sub-recipient, and to the DBH, in the final year.

Timeline

Table 4 shows the five-year evaluation timeline that includes activities discussed in this report.

Table 4. SPF-PFS Evaluation Timeline

	FY 1				FY 2				FY 3				FY 4				FY 5			
	Q1 Oct-Dec '18	Q2 Jan-Mar '19	Q3 Apr-Jun '19	Q4 Jul-Sep '19	Q1 Oct-Dec '19	Q2 Jan-Mar '20	Q3 Apr-Jun '20	Q4 Jul-Sep '20	Q1 Oct-Dec '20	Q2 Jan-Mar '21	Q3 Apr-Jun '21	Q4 Jul-Sep '21	Q1 Oct-Dec '21	Q2 Jan-Mar '22	Q3 Apr-Jun '22	Q4 Jul-Sep '22	Q1 Oct-Dec '22	Q2 Jan-Mar '23	Q3 Apr-Jun '23	Q4 Jul-Sep '23
Develop State Level Evaluation Plan		X	X																	
Develop Community Level Evaluation Plans		X	X																	
NPIRS	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Quarterly Reports				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Stakeholder Focus Groups				X														X		
NRPFSS/YRBS	X	X						X	X							X	X			
NYAAOS							X								X					
NASIS/NCAOS				X								X								X
Coalition Capacity Survey			X							X								X		
Program Level Data Collection		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Site Visits				X				X				X				X			X	
Consequence Data				X				X				X				X				X
Annual Evaluation Report						X				X				X				X		X

Appendix A: Coalition Coordinator and Capacity Surveys

Coalition Coordinator Survey

Q1 **Thank you in advance for participating in this survey. The survey will assess different aspects of the capacity of your PFS coalition. Completing this survey will help your coalition better understand its strengths and weaknesses, and as a result, better plan and implement local prevention initiatives. The survey will take approximately 20 minutes to complete. Your answers will be kept confidential and you may skip any question you do not wish to answer. Your coalition will receive a report with the combined results from all participants once they are tabulated. There will be <u>two</u> main sections to this survey. <u>Section I</u>** will consist of questions specifically for you as a coordinator to answer regarding the functioning of your coalition. **<u>Section II</u>** will consist of the Coalition Capacity Survey sent out to your membership. Your responses to these questions will be combined with others from your coalition to present aggregated results regarding perceptions of the coalition.

Q3 **During the past 12 months, how many general coalition meetings have been held?**

- ○ None (1)
- ○ 1-3 meetings (2)
- ○ 4-6 meetings (3)
- ○ 7-9 meetings (4)
- ○ 10-12 meetings (5)
- ○ 13 or more meetings (6)
- ○ I don't know (7)

Q4 **Does your coalition have established expectations for active members (e.g., setting a minimum number of meetings that must be attended annually)?**

- ○ Yes (1)
- ○ No (2)
- ○ I don't know (3)

Q5 Do new coalition members receive an orientation and copies of relevant background materials?

- ○ Yes (1)
- ○ No (2)
- ○ I don't know (3)

Q6 **Approximately how many of your coalition members are *actively* involved in the coalition?**

- ○ None (0%) (1)
- ○ Few (1-10%) (2)
- ○ Some (11-30%) (3)
- ○ Some to half (31-50%) (4)
- ○ Half to most (51-70%) (5)
- ○ Most (71-90%) (6)
- ○ Almost all (91-100%) (7)
- ○ I don't know (8)

Q7 **Does your coalition have a vision and/or mission statement?**

- ○ Yes (1)
- ○ No (2)
- ○ I don't know (3)

Display This Question:

If Does your coalition have a vision and/or mission statement? = Yes

Q8 **When was your coalition's vision and/or mission statement last updated?**

- ○ Within the past 6 months (1)
- ○ More than 6 months ago, but within the past year (2)
- ○ More than 1 year ago, but within the past 3 years (3)
- ○ More than 3 years ago, but within the past 5 years (4)
- ○ More than 5 years ago, but within the past 10 years (5)
- ○ More than 10 years ago (6)
- ○ I don't know (7)

Q9 **Has your coalition ever conducted a self-assessment assessing its strengths and weaknesses?**

- ○ Yes (1)
- ○ No (2)
- ○ I don't know (3)

Display This Question:

If Has your coalition ever conducted a self-assessment assessing its strengths and weaknesses? = Yes

Q10 **When was your coalition's self-assessment last conducted?**

- ○ Within the past 6 months (1)
- ○ More than 6 months ago, but within the past year (2)
- ○ More than 1 year ago, but within the past 3 years (3)
- ○ More than 3 years ago, but within the past 5 years (4)
- ○ More than 5 years ago, but within the past 10 years (5)
- ○ More than 10 years ago (6)
- ○ I don't know (7)

Q11 **Has your coalition ever completed an assessment of the readiness of your community to engage in substance abuse prevention activities?**

- ○ Yes (1)
- ○ No (2)
- ○ I don't know (3)

Display This Question:

If Has your coalition ever completed an assessment of the readiness of your community to engage in s... = Yes

Q12 **When was your coalition's assessment of the readiness of your community last conducted?**

- ○ Within the past 6 months (1)
- ○ More than 6 months ago, but within the past year (2)
- ○ More than 1 year ago, but within the past 3 years (3)
- ○ More than 3 years ago, but within the past 5 years (4)
- ○ More than 5 years ago, but within the past 10 years (5)
- ○ More than 10 years ago (6)
- ○ I don't know (7)

Q13 **Has your coalition ever assessed the human resources (e.g., staff, volunteers) available in your community to support substance abuse prevention?**

- ○ Yes (1)
- ○ No (2)
- ○ I don't know (3)

Display This Question:

If Has your coalition ever assessed the human resources (e.g., staff, volunteers) available in your... = Yes

Q14 **When was your coalition's assessment of the human resources available in your community last conducted?**

- ○ Within the past 6 months (1)
- ○ More than 6 months ago, but within the past year (2)
- ○ More than 1 year ago, but within the past 3 years (3)
- ○ More than 3 years ago, but within the past 5 years (4)
- ○ More than 5 years ago, but within the past 10 years (5)
- ○ More than 10 years ago (6)
- ○ I don't know (7)

Q15 Has your coalition ever assessed the financial resources (e.g., donations, in-kind contributions, funding) available in your community to support substance abuse prevention?

- ○ Yes (1)
- ○ No (2)
- ○ I don't know (3)

Display This Question:

If Has your coalition ever assessed the financial resources (e.g., donations, in-kind contributions,... = Yes

Q16 **When was your coalition's assessment of the financial resources available in your community last conducted?**

- ○ Within the past 6 months (1)
- ○ More than 6 months ago, but within the past year (2)
- ○ More than 1 year ago, but within the past 3 years (3)
- ○ More than 3 years ago, but within the past 5 years (4)
- ○ More than 5 years ago, but within the past 10 years (5)
- ○ More than 10 years ago (6)
- ○ I don't know (7)

Q21 **Does your coalition have established by-laws?**

- Yes (1)
- No (2)
- I don't know (3)

Q22 **Does your coalition have an executive board or core group of leaders who meet independent of the larger coalition?**

- Yes (1)
- No (2)
- I don't know (3)

Display This Question:

If Does your coalition have an executive board or core group of leaders who meet independent of the... = Yes

Q23
How are the leadership of the executive board organized and tasks delegated?

- Coordinator delegates tasks (1)
- Each member volunteers for desired tasks (2)
- Staff, members, and coordinator work interdependently with one another (4)
- No organization (3)

Q24 **Does your coalition have established subcommittees? Note that subcommittees are not sub-coalitions; rather, they are smaller groups of coalition members**

addressing specific topics (e.g., media, policy, capacity building, cultural competency, grant writing, etc.).

- ○ Yes (1)
- ○ No (2)
- ○ I don't know (3)

Display This Question:

If Does your coalition have established subcommittees? Note that subcommittees are not sub-coalition... = Yes

Q25 **How are the leadership of the subcommittees organized and tasks delegated?**

- ○ Coordinator delegates tasks (1)
- ○ Each member volunteers for desired tasks (2)
- ○ Staff, members, and coordinator work interdependently with one another (4)
- ○ No organization (3)

Q26 **Does your coalition have a written sustainability plan?**

- Yes (1)
- No (2)
- I don't know (3)

Display This Question:

If Does your coalition have a written sustainability plan? = Yes

Q27 When was your coalition's written sustainability plan most recently completed?

- Within the past 6 months (1)
- More than 6 months ago, but within the past year (2)
- More than 1 year ago, but within the past 3 years (3)
- More than 3 years ago, but within the past 5 years (4)
- More than 5 years ago, but within the past 10 years (5)
- More than 10 years ago (6)
- I don't know (7)

Q28 **Has your coalition discussed how to sustain community outcomes beyond current funding?**

- ○ Yes (1)
- ○ No (2)
- ○ I don't know (3)

Q29 **Has your coalition discussed how to obtain future funding (e.g., Block Grant, DFC, Juvenile Justice, other)?**

- ○ Yes (1)
- ○ No (2)
- ○ I don't know (3)

Q30 Does your coalition keep the community updated on its activities (through a newsletter, website, etc.)?

- ○ Yes (1)
- ○ No (2)
- ○ I don't know (3)

Q31 **How would you rate the Training and Technical Assistance (T/TA) you've received regarding PFS from Regional Behavioral Health Prevention staff?**

- ○ Very Poor (1)
- ○ Poor (2)
- ○ Fair (3)
- ○ Good (4)
- ○ Very Good (6)
- ○ Not applicable (5)

Q32 How would you rate the Training and Technical Assistance (T/TA) you've received regarding PFS from DHHS Division of Behavioral Health?

- ○ Very Poor (1)
- ○ Poor (2)
- ○ Fair (3)
- ○ Good (4)
- ○ Very Good (5)
- ○ Not applicable (6)

Q33 **How would you rate the performance of the DHHS Division of Behavioral Health staff in the following areas with regard to the goals of the PFS grant?**

	Very Poor (50)	Poor (51)	Fair (52)	Good (53)	Very Good (54)	I don't know (55)
Coordination with Regional Behavioral Health Prevention Staff (1)	○	○	○	○	○	○
Data collection and report management (2)	○	○	○	○	○	○
Promotion of evidence based practices (3)	○	○	○	○	○	○
Workforce development and training (9)	○	○	○	○	○	○
Clear and effective communication (10)	○	○	○	○	○	○
Providing solutions when problems arise (11)	○	○	○	○	○	○
Response time and quality of feedback (12)	○	○	○	○	○	○

Q34 **How often do you communicate with other PFS-funded coalitions within your region?**

- ○ Often (1)
- ○ Sometimes (2)
- ○ Not very often (3)
- ○ Not at all (4)
- ○ I don't know (5)

Q35 How often do you communicate with other PFS-funded coalitions outside of your region?

- ○ Often (1)
- ○ Sometimes (2)
- ○ Not very often (3)
- ○ Not at all (4)
- ○ I don't know (5)

Q36 **How valuable are the Prevention Advisory Council (PAC) meetings to your PFS efforts?**

- ○ Very valuable (1)
- ○ Somewhat valuable (2)
- ○ Not very valuable (3)
- ○ Not at all valuable (4)
- ○ I have not yet attended a PAC meeting (5)

Q37 **How well does the Prevention Advisory Council (PAC) represent the diversity of the state in regards to population demographics and agency-level stakeholders?**

- ○ Very well (1)
- ○ Somewhat well (2)
- ○ Not very well (3)
- ○ Not at all well (4)
- ○ I don't know (5)

Display This Question:

If How well does the Prevention Advisory Council (PAC) represent the diversity of the state in regar... = Not very well

Or How well does the Prevention Advisory Council (PAC) represent the diversity of the state in regar... = Not at all well

Q38

Who do you believe should be added to the PAC?

_____

_____

_____

Q39 To what extent do you agree or disagree with each of the following statements?

	Strongly Disagree (1)	Disagree (2)	Agree (3)	Strongly Agree (4)	Not applicable (5)
The PAC contributes to statewide prevention system development efforts. (1)	○	○	○	○	○
The PAC effectively advises PFS efforts. (2)	○	○	○	○	○
The Statewide Epidemiological Outcomes Workgroup (SEOW) contributes to statewide prevention system development efforts. (3)	○	○	○	○	○
The Statewide Epidemiological Outcomes Workgroup (SEOW) effectively contributes to PFS efforts. (4)	○	○	○	○	○
Our coalition benefits from interacting with other PFS-funded coalitions. (5)	○	○	○	○	○
Our coalition has enough staff with the right skills. (6)	○	○	○	○	○

Appendix B: Coalition Capacity Survey

Partnerships for Success (PFS)
Coalition Capacity Survey

Thank you in advance for participating in this survey. The survey will assess different aspects of the capacity of your coalition/community group. Completing this survey will help your coalition better understand its strengths and weaknesses, and as a result, better plan and implement local prevention initiatives. The survey will take approximately 10 minutes to complete. Your answers will be kept confidential and you may skip any question you do not wish to answer. Your coalition/community group will receive a report with the combined results from all participants once they are tabulated, but no individual responses will be reported.

The first set of questions focuses on applying the Strategic Prevention Framework (SPF) in your coalition/community group.

1. To what extent do you agree or disagree with the following statements about your coalition's/ community group's capacity to conduct <u>assessment</u>?

	Strongly Disagree	Disagree	Agree	Strongly Agree	Not applicable
I participate in reviewing needs assessment data.	○	○	○	○	○
I have a clear understanding of the needs of my community.	○	○	○	○	○
Limited data at the local level presents a barrier to our assessment process.	○	○	○	○	○

2. Additional comments regarding strengths or challenges related to assessment.

3. The following section is about your <u>planning</u> experience. To what extent do you agree or disagree with each of the following statements?

	Strongly disagree	Disagree	Agree	Strongly Agree	Not applicable
Our coalition/community group develops an annual workplan based on input from members.	○	○	○	○	○
I am actively involved in the planning process.	○	○	○	○	○
Our coalition/community group selects effective strategies.	○	○	○	○	○

4. Additional comments regarding strengths or challenges related to planning.

5. The next section is about your experience with <u>implementation</u> of strategies. To what extent do you agree or disagree with each of the following statements?

	Strongly Disagree	Disagree	Agree	Strongly Agree	Not applicable
Our coalition/community group strictly implements strategies in the manner they are designed.	○	○	○	○	○
I understand the need for implementing evidence-based programs, policies, and practices.	○	○	○	○	○
Action plans and target dates are developed for each task or project.	○	○	○	○	○

6. Additional comments regarding strengths or challenges related to implementation.

7. The following section is about your coalition's/community group's <u>evaluation</u> experience. To what extend do you agree with each of the following statements?

	Strongly Disagree	Disagree	Agree	Strongly Agree	Not applicable
Our coalition/community group uses the data we collect to evaluate our work and report the results of those evaluations.	○	○	○	○	○
Coalition/community group members participate in reviewing data for planning and evaluation purposes.	○	○	○	○	○
Our coalition/community group uses evaluation data to modify our efforts.	○	○	○	○	○

8. Additional comments regarding strengths or challenges related to evaluation.

9. Please indicate the extent to which you agree or disagree with each of the following statements about your coalition's/community group's attention to cultural competency and behavioral health disparities?

	Strongly Disagree	Disagree	Agree	Strongly Agree	Not applicable
Our coalition/community group considers cultural factors when selecting strategies.	○	○	○	○	○
Our coalition/community group lacks representation from cultural groups in our community.	○	○	○	○	○
Our coalition/community group recognizes the importance of respecting cultural diversity (including racial/ethnic, gender, socioeconomic, and lifestyle).	○	○	○	○	○

10. What cultural groups, if any, do you believe are lacking representation in your coalition/community group?

11. Additional comments regarding strengths or challenges related to cultural competency and behavioral health disparities.

12. To what extent do you agree or disagree with the following statements regarding the sustainability of your coalition/community group?

	Strongly Disagree	Disagree	Agree	Strongly Agree	Not applicable
Our coalition/community group plans ahead for its long-term sustainability.	○	○	○	○	○
I believe our coalition/community group has the capacity to sustain our prevention efforts over time.	○	○	○	○	○
I am confident that most of our selected strategies will continue after the PFS grant funding ends.	○	○	○	○	○

13. Additional comments regarding strengths or challenges related to sustainability.

The next set of questions ask about training and technical assistance.

14. To what extent do you agree or disagree that training is provided to coalition/community group members on relevant topics?

Strongly Disagree	Disagree	Agree	Strongly Agree
○	○	○	○

15. The following is a list of training or technical assistance areas. Please select which of these areas would be of interest to you or your coalition/community group over the next 2 years? (Select all that apply)

- ☐ Assessing the needs and interests of the community
- ☐ Collecting, analyzing, and/or reporting data
- ☐ Obtaining and/or staying informed about substance abuse research
- ☐ Keeping coalition members engaged
- ☐ Recruiting new coalition members
- ☐ Sharing information about the work of the coalition within the community
- ☐ Building partnerships with community leaders
- ☐ Improving leadership skills
- ☐ Identifying strategies to address substance abuse prevention in the community
- ☐ Implementing environmental strategies
- ☐ Evaluating the coalition's substance abuse prevention efforts
- ☐ Implementing individual strategies
- ☐ Prevention Skills Training
- ☐ Addressing behavioral health disparities in substance abuse prevention work
- ☐ Sustaining community outcomes beyond current funding
- ☐ Obtaining additional funding

16. Please describe any other training or technical assistance that your coalition/community group would benefit from?

17. The following statements are about your coalition's/community group's structure and membership. Please indicate to what extent you agree or disagree with each of the statements.

	Strongly Disagree	Disagree	Agree	Strongly Agree	Not applicable
Our coalition/community group lacks representation from groups that would help us accomplish our goals (e.g. youth, schools, law enforcement).	○	○	○	○	○
My role in the coalition/ community group is well-defined.	○	○	○	○	○
Meetings are held in centrally accessible, comfortable places at convenient times for all members.	○	○	○	○	○
We accomplish meeting objectives in meetings that start and end on time.	○	○	○	○	○
I know where to access substance use prevention resources.	○	○	○	○	○

18. Who do you feel your coalition/community group is currently lacking representation from that would help your coalition/community group in accomplishing your goals? (Select all that apply)

- ☐ Youth
- ☐ Parents
- ☐ Businesses
- ☐ Media
- ☐ Schools
- ☐ Youth serving organizations
- ☐ Law enforcement
- ☐ Faith based community
- ☐ Civic and volunteer groups
- ☐ Health care professionals
- ☐ State, local, or tribal agencies
- ☐ Other

19. Additional comments regarding strengths or challenges related to the coalition/community group structure and membership, including any suggestions to improve its effectiveness.

20. Please rate the strength of your coalition's/community group's collaboration with each of the following organizations on a scale or 1-5, where 1 is weak and 5 is strong.

	1 (Weak)	2	3	4	5 (Strong)
Elementary, middle, or high schools	○	○	○	○	○
Faith based organizations	○	○	○	○	○
Law enforcement	○	○	○	○	○
City government	○	○	○	○	○
Business community	○	○	○	○	○
Local media (newspaper, radio, TV)	○	○	○	○	○
Community organizations	○	○	○	○	○

21. Describe any specific organizations you believe your coalition/community group should work toward strengthening a collaboration with.

22. Please indicate to what extent you agree or disagree with each of the following statements about the coalition's/community group's leadership.

	Strongly disagree	Disagree	Agree	Strongly agree	Not applicable
Leaders keep the coalition/community group focused on and progressing towards its goals.	○	○	○	○	○
Leaders encourage open dialog and expression of views among members.	○	○	○	○	○
Leaders utilize the skills and experience of the members.	○	○	○	○	○
I am satisfied with the balance of power between staff, leaders, and members.	○	○	○	○	○
There are opportunities for coalition/community group members to take leadership roles.	○	○	○	○	○

23. Please indicate to what extent you agree or disagree with each of the following statements about your involvement in the coalition/community group.

	Strongly disagree	Disagree	Agree	Strongly agree	Not applicable
My time spent on coalition/community group efforts is worthwhile.	○	○	○	○	○
Our coalition/community group is making a difference in the community.	○	○	○	○	○
Our coalition/community group is stronger because I am a member.	○	○	○	○	○

24. How satisfied are you with the...

	Strongly disagree	Disagree	Agree	Strongly agree	Not applicable
Use of media (including social media) to promote awareness of the coalition's/community group's goals, actions, and accomplishments?	○	○	○	○	○
Communication between coalition/community group members and staff?	○	○	○	○	○
Extent to which coalition/community group members are listened to and heard?	○	○	○	○	○
Communication between the coalition/community group and the community?	○	○	○	○	○

Finally, we have some questions about you.

25. **How long have you been or were you a member of your coalition/community group?**
    - ○ Less than a year
    - ○ 1 year – less than 3 years
    - ○ 3 years – less than 5 years
    - ○ 5 years of more
    - ○ I am not a member
26. **During the past 12 months, how many of your coalition's/community group's meetings have you attended?**
    - ○ None
    - ○ At least one, but less than half
    - ○ About half
    - ○ More than half, but not all
    - ○ All or nearly all
27. **Please describe any suggested changes that would increase your attendance.**

    [ ]
28. **Why are you a member of your coalition/community group?**

    [ ]
29. **Are you a member of your coalition/community group because it is a part of your job?**
    - ○ Yes
    - ○ No
30. **Do you live or work in the community served by your coalition/community group?**
    - ○ Yes, I live in the community
    - ○ Yes, I work in the community
    - ○ Yes, I live AND work in the community
    - ○ No, I do not live or work in the community
31. **What is your age?**
    - ○ Less than 24 years
    - ○ 25-39 years
    - ○ 40-64 years
    - ○ 65+ years
32. **Are you:**
    - ○ Male
    - ○ Female
    - ○ [ ]
33. **Do you consider yourself to be Hispanic or Latino/a?**
    - ○ Yes
    - ○ No
34. **What race or races do you consider yourself to be? (Check all that apply)**
    - ○ White
    - ○ Black or African American
    - ○ Asian or Asian American
    - ○ American Indian or Alaska Native
    - ○ Native Hawaiian or other Pacific Islander
    - ○ Other, specify [ ]

Appendix C: Site Visit Protocol

Coalition Stakeholders Interview Form

Coalition Name: Click here to enter text.
Location of Interview: Click here to enter text.
Name of Person Interviewed: Click here to enter text.
Role of Person Interviewed: Click here to enter text.
Date of Interview: Click here to enter text.

Introduction

Thank you for agreeing to participate in this interview. I wanted to take a moment to share more details about the purpose of this interview and our site visit more broadly.

This site visit will support the goals of the Nebraska PFS evaluation, including describing how SPF steps were implemented and examining the impact of PFS efforts on alcohol and marijuana-related outcomes in the state. We will use this visit as an opportunity to learn more about the activities that your coalition is implementing and how you are going about this process.

We will share results from your site visit with both your coalition in an annual report, along with other data. We will also share this information, in aggregate with the State, in an annual report. We hope that this will be a helpful source of insights about your coalition's strengths and potential areas for improvement.

Do you have any questions for me before we begin?
Click here to enter text.

What is your Role?
Click here to enter text.

A. *History of the Initiative (initial site visit only)*
First, we would like to learn more about how your coalition became involved in the grant.

1. How did you learn about the PFS grant opportunity?
   Click here to enter text.
2. What prompted your coalition to apply for PFS funding? *(probe: Who initiated discussions and decisions in your area about applying for the PFS grant?)*
   Click here to enter text.
3. Was the grant seen as an opportunity to expand existing strategies, or as more of an opportunity to adopt new strategies to address underage drinking and marijuana use? *(probe: Who made these decisions (e.g. coalition meeting, coordinator)? Who participated in writing the grant application?)*
   Click here to enter text.

B. *The PFS Coalition (initial site visit only)*
Now we'd like to learn more about the formation and structure of your PFS coalition.

i. Formation

1. Was this coalition in existence prior to PFS?
   Click here to enter text.
2. How were people identified, recruited, and retained for membership or participation in the coalition? Were there any changes in this after receiving PFS funding? *(probe: obtain answers for each "identified", "recruited", and "retained")*
   Click here to enter text.

3. What successes have you observed with identifying, recruiting, and retaining membership or participation in the coalition? *(probe: filled all sectors, have champions)*
   Click here to enter text.
4. What challenges have you faced with identifying, recruiting, and retaining membership or participation in the coalition? *(probe: members left, unwilling, unable to find from specific sector)*
   Click here to enter text.

ii. Structure and Functioning

The following questions ask your opinion about the way things have run in your coalition.

1. How formal are your coalition meetings? *(probe: are there agendas, how are decisions made, do you follow robert's rules of order)*
   Click here to enter text.
2. How is the workflow distributed? *(probe: do paid staff do the bulk of the work, do subcommittees take responsibility for specific tasks)*
   Click here to enter text.
3. How are new coalition members onboarded? Is there a training or orientation?
   Click here to enter text.
4. From the coalition capacity survey, your coalition members ranked the structure of the coalition as a X on a 4 point scale, where 1 is strongly disagree and 4 is strongly agree. For context, the average across all PFS coalitions was X. Was is your reaction to this? Why do you think this is?
   Click here to enter text.
5. Among the items asked about with regard to structure, the item showing the strongest agreement was X, while the item showing the least agreement X. Was is your reaction to this? Why do you think this is?
   Click here to enter text.
6. Is there anything you would change about the coalition's structure at this point? If yes, please describe.
   Click here to enter text.

iii. Leadership

1. From the coalition capacity survey, your coalition ranked your coalition's leadership as a X on a 4 point scale, where 1 is strongly disagree and 4 is strongly agree. For context, the average across all PFS coalitions was X. Was is your reaction to this? Why do you think this is?
   Click here to enter text.
2. Among the items asked about with regard to leadership, the item showing the strongest agreement was X, while the item showing the least agreement X. Was is your reaction to this? Why do you think this is?
   Click here to enter text.
3. What, if anything, would you change about the coalition's leadership at this point?
   Click here to enter text.

iv. Communication

1. From the coalition capacity survey, your coalition ranked their satisfaction with your coalition's communication as a X on a 4 point scale, where 1 is strongly disagree and 4 is strongly agree. For context, the average across all PFS coalitions was X. Was is your reaction to this? Why do you think this is?
   Click here to enter text.
2. Among the items asked about with regard to communication, the item showing the strongest agreement was X, while the item showing the least agreement X. Was is

your reaction to this? Why do you think this is?
Click here to enter text.

3. What, if anything, would you change about the coalition's communication at this point?
Click here to enter text.

v. Membership and Collaboration

1. From the capacity survey, coalition members were most likely to report that the coalition is missing representation on the coalition from X, X, and X. What have been the challenges with gaining participation from these groups?
Click here to enter text.
2. Figure X from the capacity survey report shows the level of collaboration reported in the capacity survey with each of those organizations from weak (1) to strong (5). As you can see, your coalition has the strongest collaborations with X and the weakest collaborations with X. In addition, the survey revealed that members expressed an interest in working toward strengthening a collaboration with X (from open-end). First, can you tell me how you've been so successful in building your collaboration with X?
Click here to enter text.
3. Next, what have been the challenges in building collaborations with X?
Click here to enter text.
4. How has the level of collaboration among organizations, agencies and individuals doing substance abuse prevention work in your area changed as a result of PFS, if at all?
Click here to enter text.

vi. Impact

1. From the coalition capacity survey, your coalition members' perception of their impact was ranked as a X on a 4 point scale, where 1 is strongly disagree and 4 is strongly agree. For context, the average across all PFS coalitions was X. Was is your reaction to this? Why do you think this is?
Click here to enter text.
2. Among the items asked about with regard to impact, the item showing the strongest agreement was X, while the item showing the least agreement X. Was is your reaction to this? Why do you think this is?
Click here to enter text.
3. Do you have any recommendations to improve your coalition's impact for your members or in the community?
Click here to enter text.

C. *Understanding and Implementation of SPF Steps*

Next we are going to discuss the SPF steps.

1. Overall, looking at figure X from the capacity survey results, are you surprised to see where your strengths and weaknesses are with regard to the SPF steps? Why/why not?
Click here to enter text.

i. Assessment

1. Complete Assessment fidelity rubric

Core Activity	Fidelity Questions

1. Needs assessment management: an authorized entity (e.g., a data management workgroup or individual) has been identified and charged with collecting, reviewing, and analyzing community- level data on substance abuse-related (1) consequences, (2) consumption patterns, (3) geographic/target population differences, (4) intervening variables (such as risk and protective factors), (5) prevention resources, and (6) community readiness to address the targeted issue and/or contributing factors.	Has an entity been authorized to carry out needs assessment activities on behalf of the community project? Has the entity been charged with needs assessment activities in each of the six core data areas (i.e., 1. consequences, 2. consumption patterns, 3. geographic/ target population differences, 4. intervening variables, 5. prevention resources and infrastructure, and 6. community readiness)?
2. Requisite skills: an authorized entity (e.g., data- management work group or individual) has the expertise to collect, review, and analyze community-level data on substance abuse (1) consequences, (2) consumption patterns, (3) geographic/target population differences, (4) intervening variables (such as risk and protective factor), (5) prevention resources, and (6) community readiness to address the targeted issue and/or contributing factors.	Does the entity possess the requisite skills with regards to needs assessment data collection, management and analysis? Does the needs assessment entity have the requisite skills with regards to local substance abuse data and cultural issues? Does the entity develop its membership to address gaps in expertise?
3. Data acquisition: all data necessary to assess substance abuse (1) consequences, (2) consumption patterns, (3) geographic/target population differences, and (4) intervening variables (such as risk and protective factors), (5) prevention resources, and (6) community readiness are acquired to address the targeted issue.	Were data obtained on each of the 6 core data areas specified by the Framework: (1) causes (also intervening variables), (2) consequences, (3) consumption patterns, (4) variation by sub-populations and/or geographic regions, (5) prevention resources and (6) community readiness? Are the acquired data of sufficient quality to reach solid conclusions about community needs and to inform strategic planning? Were gaps in available information and/or data limitations identified? Were new data sources identified to address these gaps? Were new data acquired as a result of identifying data limitations and new sources of data?
4. Data analyses examine patterns in substance abuse consequences, consumption, and intervening variables in relation to geographic/target population differences.	Were data analyses conducted to examine the relationship between causes, consumption and consequences? Does the data and research support the types of relationships examined and conclusions drawn?

5. Needs assessment results are used to specify the target issue(s). The target issue(s) that are specified are clearly linked to identified substance abuse target consequence and consumption patterns.	Were target issues specified based on needs assessment results, or did other factors (not data based) enter into the consideration? Were needs assessment results used to prioritize the different issues identified?
6. Needs assessment results are used to specify the target geographic area and/or population.	Was a target geographic area or population identified based on needs assessment results, or did other factors (not data based) enter into the consideration? Were needs assessment results used to prioritize different target geographic areas or populations?
7. Data are used to specify intervening variables that should be addressed in order to change target issues.	Were results used to identify and specify target intervening variables (i.e., causal or contributing factors), or did other factors (not data-based) enter into the consideration? Were needs assessment results used to prioritize different intervening variables?
8. Gaps in substance abuse prevention resources and infrastructure needed to address substance abuse consequences, consumption patterns, and intervening variables in the target geographic area and/or population were identified.	Were results used to identify gaps in substance abuse prevention resources and infrastructure, or did other factors (not data-based) enter into the consideration?
9. Community readiness to address the target issue(s) was assessed, and data were used to help specify community prevention needs and resources.	Were results used to identify gaps in community readiness to address the target issue(s), or did other factors (not data-based) enter into the consideration? Were readiness assessment results used to prioritize community prevention needs and resources?
10. Needs assessment data (consequences, consumption patterns, resource gaps and readiness) are updated and re-analyzed on a regular basis. NOTE: This item is not applicable (NA) in the initial Step 1 assessment.	Are needs assessment activities ongoing? Are results updated on a regular basis?

2. What is your reaction to how your coalition scored on this rubric? What facilitators and barriers are affecting this?
   Click here to enter text.
3. What do you think your coalition can do to improve in this area?
   Click here to enter text.

ii. Capacity

1. Complete Capacity fidelity rubric

Core Activity	Fidelity Questions
1. Identify capacities to address prioritized problems	Are capacity building efforts directed at resource gaps and redundancies identified in the resource assessment? Are capacity building efforts clearly documented?
2. Mobilize community capacity	Are community education and recruitment efforts directed at weaknesses identified in the readiness assessment? Are community education and recruitment efforts clearly documented?
3. Reach out to new partners (Recruitment)	Are missing partners systematically identified and recruited? Are formal recruitment and membership procedures established and observed?
4. Nurture coalition capacity	Is lead organization or coalition meeting infrastructure established, including identified procedures for communication, decision making, conflict resolution, and leadership? Is guidance from target populations sought and used in planning and implementation? Is capacity for sustainability of the prevention project being built (documenting process, leveraging resources, building buy-in)?

2. What is your reaction to how your coalition scored on this rubric? What facilitators and barriers are affecting this?
   Click here to enter text.
3. Taking this into account, in combination with what you've learned from the capacity survey, where would you like to see your coalition grow in capacity?
   Click here to enter text.
4. How has the capacity (i.e. resources, knowledge, skills) of the Region impacted your PFS efforts? *(probe: trainings, availability for TA)*
   Click here to enter text.
5. In which areas could the regional-level capacity be improved?
   Click here to enter text.
6. How has the capacity (i.e. resources, knowledge, skills) of the State (Division of Behavioral Health) impacted your PFS efforts? *(probe: PAC/SEOW, EBP matrix, provided data)*
   Click here to enter text.
7. In which areas could the state-level capacity be improved?
   Click here to enter text.

iii. Initial Planning and Selection of Strategies

I would now like to discuss the process that your coalition took to select the strategies that you plan to implement or are already implementing.

1. Complete Planning fidelity rubric

1. To what extent does the community strategic plan (SP) include a vision for prevention activities at the community level?	Does the community strategic plan include a description of the vision for prevention activities? Does the statement clearly describe the scope of planned prevention activities? Does the statement contain adequate detail about the activities?

2. To what extent does the community strategic plan use assessment results?	Does the community strategic plan describe the needs assessment results? Does the plan include evidence that needs assessment results were used to make decisions? Did plans clearly identify target populations, consumption patterns and consequences on the basis of the needs assessment results?
3. To what extent does the community strategic plan include the State's priorities for prevention?	Does the community strategic plan include statements about the relevance of planned activities to State prevention priorities? Were local priorities linked to State priorities? Was the linkage between local and State priorities logical and supported by evidence?
4. To what extent are there measures of community capacity and infrastructure accompanied by plans to increase capacity and infrastructure, where needed?	Were community capacity and infrastructure assessed? Were strategies to address capacity and infrastructure needs described? Are the planned strategies logically linked to the identified needs?
5. To what extent does the plan identify appropriate (i.e., logically connected) evidence-based strategies for addressing the community priorities?	Were prevention strategies specified in the plan? Do the specified strategies appear to address the identified priorities? Was evidence presented indicating that selected strategies were evidence- based?
6. To what extent is there discussion of how the community will implement culturally appropriate strategies with competence?	Does the plan include a description of the culturally appropriate strategies? Are specific action steps described? Does the description of the action steps suggest that the activities will be implemented in a competent manner?
7. To what extent are there methods and measures for monitoring community level outcomes?	Does the plan specify the methods for monitoring community-level outcomes? Does the plan describe existing data sources and data collection instruments that will be developed? Does the plan include a clear description of how the data will be used to monitor community outcomes?
8. To what extent is there a discussion of how the community will develop a plan for sustaining the strategies after SPF SIG funding has been depleted?	Does the plan include a description of procedures for developing a plan for sustaining strategies after the funding period? Does the discussion include specific steps? Are the proposed steps feasible?

2. What is your reaction to how your coalition scored on this rubric? What facilitators and barriers are affecting this?
   Click here to enter text.
3. What do you think your coalition can do to improve in the area of planning?
   Click here to enter text.

4. Next, walk me through the process of developing your work plans and selecting your strategies. How did your coalition decide which strategies, and who was involved? What were the facilitators and barriers that affected this process?
   Click here to enter text.
5. Were health disparities discussed during this process?
   Click here to enter text.
6. In what ways, if at all, do you feel the SPF process affected the selection of your strategies?
   Click here to enter text.
7. Did the Region provide any resources and/or guidance in developing your work plans? *If yes*, please describe.
   Click here to enter text.
8. Did the State (Division of Behavior Health) provide any resources and/or guidance in developing your work plans? *If yes*, please describe.
   Click here to enter text.
9. How are you using the data briefs, capacity survey results, and EBP matrix as you develop your Year 2 work plan? Describe how, if at all, they were helpful.
   Click here to enter text.
10. Complete Implementation (selection) fidelity rubric

Core Activity	Fidelity Questions
1. Results of needs assessment are used to identify potential EBPPPs	To what extent were the results of needs assessment used to identify potential EBPPPs?
2. Identification of EBPPPs is consistent w/overarching logic model	To what extent was Identification of EBPPPs consistent w/ the overarching logic model?
3. The EBPPPs identified are selected from credible sources	To what extent were the interventions identified selected from credible sources?
4. Other (non EBPPP) programs selected or designed are consistent w/assessed needs, identified target populations and current prevention theory	Are other (non EBPPP) programs selected or designed consistent w/assessed needs, identified target populations and current prevention theory?
5. Implementation requirements (training, materials, logistics) were considered in selecting EBPPPs and other prevention programs	Were implementation requirements (training, materials, logistics) considered in selecting EBPPPs and other prevention programs?
6. Needed adaptations in EBPPP implementation (cultural or otherwise) were determined and planned for	To what extent were needed adaptations in EBPPP implementation (cultural or otherwise) determined and planned for?

11. What is your reaction to how your coalition scored on this rubric? What facilitators and barriers are affecting this?
    Click here to enter text.
12. In your opinion, what would be the ideal way to select strategies?
    Click here to enter text.

iv. Implementation

Next, I'm going to review each of the strategies that were proposed in your Y1 workplan. Let me know approximately when, if at all, you began implementing each strategy.

Strategies	Y1 Implementation start date

1. We will review any data available to look at outcomes from the strategies you implemented, but I would also like to know your perspective of the outcomes. Do you feel as though the strategies you implemented thus far have had the intended outcomes? Why/why not? What aspects have advanced your efforts or created challenges with regard to your ability to successfully implement these strategies? *(Probe: community characteristics, staffing capacity, buy-in, timing, weather)*

Strategies	Response

2. In your opinion, how did your coalition's capacity and functioning affect your ability to implement your proposed strategies?
   Click here to enter text.

3. Are there any resources that might help you in better implementing any of your strategies? *(Probe: trainings, materials, community buy-in)*
   Click here to enter text.

v. Evaluation

1. Complete Evaluation fidelity rubric

Core Activity	Fidelity Questions
1. To what extent has a logic model been developed?	To what extent has logic model been developed?
2. Has the community hired or consulted with an evaluator?	Has the community hired or consulted with an evaluator?
3. To what extent does the local community understand the relationships between local and state priorities and federal outcomes?	To what extent does the local community understand the relationships between local and state priorities and federal outcomes?
4. To what extent are the measures identified for local and state priorities and federal outcomes appropriate?	To what extent are the measures identified for local and state priorities and federal outcomes appropriate?
5. To what extent are outcome data collection procedures developed?	To what extent are outcome data collection procedures developed?
6. To what extent are fidelity data collection procedures developed?	To what extent are fidelity data collection procedures developed?
7. To what extent is evaluation capacity developed?	To what extent is evaluation capacity developed?

8. To what extent are implementation plans developed for local evaluation procedures?	To what extent are implementation plans developed for local evaluation procedures?
9. To what extent are plans developed for feedback from evaluator to community?	To what extent are plans developed for feedback from evaluator to community?
10. To what extent does community intend to use feedback to inform future prevention programming?	To what extent does community intend to use feedback to inform future prevention programming?
11. To what extent is process identified for monitoring 5 SPF steps (using the CLI as much as possible)?	To what extent is process identified for monitoring 5 SPF steps?

2. What is your reaction to how your coalition scored on this rubric? What facilitators and barriers are affecting this?
   Click here to enter text.
3. What do you think your coalition can do to improve in this area?
   Click here to enter text.

D. *Sustainability*

1. Are you using leveraging, redirecting, or realigning local funding streams other than PFS funding for prevention related to underage drinking and marijuana use? If yes, please describe.
   Click here to enter text.
2. What other strategies, beyond what you are implementing as part of PFS, is your coalition implementing to address underage drinking, if any?
   Click here to enter text.

If leveraging:

   a. How has your coalition used this approach to fund its prevention plan? What have been the advantages and disadvantages of using this approach?
   Click here to enter text.

If not leveraging:

   b. What has prevented your coalition from using this approach?
   Click here to enter text.

3. What are your plans for sustaining the strategies you are currently implementing once PFS grant funding ends? *(probe: Do you have a written sustainability plan?)*
   Click here to enter text.
4. What are your plans for sustaining the coalition once PFS grant funding ends? *(probe: Are you taking any actions now toward sustaining the coalition's prevention system?)*
   Click here to enter text.

E. *Behavioral Health Disparities*

1. In your opinion, what steps have been taken to ensure cultural competency is addressed (i.e. CLAS standards) from the State level?
   Click here to enter text.
2. What steps have been taken to ensure cultural competency is addressed (i.e. CLAS standards) in the actions of your coalition?
   Click here to enter text.

F. ***Training/Technical Assistance***

1. Please describe how training and technical assistance from the State (Division of Behavioral Health) has impacted your PFS efforts. Describe the types of T/TA provided and how it has impacted your PFS efforts. *(Probe: onboarding visits, Aug 7/8 meetings, PAC meetings)*
   Click here to enter text.
2. Please describe how training and technical assistance from Regional Prevention Coordinators (RPC's) have impacted your PFS efforts. Describe the types of T/TA provided and how it has impacted your PFS efforts. *(Probe: regional meetings, assistance with developing workplans)*
   Click here to enter text.
3. Have you received any other training and technical assistance for your PFS efforts beyond what you have received from the State and Region? If so, please describe the types of T/TA provided and how it has impacted your PFS efforts.
   Click here to enter text.
4. Are there ways that you feel training and technical assistance could be improved or more beneficial to your coalition? *(Probe: need more T/TA, better quality)*
   Click here to enter text.
5. Please describe how you have interacted, if at all, with other PFS funded coalitions (e.g., through Region/State activities, informally)? What have you learned from them?
   Click here to enter text.
   a. Would you prefer to have more interaction with other PFS funded coalitions? If so, do you have recommendations for how best to facilitate that interaction?

   Click here to enter text.
6. How well is entering data into the NPIRS system working? *(probes: How often are you entering data into NPIRS? Do you understand the categories in NPIRS? Do you need any additional technical assistance on NPIRS?)*
   Click here to enter text.

G. ***Overall***

What have been your biggest successes and biggest challenges in Year 1 of this grant?
Success: Click here to enter text.
Challenge: Click here to enter text.

Overall, what would you like to accomplish in Y2?
Click here to enter text.

Additional Comments:
Click here to enter text.

Appendix D: Focus Group Protocols

Regional Prevention Coordinators Focus Group

1. Describe the process of selecting grantees within your region. (Probe: Open announcement, specific coalitions sought out?) If you were to do this over again, what would you do differently, if anything?
   Click here to enter text.

2. Describe how your coalitions developed their work plans. Do you feel that their work plans were data driven? Did they utilize support from the Region and/or the State in developing these plans?
   Click here to enter text.

3. How has the level of capacity at the state level impacted PFS in year 1, both for you as a region and for your coalitions? In what areas do you believe the state's capacity has grown, and in what areas do you believe growth is needed?
   Click here to enter text.

4. Some of you were involved in the development of the EBP Matrix. In developing that matrix, what aspects advanced that effort and what aspects created challenges?
   Click here to enter text.

5. How well do you believe your coalitions understand the objective of the grant to increase the use of evidence based programs, and what EBP's are? Do you believe the EBP Matrix will be a useful tool in helping them move toward reaching the goal of 70% of funding on EBP's?
   Click here to enter text.

6. What impact do you believe the training and technical assistance that you've provided has had on your PFS coalitions in year 1? Do you have recommendations on how the State can best supplement the T/TA that you provide, such as facilitating peer sharing or statewide trainings?
   Click here to enter text.

7. Next, thinking about health disparities, in what ways, if at all, do you believe Cultural and Linguistically Appropriate Standards (CLAS) have been used to improve capacity at the state or regional level?
   Click here to enter text.

8. Describe what works well and doesn't work well with leveraging funding streams for prevention related to underage drinking and marijuana use?
   Click here to enter text.

9. How well does the funding structure of PFS work, where the State provides funding to the regions, to then redistribute to coalitions? Do you believe there should be more state-level initiatives? Any other suggestions for changes to the funding structure?
   Click here to enter text.

10. How confident are you that the PFS coalitions will continue after PFS funding ends? What do you feel is the key to sustainability of the PFS coalitions?
    Click here to enter text.

11. Any other comments?
Click here to enter text.

SEOW/PAC Focus Group

Name, role with SEOW or PAC

First, I would like to ask some questions about the PAC.

1. Thinking about the initial establishment of the PAC, describe how the functioning of the group and its membership have evolved over time. How do you feel this evolution has impacted Nebraska's prevention efforts?
   Click here to enter text.

2. In your opinion, does the PAC appropriately represent the diversity of the state in regard to population demographics and agency-level stakeholders? If not, who do you believe is missing?
   Click here to enter text.

3. Is the PAC serving a useful purpose? How has it impacted Nebraska's preventions efforts? What suggestions do you have for improvements?
   Click here to enter text.

Next, I would like to ask some questions about the SEOW.

4. Does the SEOW appropriately represent the diversity of the state in regard to population demographics and agency-level stakeholders? If not, who do you believe is missing?
   Click here to enter text.

5. Is the SEOW serving a useful purpose? How has it impacted Nebraska's preventions efforts? What suggestions do you have for improvements?
   Click here to enter text.

6. Are there any products that you believe the SEOW should produce that might be helpful for PFS coalitions in making data driven decisions?
   Click here to enter text.

7. Some of you were involved in the development of the EBP Matrix. In developing that matrix, what aspects advanced that effort and what aspects created challenges?
   Click here to enter text.

8. How has the level of capacity at the state level impacted PFS in year 1? In what areas do you believe the state's capacity has grown, and in what areas do you believe growth is needed?
   Click here to enter text.

9. Next, thinking about health disparities, in what ways, if at all, do you believe Cultural and Linguistically Appropriate Standards (CLAS) have been used to improve capacity at the state level?
   Click here to enter text.

10. What is the key to sustaining Nebraska's prevention efforts addressing underage drinking and marijuana use?
    Click here to enter text.

11. Any other comments?
    Click here to enter text.

Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

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

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring 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.

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

List of funded Mental Health (MH) and Substance Use Disorder (SUD) Services
(** Shared Medicaid Service) (^^ pending system update to shared status)
Emergency Services & Inpatient Services: MH SUD
24 Hour Crisis Line^^ ..... YES YES
Crisis Assessment** ..... YES YES
Crisis Response ..... YES YES
Crisis Stabilization** ..... YES YES
Emergency Community Support ..... YES YES
Emergency Protective Custody ..... YES No
Emergency Psychiatric Observation** ..... YES No
Hospital Diversion <24 hrs. ..... YES No
Hospital Diversion >24 hrs. ..... YES No
Acute Hospitalization ** ..... YES No
Sub-Acute Hospitalization** ..... YES No
Mental Health Respite ..... YES No
Clinically Managed Residential Withdrawal Mgmt.** No YES
Dual Residential** ..... YES YES
Halfway House** ..... No YES
Inpatient Post Commitment Treatment ^^ ..... 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 - Matrix** ..... YES YES
Intensive Outpatient** .....YES YES
Medication Management** ..... YES No
Multisystemic Therapy** ..... YES No
Opioid Treatment Program (OTP)** ..... No YES
Outpatient Psychotherapy** ..... YES YES
Peer Support** ..... YES YES
Professional Partner ..... YES No
Recovery Homes (Oxford)^^ ..... No YES
Recovery Support ..... YES YES
Secure Residential R&B ..... No YES
Substance Abuse Prevention Services ..... No YES
SOAR ..... YES YES
Supported Education ..... YES No
Supported Employment^^ ..... YES YES
Supported Housing ..... YES YES
Therapeutic Consultation ..... YES No
Warm Hand Off ..... YES YES
Youth Assessment ** ..... YES YES
Youth Transition Services ..... No YES
#END

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

a)	Physical Health	○ Yes	● No
b)	Mental Health	● Yes	○ No
c)	Rehabilitation services	● Yes	○ No
d)	Employment services	● Yes	○ No
e)	Housing services	● Yes	○ No
f)	Educational Services	○ Yes	● No
g)	Substance misuse prevention and SUD treatment services	● Yes	○ No
h)	Medical and dental services	○ Yes	● No
i)	Support services	● Yes	○ No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	● Yes	○ No
k)	Services for persons with co-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.

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.

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.

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.

The DBH worked 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 Region, allowing for targeted problem solving and planning. Metrics include EPCs, diversion rates, community tenure, and provider information.

The DBH implemented goals for services. For example, prioritizing access to medication management after discharge from inpatient care (IP) addresses a barrier to earlier discharge and a key factor in hospital readmission. The DBH worked with Region Advisory Councils, RHBAs and network hospitals to define the access measure, and built in reporting for tracking . In FY17, 90.3% of consumers discharging from IP care could access medication management within 21 days of discharge; in FY22, timely access to appointments were at 88.3%. It is expected that improving access to medication management after IP discharge will positively impact readmission rates.

Please indicate areas of technical assistance needed 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

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

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

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

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	79,637	9,707
2.Children with SED	14,860	1,248

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.

Source Documents:
• FY2022 URS Table16 "Profile of Adults with Serious Mental Illnesses and Children with Serious Emotional Disturbances Receiving Specific Services"
• 2021 URS Table 1 (adult_smi_child_sed_prev_2021_508 (1).pdf)

Column B Estimates of "Statewide Prevalence":
• Source Row 1: Adults with SMI: URS Table 1: Estimate obtained by multiplying the 2021 estimate for 18+ adult Nebraskans [1,474,750] by [5.4%] the estimated percent of Nebraskans with SMI
• Source Row2: Children with SED: URS Table 1: Number of Children with a Serious Emotional Disturbance, age 9 to 17 [123,830] using 2021 State Estimate based on Level of Functioning threshold score of =60 using upper limit.

Column C Estimates of "Statewide Incidence"
• Source Row 1: Adults with SMI: FY2022 URS Table 16
• Source Row 2: Children with SED: FY2022 URS Table 16.

Use the following links for more information:
1. The Nebraska DHHS Division of Behavioral Health 2022-2024 Strategic Plan is located at URL: https://dhhs.ne.gov/Behavioral%20Health%20Documents/DBH%20Strategic%20Plan%202022-2024.pdf
2. The Division of Behavioral Health Strategic Plan 2017-2020 is located at URL: https://dhhs.ne.gov/Reports/Behavioral%20Health%20Strategic%20Plan%202017-2020.pdf
3. The Division of Behavioral Health Strategic Plan 2017-2020 End of Plan documents, including carry-over strategies and metrics, along with prioritized needs resulting from the new needs and gaps analysis (URL: https://dhhs.ne.gov/Reports/Behavioral%20Health%20Strategic%20Plan%20Final%20Report%20-%202017-2020.pdf) drove the identification of key objectives and prioritized strategies for the 2022-2024 strategic plan.

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

None at this time.

Criterion 3

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

a)	Social Services	◉ Yes	○ No
b)	Educational services, including services provided under IDEA	◉ Yes	○ No
c)	Juvenile justice services	◉ Yes	○ No
d)	Substance misuse preventiion 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

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

None at this time.

**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.*
https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

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

Criterion 4

a. Describe your state's targeted services to rural population. **See SAMHSA's Rural Behavioral Health page for program resources**

The 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, 2022, the U.S. Census estimated that Nebraska's total population was 1,967,923. Nebraska has 530 incorporated places with 89% of these communities having fewer than 3,000 people. 72% of Nebraska communities have a population between 100-800.

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 December 2021 legislative report from the Behavioral Health Education Center of Nebraska showed that 88 of 93 counties continue to meet the federal criteria as federal mental health professional shortage areas; that 29 counties lack a behavioral health provider of any kind; and the workforce is aging. DBH directs mental health funding to programs supporting residents living in all 93 counties.

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). DBH contracts for the NOC, an online resource, with information about treatment, resources and diagnoses, and wellness recovery action plans. DBH is currently developing an RFP for updated NOC type resource.

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

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

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.

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. Preliminary FY2023 data indicates that 84.5% of services were delivered via traditional face to face, 9.8% by telehealth, 2.0% by telephone only and 3.1% combinations of traditional, telehealth and telephone. DBH will continue to capture the data and trend the information.

b. Describe your state's targeted services to people experiencing homelessness. **See SAMHSA's Homeless Programs and Resources for program resources**

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 Children and Family Services, 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

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.

In SFY2022, DBH reported70.9% of individuals were discharged to stable living arrangements across all services and 91.4% of individuals were discharged to stable living from supported housing.

c. Describe your state's targeted services to the older adult population. **See SAMHSA's Resources for Older Adults webpage for resources.**

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.

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.

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

None at this time.

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.

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 for SAMHSA 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 or underserved 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 SAMHSA Evidence Based Resource Guide, **Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders**.

Criterion 5

a. Describe your state's management systems.

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

The 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 contracts with the National Alliance of Mental Illness (NAMI) are managed through the OCA.

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.

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.

In September 2022, DBH, in collaboration with Office of Probation Administration, held the Justice and Behavioral Health Conference. Over 800 participants received targeted training on topics including Special Populations, Self-care and Resiliency, Diversity, Equity and Inclusion, Brain Disease and Forensic Behavioral Health. self-care and resiliency, on problem solving courts, with over 800 participants.

The Division of Behavioral Health (DBH) ensures block grant funds and state dollars are used in accordance with SAMHSA's expectations that the FFY2024-2025 block grants funds to be directed toward four purposes:
1. To fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time;
2. To fund those priority treatment and support services not covered by CHIP, Medicaid, Medicare, or private insurance for low-income individuals and that demonstrate success in improving outcomes and/or supporting recovery;
3. For SABG funds, to fund primary prevention: universal, selective, and indicated prevention activities and services for persons not identified as needing SUD treatment; and
4. To collect performance and outcome data to determine the ongoing effectiveness of promotion/SUD prevention, treatment and recovery supports and to plan the implementation of new services.

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

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

Requirements for prevention activities within regulations and subawards require the use of the Strategic Prevention Framework for funded initiatives. RBHAs are required to utilize and fund the six prevention strategies and have a minimum amount of funding that must be dedicated to substance abuse prevention activities each year. Data is collected through the Nebraska Prevention Information and Referral system (NPRS) 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 a culture that fosters improvement; a culture where data is collected, reported, and used to guide policy and implementation. The DBH administrative oversight includes, but is not limited to, the of use statewide data, including:
• Capacity and Waiting Lists
• 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 has implemented an in-house Electronic Billing System (EBS) for the purpose of contract management and reporting of various funds to assist Community-Based Consumers. EBS is a billing system, not a claims system. The EBS structure includes five principal layers: Service; Provider; Contract; Payment Methodology, and Spending Authority. Functionality within EBS includes:
• Contract building
• Budgeting
• Payment Processing
• Reallocation of Funds, and
• Reports and dashboards including costs per service and costs per person served

DBH administrative tools, including the annual Region Budget Plan Guidelines and the contracts with the six RBHAs, are the primary mechanisms to support program integrity. 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 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.

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

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

Internal measures are performed by DBH and 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 and 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.

b. 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. Although 85% of service utilization is primarily face to face delivery (traditional), presently 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. Preliminary data for FY2023 indicate that delivery of services via telehealth accounted for 11.6% of utilization

overall (9.8% via telehealth only and 1.8% in part or combined with other delivery methods).

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

None at this time.

Footnotes:

DBH contracts with the six RBHAs for targeted case management based on a high-fidelity wraparound approach. The philosophy of the Professional Partner Program is to be strength-based, family-centered, and acknowledge families as equal partners. The Program provides a flexible, individualized approach that promotes utilization of the least restrictive, least intrusive developmentally appropriate interventions in accordance with the strengths and needs of the youth. The purpose of the program is to improve the lives of children with serious emotional disturbances and their families. The mission of the program is to use the wraparound approach to coordinate services and supports to these families. The service coordinator, referred to as a Professional Partner, works in partnership with each youth and his or her family entering the Professional Partner Program. The Partner, as a part of the child and family team, assists the family with obtaining a comprehensive assessment, developing an Individual Family Support Plan (IFSP), purchasing both traditional services and flexible supports identified in the IFSP, and monitoring the outcomes.

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required 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

i)	Screening	● Yes	○ No
ii)	Education	● Yes	○ No
iii)	Brief Intervention	● Yes	○ No
iv)	Assessment	● Yes	○ No
v)	Detox (inpatient/residential)	● Yes	○ No
vi)	Outpatient	● Yes	○ No
vii)	Intensive Outpatient	● Yes	○ No
viii)	Inpatient/Residential	● Yes	○ No
ix)	Aftercare; 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. 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 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 Division continues to work with the RBHAs providing guidance on expectations for PWWDC, providing information and annually collecting information on trainings on this topic done by RBHAs. 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.

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)	Syringe services programs, if applicable	( ) Yes	(●) No
e)	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, LGBTQI+, 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 inclusion in the RBHA to Network Provider contract.

Regional providers of substance use services are required to admit Persons Who Inject Drugs (PWID) into services within 48 hours of initial contact. Admission may be immediate into the appropriate recommended treatment or placement on the waiting list with the provision of interim services within 48 hours, with these interim services continuing until the PWID is admitted into the recommended treatment. Should the provider not have an opening immediately available, the provider works with RBHA personnel to find openings within the RBHA and throughout the state to offer the PWID. Should the PWID choose to wait for an opening with the intake provider, the person's name is placed on the waitlist, according to his/her priority, and no later than 48 hours following initial contact, is offered interim services. The intake provider contacts the PWID weekly to follow his/her progress and to update her on available openings with the intake provider as well as available openings statewide. The provider maintains this weekly contact with the PWID until admitted into services or substance use treatment services are declined.

Providers of substance use services are required to submit information regarding consumers to the RHBA and DBH through entry into the Centralized Data System. This information includes but is not limited to priority type who are receiving services in addition to information for all consumers according to their priority level who are placed on the provider's waiting list for specified services. Priority levels include: (1) pregnant injecting drug users; (2) other pregnant substance users; (3) other injecting drug users; (4) women with dependent children; and, (5) all others, including those consumers with Mental Health Board Commitments. The submitted data by RBHA, the resultant reports, the (Statewide) Weekly Substance Abuse Capacity Report, and, the (Statewide) Weekly Substance Abuse Priority Waiting/Interim Services List for Priority Populations, are compiled and distributed to the RBHAs to monitor and to share with providers.

Through the annual Services Purchased and tri-annual Program Fidelity reviews and audits, the RBHA conducts formal reviews of individual consumer substance use treatment at the provider level. A component of these reviews is the timeliness of admission into interim and recommended substance use treatment. At least once per 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.

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 DBH.

These processes are achieved through the propagation of the annual Regional Budget Plan Guidelines and State to RBHA contract. In the State to RBHA contract for substance use services, the RBHA will ensure that providers receiving State or Federal Dollars will routinely make TB services available to each individual receiving treatment for substance use disorders and to monitor such service delivery. The RBHA ensures that this requirement is maintained at the provider level via inclusion in the RBHA to Network Provider contract.

Each RBHA has established procedures that ensure that the following TB services are provided, either directly or through arrangements/agreements with other public or non-profit private entities:
a. Screening of all admissions for TB
b. Positive screenings shall receive test for TB
c. Counseling related to TB
d. Referral for appropriate medical evaluations or TB treatment
e. Case management for obtaining any TB services
f. Report any active cases of TB to state health officials
g. Document screening, testing, referrals and/or any necessary follow-up information

Tools include a Network Contractual Compliance Checklist which specifically verifies Network Administration and Management Systems ensure the RBHA provider network has the capacity to provide such substance abuse prevention services and substance use treatment services, and the mechanisms the RBHA employs to address requirements and monitor timeframes. The Network Contractual Compliance Checklist tool identifies the need for corrective actions, plan of corrective status and next steps by the Provider/RBHA.

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 SAPTBG funds and is conducted at the time of the services purchased review. Please see PWID question #3 above for more detail.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring 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

Syringe Service Programs

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(42 U.S.CÂ§ 300x-31(a)(1)(F)? ○ Yes ● No

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program? ○ Yes ● No

3. Do any of the programs use SUPTRS BG funds to support elements of a Syringe Services Program? ○ Yes ● No

If yes, plese provide a brief description of the elements and the arrangement

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement — (●) 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 memebers, veterans, tribal entities, older adults, sexual and gender minorities) — (●) Yes ( ) No
- **e)** Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations — (●) Yes ( ) No
- **f)** Explore expansion of services for:
  - **i)** MOUD — (●) Yes ( ) No
  - **ii)** Tele-Health — (●) Yes ( ) No
  - **iii)** Social Media Outreach — ( ) Yes (●) No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care? — (●) 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 systems, adult criminal justice systems, 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

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — (●) 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 (Chapter 5, section 001.3).

The only exceptions would be for substance abuse prevention funds, when a nationally recognized accreditation organization appropriate to the organization's services cannot be identified, and/or when there is evidence that, due to the organization's size and service utilization, accreditation is not fiscally feasible.

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

a) Development of a quality improvement plan — (●) Yes ( ) No

b) Establishment of policies and procedures related to independent peer review — ( ) Yes (●) No

c) Development of long-term planning for service revision and expansion to meet the needs of specific populations — (●) Yes ( ) No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? — (●) Yes ( ) No

If Yes, please identify the accreditation organization(s)

i) [✓] Commission on the Accreditation of Rehabilitation Facilities

ii) [✓] The Joint Commission

iii) [✓] Other (please specify)

Commission on Accreditation

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? (●) Yes ( ) No

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

a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service (●) Yes ( ) No

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing (●) Yes ( ) No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:

a) Recent trends in substance use disorders in the state (●) Yes ( ) No

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services (●) Yes ( ) No

c) Performance-based accountability: (●) Yes ( ) No

d) Data collection and reporting requirements (●) Yes ( ) No

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

a) A comprehensive review of the current training schedule and identification of additional training needs ( ) Yes (●) No

b) Addition of training sessions designed to increase employee understanding of recovery support services ( ) Yes (●) No

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services (●) Yes ( ) No

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort (●) Yes ( ) No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?

a) Prevention TTC? (●) Yes ( ) No

b) Mental Health TTC? (●) Yes ( ) No

c) Addiction TTC? (●) Yes ( ) No

d) State Targeted Response TTC? (●) Yes ( ) No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

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

a) Allocations regarding women (●) Yes ( ) No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

a) Tuberculosis ( ) Yes (●) No

b) Early Intervention Services Regarding HIV ( ) Yes (●) No

3. Additional Agreements

a)	Improvement of Process for Appropriate Referrals for Treatment	○ Yes	◉ No
b)	Professional Development	○ Yes	◉ No
c)	Coordination of Various Activities and Services	○ 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

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

Question 1. "Is your state considering requesting a waiver of any requirements related to a) Allocations regarding women?" Nebraska is considering the possibility of requesting a waiver related to Allocations Regarding Women dependent upon SAMHSA's response to a pending request for material compliance with the WSA MOE requirement in SFY2022.

For the past three years, Nebraska's public behavioral health system has been affected by the Public Health Emergency (PHE) as well as being transformed by Medicaid changes. As you are aware, the DHHS Division of Behavioral Health (BH) administers the SABG and uses these funds in addition to state appropriations to provide coverage for low-income persons that do not have Medicaid or who are under insured. In October 2020, Nebraska expanded Medicaid coverage, something most other states had completed in prior years. This resulted in a number of persons previously covered by BH funding to have services paid for by Medicaid. In addition to expansion, a co-occurring Medicaid event impacted SABG spending also. Prior to June 2020, opioid treatment programs (ORT) were not covered by Nebraska Medicaid but was rather supported with SABG funding. In June 2020, Nebraska Medicaid began to cover opioid treatment.

Additionally enhanced Federal Medical Assistance Percentage (FMAP) for expansion population meant that Medicaid had to only expend ten cents to every dollar previously spent by BH to serve persons that transitioned to Medicaid. This resulted in less spending of state funds. State funds available in BH for services was not reduced by the Legislature, but it was not expended.

The impact of these changes was significant, especially for the WSA designated programs. While a portion of persons served in WSA designated providers have always been covered by Medicaid, with expansion, this significantly increased those served being covered by Medicaid.

The State of Nebraska has submitted a request to SAMHSA to include Medicaid expenditures for women and women with children in WSA designated programs, which enable Nebraska to meet the WSA MOE for FY22 based on inclusion of the single service identifiable at this point soley serving the targe population. To include all services previously paid by BH in these designated WSA programs that are now being covered by Medicaid, it will take additional work to determine if this is possible from Medicaid claims.

Question 2a. Is your state considering requesting a waiver of any Requirements Regarding Tuberculosis Services - Tuberculosis? No. Existing requirements regarding Tuberculosis services are provided for in existing services and contractual requirements fulfill expectations and needs of the system.

Question 2b. Is your state considering requesting a waiver of any Requirements Regarding Human Human Immunodeficiency Virus – Early Intervention Services? No. The State of Nebraska is not a designated state and has not identified the need for agreements 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.

Question 3a. Additional Agreements for "Improvement of Process Appropriate Referrals for Treatment" have not been created because the processes in place to provide for referrals to treatment fulfill expectations and needs of the system.

Question 3b. Additional Agreements for "Professional Development" have not been created because the processes in place to provide for professional development fulfill expectations and needs of the system.

Question 3c. Additional Agreements for "Coordination of Various Activities and Services" have not been created because the processes in place to provide for coordination activities fulfill expectations and needs in the system.

Footnotes:

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2022-FFY 2023? (●) Yes ( ) No

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

None at this time.

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Footnotes:

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma[1] is a common experience for adults and children in communities, and it is especially common in the lives of people with mental and substance use disorders. For this reason, the need to address trauma is increasingly seen as an important part of effective behavioral health care and an integral part of the healing and recovery process. It occurs because of violence, abuse, neglect, loss, disaster, war, and other emotionally harmful and/or life-threatening experiences. Trauma has no boundaries regarding age, gender, socioeconomic status, race, ethnicity, geography, ability, or sexual orientation. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system and children and families in the child welfare system have high rates of mental illness, substance use disorders and personal histories of trauma. Similarly, many individuals in primary, specialty, emergency, and rehabilitative health care also have significant trauma histories, which impacts their health and responsiveness to health interventions. Also, schools are now recognizing that the impact of traumatic exposure among their students makes it difficult for students to learn and meet academic goals. As communities experience trauma, for some, these are rare events and for others, these are daily events. Children and families living in resource scarce communities remain especially vulnerable to experiences of trauma and thus face obstacles in accessing and receiving M/SUD care. States should work with these communities to identify interventions that best meet the needs of their residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink how practices are conducted. These public institutions and service settings are increasingly adopting a trauma-informed approach distinct from trauma-specific assessments and treatments. Trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues with a focus on equity and inclusion. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[2] paper.

[1] Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

[2] *Ibid*

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a plan or policy for M/SUD providers that guides how they will address individuals with trauma-related issues? (●) Yes ( ) No

2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers? (●) Yes ( ) No

3. Does the state provide training on trauma-specific treatment and interventions for M/SUD providers? (●) Yes ( ) No

4. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care? (●) Yes ( ) No

5. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? (●) Yes ( ) No

6. Does the state use an evidence-based intervention to treat trauma? (●) Yes ( ) No

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

The Division of Behavioral Health (DBH) has a public policy statement to promote the provision of a Trauma-Informed System of Care which describes our commitment to transform public funded systems by strengthening the understanding of the broad effect of trauma, including safety, on the lives and communities of all Nebraskans. The State of Nebraska is committed to infusing trauma informed awareness, knowledge and skills into the organizational cultures, practices and policies that impact the system of care for children and adults.

DBH has included definitions and language in the regulations to support trauma-informed care and provide clarity in expectations related to psychological trauma, trauma-informed services and coordination of a trauma-informed system. More on regulation can be found at: https://dhhs.ne.gov/Pages/Title-206.aspx

The DBH believes that all system of care stakeholders and providers:
a) Understand their role and capacity to ensure trauma-informed responses in every interaction with children, adolescents and adults;
b) Are informed about the effects of psychological trauma and ensure agency wide commitment to a trauma-sensitive environment;
c) Ensure staff at every level is equipped with appropriate competencies to effectively address trauma;
d) Ensure that early assessment for trauma occurs utilizing research based strategies;
e) Ensure that all consumer interactions and services are recovery-oriented and trauma-sensitive; and
f) Understand that re-traumatization may occur if safe, effective, responsive services and practices are not available.

Through the DBH Regional Budget Plan (RBP) Guidelines and contracts with the six Regional Behavioral Health Authorities (RBHAs), it is expected that providers are competent in the delivery of trauma informed care. Expectations include that RBHA network development and coordination must develop and implement strategies to ensure that all behavioral health providers are informed about the effects of trauma, consistently screen for trauma symptoms and history of traumatic events, provide ongoing assessment of trauma symptoms and problems related to that trauma, offer services that are recovery oriented and trauma sensitive and are made aware that re-traumatization may occur if safe, effective, responsive services are not available.

DBH directs providers to screen clients for a personal history of trauma. Disclosure of trauma information by consumers takes a trusting relationship and may not be best captured right at the time of admission. Trauma screening information may be available at admission but is not required until discharge, thus allowing for rapport between the consumer and provider to be established. Trauma information can be updated in the DBH Centralized Data System (CDS) at any time the provider identifies new information relevant to the treatment program. Data is constantly available to the RBHAs and providers for review through the CDS. DBH uses the philosophy of trauma screening as a universal precaution. When screenings were initiated, the DBH provided specific instructions to providers about the process of screening which was based on the Harris and Fallot Universal Trauma Screening Guidelines (2001). Key principles include being aware of the individual's needs, strengths and vulnerabilities prior to the screening, and using the screening as early as possible (and appropriate) in the assessment process.

DBH supports an online information portal called the Network of Care for Mental/Behavioral Health,for individuals, families and social service agencies concerned with community mental health services, substance use treatment programs and help for people with developmental disabilities. This online community provides critical information, including information on trauma informed care, that will provide a list of service providers in the individuals geographical location. This portal also supports seeking information on specific disorders by topic where they can type in the keyword they are seeking additional information on to educate themselves on trauma related and other behavioral health disorders.

The DBH Strategic Plan requires effectiveness and specifies a continuous quality improvement (CQI) process for services funded by the DBH, focusing on a number of factors including trauma. Providers were initially trained on the Harris and Fallot TIC tool and required to complete the self/peer assessment beginning in 2013 and with regular reassessment every other year thereafter. Reassessment is currently underway in 2021. After the Trauma-Informed Care (TIC) assessment was completed, results were reviewed and strengths for continued growth as well as opportunities for improvement were reviewed. Focus has been aimed at improvement in consideration of trauma across all service components including but not limited to: Program Procedures and Settings; Formal Service Policies; Trauma Screening, Assessment, and Service Planning; Program Procedures and Settings; Administrative Support for Program-Wide Trauma-Informed Services; Human Resources Practices; and Staff Trauma Training and Education. Analyses is conducted for continuation of improvement efforts and to identify ongoing training needs.

DBH promotes Trauma Informed Care through a statewide initiative, Trauma Informed Nebraska (TIN). The purpose of TIN is to promote the development and implementation of a statewide, consumer-driven, recovery-oriented, trauma-informed system that ensures all behavioral health providers are informed about the effects of psychological trauma and are aware of the origin and effects of trauma on survivors. Through TIN, the DBH and the Behavioral Health Education Center of Nebraska (BHECN), multiple trainings called Trauma 101 and Recovery, have been provided to network providers over the last several years . A train the trainer process was established to ensure there is ongoing training throughout the state. Trauma 101 and Recovery includes: Introductions/Opening Exercise; Define PTSD and Trauma; Trauma Informed and Trauma Specific; Symptoms of PTSD/Triggers; ACES Study/Survey/Applications; Screening; Healing Neen Video; PTSD and Substance Use Disorder; Memory and Trauma; Creating Safe Environments; Vicarious Trauma – Exercise; Treatment Approaches; Trauma/Addiction/Recovery; Resources. DBH in conjunction with the UNL PPC has sponsored numerous TIC trainings and have training specific for CPSS (Peer Certification) to ensure best practices.

Trauma educational opportunities and resources about trauma specific services are not uncommon. Materials on Seeking Safety, PCIT and TF-CBT are examples. Nebraska has had a number of providers and RBHAs involved in the National Learning Community on trauma. Training material and resources continue to be shared.

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

Footnotes:

Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than a third of people in prisons and nearly half of people in jail have a history of mental health problems.[1] Almost two thirds of people in prison and jail meet criteria for a substance use disorder.[2] As many as 70 percent of youth in the juvenile justice system have a diagnosable mental health problem.[3] States have numerous ways that they can work to improve care for these individuals and the other people with mental and substance use disorders involved in the criminal justice system. This is particularly important given the overrepresentation of populations that face mental health and substance use disorder disparities in the criminal justice system.

Addressing the mental health and substance use disorder treatment and service needs of people involved in the criminal justice system requires a variety of approaches. These include:

- Better coordination across mental health, substance use, criminal justice and other systems (including coordination across entities at the state and local levels);
- Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups;
- Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system;
- Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community;
- Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems);
- Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, at booking, jails, the courts, at reentry, and through community corrections);
- Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system;
- Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met;
- Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges;
- Partnering with the judicial system to engage in cross-system planning and development at the state and local levels;
- Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system; and
- Supporting court-based programs, including specialty courts and diversion programs that serve people with M/ SUD.
- Addressing the increasing number of individuals who are detained in jails or state hospitals/facilities awaiting competence to stand trial assessments and restoration.

These types of approaches can improve outcomes and experiences for people with M/SUD involved in the criminal justice system and support more efficient use of criminal justice resources. The MHBG and SUPTRS BG may be especially valuable in supporting a stronger array of community-based services in these and other areas. SSAs and SMHAs can also play a key role in partnering with state and local agencies to improve coordination of systems and services. This includes state and local law enforcement, correctional systems, and courts. SAMHSA strongly encourages state behavioral health authorities to work closely with these partners, including their state courts, to ensure the best coordination of services and outcomes, especially in light of health disparities and inequities, and to develop closer interdisciplinary programming for justice system involved individuals. Promoting and supporting these efforts with a health equity lens is a SAMHSA priority.

[1]Bronson, J., & Berzofsky, M. (2017). Indicators of mental health problems reported by prisoners and jail inmates, 2011–12. Bureau of Justice Statistics, 1-16.

[2]Bronson, J., Stroop, J., Zimmer, S., & Berzofsky, M. (2017). Drug use, dependence, and abuse among state prisoners and jail inmates, 2007–2009. Washington, DC: United States Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[3]Vincent, G. M., Thomas Grisso, Anna Terry, and Steven M. Banks. 2008. "Sex and Race Differences in Mental Health Symptoms in Juvenile Justice: The MAYSI-2 National Meta-Analysis." Journal of the American Academy of Child and Adolescent Psychiatry 47(3):282–90.

Please respond to the following items

1. Does the state (SMHA and SSA) engage in any activities of the following activities:

- [x] Coordination across mental health, substance use disorder, criminal justice and other systems
- [ ] Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups
- [x] Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system, including those related to medications for opioid use disorder
- [x] Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- [x] Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- [x] Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community
- [x] Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems)
- [x] Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, booking, jails, the courts, at reentry, and through community corrections)
- [x] Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system
- [x] Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met
- [x] Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges
- [x] Partnering with the judicial system to engage in cross-system planning and development at the state and local levels
- [x] Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system
- [x] Supporting court-based programs, including specialty courts and diversion programs that serve people with M/SUD
- [x] Addressing Competence to Stand Trial; assessments and restoration activities.

2. Does the state have any specific activities related to reducing disparities in service receipt and outcomes across racial and ethnic groups for individuals with M/SUD who are involved in the criminal justice system? If so, please describe.

○ Yes ◉ No

3. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances?

◉ Yes ○ No

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

The Justice Behavioral Health Committee (JBHC), formerly known as the Justice Substance Abuse Team, was created in 2003 to help improve communication and collaboration between the criminal justice and treatment systems. JBHC is staffed by the Administrative Office of Probation. This group meets quarterly and consists of 34 members representing the Executive and Judicial branches as well as behavioral health treatment providers and consumers. JBHC has established the Data, Curriculum, Sex Offender, and Provider sub-committees to assist in fulfilling its mission. The Division of Behavioral Health (DBH), in partnership with justice partners, and through the work of the Justice Behavioral Health Committee, established assessment standards and core curriculum rubrics incorporated into justice and behavioral health trainings. Confirmation of the rubrics and associated trainings are reviewed annually with the committee which includes representatives from Corrections, Parole, Probation, Problem Solving Courts, Regional Behavioral Health Authorities (RBHAs) and providers, Licensing Boards, Medicaid, Public Health, Child and Family Services, Public Defense, research and academia.

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.

The DBH and the Office of Probation Administration held a well received Behavioral Health Justice statewide conference in 2019 and again in 2022, and has set goals to offer such a conference every 3 years.

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.

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.

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 identify opportunities to further divert and support individuals with mental health and substance use disorders involved in the criminal justice system.

The Nebraska System of Care (NeSOC) efforts have been previously supported through a SAMHSA SOC Expansion and Sustainability grant. This grant cycle ended in September 2020; however, the Administrative Office of the Courts and Probation (AOCP) continue to be directly involved in ongoing system of care efforts, including data collection, across the youth service system.

Crisis Intervention Team: In Omaha, a Crisis Intervention Team (CIT) model was developed and adopted as a cooperative community partnership involving law enforcement agencies, mental health service providers, mental health consumers, family members, and community funders. Through participation in this program, CIT police officers learn to recognize common forms of mental illness and to utilize the most effective means of communicating with people undergoing crisis. The officers are trained to de-escalate the individuals in crisis and allow the consumer to participate in the decision-making regarding their treatment. CIT officers must successfully complete 40 hours of training to become certified. This training has been offered to law enforcement providers in other RBHAs. To learn more about the Heartland Crisis Intervention Team program see their web page https://www.heartlandcit.org.

Behavioral Health Threat Assessment (BETA): 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 identify and describe signs and symptoms of mental illness), systems issues, and how to conduct a basic threat assessment. There is heavy involvement in the training by consumers of mental health services, helping students learn to connect at several levels and improve positive outcomes between law enforcement and people who have mental health problems. This training has been offered to law enforcement providers in other RBHAs. BETA training began in 2010 and to date 840 Law Enforcement and partners have been trained. An 8-hour Mini-BETA

and a Youth BETA began in 2018 as an adaptation and reach rural partners. To date 238 and 240 law enforcement and partners respectively have been trained in those sessions. Training was cancelled in 2021 due to the pandemic resumed in 2022.

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.

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

None at this time.

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Footnotes:

Environmental Factors and Plan

14. Medications in the Treatment of Substance Use Disorders, Including Medication for Opioid Use Disorder (MOUD) – Requested (SUPTRS BG only)

Narrative Question

In line with the goals of the Overdose Prevention Strategy and SAMHSA's priority on Preventing Overdose, SAMHSA strongly request that information related to medications in the treatment of substance use disorders be included in the application.

There is a voluminous literature on the efficacy of the combination of medications for addiction treatment and other interventions and therapies to treat substance use disorders, particularly opioid, alcohol, and tobacco use disorders. This is particularly the case for medications used in the treatment of opioid use disorder, also increasingly known as Medications for Opioid Use Disorder (MOUD). The combination of medications such as MOUD; counseling; other behavioral therapies including contingency management; and social support services, provided in individualized, tailored ways, has helped countless number of individuals achieve and sustain remission and recovery from their substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based, or non-medication inclusive, treatment for these conditions. The evidence base for medications as standards of care for SUDs is described in SAMHSA TIP 49 Incorporating Alcohol Pharmacotherapies Into Medical Practice and TIP 63 Medications for Opioid Use Disorders.

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to offer MOUD and medications for alcohol use disorder or have collaborative relationships with other providers that can provide all FDA-approved medications for opioid and alcohol use disorder and other clinically needed services.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs. States should use Block Grant funds for the spectrum of evidence-based interventions for opioids and stimulants including medications for opioids use disorders and contingency management.

In addition, SAMHSA also encourages states to require equitable access to and implementation of medications for opioid use disorder (MOUD), alcohol use disorder (MAUD) and tobacco use disorders within their systems of care.

SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding the use of medications for substance use disorders? (●) Yes ( ) No

2. Has the state implemented a plan to educate and raise awareness of the use of medications for substance disorder, including MOUD, within special target audiences, particularly pregnant women? (●) Yes ( ) No

3. Does the state purchase any of the following medication with block grant funds?

- **a)** [x] Methadone
- **b)** [ ] Buprenophine, Buprenorphine/naloxone
- **c)** [ ] Disulfiram
- **d)** [ ] Acamprosate
- **e)** [ ] Naltrexone (oral, IM)
- **f)** [ ] Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based treatment with the use of FDA-approved medications for treatment of substance use disorders is combined with other therapies and services based on individualized assessments and needs?

(●) Yes ( ) No

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

The Nebraska Division of Behavioral Health (DBH) contracts with six Regional Behavioral Health Authorities (RBHAs) and includes a provision in these contracts that SUD providers may not refuse to serve individuals receiving Medication Assisted Treatment (MAT). DBH will continue to promote and sponsor training opportunities and disseminate materials to increase provider competence in this area and to educate consumers on how to effectively use these services. Furthermore, provider education will be furthered by updates to both DBH and Medicaid service definitions to further highlight that MAT services should be available to all individuals enrolled in substance use disorder programming.

To promote education of providers, the DBH maintains linkages on its website (http://dhhs.ne.gov/Pages/State-Opioid-Response.aspx) to the Pain and Substance Use Disorder Project ECHO as well as the American College of Academic Addiction Medicine. Once on the DBH site, providers can also access a variety of resources, information and training materials on MAT. DBH partners with a variety of entities to educate providers on the utility of MAT. Discussion continues with systems partners, including the Division of Medicaid and Long- Term Care, Department of Corrections, Administrative Office of the Courts and Probation and others, gathering information on current expenditures, utilization and other data to make informed decisions. The DBH continues partnership with the Division of Public Health (DPH) in their opioid overdose prevention activities. The DPH receives a number of grants supporting this work and the DBH collaborates with their efforts. Additionally, the DBH partners with the Nebraska Medical Association (NMA) to coordinate MAT training efforts in an attempt to integrate with primary care physicians. Recent outreach efforts by the NMA also include special populations such as probation, drug-solving courts, corrections, and emergency departments.

Additionally, Nebraska is a 2022 recipient of the State Opioid Response grant, which is purposed to mitigate the effects of opioid use disorders, including both prescription opioids and illicit drugs, such as heroin, as well as stimulant use disorder by identifying statewide needs, increasing access to treatment, including medication assisted treatment, and reducing prescription drug overdose deaths through the provision of prevention, treatment and recovery activities.

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Footnotes:

Environmental Factors and Plan

15. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Substance Abuse and Mental Health Services Administration (SAMHSA) is directed by Congress to set aside 5 percent of the Mental Health Block Grant (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 evidenced-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 expend 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 expanding 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 will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-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 service to support reducing distress, promoting skill development and outcomes, manage costs, and better invest resources.

SAMHSA developed **Crisis Services: Meeting Needs, Saving Lives**, which includes "**National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit**" as well as an **Advisory: Peer Support Services in Crisis Care** and other related National Association of State Mental Health Programs Directors (NASMHPD) papers on crisis services. SAMHSA also developed "**National Guidelines for Child and Youth Behavioral Health Crisis Care**" which offers best practicies, 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 this new 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

1. Briefly narrate your state's crisis system. For all regions/areas of your state, include a description of access to the crisis call centers, availability of mobile crisis and behavioral health first responder services, utilization of crsis 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 a crisis receiving and stabilization centers in all six geographic Regions.

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 SAMHSA 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 SAMHSA 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.*

Other program implementation data that characterizes crisis services system development.
1. Someone to talk to: Crisis Call Capacity
a. Number of locally based crisis call Centers in state
i. In the 988 Suicide and Crisis lifeline network
ii. Not in the suicide lifeline network
b. Number of Crisis Call Centers with follow up protocols in place
c. Percent of 911 calls that are coded as BH related
2. 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 first responder structures (police, paramedic, fire)
b. Integrated with first responder structures (police, paramedic, fire)
c. Number that employs peers
3. Safe place to go or to be:
a. Number of Emergency Departments
b. Number of Emergency Departments that operate a specialized behavioral health component
c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis)

a. 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 talk to	☐	☐	☐	☐	☑	☐
Someone to respond	☐	☐	☐	☐	☑	☐
Safe place to go or to be	☐	☐	☐	☑	☐	☐

b. Briefly explain your stages of implementation selections here.

Someone to Talk to: 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 as part of the Suicide Prevention Lifeline. 911 centers in Nebraska do not track the number of mental health related calls. Through a Joint Protocols workgroup with the Nebraska 911 Public Service Access Points (PSAPs), protocols are still in the process of being developed. There are some PSAPs in the state that have mental health professionals available to consult when needed.

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. There are 3 areas of Nebraska that have co-responder models. Various mobile crisis teams across the state are exploring the addition of peers to their mobile crisis teams.

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. This is an area that Nebraska continues to expand.

3. Based on SAMHSA's National Guidelines for Behavioral Health Crisis Care, explain how the state will develop the crisis system.

SAMHSA's National Guidelines for Behavioral Health Crisis Care was reviewed and referred to during Nebraska's planning phase. The information about best practices when delivering behavioral health crisis care was shared with the various workgroups and stakeholders.

• 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 has 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.
• 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.
• 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. 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.

4. Briefly describe the proposed/planned activities utilizing the 5 percent set aside.

The 5% set aside will be used to support the use of 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 persons with SMI/SED to services in a more efficient and effective manner. Additionally, the set aside may be used to support training for mobile crisis team members to improve skills and interventions with persons with SMI/SED.

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

None at this time.

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Footnotes:

Environmental Factors and Plan

16. Recovery - Required

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders.

Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery- guided the approach to person-centered care that is inclusive of shared decision-making, culturally welcoming and sensitive to social determinants of health. The continuum of care for these conditions involves psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder, and services to reduce risk related to them. Because mental and substance use disorders can become chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management recovery and personal success over the lifespan.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

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 funding of recovery support services? (●) Yes ( ) No

d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD 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 has promulgated new regulations for the training and certification of peer support (mental health/substance use). Service standards, including peer run services, are within the Title 206 Behavioral Health Services Regulations and Service Definitions. The new regulations went into effect June 27, 2021 upon the Governor's signature. The new 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. One example of a service that utilizes a peer-run model is Hospital Diversion.

Hospital Diversion is a peer-operated service designed to assist consumers in decreasing psychiatric distress, which may lead to hospitalization. It is designed to help consumers rethink crisis as an opportunity to change toward a more self-determined independent life. Meaningful involvement can ensure that consumers lead a self-determined life in the community, rather than remaining dependent on the behavioral health system for a lifetime. Hospital Diversion offers consumers the opportunity to take control of their crisis or potential crisis and develop new skills through a variety of traditional self-help and proactive tools designed to maintain wellness. Trained Peer Companions are the key ingredients in helping other consumers utilize self-help tools. Peer Companions provide contact, support, and/or referral for services, as requested, during and after the stay as well as manning a Warm Line. Hospital Diversion is located in a family/home setting in a residential district that offers at least 4-5 guest bedrooms and is fully furnished for comfort. Participation in the service is voluntary.

The Mental Health Association of Nebraska, a peer run organization, is CARF Accredited and operates Keya House (Hospital Diversion Services). Community Alliance is CARF Accredited and operates Safe Harbor Peer Services.

Nebraska also has:
- Family Peer Supp ort Navigators
- Peer-Run Crisis Diversion Services
- Peer-Run Warmlines- Lincoln, Omaha, and North Platte
- Housing Related Assistance (MH/SU)
- Supported Employment
- Peer Support services (Individual, Family, Youth)
- Recovery Support services
- Recovery/Oxford Houses
- Wellness Recovery Action Planning
- Person Centered Planning
- Self-directed Care

For additional information on service delivery, see the 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,

Case management facilitates the achievement of individual wellness through advocacy, assessment, planning, linking, communication, education, resource management, and service facilitation. Additionally, block grant funded providers are to be welcoming, engaging and continually improving integrated services to the populations they serve, including those with developmental disabilities who have mental health and substance abuse disorders and all other individuals who have complex needs. Recovery support services are initiated at the onset of the individual's treatment planning and service delivery process. To the extent possible, the development of a service plan is to be a collaborative process involving the consumer, family members, and other support/service systems. A key component of service coordination is the expectation to develop and sustain strong working relationships with community partners who provide the necessary supports and services which assist individuals with behavioral health disorders. Establishing strong working relations with law enforcement, community hospital(s), housing providers, vocational/employment agencies, educational institutions, child welfare representatives, advocacy organizations, criminal justice representatives, etc., is vital to fully assess the effectiveness of on-going services and to determine if additional services are needed.

DBH has the authority and responsibility to direct and coordinate the public behavioral health system, including integration and coordination of the system; comprehensive statewide planning for the provision of an appropriate array of community-based behavioral health services and continuum of care; development and management of data and information systems; prioritization and approval of all expenditures of funds received and administered by the division; and promotion of activities in research and education to improve the quality of behavioral health services, recruitment and retention of behavioral health professionals, and access to behavioral health programs and services. DBH works in partnership and contracts with six Regional Behavioral Health Authorities (RBHA) to carry out its charge.

The RBHA have structures and mechanisms to support a coordinated system of care approach to support recovery and resilience of children and youth with behavioral health needs. The RBHA develop local systems of care across the state responsive to local needs and building upon the unique strengths and communities of each region, forging partnerships with youth, families, providers, DHHS divisions of Children and Family Services (CFS) and Medicaid and Long-Term Care (MLTC), county leaders, local system stakeholders, and community leaders and members.

Funding administered through the 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 and Inclusion, Network Management, Emergency Services System, Prevention Services System, and Youth System of Care (YSC). Each RBHA has implemented since 1995 a Professional Partner Program (PPP) using a fidelity-based version of the wraparound care coordination model to support services to families who have children with serious emotional disorders and to ensure that youth and families have a voice and ownership in developing an accessible, comprehensive, individualized family support plan.

In collaboration with system partners, the DBH developed and implemented guidelines, as outlined in the PPP manual, for children and young adults with mental and substance use disorders and their families for individualized care planning. The PPP manual is reviewed at least annually, with updates identified and incorporated as needed based upon quality improvement processes led by DBH. The PPP program evaluation, outcomes, and admission criteria are being re-assessed in order to continue to identify improvements that better assess the impact of PPP on children and youth, better measure family functioning over time, improve quality care, increase access to High Fidelity Wraparound Services, increase involvement of children, youth, and families, and continue in efforts to build strong partnerships across child serving agencies to implement family centered care.

With ten wraparound components at its core, an individualized service plan is developed for each youth/young adult and his/her family, based upon the strengths and concerns of the youth/young adult and his/her family across life domains, including mental health, substance abuse, residential, family, education, vocational, financial, social/recreational, medical, legal, safety, and cultural.

The Professional Partner, youth/young adult and family identifies wraparound team members who will contribute to the development of an Individual Family Service Plan (IFSP) (or Plan of Care - for the purposes of transition aged programs). The IFSP must be a clear, outcome focused plan with time sensitive and measurable goals and objectives that are purposed to support the safety, well-being, recovery and resiliency of the youth. The identified goals and objectives will directly reflect the information reported in the Intake/Interpretative Summary.

The format for the IFSP plan may vary but must include at a minimum:
- Clear demonstration of youth/young adult/family partnership in the plan development
- Youth/young adult and Family Strengths
- Presenting Problems
- Goals and Expected Outcomes/Pre-Discharge Plan
- Objectives/Interventions must be measurable and timely
- Team Members, both formal and informal
- Safety planning

Each RBHA Network includes a Youth Systems coordination function, responsible for the children's behavioral health system within their respective RBHA. The Youth Systems Coordinator coordinates activities and collaborates with community based partners to ensure that children and youth with behavioral health disorders receive the most appropriate services located within their community, whenever possible. They also collaborate with the RBHA Network providers and other agencies serving youth to engage in activities that address the behavioral health needs of youth transitioning into adulthood. Youth Systems Coordinators promote quality improvement by participating in statewide youth system coordination, enhance Nebraska System of Care (NeSOC) principles, assess RBHA Network providers of youth services for Family Centered Practice models (FCP), and provide technical assistance when needed and as appropriate to increase providers' ability to incorporate FCP and NeSOC principles into their practices.

The youth systems services infrastructure facilitates the involvement of youth, families, and system partners at the regional and individual family levels. The structures in each RBHA, alongside parallel structures for child welfare through the CFS's five Service Areas (SAs) are long-standing and provide a key component of the foundation upon which the NeSOC strategic plan implementation efforts are built. While their geographic boundaries are not fully aligned, there is much overlap and each RBHA works with assigned SAs. This enhanced regional alignment is key to sustainability, as both RBHAs and SAs have established networks among NeSOC stakeholders in each RBHA

The population of focus for Nebraska System of Care Strategic Plan is defined, inclusively, as:
Children and youth with serious emotional and behavioral health needs and their families across all of Nebraska's child-serving systems. Our vision, mission and values describe our hopes and intentions for the future, guides our efforts and provides a foundation for a system of care for children, youth and their families.

Vision Simply Said: All Nebraska children, youth and families will reach their full potential by experiencing improved wellness and mental health, exhibiting greater well-being, functioning successfully in the community and realizing greater stability in their living situation.

Mission Simply Said: Nebraska will improve the lives of children, youth and families by working within the partnerships to improve service delivery systems, including the cost and quality of care, as a means of providing meaningful benefits and measurable outcomes to children, youth and families as experienced in the context of everyday living.

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

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations

The Division of Behavioral Health Strategic Plan is designed to move the system to improve services for these populations through "person-centered and self-directed" approaches of care in recovery-oriented systems. Within the framework of recovery-oriented systems of care, the person-centered approach allows for greater flexibility for cultural adaptations within service delivery.

The peer support service definition, requirements for training and certification are integrated for mental health and substance use. The curriculum is a trauma informed and culturally competent model of peer support and is based upon the SAMHSA domains of peer support. Additional information on the new training and certification process and its implementation is located at DHHS – DBH – Office of Consumer Affairs website. http://dhhs.ne.gov/Pages/Consumer-Advocacy.aspx

The DBH offers multiple training opportunities for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers. Trainings specific to the peer support workforce growth and development have targeted certified peer support specialists as well as behavioral health providers to educate on the value and use of peer support within the behavioral health system. Trainings were also offered on ethical issues and practical strategies designed to protect clients and practitioners. DBH also offered a motivational interviewing training that addressed the fundamental concepts of MI for peer support specialists and identified critical conditions necessary for change to occur. Clinical supervision of nonclinical staff and peer to peer supervision are training breakout sessions planned for the 2019 Behavioral Health – Justice Conference. DBH and the University of Nebraska Medical Center and Behavioral Health Education Center of Nebraska (BHECN) continue to collaborate on peer workforce development, the role of peers, and curriculum improvements. In 2018, BHECN was awarded the MH – ATTC and it is anticipated that the competency of and the role of peers in the workforce will grow. Additionally, though funding support of the State Targeted Response to the Opioid Crisis grant, DBH offered training specific to Medication Assisted Treatment to peer support specialists in the state. Additional training needs are being assessed and will be developed to meet identified needs. Research is currently underway to identify specific peer support training curriculum standards that could be considered to establish a specialized endorsement in SUD peer support. Other potential training endorsements being considered include Youth Peer Support and Family Peer Support.

5. Does the state have any activities that it would like to highlight?

The Office of Consumer Affairs plays a significant role in promoting mental health and substance use recovery. They have implemented various initiatives to raise awareness and reduce stigma surrounding these disorders.

One of their campaigns is a monthly social media campaign that focuses on highlighting recovery from both mental health and substance use. They partner with community providers to support Mental Health Awareness Month and Children's Mental Health Awareness. They also collaborate 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.

In September 2023, they have planned to celebrate National Recovery Month by organizing a live event that aims to create a statewide partnership. This event will feature a speaker who will emphasize addiction, recovery, and wellness.

Looking back at Recovery Month activities, the Office of Consumer Affairs has organized a month-long series of educational and

stigma-reducing efforts. These efforts have included weekly Facebook live post where individuals and family members in recovery, shared their personal experiences related to mental health and addiction recovery. Additionally, an on- line virtual candle lighting campaign was held to encourage individuals and family members with mental health and substance use disorders to light a virtual candle and share their personal messages of hope.

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.

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

None at this time.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in **Olmstead v. L.C., 527 U.S. 581 (1999)**, provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights **(OCR)** cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Does the state's Olmstead plan include:

Housing services provided	(●) Yes	( ) No
Home and community-based services	(●) Yes	( ) No
Peer support services	(●) Yes	( ) No
Employment services.	(●) Yes	( ) No

2. Does the state have a plan to transition individuals from hospital to community settings? (●) Yes ( ) No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

Nebraska's Olmstead Plan is a roadmap to a strong state where we can all live and work in our communities. The Olmstead Vision is “People with disabilities are living, learning, working, and enjoying life in the most integrated setting." You can read the Nebraska Olmstead Plan at https://dhhs.ne.gov/Olmstead/Nebraska%20Olmstead%20Plan%20FINAL%20for%20Submission%20to%20Legislature.pdf

The Division of Behavioral Health is actively participating in the Nebraska Olmstead Workgroups. DHHS has workgroups to look at Housing, Education and Employment, Data, and Transportation. Workgroups include people with disabilities who can share lived experience in these areas. Over the last two state fiscal years, DBH has received state funds allocations of $2 million to promote the development of affordable housing available to people with disabilities.

Nebraska's Olmstead Plan reflects the following fundamental beliefs in supporting individuals with disabilities. Nebraska is committed to:

- Person- and family-centered approaches;
- Ensuring the safety of, and an improved quality of life for, people with disabilities;
- Services that are readily available, at locations accessible to individuals in need and their families; and,
- Supporting individuals to live a meaningful life in the community they choose.

Nebraska's vision is for all individuals with disabilities to live, learn, work, and enjoy life in the most integrated setting of their choosing. This Plan sets forth the following goals in order to achieve this vision.

Goal 1: Nebraskans with disabilities will have access to individualized community-based services and supports that meet their needs and preferences.

Goal 2: Nebraskans with disabilities will have access to safe, affordable, accessible housing in the communities in which they choose to live.
• Please see Nebraska Supportive Housing Plan URL: https://dhhs.ne.gov/Olmstead/Nebraska%20Supportive%20Housing%20Plan_Final%206%2030%2016.pdf

Goal 3: Nebraskans with disabilities will receive services in the settings most appropriate to meet their needs and preferences.
• Please see Person-Centered Planning Initiative URL: https://dhhs.ne.gov/Pages/DD-Person-Centered-Planning.aspx

Goal 4: Nebraskans with disabilities will have increased access to education and choice in competitive, integrated employment opportunities.

Goal 5: Nebraskans with disabilities will have access to affordable and accessible transportation statewide.

Goal 6: Individuals with disabilities will receive services and supports that reflect data-driven decision-making, improvement in the quality of services, and enhanced accountability across systems.

Goal 7: Nebraskans with disabilities will receive services and supports from a high-quality workforce.

The Nebraska Olmstead Advisory Committee meets regularly via Zoom. Advisory Committee documents are posted on the DHHS website, including Advisory Committee meeting agenda and minutes: https://dhhs.ne.gov/Pages/Olmstead.aspx

Report on progress with plan implementation June 2020 to December 2021 prepared by independent consultant, Technical Assistance Collaborative at https://nebraskalegislature.gov/FloorDocs/107/PDF/Agencies/Health_and_Human_Services__Department_of/708_20211215-142757.pdf

Changes to the Olmstead Advisory Committee Guidelines have been developed and are available to the public here: https://dhhs.ne.gov/Olmstead/DRAFT%20Olmstead%20Advisory%20Committee%20Guidelines%20for%20Review.pdf

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

None at this time.

Footnotes:

Environmental Factors and Plan

18. 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 condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[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 smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[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 abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[5].

According to data from the 2017 Report to Congress[6] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system.
2. improve emotional and behavioral outcomes for children and youth.
3. enhance family outcomes, such as decreased caregiver stress.
4. decrease suicidal ideation and gestures.
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and

employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

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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 Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: 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**

[6] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

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 misuse 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 FEP and Clinical High Risk for Psychosis (CHRP) systems? ◉ Yes ○ No

d) Does the state have an established FEP program? ◉ Yes ○ No

Does the state have an established CHRP program? ○ Yes ◉ No

e) Is the state providing trauma informed care? ◉ Yes ○ No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

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

The RBHA have structures and mechanisms to support a coordinated system of care approach to support recovery and resilience of children and youth with behavioral health needs. The RBHAs develop local systems of care across the state responsive to local needs and building upon the unique strengths and communities of each region, forging partnerships with youth, families, providers, DHHS Divisions of Children and Family Services (CFS) and Medicaid and Long-Term Care (MLTC), Developmental Disabilities (DD), Administrative Office of Probation and the Courts, county leaders, local system stakeholders, and community leaders and members.

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 non-traditional supports not covered by Medicaid are available, ranging from emergency to resiliency-oriented supports to wraparound. System coordination is central to their purpose, coordinating the local behavioral health system in the region through strategic strengths-based/recovery-focused processes that empower individuals and communities to assure that network providers, system partners and the many stakeholders of the behavioral health system work in a coordinated manner that supports individuals across the life span to promote resiliency and achieve recovery. Each RBHA has established multi-stakeholder collaborative structures to coordinate efforts in formal functional areas for Consumers (including youth) and Family Involvement and Inclusion, Network Management, Emergency Services System, Prevention Services System, and Youth System of Care (YSC). Each RBHA has 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 and to ensure that youth and families have a voice and ownership in developing an accessible, comprehensive, individualized family support plan.

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 transitioning into adulthood. 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 assigned SAs. This enhanced regional alignment is key to sustainability, as both RBHAs and SAs have established networks among NeSOC stakeholders in each region.

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 them 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.

SCIP also networks with multiple community partners, working together to ensure communities are well educated and youth have the appropriate resources to meet their needs to reach their full potential.

DHHS DBH received a grant in September of 2016 to expand and sustain 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.

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, inclusive of data from the DHHS Divisions of Medicaid, Behavioral Health, and Children and Family Services/Nebraska Families Collaborative and the Office of Probation, represents 37,996 unique youth involved with any of these agencies for any period of time during FY15.

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.

The NeSOC implemented a phased work plan which guides the NeSOC efforts. The work plan had 64 action steps identified over a 3 year period which addressed: NeSOC infrastructure, Service Design and Delivery, Evaluation and CQI and Workforce development. Additionally there were performance measures identified for each phase.

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. In January of 2019, the NeSOC Leadership Board met to revisit the identified desired outcomes and the governance structure of the NeSOC efforts. The desired outcomes remained relatively unchanged however activities of focus for the next 18 months were identified.

Additionally the governance structure of the NeSOC was changed to be more inclusive 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.

Additionally Nebraska completed a financial investment blue print outlining several areas where cost efficiencies may be found in the youth and family serving systems which could be reinvested into the behavioral health system to development of additional evidence based services and supports and work force development.

Since implementation of the NeSOC efforts, Nebraska has added capacity to the Professional Partner Program which serves the state through a contract with the behavioral health authorities to provided centralized case management using the Wraparound approach. Additionally, Nebraska has added a state wide mobile crisis support service accessed through a centralized intake line which will connect families with a licensed clinician either in person or via telehealth within one hour. Other highlighted results of the NeSOC efforts include clinical training (expanded capacity in Child and Parent Psychotherapy, Intensive Outpatient Therapy, Mental health services in schools, Multi-systemic Therapy (MST), Parent Child Interaction Therapy, Parents and Children Together, Therapeutic consultation and youth and family peer support. Competency development has been an area focus for the NeSOC efforts. Clinical endorsement training was provided to increase competency among clinicians serving youth with low cognitive disorders and SED. During summer 2019 and 2020, clinical endorsement training to serve youth with problematic sexual behavior was provided. Through the NeSOC efforts the Lead Family Contact (in coordination with the Family Advisory Council) has developed a Family Leadership Academy. The Academy includes a general training as well as a train the trainer option.

The SOC framework developed under the grant also continues to operate today, with ongoing commitment from multiple system partners to operationalize SOC values and principles across the youth service system. The CIC is in the process of identifying priority initiatives to be focused on over the next one-two years. These will be aligned with DBH strategic planning efforts identified through needs assessment activities as well as annual SOC evaluation activities completed during the grant.

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

The Munroe-Meyer Institute is conducting a project to improve access to pediatric mental health services in Nebraska, working as a sub-recipient in a $2.2 million five-year grant awarded to the Nebraska DHHS Title V Maternal and Child Health program.

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 will utilize the information and recommendations to outline a vision and plan for how best to disseminate information to families; to develop a website as an online resource repository; to determine the needs for training and education of families; and to identify steps for addressing gaps in resources. By April 2025, the project will deliver a white paper and an action plan.

Additionally, DBH has partnered with the Nebraska Department of Education to provide support to four local education agencies who were awarded the Advancing Wellness and Resilience in Education (AWARE) grant. 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.

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

None at this time.

Footnotes:

Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death overall, with over 47,000 people dying by suicide in 2021 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following:

1. Have you updated your state's suicide prevention plan in the last 2 years? (●) 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 this 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 in a manner that every Nebraskan can access it, find the information they are looking for and implement it in their lives or community.

Nebraska's 2022 – 2025 Statewide Suicide Prevention Plan was built on the National Strategies 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:
> 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, mental health or substance use crisis, or any other kind of emotional distress. The creation of 988 is the first step in creating 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 houses the Lifeline, ensuring a smooth transition to 988.

There are also text and chat features available through 988. When someone reaches out to 988, they will reach a trained crisis counselor who can work to de-escalate the caller, assess the severity of the situation, assist the caller in creating a safety plan or connect them with additional resources if needed.
• Objective 1: Utilize the statewide 988 marketing and communications plan to increase awareness of 988 and suicide prevention.
• Objective 2: Designate a portion of 988 communication funds to develop and place quality, hopeful messaging that reaches every pocket of the state in both Spanish and English through radio, social media boosted posts, printed materials, promotional items for communities to order, local communication avenues, newspapers, billboards and other relevant communication outlets.
• 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 items.
• 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 organizations and any existing group that is willing to offer their communication tools and networks to broaden the reach of 988 messages.

> Health and Empowered Individuals, Families and Communities
Strategy 1: Create and/or enhance suicide prevention coalitions in all communities or geographical regions.
This strategy focuses on implementing targeted communications on the importance of coalitions in the community that reach not only those in the behavioral health community but the broader population. Providing a framework from the Nebraska State Suicide Prevention Coalition (NSSPC) for interested communities on how to create a coalition and if a community has an existing coalition that needs to be reenergized, NSSPC can provide resources on how to do so.

Strategy 2: Increase Nebraskans' knowledge of factors promoting wellness and recovery in regard to suicide prevention.
This strategy focuses on statewide public awareness campaigns that take a hopeful approach to mental wellness and suicide prevention. The campaign would be branded as a public/private partnership initiative, promoting the well-being of self and others while empowering all to join.
Strategy 3: Work with the physical health community to empower all medical professionals to have conversations with patients about behavioral health, while creating a safe space for patients to address any concerns at regular appointments.

This strategy focuses on encouraging statewide medical associations to partner of the public awareness campaign and assist in providing suicide prevention training to all medical professionals statewide and promotion of suicide prevention as a core component of all health care services.

> Clinical and Community Prevention Services
Strategy 1: Integrate evidence-informed, culturally, and population-specific prevention strategies in all systems that serve Nebraskans.
This strategy focuses on identifying all diverse populations that exist statewide to get a clear picture of suicide risk and needs across our state. Utilize resources and systems such as 988 and culturally and population-specific suicide prevention trainings and enhancing family and/or support navigation programs for those in need.

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.

Strategy 3: Implement suicide prevention messaging through multiple sectors and settings where Nebraskans are.
This strategy focuses on promoting mental wellness and suicide prevention training and education in a community sectors including corporate business settings, utilizing existing resources that have a built rapport and trust with Nebraskans, and provide resources to schools, churches, and companies to increase knowledge and change attitudes and behaviors towards suicide prevention and behavioral health.

Strategy 4: Expand mental wellness and suicide prevention education for all students attending state-funded schools.
This strategy focuses on the expansion of hope squads in schools, collaborating with the Nebraska Department of Education in promoting and disseminating its school-focused suicide prevention toolkit, and teaching children and youth on how to identify, cope with and manage emotions at schools.

Strategy 5: Create and support more peer-support groups for both youth and adults.
This strategy focuses on expanding Nebraska's peer support groups for both youth and adults.

> Treatment and Support Services
Strategy 1: Enhance the continuum of care for Nebraskans in need of behavioral health care.
This strategy focuses on increasing crisis response through 988, expanding the continuum of prevention, treatment and recovery community-based services, enhancing peer-based respite care centers, identifying technological solutions that improve coordination for youth transitioning from behavioral health services back into the schools, and creating/expanding public/private partnerships that support early intervention and prevention programming and resources.

Strategy 2: Work closely with the Behavioral Health Education Center of Nebraska (BHECN) to develop workforce shortage solutions.
This strategy focuses on creating and/or enhancing public/private partnerships and implementing behavioral workforce strategies.

Strategy 3: Increase availability of crisis management services across the state, with specific attention to the rural areas of western Nebraska.
This strategy focuses on identifying funding and reimbursement for crisis response and crisis response training, enhancing drop-in and/or urgent care behavioral health services for youth and adults, and developing standardized policies and protocols for emergency department settings on the presentation of the patient, which will allow for more differentiated responses based on risk profiles and assessed clinical needs.

Strategy 4: Build equitable access to behavioral health care services statewide.
This strategy focuses on addressing transportation, technology capabilities, increasing workforce, and sustainable funding.

Strategy 5: Partner closely with law enforcement, as they are a valuable partner, but lead the way to decriminalizing mental illness.
This strategy focuses on promoting crisis response programs that do not involve law enforcement when not needed for safety purposes and including messaging that garners collaboration and communication between law enforcement and those wit lived experience.

> 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 universal, timely method of data collection resource that can be utilized statewide and identifying an organization or data collection point per geographical state region that public/private partners support for serving as the central data collection point.

Strategy 2: Utilize existing death review committees' reports and information to direct our prevention efforts.
This strategy focuses on identifying which death review committees exist, who the point of contact is for each, and explore implementation of statewide psychological autopsy programs in each region.

Strategy 3: Rely on the previously recommended State Suicide Prevention Coordinator to gather statewide data, evaluate it for trends, and provide the outcomes to state and local coalitions in a timely manner so that trends driving prevention efforts remain relevant.
This strategy focuses on ensuing the state suicide prevention coordinator role is supported to have the tools and information needed to fulfil the strategy.

Strategy 4: Utilize data collected from the previously recommended public awareness campaign to determine how many Nebraskans are reached through the various messaging efforts and platforms to best determine continuous updates to the campaign.
This strategy focuses on coordinating and disseminating pf public/private partner data to monitor and evaluate the data and identify relevant themes to state and local coalitions so they can implement more targeted efforts in their communities based on the data.

> Lethal Means Safety and Risk Reduction
Strategy 1: Implement a wellness and safety plan requirement policy for organizations to adhere to with each client where it doesn't already exist.
This strategy focuses on gathering approved sample wellness or safety plans and make accessible to all providers, target messaging to the public about the value of creating a wellness plan, and training and/or tutorial on how to use safety or wellness plans for individuals, as well as how to help someone else create one.

Strategy 2: Promote the importance of connectedness throughout the state.
This strategy focuses on promoting messaging that illustrates what connectedness means and can look like and increase peer-based services for youth and adults.

Strategy 3: Implement statewide suicide and behavioral health screening to early identify individuals who may be at risk.
This strategy focuses on gathering approved screening tools for health providers, screening students, making follow-up connections with community resources for any student who is identified through the screening process, gathering feedback from medial and hospital associations on the implementation of screeners in health care setting and encouraging providers who serve patients and clients that identify as at risk for suicide to routinely assess their access to lethal means.

Strategy 4: Promote messaging and education on lethal means safety and safe gun ownership, empowering individuals to learn how to safeguard their homes.
This strategy focuses on messaging on the power of lethal means safety for the public, the availability of no cost prescription lock boxes and gun safety locks, incorporating HOPE signs on bridge and parking structures, messaging at sporting events, training for gun range dealers and staff, and partnering with pharmacists statewide to provide materials for safe disposal of unused prescriptions.

> Governor's Challenge to Prevent Suicide Among Service Members, Veterans and Their Families
In March of 2022, Nebraska Governor Pete Ricketts confirmed Nebraska's participation in the national Governor's Challenge, which is a call to action asking state military and civilian interagency teams to embark on a process of collaborating, planning, and implementing suicide prevention best practices and policies for Service Members, Veterans and their Families (SMVF) statewide. The Nebraska team for the Governor's Challenge is comprised of veterans, government agencies, those with lived experience, advocates and community resources. At the time of this statewide plan's creation, this group is working to finalize Nebraska's path forward to save lives of service members, veterans and their families. We will ensure the Governor's Challenge plan aligns and is woven into our statewide plan.

The goals of the Nebraska Governor's Challenge include:
1. Identifying SMVF and screening for suicide risk;
2. Promoting connectedness and improving care transition;
3. Increasing lethal means safety and safety planning.

3. Have you incorporated any strategies supportive of Zero Suicide? (●) Yes ( ) No

4. Do you have any initiatives focused on improving care transitions for suicidal patients 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 2022 - 2023 plan was submitted? (●) Yes ( ) No

If so, please describe the population of focus?

The University of Nebraska Public Policy Center has been awarded the GLS Suicide Prevention Grant since October 2019. The purpose of Nebraska's project is to reduce the number of suicides and attempts for youth ages 10-24 with a focus on outreach to individuals 15-24 years of age because their suicide rate is increasing in Nebraska, exceeding the US rate. Prevention activities are concentrated in southeast Nebraska because the youth suicide rate for this area exceeds the state and US rate. The entire state is reached by including suicide prevention in coordinated school health plans for K-12 schools and workforce development for clinicians serving youth in crisis. Nebraska will promote the zero suicide approach for health and behavioral health organizations

along with evidence-based strategies and practices to prevent youth suicide. The project has four goals. 1) Decrease the youth suicide rate 80% in Regional Behavioral Health Authority (RBHA) Region V Systems by 2024. 2) 100% of Nebraska public school districts will have policies and protocols in place for suicide prevention, post-suicide intervention, and transition back to school after a suicide crisis by 2024. 3) Twenty (20) Nebraska providers or healthcare systems will implement the zero suicide approach by 2024. 4) 100% of Nebraska's child serving systems will adopt evidence-based practices to follow-up with youth after a suicide attempt or hospitalization by 2024.

During the grant, approximately 70,000 15 to 24-year-olds will be reached in RHBA Region V Systems and embed suicide prevention practices in 244 school districts reaching 187,000 public school students in grades 5-12 statewide. At least 200 clinicians will be trained by introducing 30 organizations to the zero-suicide initiative, embed suicide screening with school psychologist services in 17 educational service units and 12 treatment organizations. Evidence-based follow-up after youth experience a suicide crisis will be implemented in five child serving systems and two healthcare systems, and implement evidence-based post-suicide intervention practices on five post-secondary campuses impacting lives of 40,000 college age students.

In addition to the above mentioned activities, the Nebraska's Department of Education (NDE) is a recipient of SAMSHA's Project AWARE grant. As a key partner, the DBH is actively involved in grant management and grant implementation activities. Mental Health prevention, promotion, early identification, and suicide prevention are all targeted activities within this grant.

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

None at this time.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SUPTRS BG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The 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's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and M/SUD conditions.
- 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.
- SAMHSA seeks to enhance the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states. 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?

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, and treatment, prevention and support service providers.

Cross system partnerships at the state level are facilitated through state agency representative membership on advisory committees, including the DBH Joint Advisory Committee (State Advisory Committees on Mental Health and Substance Use Disorder Services) and DBH Prevention Advisory Committee.

Nebraska's Adult System of Care incorporates this conceptual framework and the associated system of care guiding principles and core values into a spectrum of effective, community-based services and supports that is organized within a coordinated system of care network.

DBH works through and in partnership with six Regional Behavioral Health Authorities (RBHAs) to carry out its charge to support a coordinated system of care approach to children and youth services. The RBHAs have structures and mechanisms to support a coordinated system of care approach to support recovery and resilience of children and youth with behavioral health needs. The RBHAs develop local systems of care across the state responsive to local needs and building upon the unique strengths and communities of each region, forging partnerships with youth, families, providers, DHHS Divisions of Children and Family Services (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.

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
o Office of Health Disparities
• Nebraska Judicial System - Administrative Office of the Courts
• Nebraska Judicial System - Administrative Office of Probation
• Nebraska Judicial System - Court Improvement Project
• Nebraska Children's Commission
• Family Organizations
o Speak Out
o Families Care
o Families Inspiring Families
o Healthy Families Project
• 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

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 V Systems
Region 6 Behavioral Healthcare
Behavioral Health Education Center of Nebraska

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

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.

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 to ensure a smooth transition, identify joint needs and coordinate initiatives. In 2023 DBH continues to engage Medicaid and the MCO vendors in initial and ongoing performance contracting and sharing of performance indicators.

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 them of 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.

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.

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.

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
http://dhhs.ne.gov/Pages/Drug-Overdose-Prevention-PDMP-Reporting.aspx

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, parity in coverage of services and access.

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.

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.

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.

The DBH and the Office of Probation Administration held a well received Behavioral Health Justice statewide conference in 2019 and again in 2022 and has set goals to offer such a conference every 3 years.

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.

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.

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 identify opportunities to further divert and support individuals with mental health and substance use disorders involved in the criminal justice system.

The Nebraska System of Care (NeSOC) efforts have been previously supported through a SAMHSA SOC Expansion and Sustainability grant. This grant cycle ended in September 2020; however, the Administrative Office of the Courts and Probation (AOCP) continue to be directly involved in ongoing system of care efforts, including data collection, across the youth service system.

Crisis Intervention Team: In Omaha, a Crisis Intervention Team (CIT) model was developed and adopted as a cooperative community partnership involving law enforcement agencies, mental health service providers, mental health consumers, family members, and community funders. Through participation in this program, CIT police officers learn to recognize common forms of mental illness and to utilize the most effective means of communicating with people undergoing crisis. The officers are trained to de-escalate the individuals in crisis and allow the consumer to participate in the decision-making regarding their treatment. CIT officers must successfully complete 40 hours of training to become certified. This training has been offered to law enforcement providers in other RBHAs. To learn more about the Heartland Crisis Intervention Team program see their web page https://www.heartlandcit.org.

Behavioral Health Threat Assessment (BETA): 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 identify and describe signs and symptoms of mental illness), systems issues, and how to conduct a basic threat assessment. There is heavy involvement in the training by consumers of mental health services, helping students learn to connect at several levels and improve positive outcomes between law enforcement and people who have mental health problems. This training has been offered to law enforcement providers in other RBHAs. BETA training began in 2010 and to date 840 Law Enforcement and partners have been trained. An 8-hour Mini-BETA and a Youth BETA began in 2018 as an adaptation and reach rural partners. To date 238 and 240 law enforcement and partners respectively have been trained in those sessions. Training was cancelled in 2021 due to the pandemic and resumed in 2022.

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.

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.

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.

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.

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 multicultural orientation – engaging diverse 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 expanded its footprint in rural Nebraska to support efforts increase retention of behavioral health providers, recruitment and establishing a statewide network of behavioral health providers. BHECN offices now include a presence at the University of Nebraska – Kearney, a rural hub in central Nebraska.

Project AWARE
In September 2018, the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS) awarded the State of Nebraska the Project AWARE (Advancing Wellness and Resilience in Education) - State Education Agency (SEA) grant. This five year program supports the development and implementation of a comprehensive plan of activities, services, and strategies to decrease youth violence and support the healthy development of school-aged youth.

Nebraska's AWARE-SEA Project is being jointly undertaken by the Nebraska Department of Education (NDE) and Nebraska Department of Health and Human Services – Division of Behavioral Health (DBH) to build and enhance partnerships and collaboration between State and local systems. The project focuses on the high level of mental and behavioral health needs of school-age children in rural schools, including depression, anxiety, suicide ideation, trauma, and substance use. Educators statewide feel unprepared to handle the severity of mental health issues arising daily in schools. Training for school staff to better address students' mental and behavioral health needs has been identified as a critical priority.

NDE and DBH are partnering at the State level to collaborate with three Local Education Agencies (LEAs) to improve school-based mental health services. The LEAs of Chadron, Hastings, and South Sioux City are demographically and geographically diverse, with varying levels of poverty and scarcity of mental health resources. Two sites have higher free/reduced lunch rates, indicative of poverty and student mobility. Each differs in racial/ethnic composition, with higher proportions of Hispanic and Native American students. All three LEAs have strong, long-standing track records of successful collaborations with State and local partners, including mental health providers, community coalitions, civic organizations, the business and private sector, and stakeholders, including students and families.

This project is intended to build and expand the capacity of the NDE, in partnership with the DBH and the three LEA Site partners, to:
• Prevent the development of mental health and behavioral disorders among students by providing a positive, supportive, and trauma-informed learning environment.
• Increase awareness of mental health issues among school-aged youth and skills fostering resilience and pro-social behaviors through strength-based approaches and social-emotional learning.
• Increase the school-based mental health services available and connect students with mental health issues and their families to

the appropriate services.
• Increase schools' capacity to identify and immediately respond to the mental health needs of students exhibiting behavioral or psychological signs requiring clinical intervention.
• Increase schools' capacity to identify and intervene in bullying and aggressive or violent behaviors of students that may contribute to school violence.

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.

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 identify treatment services and refer patients to care in a few clicks. Data collected during the pilot will identify capacity challenges and provide data driven opportunities to find solutions.

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.

Nebraska's registry serves the state's most populous RBHA, Region 6 Behavioral Healthcare, which includes Cass, Dodge, Douglas, Sarpy and Washington counties in eastern Nebraska. Region 6 Behavioral Healthcare has a diverse mix of publicly contracted hospitals and private hospitals that afford the opportunity to capture capacity issues and process variables. Data from the pilot will be used to analyze bed capacity, workforce, and system barriers to access. In addition, the data will be used to inform policy decisions about alternate payment models such as value-based contracting and innovations to payment structures supporting efficient service delivery. Nebraska's registry will have the opportunity to learn from best practices from the other 22 states developing crisis intervention registry projects.

The planning process began in the spring of 2019. The DBH and Region 6 Behavioral Healthcare have developed a workgroup, which will include representatives from the RBHA, DHHS, local emergency departments, public and private hospitals, law enforcement, behavioral health providers, county attorneys, community stakeholders and consumers with lived experience. The workgroup will develop a centralized, real-time system to track inpatient beds and assess capacity for inpatient psychiatric beds in the area.

The pilot project in Region 6 Behavioral Healthcare area was fully operational in October 2020. DBH is working with the current vendor on potential expansion of the bed registry throughout the state.

System of Care
The Nebraska Division of Behavioral Health Nebraska System of Care (NeSOC) integrates the state educational system as a corner stone in its work. The NeSOC connects and coordinates the work of State child-serving agencies, nonprofit and local governments, behavioral health care providers, families and patient advocates. It helps children, youth, and families function better at home, in school, in the community, and in life.

In 2013-2014, over 1,000 families, youth, service providers and other stakeholders were involved in the development of a System of Care Strategic Plan. The Nebraska Department of Health and Human Services - Division of Behavioral Health received a grant in 2016 to expand and sustain the System of Care. Partners from across the state are working to implement the elements which were identified through the System of Care strategic plan.

The state-level leadership team actively engages with multiple state agency offices to improve overall state infrastructure in order to globally enhance the state's capacity to improve access and service provision to children and youth and families. This work includes the representatives of partners serving as members and representatives on the Nebraska State Advisory Committee on Mental Health Services.

The educational system is often the first system families turn to when they have concerns about their children's social emotional development or behavioral health. Additionally the education system provides strong ongoing support to youth and their families. The NeSOC is building upon existing relationships with the Nebraska Department of Education as well as local school districts and the Educational Service Units. Partners from the education field are embedded throughout the NeSOC governance

structure. As stated above, DBH is actively engaged in the implementation and management of the Project AWARE grant in partnership with the Nebraska Department of Education.

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 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.

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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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.

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, parity in coverage of services and access.

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.

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.

The DBH and the Office of Probation Administration held a well received Behavioral Health Justice statewide conference in 2019 and again in 2022 and has set goals to offer such a conference every 3 years.

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.

NDE and DBH are partnering at the State level to collaborate with three Local Education Agencies (LEAs) to improve school-based mental health services. The LEAs of Chadron, Hastings, and South Sioux City are demographically and geographically diverse, with varying levels of poverty and scarcity of mental health resources. Two sites have higher free/reduced lunch rates, indicative of poverty and student mobility. Each differs in racial/ethnic composition, with higher proportions of Hispanic and Native American students. All three LEAs have strong, long-standing track records of successful collaborations with State and local partners, including mental health providers, community coalitions, civic organizations, the business and private sector, and stakeholders, including students and families.

This project is intended to build and expand the capacity of the NDE, in partnership with the DBH and the three LEA Site partners, to:

• Prevent the development of mental health and behavioral disorders among students by providing a positive, supportive, and trauma-informed learning environment.
• Increase awareness of mental health issues among school-aged youth and skills fostering resilience and pro-social behaviors through strength-based approaches and social-emotional learning.
• Increase the school-based mental health services available and connect students with mental health issues and their families to the appropriate services.
• Increase schools' capacity to identify and immediately respond to the mental health needs of students exhibiting behavioral or psychological signs requiring clinical intervention.
• Increase schools' capacity to identify and intervene in bullying and aggressive or violent behaviors of students that may contribute to school violence.

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

None at this time.

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Footnotes:

Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance use disorder Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SUPTRS BG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[1]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

[1] **https://www.samhsa.gov/grants/block-grants/resources [samhsa.gov]**

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, 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. When meeting in joint session, the two advisory committees serve as a behavioral health advisory council.

The joint committee continues its active involvement in the state plan guiding the public health behavioral system by providing advice and assistance to the DBH on the ongoing planning efforts that inform and shape planning at State, regional, and local levels. This includes guiding review of behavioral health strategic plan initiatives, needs assessments, consumer surveys, Results-based Accountability, Continuous Quality Improvement and other efforts guiding activities across the systems, and prioritization of state planning activities in the state application.

The DBH web page URL for Joint Advisory Committee meeting agenda and minutes is:
https://dhhs.ne.gov/Pages/behavioral-health-public-participation.aspx

Recent activities include:

<> April 20, 2023 Joint Advisory Committee Meeting
Meeting topics included: DBH Director Update; Governor's Challenge Veteran Suicide; Synar Report and Coverage Study; Planning for the FFY2024-2025 SAMHSA Combined Mental Health and Substance Abuse Block Grant Application; and, 988 Suicide and Crisis Lifeline. The presentation and discussion of the FFY2024-2025 MH/SUPTRS BG Application introduced the Application and the current two-year Behavioral Health Systems Assessment and Plan for FFY2024/25 Planning Table 1 – Priority Areas and Annual Performance Indicators.

<> August 24, 2023 Joint Advisory Committee Meeting
Meeting topics included: DBH Director Update; Substance Use Recovery Month; Presentation and review of the FFY2024-2025 SAMHSA Combined Mental Health and Substance Use Prevention, Treatment, Recovery Services Block Grant Application; Presentation on the DBH Continuum of Care; and, Presentation on "Nebraska Office of Public Guardian" by the Office of Public Guardian. The presentation and review of the FFY2024-2025 MH/SUPTRS BG Application included budgets and Planning Table 1 - Priority Areas and Annual Performance Indicators. The State Advisory Committee on Mental

Health Services passed a recommendation in support of the identified application activities and priorities.

On August 15, 2023, the DBH posted an email notice on the DBH Listserv to invite DBH audiences to inspect and comment on the draft application. These 1,100+ 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, state Peer People's Council, Family Organizations, Certified Peer Specialists, Regional Behavioral Health Authorities, NBHS Network Providers, the four federally recognized tribes in Nebraska and partner state, regional, and local agencies. The email notice is below.

-Start Notice-
Notice of Opportunity for Public Comment on the Combined FFY2024-2025 MH/SUPTRS Block Grant Application

Comments are invited on the Nebraska DRAFT Combined FFY2024-2025 MH/SUPTRS Block Grant Application.

Nebraska has been invited to submit an application to the Federal Substance Abuse Mental Health Services Administration (SAMHSA) for the Uniform FFY 2024-2025 Combined Block Grant Application for Community Mental Health Services Block Grant and the Substance Use Prevention, Treatment, Recovery Services Block Grant.
• To review the draft Nebraska Application for SAMHSA Uniform FFY 2024-2025 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
• To provide comment on the FFY 2024-2025 Combined Community Mental Health Services Block Grant and Substance Use Prevention, Treatment, Recovery Services Block Grant – Draft Application for Public Review and Comment

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
Comments will be accepted between August 17, 2023 and 4:00 p.m. August 27, 2023.
-30-

DBH did not receive any written comments from the public during the August 27 - August 27, 2023 public comment period and on-line posting of draft block grant application.

No additional comments were received via other media up to the time of grant submission. 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.

The DBH web page URL for Joint Advisory Committee current meeting agenda and minutes is: https://dhhs.ne.gov/Pages/behavioral-health-public-participation.aspx. Previous meeting agenda and minutes are in available in the General Documents section of the home page, URL https://dhhs.ne.gov/Pages/Behavioral-Health.aspx.

2. What mechanism does the state use to plan and implement community mental health treatment, substance misuse 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.

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.

3. Has the Council successfully integrated substance misuse prevention and SUD treatment and recovery or co-occurring disorder issues, concerns, and activities into its work? (●) Yes ( ) No

4. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? (●) Yes ( ) No

5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

Nebraska Revised Statute 71-814 (2) establishes the responsibilities and duties of the State Advisory Committee on Mental Health Services: "The committee shall be responsible to the division and shall (a) serve as the state's mental health planning council as required by Public Law 102-321, (b) conduct regular meetings, (c) provide advice and assistance to the division relating to the provision of mental health services in the State of Nebraska, including, but not limited to, the development, implementation, provision, and funding of organized peer support services, (d) promote the interests of consumers and their families, including, but not limited to, their inclusion and involvement in all aspects of services design, planning, implementation, provision, education, evaluation, and research, (e) provide reports as requested by the division, and (f) engage in such other activities as directed or authorized by the division."

Nebraska Revised Statute 71-815 (2) establishes the responsibilities and duties of the State Advisory Committee on Substance Abuse Services: "The committee shall be responsible to the division and shall (a) conduct regular meetings, (b) provide advice and assistance to the division relating to the provision of substance abuse services in the State of Nebraska, (c) promote the interests of consumers and their families, (d) provide reports as requested by the division, and (e) engage in such other activities as directed or authorized by the division."

Committee meetings include two opportunities (near the beginning and the end of meetings) for public comment regarding discussions and issues that are before the committees. Throughout the day, committee members are engaged in discussion of agenda items and following each topic committee members are asked for recommendations to the DBH regarding actions or next steps for the DBH to consider when moving forward in each respective area. All committee members have equal voice/vote in committee recommendations. Administrative staff from the Community-Based Services Section of DBH, 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.

A lunch presentation during each meeting may include individuals with lived experience, 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 keeps 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.

Please indicate areas of technical assistance needed 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 Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.
State Medicaid Agency

Start Year: 2024 End Year: 2025

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Kenneth Beau Boryca (SA)	Persons in recovery from or providing treatment for or advocating for SUD services		18923 Redwood Street Omaha NE, 68136 PH: 402-346-0902	
Ashley Berg (SA)	Persons in recovery from or providing treatment for or advocating for SUD services		2535 Country Club Avenue Omaha NE, 68104 PH: 515-298-0214	
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 (to include family members of adults with SMI)		1145 Piedmont Road Lincoln NE, 68510 PH: 402-429-1315	
Mary Ann Borgeson (MH)	Others (Advocates who are not State employees or providers)		12503 Anne Street Omaha NE, 68137 PH: 402-444-6413	
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 (to include 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	
Kris Elmshaeuser (MH)	State Employees		500 S 84 Street 2nd Floor Lincoln NE, 68510 PH: 402-471-6429	
Lindy Foley (MH)	State Employees		3410 N 205 Street Elkhorn NE, 68022 PH: 402-371-2745	

Ingrid Gansebom (MH)	Providers		54597 862 Road Osmond NE, 68765 PH: 402-380-5207	
Victor Gehrig (MH)	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		304 E 9th Street Gordon NE, 69343 PH: 402-499-5387	
Jill Gregg (SA)	Persons in recovery from or providing treatment for or advocating for SUD services		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)	Parents of children with SED		2110 S 25th Street Omaha NE, 68105 PH: 402-932-8197	
Robert Hutt (MH)	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		331 N 5th Street Tecumseh NE, 68450 PH: 402-209-4956	
Susan Jensen (MH)	Family Members of Individuals in Recovery (to include family members of adults with SMI)		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, Fourth Floor 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	
Diana Meadors (MH)	Providers		191 S 42nd Street Ste 210 Omaha NE, 68105 PH: 402-341-6220	
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 (to include 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)	Family Members of Individuals in Recovery (to include family members of adults with SMI)		501 Ann Street Chadron NE, 69337 PH: 801-430-1215	
Carisa Schweitzer Masek (MH)	State Employees		301 Centennial Mall South Lincoln NE, 68509	

			PH: 402-471-1920	
Micheal Sheridan (SA)	Persons in recovery from or providing treatment for or advocating for SUD services		5119 Decatur Street Omaha NE, 68104 PH: 402-206-3202	
Athena Sherman (MH)	State Employees		Nebraska Crime Commission Lincoln NE, 68509 PH: 402-499-7586	
Danielle Smith (MH)	Individuals in Recovery (to include 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	

*Council members should be listed only once by type of membership and Agency/organization represented.

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Footnotes:

State Council vacancies include four 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.

> Two positions are vacant in Type of Membership – Persons in recovery from or providing treatment for or advocating 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: 2024 End Year: 2025

Type of Membership	Number	Percentage of Total Membership
Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	5	
Family Members of Individuals in Recovery (to include family members of adults with SMI)	3	
Parents of children with SED	3	
Vacancies (individual & family members)	1	
Others (Advocates who are not State employees or providers)	1	
Total Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services), Family Members and Others	**13**	**54.17%**
State Employees	7	
Providers	3	
Vacancies	1	
Total State Employees & Providers	**11**	**45.83%**
Individuals/Family Members from Diverse Racial and Ethnic Populations	0	
Individuals/Family Members from LGBTQI+ Populations	0	
Persons in recovery from or providing treatment for or advocating for SUD services	10	
Representatives from Federally Recognized Tribes	0	
Youth/adolescent representative (or member from an organization serving young people)	0	
Total Membership (Should count all members of the council)	**34**	

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Footnotes:

Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? (●) Yes ( ) No

b) Posting of the plan on the web for public comment? (●) Yes ( ) No

If yes, provide URL:

To review the draft Nebraska Application for SAMHSA Uniform FFY 2024-25 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 plan year application was posted and can be viewed here: https://dhhs.ne.gov/Behavioral%20Health%20Documents/Nebraska-2022-2023-Uniform-MH-SAPT-BG-Application-RevThru07152022.pdf

c) Other (e.g. public service announcements, print media) (●) Yes ( ) No

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

None at this time.

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Footnotes:

Environmental Factors and Plan

23. Syringe Services Program (SSP) - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction[1,2] on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the **Consolidated Appropriations Act**, 2018 (P.L. 115-141) signed by President Trump on March 23, 2018[3].

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG 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 SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers[4]. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs[5]: These documents can be found on the Hiv.gov website: **https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs**,

1. **Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016** from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy **https://www.samhsa.gov/sites/default/files/grants/ssp-guidance-for-hiv-grants.pdf ,**

2. **Centers for Disease Control and Prevention (CDC)Program Guidance for Implementing Certain Components of Syringe ServicesPrograms,2016** The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention **http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf,**

3. **The Substance Abuse and Mental Health Services Administration (SAMHSA)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf ,**

Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC
- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
  - Include proposed protocols, timeline for implementation, and overall budget
  - Submit planned expenditures and agency information on Table A listed below
- **Step 3** - Obtain State Project Officer Approval

Future years are subject to authorizing language in appropriations bills.

End Notes

[1] Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds ***only*** and is consistent with guidance issued by SAMHSA.

[2] Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C.§ 300x-31(a)(1)(F)) and 45 CFR § 96.135(a)(6) explicitly prohibits the use of SABG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

[3] Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2018 (P.L. 115-141)

[4] 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 SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR 96.128 requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

[5]***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a **description of the elements of an SSP** that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and

HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

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Footnotes:

Nebraska - FFY 2024-2025 Block Grant Application
Environmental Factors and Plan - Section 23 Syringe Services (SSP)

Nebraska Department of Health and Human Services Division of Behavioral Health does not use SABG or state funds to support elements of any Syringe Services Program nor has it developed or submitted a plan to the State Project Officer to repurpose SABG funds for an SSP.

Environmental Factors and Plan

Syringe Services Program (SSP) Information – Table A - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Dollar Amount of SUBG Funds to be Expended for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Naloxone Provider (Yes or No)
No Data Available					

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Footnotes:

Nebraska - FFY 2024-2025 Block Grant Application
Environmental Factors and Plan - Section 23 Syringe Services (SSP) - Table A

Nebraska Department of Health and Human Services Division of Behavioral Health does not use SABG or state funds to support elements of any Syringe Services Program nor has it developed or submitted a plan to the State Project Officer to repurpose SABG funds for an SSP.