Department of Health and Human Services
Division of Behavioral Health

SYSTEM MANUALS

TABLE OF CONTENTS

Nebraska Behavioral Health Services Audit Manual

January 22, 2016

Table of Contents

Section 1:
Oversight Functions

The Division of Behavioral Health (Division) and Regional Behavioral Health Authorities (Regions), as contractually required, monitor, review, and perform programmatic, administrative, quality improvement and fiscal accountability and oversight functions on a regular basis with all subcontractors. If the Region is a direct provider of services, the Division is responsible for the oversight functions for the services provided directly by the Region.

The Region and Division use internal and external measures for oversight of services purchased through the contract between the Division and the Region.

External measures are performed by entities outside of the Nebraska Behavioral Health System (NBHS*), and include as appropriate:

1. Fiscal audit as conducted by a certified public accountant, and
2. Accreditation by a nationally recognized accrediting body

Internal measures are performed by entities within NBHS, and include:

1. Services Purchased Verifications (unit/fiscal)
2. Program Fidelity Reviews (programmatic)
3. Internal Controls (self-review & monitoring)
    a. In compliance with the COSO (Committee Of Sponsoring Organizations) 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).

The written procedures outlined in this document provide a systematic approach (across all Regions and the Division) to the oversight of network management, including the monitoring and reviewing of services in the network. Each Region is charged with developing Regional written procedures, consistent with the components outlined in this manual, for use in the review of services purchased from all subcontracted entities. Regions should include, at a minimum, all of the components included in the most recently agreed upon NBHS Audit Manual in their written procedures. Any changes made to the NBHS manual should be reflected in the Region's written procedures, and should be submitted to the Division with the fiscal year Regional Budget Plan. Unless otherwise agreed upon or required, the Division will use the Region's procedures and review forms when conducting reviews of Region-provided services for Services Purchased and Program Fidelity reviews.

Audit elements, policies and procedures may be continually revised subject to changes in health care reform and the role of other payers in auditing for quality and/or fidelity. Regions will be notified in writing 30 days prior to the effective date of any change in the Audit Manual.

All consumers must be assessed for their ability to pay for services received in accordance with the provider policy as approved by the Region, and through use of the approved format. The Financial Eligibility Policy and resulting fee schedules are to be consistent with Regional policies, approved by the Division, and are to be applied consistently across all services.

These activities together demonstrate our commitment to fiscal accountability, continuous quality improvement, and organizational management of the NBHS service delivery system.

*NBHS – The Nebraska Behavioral Health System is composed of the Division of Behavioral Health, Regional Governing Boards and their contracted network of providers and state-operated Regional Centers.

Section 2:
Description of Oversight Functions

External Measures

Independent Annual Financial Audit by a Certified Public Accountant (CPA)

The purpose of the CPA audit is to assess the accuracy and reliability of provider accounting processes and financial reports.

National Accreditation

National Accreditation refers to the standards set by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or other nationally recognized accreditation organizations approved by the Director of the Division of Behavioral Health. Each accrediting body has a set of guidelines or program standards that define expected inputs, processes, and outcomes of programs and services. Accreditation bodies assess administrative, organization, and service delivery management of providers. Programs are accredited for conformance to nationally recognized service standards for a general field category that best describes the purpose, intent, and overall focus of a program.

Internal Measures

Services Purchased Verification

The Services Purchased (SP) Verifications are conducted to verify that services claimed for reimbursement have been delivered to a consumer and that expenses are verified in financial records and are allowable costs. There are two types of services purchased verifications: **unit verification** for fee for service (FFS) services and **expense verification** for non-fee for service (NFFS) services. These reviews are generally conducted at the same time as the program fidelity review, but can be completed at separate visits. Unit verifications for fee for services reviews should be completed within the fiscal year; expense verifications for services considered as non-fee for service may be completed no later than October 31 (with subsequent report to the Division by November 1 if a Corrective Action Plan is indicated) following the Fiscal Year under review.

An SP verification of services purchased includes a review of any documentation to verify that the services purchased were delivered. This can include clinical records, progress notes, financial records, and/or other documentation as deemed necessary. Services purchased verifications shall be conducted on a fiscal year basis for all services billed to the Region and to the Division under the contract as reflected by Authorization Turn Around Documents (TADs) or other Division required supporting documentation. SP verifications must also include confirmation that the agency has written policies and procedures for “Internal Controls” and risk assessment. It does NOT require review or testing of those policies and procedures.

Program Fidelity Review

The purpose of Program Fidelity Review is to review program plans and services delivered to ensure consistency and conformance with service definitions, state regulations, policies and contract requirements governing mental health and substance abuse programming and specific federal community mental health or substance abuse prevention and treatment block grant program requirements. The Program Fidelity Review is conducted a minimum of once every three years. National accreditation may preclude the review of certain surveyed items as determined by Regional Network administration.

Internal Controls

Each organization shall develop and maintain written policies and procedures for internal controls, specifically including cash management, and determination of allowable costs. The goal of these policies and procedures is to create sound business practices to minimize the risk of fraud, or theft of an organization's funds or assets. A common internal control is a "separation of duties" requirement; all business activities are handled by at least two or more different employees, or by contractors outside the organization.

Financial Reliability of Sub-recipients

Federal requirements have strengthened oversight over Federal awards to include all pass through entities. Organizations are required to review the risks of a potential recipient prior to making an award. This risk assessment includes an ongoing review of these sub-recipients. *These requirements are outlined in the Federal Regulations at 2 CFR 200.311.* See this link for additional information: http://www.ecfr.gov/cgi-bin/text-idx?node=2:1.1.2.2.1&rgn=div5#se2.1.200_1331

Substance Abuse Prevention and Treatment Block Grant (SAPTBG) Program Fidelity Review

This 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 a minimum of once every three years for those agencies who receive SAPTBG funds and is conducted at the time of the services purchased review.

Section 3:
Schedule of Audits for Current Fiscal Year

A schedule of the verifications or reviews to be performed is submitted to the Division by the Region with the Fiscal Year's Regional Budget Plan, and submitted subsequently after updates are made. The following forms are used in this submission:

- RP-3 a-e: includes a list of all services funded by the Region and providers of those services.
- RP-2a (Services Purchased Verification & Program Fidelity Review Schedule): includes a list of all service providers and the dates in which those service providers are scheduled to be audited. Region should ensure that all services indicated on the RP-3a-e are also included on the RP-2a and are scheduled for audits.

  Notes:
  - Services purchased verifications must be conducted each fiscal year.
  - Program fidelity reviews must be conducted at least every 3 years but may occur more frequently if the Region/Division chooses.

If the Region is a service provider, the scheduling of audits is a mutual responsibility between the Region and the Division. The need for the Division to audit Regionally-provided services should be reflected on the RP-2a.

For providers under Corrective Action Plans, the Division/Region will conduct follow up audits/reviews as prescribed in the Audit findings sent to the Provider.

When scheduling audits, the Division and Regions are encouraged to take into consideration the date of the provider's national accreditation review. However, this does not preclude either entity from doing the review in the same fiscal year as the national accreditation review.

Section 4:
CPA Audit

CPA audits are required of all Regions and some service providers (see the CPA Flow Chart on the next page of this manual). CPA audits of the Regional Behavioral Health Authority are due to the Division within the timeline requirements as specified in the contract. Provider fiscal audits, compilation financial statements (as applicable), or a review of financial statements (as applicable) from subcontracted service providers are due to the Region not more than nine (9) months after the end of the service provider's fiscal year, as reflected by the Region on the RP-2.

The Region shall complete a review of each service provider financial audit by a CPA firm. Documentation of the Region's review and comments shall be made available to the Division upon request along with the service provider's financial audit. A coversheet will accompany the CPA audit of the service provider that indicates:

- Date service provider audit was received and reviewed by the Region
- Any material weaknesses identified
- Date corrective action information requested and due to the Region
- Subsequent date the corrective action material will be submitted to DBH.

Audit Parameters:

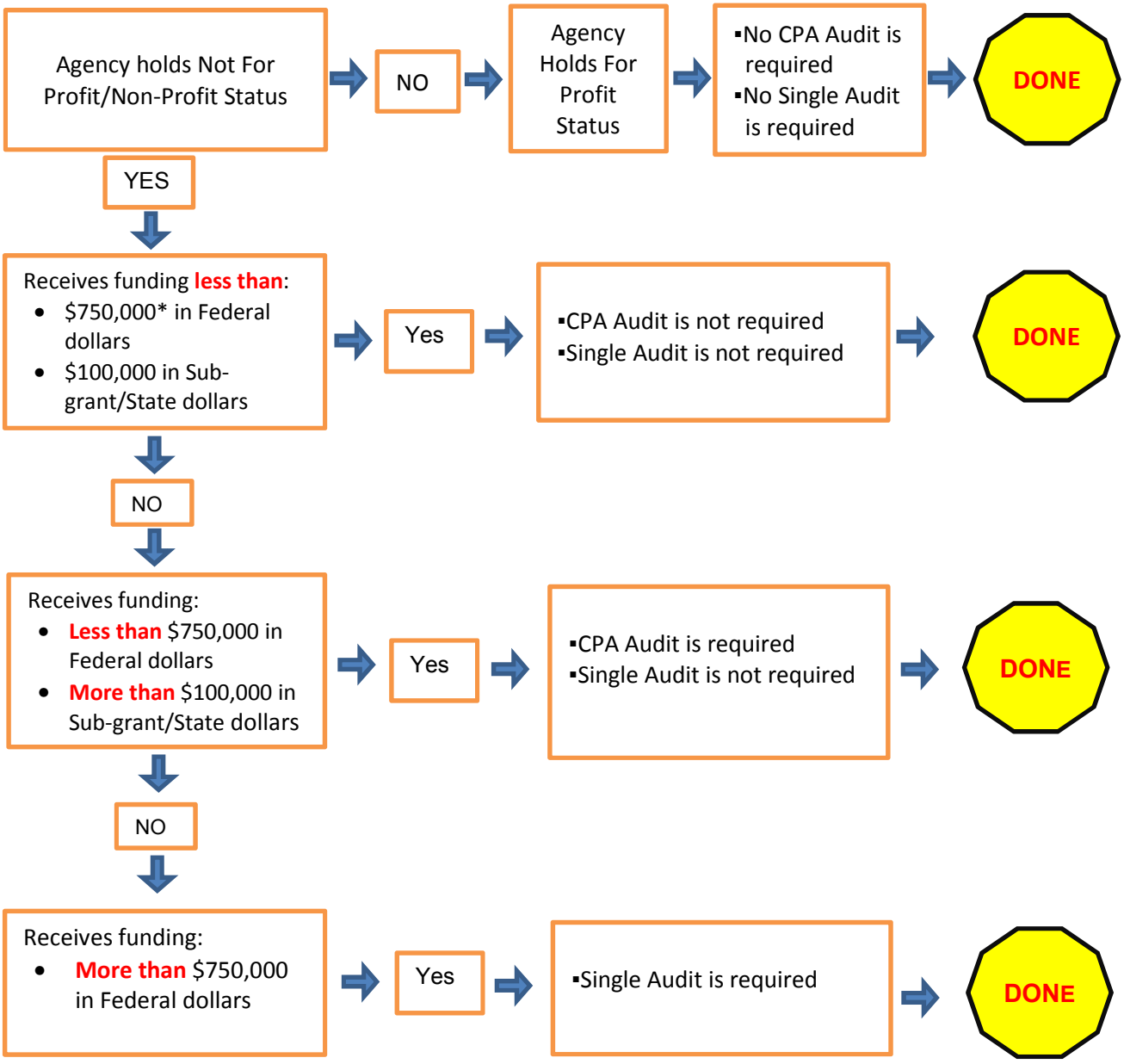
If applicable, service providers must submit audited financial documents conducted by a Certified Public Accountant to the Region. Regional CPA audits are to include a two year comparison of expenditures.

Expenditure Threshold under the Single Audit Act:

*Note: 2 CFR Part 200, raised the expenditure threshold under the Single Audit Act to $750,000 in federal funds for audits of fiscal years beginning after December 26, 2014 (i.e., for entities with fiscal year that ends on, or after, December 31, 2015). Furthermore, the cost of auditing an entity that is exempt from having an audit under the Single Audit Act due to having less than $750,000 in federal expenditures is **NOT** allowed to be allocated or otherwise charged to federal funds.

Agencies who hold For Profit status will not be required to submit a CPA audit nor a Single Audit document.

CPA Audit Flowchart



*The $750,000 Federal threshold for Single Audit Act applies to any entity expending federal funding regardless if they are expending federal funds received directly from a federal agency or from a pass-through agency such as the State and/or Region. (see note on Pg. 7 regarding new threshold.)

Federal grant funding always retains its identity as 'federal funds' and all requirements, expectations & restrictions follow those dollars through ALL sub-recipients, regardless of how far removed.

Financial statements and auditor's report must be submitted to DHHS within the earlier of 30 days after receipt of the auditor's report(s), or nine (9) months after the end of the provider's fiscal year as reflected on by the Region on the RP-2.

Section 5:
General Verification/Review Procedures

The following procedures apply to both the Services Purchased Verification and the Program Fidelity Review.

Out of Region Network Providers

When there is an agreement between a Region and Network Provider of another Region for a consumer to receive services out of region, the consumer's home Region should request copies of the current Audit Report(s) of the provider agency providing the service as demonstration of provider oversight. When applicable, the auditing Region can include the consumer in the review sample but is not required to include the consumer in units reviewed.

Pre-Visit

All Network Providers should receive Region specific policies and procedures, which includes purpose, methods and process for Program Fidelity Reviews and Services Purchased Verifications.

The Region will work with the Provider Agency to establish the review date. The Region will send a list of file names and other information to be reviewed no more than (2) days prior to the review for program reviews and ten (10) days for fiscal reviews. The agency shall have files available for the Audit Team at the appointed time and location.

The Region will develop a site visit agenda to be used on each review/verification of providers. Such a protocol will include a schedule of events, including any opening or exit meetings, and any other items of the process. Such an agenda may be given to the provider agency prior to/at the beginning of the verification/review.

Beginning the Verification/Review

Team members should arrive on site in a timely manner, at the time agreed upon with the organization, and locate the Agency/Program Director or designee for introductions. Review Team members should meet with management, designated staff members and any other individuals requested by the organization (e.g., Board Members) to attend the opening/orientation meeting. Team members should introduce themselves, and give a brief explanation about the purpose of the audit and the day's agenda/schedule. Program Staff are given the opportunity to explain the purpose/mission and key points about program operations, where information will be located, and organization of consumer files. Review staff may want to reference the Confidentiality Authority to review/verify files.

The Review Process

A room or work area should be made available for team members to review confidential records. See Sections 6 & 7 for procedures specific to Program Fidelity Reviews and Services Purchased Verifications.

Ending the Review/Exit Conference

An exit conference is the last meeting with management and designated staff (and others), to present a summary of findings and observations, including areas of strength and areas in need of improvement. The feedback given should be focused on compliance with the services purchased verification and program fidelity review standards and procedures.

Post Review/Reporting

Following the onsite visit, a written report, providing a summary of the audit, will be completed and submitted to the provider agency within forty five (45) days of the visit. There shall be one report per provider agency but each service should be addressed separately within the report. Copies of the report will be made available to the Division upon request. A copy of the report shall be shared with other advisory or governing bodies.

A site visit satisfaction survey may also be distributed to agency providers after the review has been conducted.

Should the review result in the need for a Corrective Action Plan (CAP), the plan is due to the Region within 30 days of receipt of the audit report. A copy of the CAP will be forwarded to the Division upon receipt by the Region's final report and subsequent follow-up reports sent to the Division upon completion.

Item	Provider	Region
Services Purchased	NA	Report due to Provider Agency within 45 days; if CAP required, copy of original report sent to Division at time report sent to Provider Agency.
Program Fidelity	NA	Report due to Provider Agency within 45 days; if CAP required, copy of original report sent to Division at time report sent to Provider Agency.
CAP	Due to Region within 30 days	Due to Division upon receipt from service provider
CAP follow up reports	NA	Due to Service Provider within 45 days with copy to Division for all follow up audits until CAP resolved

Audit report summarizing the Services Purchased Verification and Program Fidelity Review findings per agency provider shall be given to the Regional Governing Board per fiscal year.

Service Provider Challenges to Services Purchased and Program Fidelity Audit Findings

For challenges that are Regulations based, refer to Title 206, Behavioral Health Services, Chapter 3 Division Administration (Amended 4/11/15), Section 3-004.

The process for challenges that are Contract Based is outlined below:

For Service Providers reviewed by Region personnel, follow the Region's grievance process.

For Service Providers who undergo the review process by Division staff:

1. Within 10 working days of the Services Purchased/Program Fidelity report, the service provider will make a written request for review to the Director of Behavioral Health.
2. Within 5 working days, the Division Director, or designee, will acknowledge, in writing, the Service Provider's request for review.
3. The Division Director serves as the decision maker for this process, and will issue a written decision to the Service Provider within 20 working days following receipt of the Service Provider's written request for review.

Confidentiality

All information concerning the identity of clients will be handled in a confidential manner (as provided in 42 CFR Part 2, 45 CFR Part 160, and 45 CFR Part 164) and providers may request that reviewers sign a confidentiality statement.

Section 6:
Services Purchased Verifications (Unit and Expense Verifications)

All services purchased must be verified on a Fiscal Year basis regardless if they are paid by the Region on a fee for service (FFS) determined rate or as non-fee for service (NFFS) expense reimbursement. This verification may be conducted in combination with the program fidelity review, or may be conducted as a stand-alone verification.

Services that are billed to the Region by a rate will be verified using the FFS process, regardless of how that service is paid in the State to Region contract. Services paid by expense reimbursement in the Region to Provider contract will use the verification of expenses methodology.

Services Purchased Verifications and Expense Verifications may be conducted together or separately. The deadline for completion of services purchased verifications is June 30 of the fiscal year under review. The deadline for completion of Expense Verification Reviews is November 1 following the fiscal year being reviewed in order to allow a more thorough review of June expenditures. The final report for Expense Verification Reviews is due December 15.

Audit elements, policies and procedures may be continually revised subject to changes in health care reform and the role of other payers in auditing for quality and/or fidelity. Regions will be notified in writing 30 days prior to the effective date of any change.

FFS Services Purchased Verification (Unit Verification)

Pre-Visit:

The unit sample of services purchased is selected from the provider agency's billing documents submitted to the Region including the Magellan Turn-Around Document (TAD), Provider Log or other Division required documentation for authorized or registered encounter units submitted with provider billings of the current fiscal year. In some cases a monthly provider log is submitted in lieu of a TAD and therefore would be reviewed to determine the services purchased sample.

At a minimum, the verification must review a random selection of two-percent (2%) of the services purchased during the fiscal year for all mental health and substance abuse services, with a minimum of five (5) files total. Source documentation for establishing the 2% sample size is the provider's current contract at the time of the audit. Audits of providers with low initial monthly utilization may be scheduled at later dates. All files within that service will be reviewed if less than the 5 file minimum.

The randomly-selected services purchased verification must be from at least two (2) non-consecutive months within the same fiscal year the services were purchased and must include services purchased from all service. It may be necessary to pull additional months/units as needed to obtain the minimum 5 files.

Process:

Compliance for audits shall be scored on a Yes / No basis. 95% compliance is the minimum acceptable threshold for services purchased verifications.

Payback will be sought for:

a. Services provided are not verifiable in the agency's consumer/program records
b. Services provided do not agree with the reimbursement claim with respect to date, type, and length of service
c. Services provided do not meet the appropriate service definitions
d. Consumer is ineligible according to the NBHS Financial Eligibility and Fee Schedule;

e. Service provision is found to have been provided by an individual without the appropriate licensure as defined by NBHS service definitions

If a service provider scores less than a 95% compliance rate, the Region/Reviewer shall expand the sample to 5% of contracted units (an additional 3%). In the event that the original 5 file minimum sample exceeded the 5%-sample size, no additional files will be reviewed. Expansion is typically done on-site during the day of the initial audit, however, can be scheduled on a separate date.

Payback of 100% of non-verified units regardless of compliance level will be required.

Post Review and Reporting

Components of the review report shall include:

- Name of agency and service audited
- Services Purchased (SP)
    - Contracted units for the service based upon fiscal year unit totals
    - 2% sample of contracted FY units as determined at the time of the audit
    - Number of files audited
    - Months that were audited
    - Number of units verified
    - Percent of units verified
    - Percent of compliance

The Region has 45 days from the date of the first audit (or date of expansion, if another date) to write a report on the findings of the review to be distributed to provider. When the 95% compliance threshold is not reached in the (expanded) 5% sample, the provider is considered to have not met the required compliance threshold in the review and a Corrective Action Plan (CAP) is required.

The CAP will be submitted to the Region within 30 days of the time of receipt of the audit summary. In all instances, service providers will be given a reasonable length of time (30 to 90 days), depending on the scope of deficiencies, to make the needed corrections and submit follow-up documentation (if indicated).

If the service provider does not take corrective action, or does not submit needed documentation for corrective action by the due date, the Region shall withhold payment from the service provider for the identified service(s) until such required documentation is received by the Region.

If similar or additional sanctions are required in successive fiscal year audits and/or financial reviews, or if corrective actions are not made, additional sanctions will be imposed. These sanctions could include, but are not limited to, requiring additional Corrective Action Plans, termination of purchasing the specific service from the provider, or termination of contract with the provider. In any case, payback will be required for any units not verified.

Re-audit shall occur within 60-90 days following receipt of the CAP. The re-audit shall consist of 5% or a minimum of 5 files of the State fiscal year total units contracted, and units shall be drawn from the months since the CAP was submitted.

Corrective Action Plans, copies of the initial review, the resultant CAP, and follow-up review reports will be sent to the Division.

Item	Provider	Region
Services Purchased Verification	NA	Report due to Provider within 45 days; if CAP required, copy of original report sent to Division at time report sent to Provider
CAP	Due to Region within 30 days	Due to Division upon receipt from provider
CAP follow up reports	NA	Due to Provider within 45 days with copy to Division for all follow up audits until CAP resolved

Reviewing CAP's that Cross Fiscal Years

The re-review process for CAPs that cross fiscal years will be the same as a normal Services Purchased Unit and Expense Verification, and the re-audit may be incorporated within the normal Fiscal Year Audit. Re-audit shall consist of 5% or a minimum of 5 files for those services in which a CAP was in place. All other services will follow normal Services Purchased processes. In the rare instance that the provider is not in compliance and payback is required, request payback; if problems arise, they will be handled on a case by case basis in consultation with the Division.

NFFS Services Purchased Verification (Expense Verification)

All services purchased on an expense reimbursement basis must be verified annually. This may be conducted in conjunction with a unit and/or program fidelity review or as a separate verification. Expense verifications for services considered as non-fee for service may be completed after June 30 but must be completed no later than November 1 following the fiscal year being reviewed.

Pre-Visit:

The Region Finance Director or designee will determine the months to verify and notify the agency at least 10 days in advance of the visit. At a minimum, two non-consecutive months of documentation must be reviewed for each service for each contract year. The provider will be notified of the months to be reviewed and the documentation that will be needed by the reviewer. This includes, but is not limited to:

- General Ledger (GL) for service(s) being reviewed,
- Payroll, receipts, mileage reimbursement, time sheets, and other expense verification documents,
- Canceled checks or other warrants used for payment of expenses claimed,
- Internal worksheets that were used to create expense reimbursement to the Region,
- Cost allocation charts or basis, and,
- Client files as necessary for the service(s) being reviewed (e.g., financial eligibility, flex funds).

Procedures for Each Service Being Reviewed:

1. Select a sample of five (5) client files from the service being verified and determine client financial eligibility was established. This may be completed in conjunction with or as part of a Program Fidelity Review or unit verification. Client file review may be waived for a service if participation in the service requires enrollment in another DBH service where financial eligibility is determined (i.e., Housing Assistance). An affirmative statement to any waiver of client file review must be made either in the Pre-visit correspondence or in the Post Review report.

2. Verify that total expenses reflected in the GL can be traced to the billing amount submitted to the Region/State. This will include verifying that any revenue received/generated by the service was deducted from the total expense and the adjusted expense amount was billed to the Region/State.

3. Randomly select at a minimum two non-employee expenses and two employee related expenses (e.g. mileage reimbursement) for each service. Verify that receipts and documentation of payments exist and are reflected in the correct expense account. It is recommended that the expenses being selected include a large or non-recurring expense as well as recurring costs. If appropriate documentation cannot be located for an expense, document the missing items and select an additional expense to verify.

4. If the expense being reviewed is part of a larger bill, determine how the amount was allocated to the service and if this is reasonable and allowable within contracted budget amounts for categories. If employee salary or wages are split between multiple services, determine how the compensation was allocated to the service being reviewed for reasonableness and accuracy.

5. Verify that payments received from the Region or other payers were credited to the services as billed.

6. During the review, note any trends or areas of needed improvement identified. If the identified areas could pose a financial risk to the agency under review or the Region/State (e.g., lack of or poor supporting documentation), a corrective action plan may be required to minimize the risk.

7. If the service is paid based on a 1/12th payment, expenses for the months under review as outlined in steps 2 through 5 listed above must be conducted. In addition, a year-to-date analysis of revenue received and expenditures charged must be completed to determine that YTD revenues do not exceed YTD expenses by 5% or more. If revenues exceed expenditures by 5% or more, future payments in the fiscal year should be adjusted to minimize pre-payment of expenses. If the YTD analysis is completed after the fiscal year, any funds received in excess of the YTD expenses charged to the service must be repaid.

If less than five percent (5%) of the expenses in the service cannot be verified or are unallowable for the months reviewed, no expansion is required. Payback is determined based on the amounts determined to be unallowable or unverified.

If more than five percent (5%) of the expenses for one or both of the months in the service cannot be verified or is deemed to be unallowable, the sample must be expanded to include a third (3rd) month of expenditures for that service. The additional month of expenditures will be reviewed as outlined in steps 2 through 5 listed above. If the expenses can be verified in the third month, any expenses determined to be unverified or unallowable in the first two months will be required to be repaid to the Region/State and a Corrective Action Plan will be required.

If more than five percent (5%) of the expenses cannot be verified for the third month reviewed, the sample must be expanded to include all months paid for the service during the fiscal year. Payback will be determined based upon the total unverified or unallowable expenditures for all months reviewed. A corrective action plan must be required in this situation.

Post Review and Reporting:

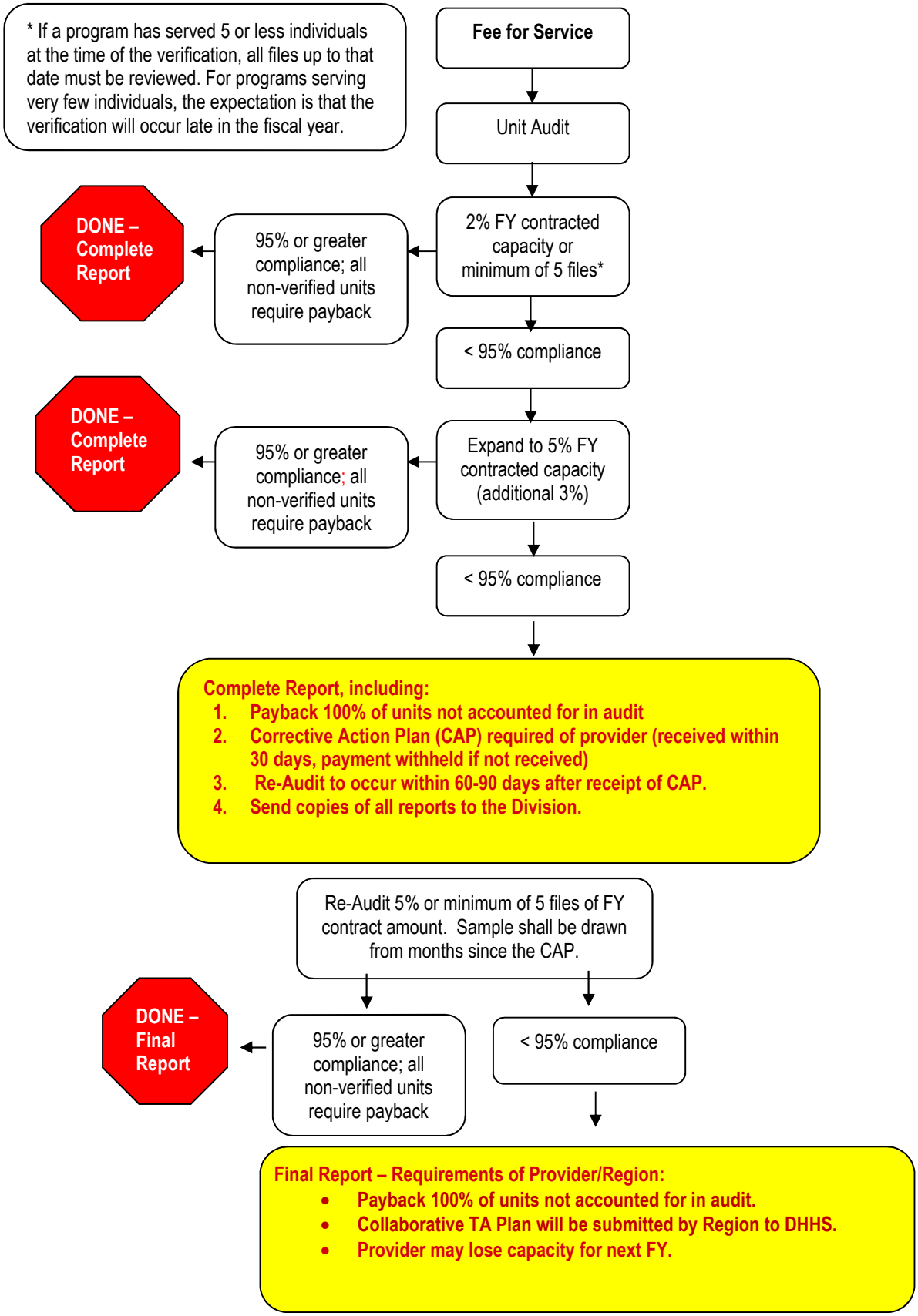
A written report, providing a summary of the audit, will be submitted to the provider and made available to the Division upon request. A copy of the report shall be shared with other advisory or governing bodies.

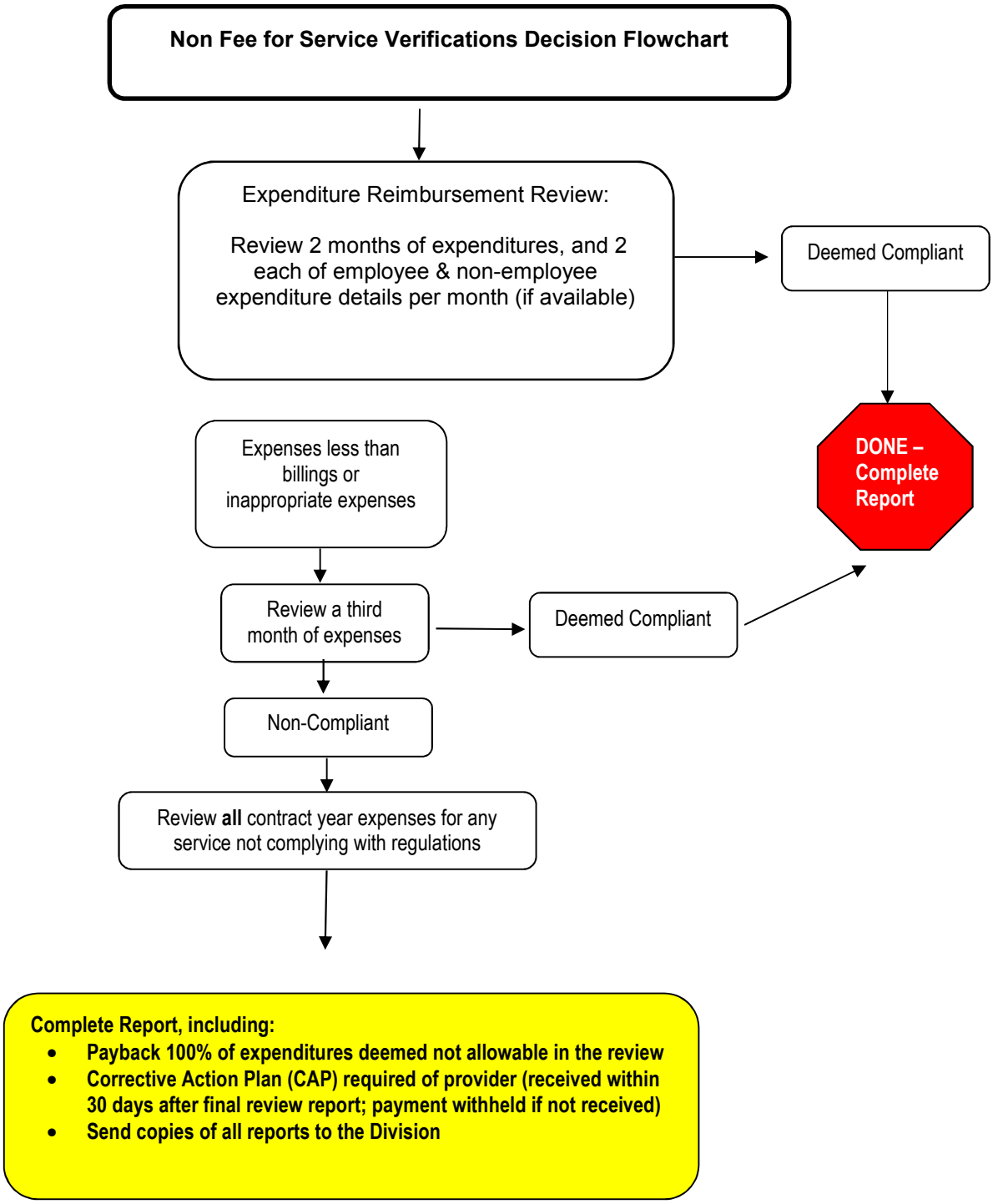
Final reports shall be written, within forty five days (45) of the completed audit or re-review. The report may be sent separately from the Services Purchased Verification review. Components of the report shall include:

- Name of agency
- Listing of documents that were reviewed
- Listing of expenses and months that were reviewed
- Narrative of findings
- Corrective actions required

- General comments and observations

Services Purchased Verification Decision Flowchart




Non Fee for Service Verifications Decision Flowchart
Expenditure Reimbursement Review:
Review 2 months of expenditures, and 2 each of employee & non-employee expenditure details per month (if available)
Deemed Compliant
DONE – Complete Report
Expenses less than billings or inappropriate expenses
Review a third month of expenses
Deemed Compliant
Non-Compliant
Review all contract year expenses for any service not complying with regulations
Complete Report, including:
Payback 100% of expenditures deemed not allowable in the review
Corrective Action Plan (CAP) required of provider (received within 30 days after final review report; payment withheld if not received)
Send copies of all reports to the Division

Section 7:
Program Fidelity Reviews

Program Fidelity Review Process

Program Fidelity Reviews shall be conducted on each service at a minimum of once every three years, and can be conducted at the same time as the services purchased verification. The reviews determine compliance with applicable state statutes, state and federal rules and regulations, state service definitions, and other mandatory guidelines for service provision.

DBH and the Region will maintain the prerogative to review all items in the respective protocol regardless of accreditation status. Review elements, policies and procedures may be continually revised subject to changes in health care reform and the role of other payers in auditing for quality and/or fidelity. Regions will be notified in writing 30 days prior to the effective date of any change.

Program Fidelity Reviews will also be conducted at a minimum of once every three years for all providers receiving Substance Abuse Block Grant funding (i.e., Women's Set Aside). The Substance Abuse Prevention and Treatment Block Grant Program Fidelity Review will be used for this review. (See Appendix A).

Pre-Visit:

Program Fidelity Reviews shall include of a minimum of three (3) files per service, per provider, and must examine files for services provided in the current fiscal year being reviewed. Reviewers can choose from files being examined as part of the services purchased verification, or can use the TADs or provider logs or other Division required documentation as applicable to choose three separate consumer files for review.

The Program Fidelity Review shall also evaluate other documentation including programmatic plans and clinical details of the service that are sufficient to verify that the services provided comply with state regulations and service definition components.

Process:

Reviewer examines the three (3) client files and program documents to ensure compliance with service definitions, rules and regulations, and other mandatory guidelines. When, in the judgment of the reviewer, a material number of errors are encountered in the initial sample, the sample size will be increased by 2 files (5 files total).

Substantial compliance is necessary for the service to pass the program fidelity audit. The following considerations are made when determining whether the provider passed or failed:

- Number of recommendations
- Type of recommendations required
- Patterns or trends in files from various programs
- Multiple reviewers encountering same issues – reviewer consensus

Post-Visit:

Components of the review report shall include:

- Name of agency and service audited
- Program Fidelity (PF)
    - Number of files reviewed
    - Identify whether PF was substantially met
- Number of exceptions for SP & PF

- Specific Unit and Program Review observations
- Suggestions / Recommendations
- Corrective actions required
- General comments / observations

The Region 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. CAP shall be submitted to Region/Division within 30 days of the notification that the provider did not meet compliance standards in the review.

Upon receipt of the CAP, the Region/Division 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, depending upon the severity of the transgression(s), 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 Region shall withhold payment from the provider for the identified service(s) until such required documentation is received by the Region. 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.

Copies of the initial review, the CAP and subsequent follow-up review reports are to be sent to the Division. However, if the Provider does not receive federal funds, the CAP does not need to be submitted to DBH.

Item	Provider	Region
Services Purchased Verification	NA	Report due to Service Provider within 45 days; if CAP required, copy of original report sent to Division at time report sent to Service Provider
CAP	Due to Region within 30 days	Due to Division upon receipt from service provider
CAP follow up reports	NA	Due to Service Provider within 45 days with copy to Division for all follow up audits until CAP resolved

Section 8:
Internal Controls and Sub-recipient Monitoring

Internal Controls

Each organization is responsible for establishing written policies and procedures for a system of internal controls. As outlined in 2 CFR 200 these internal controls must comply with the COSO (Committee Of Sponsoring Organizations) documents:

- *Standards for Internal Controls in the Federal Government*
- *Internal Control – Integrated Framework*

The websites for COSO and the COSO Internal Control documents are:

- http://coso.org/default.htm
- http://coso.org/IC.htm

An organization's Internal Controls must include policies regarding Cash Management and Allowable Costs. Additional information and reference details may be available at the following websites:

- Council on Financial Assistance Reform: https://cfo.gov/cofar/
- National Council of Nonprofits: https://www.councilofnonprofits.org/

Monitoring of Sub-recipients

Regulations require organizations to review the financial reliability of sub-recipients. This monitoring is required both prior to the sub-recipient award and ongoing through the award period. State of Nebraska regulations require the use of a form or checklist to verify this review.

Sub-recipient monitoring includes a review and follow-up of any audit findings for that agency. The use of a formal document such as a checklist is required. An example of such a checklist may be available from DBH.

Your agency MUST verify that all sub-recipients have written policies for internal controls. These internal controls must include polices covering Cash Management and Allowable Costs, as outlined in the Internal Controls section above. Your responsibility is only to VERIFY that the entity has these written policies. Testing for compliance of these internal controls shall be determined and done by the sub-recipient's CPA auditors.

Section 9:
Division Required Registration and Authorization

Provider Logs

Unless otherwise stated in contract (i.e., 24 hour crisis line, crisis response teams), all services for which reimbursement is requested from NBHS should be registered and/or authorized through the Division's required documentation procedure. Registration and pre-authorization occurs on-line or is captured in a provider log.

All registration information shall be entered as the data is required for the State to fully meet Federal Block Grant reporting requirements. NBHS and national accreditation standards require that an organization have and/or participate in an organized information management system which includes timely collection of information, use of data for decision making and improvements in the efficiency and productivity of staff.

Turn-Around Document (TAD)

A TAD is available on-line at the end of a billable month. A provider accesses the Magellan or other Division required documentation menu on-line and accesses a document indicating, by service and by client and by dates of service, authorized service units for the billable month. The provider enters encounter data (the number of units of service actually provided to the consumer for the month). This report is printable.

A TAD is available for NFFS services indicating persons registered for the service. Encounter units shall be entered by provider and used as a basis for selection of files audited. TAD reports are available on-line to designated agency staff, Regional Administration staff, and Division staff.

Authorization Modification Forms

The Authorization Modification reporting form is obtained from Magellan or other Division required documentation and submitted to Magellan or to other Division authorization system to correct errors in TADs.

Discharge Form

If reviewing the file of an individual who has been discharged, a discharge reporting form should be in the file. The discharge reporting form is obtained from Magellan or system authorized by the Division. The Magellan or other Division authorized system's provider handbook and other updated forms can be found on the Magellan or Division's Website.

Provider Logs

A Provider Log is maintained at the Region and is used when a service is neither registered nor authorized with Magellan or the Division's authorized system as determined (excluding service enhancements and flexible funding). The purpose of this information allows DBH the ability to quantify numbers of consumers served with NDBH funding as well as the opportunity to cross reference consumers who may be receiving services in two or more areas.

Consumer information required in this Log includes:

- Region Identification
- Provider Number
- Provider Name
- Service Type/Service Received
- Consumer Social Security Number
- Consumer Birthdate
- Consumer First Name
- Consumer Last Name
- Month(s) of Service Provided/Number of Units Provided

Appendix A:
Contact Units As Defined in 206 Regulations

SERVICE	UNIT
Mental Health Services	
Crisis Stabilization	1 unit = 1 day
Crisis Assessment	1 unit = 1 assessment
EPC Crisis Stabilization (Region 5)	1 unit = 1 day
MH Respite	1 unit = 1 day
Adult Acute Inpatient Hospitalization	1 unit = 1 day
Adult Sub-Acute Inpatient Hospitalization	1 unit = 1 day
Day Treatment	minimum of 6 units = full day minimum of 3 units = ½ day
Community Support-Mental Health	1 unit = 1 month; face to face contact a minimum of 3 times per month or 3 total hours of contact
Day Rehabilitation	1 unit = full day/5 hours minimum ½ unit = ½ day/ 3 hours minimum
Secure Residential	1 unit = 1 day
Assertive Community Treatment/Alternative Assertive Community Treatment	1 unit = 1 day
Psychiatric Residential Rehabilitation	1 unit = 1 day
Substance Abuse Services	
Adult SA Assessment	1 unit = 1 assessment
Community Support - SA	1 unit = 1 month; face to face contact a minimum of 3 times per month or 3 total hours of contact
Halfway House – Level III.1: Adult SA	1 unit = 1 day
Social Detoxification-Level III.2D: Adult SA	1 unit = 1 day
Intermediate Residential (Dual Diagnosis Capable)-Level III.3: Adult SA	1 unit = 1 day
Therapeutic Community (Dual Diagnosis Capable)-Level III.3: Adult SA	1 unit = 1 day
Short Term Residential (Dual Diagnosis Capable)-Level III.5: Adult SA	1 unit = 1 day
Dual Disorder Residential (Dual Diagnosis Enhanced)-Level III.5: Adult SA	1 unit = 1 day

Additional Contact Unit Information as Agreed Upon Through Audit Workbook Discussions

Service	**Unit**
Intensive Outpatient Therapy	1 unit = 1 hour (50 minutes)
Medication Management	1 unit = 15 minutes (.25/hour) 2 units = 22 minutes or more
Outpatient Psychotherapy MH & SA Individual/Family/Group	1 unit = 50 minutes (1 session)
Professional Partner Program (as outlined in PPP Manual)	Minimum of 1 team meeting or other therapeutic contact {interaction between Professional Partner & supervisor or other professional staff of Professional partner Program that is expected to further accomplish the goals for child/family as identified in the IFSP/family visit or team meeting}

Appendix B
Medical and Therapeutic Leave Addendum as Defined in 206 Regulations

EFFECTIVE APRIL 11, 2015 DBH Service Definitions: an attachment to the 206 Regulations 81
Department of Health and Human Services
Division of Behavioral Health

Medical Leave Days
Beds in Psychiatric Residential Rehabilitation, Therapeutic Community, Intermediate Residential and Dual Disorder Residential Treatment and Secure Residential programs can be held up to 10 consecutive days per episode when a consumer is hospitalized for a period of medical/psychiatric stabilization and expected to return to the facility.

Individuals in ACT are allowed up to 10 consecutive days per episode when a consumer is hospitalized for a period of medical/psychiatric stabilization and the ACT team is actively involved in the planning for return to the community and the individual is expected to return to ACT.

Documentation of the need for stabilization is reflected in the consumer's treatment plan and file. The program will be reimbursed at the full program rate per day. This reimbursement is only available if the treatment placement is not used by another consumer. The Behavioral Health Managed Care Contractor must be notified within 24 hours of hospitalization and will reflect this information in the clinical database. More than 3 episodes in a calendar year will result in a Level of Care review. Leaves in excess of 10 consecutive days must be approved by the Department or its designee and requested through the Managed Care Contractor.

Therapeutic Leave Days
Beds in Psychiatric Residential Rehabilitation, Secure Residential, Therapeutic Community, Intermediate Residential, Dual Diagnosis, and Halfway House programs can be held up to 21 days annually (from the date of admission) when a consumer is on therapeutic leave for the purposes of testing ability to function at and transition to a lesser level of care. This reimbursement is only available if the treatment bed is not used by another consumer.

Individuals discharging from Assertive Community Treatment (ACT) may be allowed a 30 day period of transition when graduating and moving to a lower level of community service (outpatient therapy, medication management, community support mental health, and community support substance use disorder or day rehabilitation).

The therapeutic rationale and leave time period must be indicated in the treatment plan. Documentation of the outcome of the therapeutic leave and the need for continued residential level of care must be indicated in the consumer's record. The Department will reimburse at the full program rate per day. The Behavioral Health Managed Care Contractor must receive prior notification. Leave in excess of established time frames (21 days or 30 days for ACT per annum) must be approved by the Department or its designee and requested through the Managed Care Contractor.

Division of Behavioral Health Bed Allocation Plan Reference Manual 2016

In Compliance With:

NEB. Rev. Stat. § 83-338

Revised: January 2017

Table of Contents

Regional Center Bed Allocation Plan Background

The Nebraska Department of Health and Human Services (DHHS) Division of Behavioral Health (DBH) includes the Central Office, Office of Consumer Affairs, and three Regional Centers, located in Hastings, Lincoln, and Norfolk, Nebraska.

The Nebraska Legislature provides the Central Office the authority to distribute Behavioral Health funding to the six Regional Behavioral Health Authorities (Regions) to serve individuals seeking psychiatric services in the public sector. The Legislature also provided funding for the three Nebraska Regional Centers to provide inpatient care for individuals with mental illness. A shift in funding from the Norfolk and Hastings Regional Centers to community-based programs was adopted through LB 1083 in 2004. Funding for inpatient treatment services was allocated to five of the six Regions. As a result, the general adult psychiatric units at the Hastings and Norfolk Regional Centers have been closed, leaving the Lincoln Regional Center (LRC) as the only statewide hospital with general psychiatric beds. The total population at the Lincoln Regional Center includes individuals with the following statuses: court ordered (incompetent to stand trial, competency evaluations, and not responsible for reason of insanity), sex offenders, and mental health board (MHB) commitments (Nebraska Statute, 83-338).

As a first step in a paradigm shift from extensive institutional care to community-based care, the Division began overseeing the statewide referral system to Regional Centers in 2005. The Division provides leadership and direction in the use of Regional Center general psychiatric treatment for persons in the 90 allocated beds. The Division will work with the Regions and community-based hospitals to either divert individuals from Regional Center hospitalization or, if appropriate, obtain hospitalization at Lincoln Regional Center (LRC).

The Bed Allocation Plan is designed to provide guidance/direction for Regional Emergency System stakeholders, Regional Center staff, and Divisional Central Office staff on transitioning individuals in and out of the Lincoln Regional Center.

The Regions serve as the direct link between the individual and all system partners in seeking effective mental health and substance abuse treatment in the least restrictive environment.

The Division will resolve conflict among system partners and reserves the right to initiate systems changes when there is disagreement among system partners.

LRC Admission Criteria/ Priority of Admission

The Lincoln Regional Center, by statute (83-338), is required to admit individuals based upon the following priorities of admission:

> **State hospitals for the mentally ill; order of admission when facilities are limited.**
> If at any time it becomes necessary, for lack of capacity or other cause, to establish priorities for the admission of patients into the state hospitals for the mentally ill, the following priorities for admission shall be recognized: (1) Patients whose care in the state hospital is necessary in order to protect the public health and safety; (2) patients committed by a mental health board under the Nebraska Mental Health Commitment Act or the Sex Offender Commitment Act or by a district court; (3) patients who are most likely to be benefitted by treatment in the state hospitals, regardless of whether such patients are committed by a mental health board or whether such patients seek voluntary admission to one of the state hospitals; and (4) when cases are equally meritorious, in all other respects, patients who are indigent.

The Division of Behavioral Health will look at admissions on a case-by-case basis and admission to the Lincoln Regional Center will be based on statue. The Division of Behavioral Health will look at Mental Health Board commitment dates, court waits and safety needs when prioritizing the admissions to the Lincoln Regional Center.

Court-ordered individuals shall not be counted against the number of general psychiatric beds allocated to the Regions, due to the Regions have no statutory authority for individuals under that criteria. If the court-ordered individual has a mental health board hearing and is committed under the Nebraska Mental Health Commitment Act then they could count against the number of general psychiatric beds for a Region.

Community-based hospitals and crisis centers will contact the Region when there is an individual in their facility who meets the criteria and who they would like to refer to the Regional Center. Regions then make a determination, in consultation with the DBH Emergency System Coordinator, on who will be placed on the referral list for admission. The Lincoln Regional Center will then arrange admissions with the Regions. The referring hospital/crisis center shall provide information regarding: 1) why the referral is being made, including what treatment is needed; 2) descriptions of other alternatives to Regional Center placement which have been pursued; 3) progress notes denoting what has been done to attempt to de-escalate the aggression.

Individuals with Developmental Disabilities or Dementia, or others, who may not benefit from acute and rehabilitative care, may not be appropriate for Regional Center care and will be discussed on a case-by-case basis.

Allocation of LRC Beds

Each Region will be assigned a specific number of LRC beds for their utilization. However, the Regional bed allocation count will include only individuals with mental health board commitment status.

Bed allocation is determined by the number of beds available at LRC and calculated based on the percentage of population in the given region. The Division reserves the right to redistribute bed allocation at any time and will provide notice to the Regions. Region 5 will be allotted 18 beds above their percentage of population calculation until it obtains agreement with a local community hospital. The bed allocation will continue to be assessed for need and may be adjusted as a result.

The following chart portrays the allotted beds for each Region based on 90-bed capacity at LRC.

BEDS ALLOCATED TO EACH REGION BASED ON 90-BED CAPACITY AT LRC

	2010 Census	**Dedicated Beds @ LRC**	**Allocated Beds @ LRC**	**Total Beds @ LRC**
Region 1	4.72%	0	3	3
Region 2	5.44%	0	4	4
Region 3	12.32%	0	9	9
Region 4	11.16%	0	8	8
Region 5	24.38%	18	18	36
Region 6	41.98%	0	30	30
	100.00%	**18**	**72**	**90**

Operational Agreements

The following Operational Agreements are designed to address the most frequently anticipated situations that will arise with the Bed Allocation Procedures. Any situations not included on the list will be solved on a case-by-case basis.

I. Region

A. Region of Responsibility (Emergency Protective Custody - EPC)
Each Region will be responsible for individuals who are placed in EPC and are committed by a Mental Health Board within a county in that Region.

B. Region of Responsibility (Post Mental Health Board Commitment)
LRC uses county of residence to determine Region of Responsibility. The Division will determine Region of Responsibility when disputes occur. Every effort will be made to expedite the decision of Region of Responsibility before individuals are admitted to LRC.

C. Individual Choice
Individual's choice in determining aftercare services is valued. In the event an individual chooses to move from the Region of Responsibility to another Region upon discharge from LRC, individual choice will be honored through negotiations between the two Regions.

D. Changes in Region of Responsibility
Due to various reasons, such as individual's choice or availability of services, an individual may be discharged to a different Region than the original Region of Responsibility. The Emergency Coordinator from the receiving Region shall be contacted as soon as possible prior to the discharge, so negotiations can occur between the Region of Responsibility and the receiving Region.

Regions shall work together with LRC social workers to assist and support individuals in creating a crisis/safety plan or Wellness Recovery Action Plan (WRAP) to avoid readmission into the Emergency System. WRAP plans will be developed prior to discharge.

Some Regions may ask for the individual to be discharged on an outpatient commitment if the Region of Responsibility is changed. With guidance from Regions, Regional Center staff will make the recommendation for the individual to be discharged on an outpatient commitment. The Mental Health Board of the county of EPC determines the commitment order.

DISCHARGED FROM LRC ON **OUTPATIENT COMMITMENT**: If an individual discharges from LRC to a different Region, on an outpatient commitment from the original Region, is placed in Emergency Protective Custody, then the **ORIGINAL REGION**:

1. Continues to be the "Region of Responsibility" for the duration of the outpatient commitment,
2. Is required to use one of their allocated beds if the individual is sent to the Lincoln Regional Center for treatment, and
3. Once the commitment order is dropped, the new Region becomes the Region of Responsibility.

DISCHARGED FROM LRC **WITHOUT** A COMMITMENT ORDER: If an individual discharges from LRC to a different Region without an outpatient commitment is placed in Emergency Protective Custody, then the **NEW REGION**:

1. Is the new "Region of Responsibility," and
2. Is required to use one of their allocated beds if the individual is sent to the Lincoln Regional Center for treatment.

E. Unused Capacity

It is anticipated that at times, Regions will not utilize all of their Regional Center capacity. Every effort to minimize freed up capacity must be made if referrals exist in other Regions. Regions are encouraged to negotiate with each other in a timely manner to fill open capacity. The Division reserves the right to intervene when negotiations are unsuccessful or untimely.

F. Communication

1. Regions will submit the Referral List to LRC's Health Information Management office and the DBH Emergency System Coordinator each week by Monday afternoon. Information on the Referral List will include: region of responsibility, individual name, hospital admission date, county of residence, referral source, referral source contact and phone number, legal status, county of commitment, commitment date, level of care and referral date.
2. Regions will appoint a contact person (Emergency Systems Coordinators) and a back-up contact person and communicate this with LRC and the DBH Emergency System Coordinator.
3. Regions will work with referral sources to ensure Magellan screenings are completed for individuals listed on the referral list. If individuals have received a substance abuse assessment, the assessment, with proper consent, must be sent to LRC.

G. Mental Health Priority Population Levels

The following populations shall be considered priority for admission to community-based services:

1. Individuals being treated in the Regional Center who are Mental Health Board committed and in the 90 bed Regional allocation (regardless of legal status).
2. Individuals in a community inpatient setting or crisis center and are awaiting discharge.
3. Individuals committed to outpatient care by a Mental Health Board.
4. All others.

II. Regional Center

A. Need for Private Room

At times, individuals at LRC require private rooms. The need for a private room will be at the sole discretion of LRC nursing staff based upon the needs of the individual, individuals on the unit, and LRC policies and procedures. A private room may be needed for medical reasons such as for individuals with Methicillin-resistant Staphylococcus aureus (MRSA) or other contagious infections, illnesses, or diseases.

B. Individual Movement within LRC

1. LRC reserves the right to make decisions regarding the best possible treatment setting for individuals receiving treatment at LRC. Movement among treatment programs will be minimized as much as possible, but may be necessary for the achievement of the most appropriate treatment setting.
2. A designated LRC representative will refer individuals who no longer need Forensic level of care and are recommended by their treatment team for movement to a less

restrictive environment to the Region so the Region can contemplate a community placement.

3. If the determination is made that a transfer to another treatment setting on LRC campus is most appropriate, LRC staff will inform Region staff prior to the date of the move.
4. At times, LRC will need to transfer an individual from Forensics to a less restrictive environment in a very short period of time to make room for an individual who is court ordered to the Regional Center.

C. Emergency Admissions

Requests from Regions for emergency admissions of mental health board committed individuals because of intense and frequent violent behavior, which cannot be appropriately managed in a local hospital, or crisis center will be handled by the LRC CEO. If the CEO is not readily available, the Facility Operating Officer at LRC will handle the situation.

Once an individual determined to be an emergency admission is stabilized, the LRC treatment team will decide if the individual should be discharged back to the community or needs to continue treatment at LRC.

D. Admission/Discharge Timelines

LRC will determine the date individuals will be admitted. At times, a time lag may occur between the time an individual is discharged from LRC and when another individual can be admitted. This is a result of internal processes or individual movement that must be completed before another admission can occur.

E. Individuals Hospitalized from LRC for Medical Reasons

Individuals needing medical treatment beyond the capacity of LRC will be officially discharged from LRC and treated in a community hospital. Regional Center staff will communicate the movement to the Region. In the expectation that the individual will not return to LRC within a short period of time (less than one week), Regions will be asked to make the determination whether to fill the open bed at LRC or hold it for the hospitalized individual.

F. Court Orders

Admissions for a court-ordered individuals will be based on statute. The Division of Behavioral Health will look at Mental Health Board commitment dates, court waits and safety needs when prioritizing the admissions to the Lincoln Regional Center.

III. Conflict Resolution

A. Determining Order of Admissions When Multiple Regions have Open Capacity

In the event that multiple Regions have open beds in their allocation and have individual(s) on their waiting list to get into the Regional Center, but the Regional Center does not have the capacity to allow for all the admissions, the order of admissions will be determined Mental Health Board commitment dates, court waits and safety needs.

B. Discharge from Regional Center

Occasionally conflicts occur between the various stakeholders in the discharge planning process. When discharge conflicts surface, every effort will be made to resolve the conflict through a clinical process rather than an administrative process. Discussions will occur throughout a variety of levels to facilitate the most appropriate clinical decision. It is expected that individual voice is taken into consideration throughout the discharge process, and the individual and LRC

Consumer Advocate or Regional Consumer Specialists will be involved. The following process should be used in conflict resolution on disputes in discharge planning of Mental Health Board committed individuals at the Regional Center:

1. Regional Emergency Coordinator/Representative or individual will express concern in discharge plan to Regional Center Social Worker. Parties will work together to resolve disagreement. Social Worker will take the plan to the Regional Center Treatment Team for approval.
2. If the above parties are unable to resolve dispute or if the Regional Center Treatment Team does not agree to the plan, the Regional Emergency Coordinator will respond to the Treatment Team/Social Worker in writing, with a 'cc' to the Regional Center Program Director, Social Work Supervisor, and DBH Emergency System Coordinator.
3. The DBH Emergency System Coordinator will convene a conference among the Division's Chief Clinical Officer, the Regional Center Program Director and/or CEO, the Regional Center Treatment Team (including social worker and psychiatrist), and the Regional Emergency System Coordinator to discuss the dispute and come to a compromise.
4. If the group is unable to come to a compromise, the Chief Clinical Officer of the Division of Behavioral Health shall make the final determination regarding the dispute.

IV. Division

A. Guardianship Issues

The Division assumes responsibility for the legal work necessary in the event that a guardian refuses to work with the Region and Regional Center on the discharge of an individual from a Regional Center when it has been determined by the treatment team that the individual is appropriate for a less restrictive environment in the community. The Regional Center CEO will draft a letter to the guardian with guidance of the DHHS legal Section. Actions beyond the guardian letter will be addressed by appropriate DHHS staff, including the Division and DHHS Legal Services Section.

B. Interstate Compact Referrals

The Interstate Compact on Mental Health provides the legal basis for the proper care, treatment and institutionalization of the mentally disabled. The 44-state compact allows for patient transfers between states when mental health officials decide a patient's care and treatment will be improved by the transfer. Compact states must ensure that services are available to all based on need and not where they live or citizenship status. All states belong to the compact except Arizona, California, Mississippi, Nevada, Utah and Virginia.

The State of Nebraska contact person for the Interstate Compact on Mental Health is:

Lincoln Regional Center, Facility Operating Officer
Nebraska Department of Health and Human Services
P.O. Box 95026
Lincoln, NE 68509-5026
Phone: (402) 479-5271
E-mail address: stacey.werthsweeney@nebraska.gov.

Implementation

Initial implementation for all Regions for the Bed Allocation Plan was April 1, 2007.

On July 29, 2009, the status of individuals counting toward a Region's allocation count changed to include only individuals with a mental health board commitment status or a voluntary per guardian status. While the Regional Allocation Count includes individuals currently at the Regional Center on a voluntary per guardian status, new admissions under this status are no longer permissible.

Revision of the Bed Allocation Plan occurred December 5, 2011, February 12, 2012, February 25, 2016 and January 9, 2017.

Operating Procedures

Regional BH Referral List

Individual is admitted to hospital or crisis center. Emergency Protective Custody and Commitment Procedures vary by Region.

Individual is prioritized for Regional Center admission based on the Region's designated process and added to the Region's BH Referral List which is kept by the Regional Emergency System Coordinator. Regional BH Referral Lists are communicated to the DBH Community-Based Services Section, and the Lincoln Regional Center, on a weekly basis by Regional Center.

Regional Center Admission

1. Regional Center tracks individuals on LRC referral list by date of commitment.
2. Regional Center communicates any bed openings to designated Region staff, based open whether the Regions have any open slots in their allocation and if they have individuals on their referral list.
3. If multiple Regions have open slots in their allocation, and have individuals on their referral list, Regional Center designee determines the next admission by Mental Health Board commitment dates, court waits and safety needs.
4. Regional Center facilitates the admission with the Region Representative and/or the Hospital/Crisis Center (H/CC).
5. Regional Center registers and authorizes the admission (Level of Care designated/continued stay review.)

Regional Center Discharge

1. Regional Center staff, with input from Region Emergency Coordinator, develops a discharge plan, contact appropriate community-based providers, and determine an anticipated discharge date.
2. Region and Regional Center staff works cooperatively with the community provider to facilitate the discharge in a timely manner.
3. Prior to discharge, Regional Center staff alerts Region staff to discharge date.
4. Region and Regional Center staff facilitates discharge.
5. Regional Center provides Region with a discharge summary.
6. Regional Center discharges from ASO/web-based data.

System Communication

1. Regions will forward their referral list on Monday of each week to the Division (DBH Emergency Coordinator and LRC Admissions Coordinator).
2. The Regional Center will communicate a Regional census list with names to a Regional representative on a weekly basis.
3. The Regional Center will communicate a statewide census report (numbers only) on a weekly basis.
4. Regional Center Case Reviews are scheduled on a monthly basis to communicate and brainstorm possible discharge plans for individuals who Regions/Regional Center are finding it difficult to develop a discharge plan.
5. The Regional Center will communicate any individual moves within the center on a weekly basis.
6. The designated point person for the Bed Allocation Plan at the Division will be the DBH Emergency Systems Coordinator.

Notwithstanding these guidelines/procedures, the Regional Center CEO is the final decision maker.

System Partner Roles

The success of the Bed Allocation Plan relies on the communication and coordination of all system partners. The goal of the system is to return individuals to a community setting of their choice through the assistance of personnel throughout the system. Instrumental in the process are the Behavioral Health Regions. The Regions serve as the connecting point to all of the system partners and take the lead in coordinating the appropriate level of care for individuals. The role of each of the system partners is described in the following pages.

Role of the Individual

- Be an active participant in the system of care, from individual treatment planning to Region and Statewide resource development.
- Be present and participate actively in team meetings. Clearly convey personal vision for future, recovery, and wellness.
- Communicate with advocates who can lend legal, social, financial, educational, vocational, and/or spiritual support.
- Make certain treatment team is aware of WRAP plan, if present.
- Request community involvement as desired. Contact placements directly to discuss specific needs and interests. Individuals may contact Regional Consumer Specialists to access information from their specific Region.
- Request access to educational materials that promote wellness and recovery.
- Participate in the development and analysis of outcome measures.

Role of DHHS Division of Behavioral Health Central Office

System Oversight

- Ensure least restrictive level of care is obtained.
- Provide mental health boards with appropriate information/training to do their jobs effectively.
- Provide consultation/technical assistance in the location/determination of funding sources for various aspects of individual's care (transportation, Medicaid funding, flexible funding, etc.).
- Determine Regional Center bed allocation dependent upon system needs.
- Promote system adjustments to accommodate better outcomes for the individual.
- Monitor and evaluate effective use of financial resources.
- Strengthen Utilization Management Role with Magellan.
- Resolve conflicts on a limited basis, including assisting in determining Region of Responsibility.
- Provide access to BH Division Clinical Team to settle admission/discharge disagreements between Regions and Hospital/Crisis Center (H/CC) or Regional Centers.
- Provider answers to questions regarding the interpretation of bed allocation procedures.

Facilitate Communication between System Partners

- Provide appropriate facilitation to promote smooth transitions from one setting to another.
- Provide opportunities for on-going communication and opportunities for feedback from individuals. Make certain that individual input is incorporated into planning, decision-making, and problem solving.
- Provide opportunities for on-going communication, problem-solving, and planning with all system partners.

Quality Improvement

- Work with system stakeholders to identify desired outcomes and criteria for measuring success.
- Work with system stakeholders to develop methods and frequency of data collection, and system for tracking/reporting outcomes

Role of Regions

Facilitate Referral to Regional Center

- Provide input into decision to pursue regional center placement or divert to community-based setting
- Determine placement on the Region's BH Referral List
- Communicate Region's BH Referral List to the Division & referring H/CC

Facilitate Admissions to Regional Center

- Prioritize referrals from all sources (H/CC) for admission to Regional Center
- Serve as liaison between H/CC & Regional Center
- Ensure referral documentation, including the H/CC discharge plan, is made available to the Regional Center

Facilitate Individual Discharge

- Work with Regional Center professionals and individual in finalizing discharge to the community
- Establish relationship between individual and ERCS/CS/Intensive Case Manager prior to discharge
- Work directly with staff and individual to facilitate positive transition to community
- Assist with problem-solving transportation issues
- Continue to develop capacity to serve individuals who are discharged from Regional Centers
- Ensure individual access to needed community-based services such as Emergency Community Support

Data Collection and Outcomes

- Gather and collect data as determined by a collaborative group including the Division, Regions, Regional Centers, and community stakeholders.

Role of Regional Center

Ensure Individual Involvement

- Function as an advocate for the individual.
- Make certain individual has meaningful input in treatment/discharge planning in Regional Center.
- Involve individuals in all aspects of service planning and delivery. Seek input and use it to affect policy and resource development.

Facilitate Admissions

- Communicate with the Division & appropriate Region when an opening occurs
- Coordinate admission arrangements with Region Representatives and H/CC professionals
- Facilitate programmatic adjustments when appropriate to meet individual needs

Provide Treatment

- Make certain individual's voice is heard, and individual's needs, goals and wishes are considered
- Provide appropriate and most current treatment in a safe environment

- Communicate individual treatment progress with Region, Division, and individual
- Makes certain individual's WRAP plan is at the center of the planning process
- Assists with procuring resources if individual does not have WRAP plan and wishes to develop one

Facilitate Discharges

- Coordinate community discharges with Region staff and individual

Data Collection and Outcomes

- Gather and collect data as determined by a collaborative group including the Division, Regions, Regional Centers, and community stakeholders.

Housing Assistance Program Manual

Division of Behavioral Health
Nebraska Department of Health and Human Services

June 28, 2017

HOUSING ASSISTANCE PROGRAM

The Department of Health and Human Services Division of Behavioral Health – Community-based Services (Division) provides housing assistance to support eligible consumers with their recovery goal of independent living. Safe and stable housing are components needed for recovery by people who have behavioral health disorders and experience extremely low income. Assistance provided by the Housing Assistance Program affords opportunity to a consumer to achieve or remain in permanent, affordable, community integrated housing while receiving behavioral health services supportive of recovery.

The Housing Assistance Program was developed following the general principles of the evidence-based practice of Supported Housing. Supported Housing is permanent, affordable housing linked to a range of support services that enable individuals to live independently and participate in community life. The Division's housing assistance program provides funding for extremely low-income adults with serious mental illness or substance use disorders (or co-occurring) to serve as a "bridge" to other housing resources such as the Federal Housing Choice Voucher Program (also known as Section 8) and public subsidized housing or living in independent housing without rental assistance.

Originally, the *Housing-**Related** Assistance* (HRA) Program was created in 2005 and utilizes Nebraska state documentary stamp tax dollars (Nebraska Revised Statute 71-812(3)) to provide housing assistance to eligible individuals with a serious mental illness (or co-occurring disorder) and who are receiving behavioral health services funded by the Department of Health and Human Services (DHHS). Recently, state general funds were made available to serve eligible individuals with either a serious mental illness or substance use disorder (or co-occurring disorder) and who are receiving behavioral health services funded by DHHS.

I. Purpose

The purpose of the Housing Assistance Program is to address housing needs for people with behavioral health disorders. This includes the use of rental assistance, other housing-related assistance, facilitation of community integration and a housing first approach as strategies to prevent homelessness as well as sustain stable housing. The Division contracts with each Regional Behavioral Health Authority (RBHA) for the provision of housing assistance. The RBHA provides Housing Assistance Program coordination and assistance within the Region.

II. General Program Requirements

The Housing Assistance Program provides funding for a key component of recovery for individuals: Home – housing with needed supports. As such, it is part of the Permanent Supported Housing capacity in each of the six behavioral health regions.

General housing assistance requirements of the Housing Assistance Program include:

1. The principles of the evidence based practice of Supported Housing should be followed. This includes:
    a. Permanence
    b. Functional separation of housing and supportive services
    c. Integration
    d. Affordability, and
    e. Flexibility

2. Funds for housing assistance shall be used for the Priority Populations established in the eligibility criteria listed below.
    a. Sufficient funds shall be reserved for individuals meeting Priority One standards.
    b. The Division may limit or expand the priority populations dependent on the amount of funds allocate for the Housing Assistance Program.

3. Funds may only be used for housing assistance for consumers living in the state of Nebraska.

4. All assisted housing paid under these guidelines must meet Housing Quality Standards.

5. When housing assistance funds are used, community integration shall be required.

6. The Division has set an Annual Funding Cap of up to six thousand dollars ($6,000) per consumer in a twelve (12) consecutive month time period for state funded housing-assistance.

7. The Division has set a Housing Related Debt cap of five hundred dollars ($500) per consumer in a twelve (12) consecutive month time period for state funded housing assistance.

8. The Housing Assistance Program is the payor of last resort. A consumer must document that he/she has exhausted all other options for payment before requesting any funds under this rental assistance program.

9. Consumers are responsible for providing accurate and timely information to the program. Knowingly providing inaccurate information or withholding information regarding income levels or other changes in status that would affect eligibility for the program is grounds for immediate discharge from the program.

10. The Housing Assistance Program shall follow the *Tenant Based Rental Assistance* model as defined by the U.S. Department of Housing and Urban Development (HUD). This means funds

will be provided on the behalf of an individual/household for housing related costs and the consumer selects the housing unit of his/her choice.

11. *Project-Based Rental Assistance* is NOT an approved use of program funds. Funds for the Housing Assistance Program are to be used to assist individuals/households only and may not be retained by a particular building or development should the individual/household move to another housing unit, except under the terms of a tenant's lease agreement.

12. Rental assistance funds are NOT approved for Licensed Healthcare Facilities, including Assisted Living Facilities and Mental Health Centers as identified in DHHS Regulations.

III. Regional Behavioral Health Authority Responsibilities

Funds for the Housing Assistance Program will be distributed to the Regional Behavioral Health Authority (RBHA) through the Division contract for services with each RBHA.

1. The RBHA is responsible for providing direct services, or via oversight of contracted entity, of the Housing Assistance Program within their Region. Coordination of the program involves:
    a. Approving applications for eligible consumers for Housing-Assistance Program funds;
        i. application materials include documentation provided by the behavioral health service provider to the Regional Housing Coordinator;
    b. Authorizing Housing Quality Standards (HQS) inspections be completed for approved consumers
    c. Making payments to the landlord
    d. Developing and maintaining the Housing Assistance Program Plan consistent with the Housing Assistance Program.
    e. Making the Housing Assistance Program Plan available to the Division upon request.

2. The RBHA is responsible for developing and maintaining the Housing Assistance Program Plan. Safe and stable housing are components needed for recovery by people who experience extremely low income who have behavioral health disorders.
    a. The Housing Assistance Program Plan will identify the activities that are designed to support affordable housing services and facilitate the community integration of eligible individuals with behavioral health disorders. The Housing Assistance Program is to serve as a "bridge" to other housing resources such as the Federal Housing Choice Voucher Program (also known as Section 8) and public subsidized housing or living in independent housing without rental assistance.

3. The RBHA is responsible for providing Housing Assistance Program coordination and assistance within their Region. The RBHA may contract with a qualifying public or private nonprofit entity for this provision. For the purposes of this program, in order to be a qualified public, or private nonprofit entity the organization must meet the following requirements:

a. The designated entity shall be an organization with experience in managing affordable housing for adults who are very low income with a serious mental illness.
b. Providers of behavioral health services are excluded from filling the Regional Housing Coordination function.

4. The RBHA is responsible for managing the Housing Assistance Program funds allocated through the Division contract.
    a. Once a consumer is found eligible to receive Housing Assistance Program funds, the RBHA may bill the Division.
        i. For consumers approved for housing assistance, the RBHA shall bill the Division for reimbursement of funds expended.
        ii. The RBHA shall submit billings monthly for housing assistance provided. The amount of funds requested must not exceed the amount actually expended for the month and must be recorded in the Region's financial accounting system. No prepayment of costs will be permitted.
        iii. The RBHA is responsible to bill the Division in a manner to ensure housing assistance funds are used only for purposes intended in the Housing Assistance Program and comply with requirements pertaining to allowable and unallowable costs.

    b. The RBHA may exceed the Annual Funding Cap per consumer if the Region Administrator approves such a request.
        i. The request shall be based on the current HUD Fair Market Rent Documentation System.
        ii. The RBHA must document the need for raising the annual funding cap limit.
        iii. The RBHA must make documentation available to the Division upon request.

    c. The RBHA Regional Administrator may approve exceeding the five hundred dollars ($500) annual limit of Housing Related Debt on a case by case basis, in order for a consumer to move into public housing.
        i. The RHBA is responsible for maintaining all of the documentation on requests for additional funds, including a record of the Regional Administrator's approval.
        ii. Division approval is not necessary on a case by case basis.

    d. An RBHA which has a need for additional Housing Assistance Program funds above the contracted amount may request funds through a contract amendment by identifying a specific amount of funds needed and providing a budget justification.

5. The RBHA is responsible for Housing Assistance Program reporting.
    a. Budget reports must be submitted to the Division that document and track how Housing Assistance Program funds are expended. The RBHAs are encouraged to utilize the program template forms for reporting.
        i. Each recipient consumer provided Flex Funds must be reported and billed as specified by the Division.

ii. Each recipient consumer provided HRA funds must be reported and billed as specified by the Division.

b. Monthly financial reports must be submitted to the Division that account for the utilization of the funds.

c. HRA program monthly data reports must be submitted to the Division on a quarterly basis.

i. The Regional Housing Coordinator shall ensure providers are accurately utilizing reporting data fields related to the HRA program.

ii. Reporting requirements for the HRA program are identified in "Report Instructions for the Nebraska State Housing Related Assistance Program for Adults with Serious Mental Illness." The monthly "Supported Housing Database" must be sent via email to the Division each quarter on or before the 15th of the month following the end of the quarter. Due dates are October 15, January 15, April 15, and July 15.

IV. Consumer Eligibility

A consumer shall be considered eligible for the Housing Assistance Program if he/she meets the following criteria:

1. Is an adult with serious mental illness as defined by Nebraska Revised Statute 71-812(3) or an adult with a substance use disorder or co-occurring disorders as defined by The *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*);
2. Is an adult receiving behavioral health service(s) funded by DHHS and is participating in the behavioral health service(s);
3. Is an adult in need of housing related assistance determined by:
    a. Documented efforts to fully exhaust options available for rental assistance through local housing authorities and/or other entities; and
    b. Clear demonstration of the consumer's willingness to continue to seek other sources of rental assistance if initially turned down or placed on a waiting list.
        i. Failure to honor these agreements may be grounds for termination of the Housing Assistance Program assistance.
4. Meets residency requirements by being either:
    a. A United States Citizen; or
    b. A Legal Permanent Resident or other documented immigration status allowed under DHHS policy.
    c. Documentation of immigration status is the responsibility of the individual applying for housing related assistance.

5. Meets either Priority One or Priority Two criteria as listed below. No one under Priority Three shall be served under this policy.
    a. Priority One – either:
        i. A person with Extremely Low Income (a household income between 0 and 30 percent of the applicable Median Family Income) who is discharged from an inpatient Mental Health Board commitment, or
        ii. A person with Extremely Low Income who is eligible to move from a residential level of care to independent living to make room for a person being discharged from an inpatient Mental Health Board commitment.
    b. Priority Two – A consumer with Extremely Low Income who is "at risk" of an inpatient mental health commitment which could be at least in part due to a lack of affordable, independent housing.
        i. For the purposes of this section, "at risk" means the individual meets at least one of the following criteria:
            (1) a history of inpatient Mental Health Board commitments within the last five years
            (2) was subject to an emergency protective custody within the last five years
            (3) the housing assistance will clearly prevent a psychiatric hospitalization
            (4) the person is currently homeless
            (5) the person has no income and appears eligible for SSI
            (6) the consumer is living in independent housing that is not safe, decent, or affordable
            (7) housing assistance prevents a consumer from moving into a higher level of care
            (8) is currently committed to outpatient services by a Mental Health Board.
    c. Priority Three – A behavioral health services consumer with Very Low Income (a household income of 50 percent or less of the applicable Median Family Income) who does not meet either Priority One or Two; policy does not support consumers in this priority level unless all Priority One and Priority Two consumers have been addressed.
    d. Priority Populations* within the Housing Assistance Program priority structure are:
        i. Housing Assistance Program - Mental Health and Dual Disorder priority populations are governed by state statute (NRRS 71-812(3)(a)) and the agreement between the Division and the RBHAs, a.k.a. the State to Region contract:
            (1) Persons Mental Health Board committed and being treated in a Regional Center who are ready for discharge
            (2) Persons who are Mental Health Board committed to inpatient care being treated in a community inpatient setting or crisis center and who are awaiting discharge
            (3) Persons committed to outpatient care by a Mental Health Board
            (4) All others.
        ii. Housing Assistance Program – Substance Use Disorder priority populations are follow the Federal SAPTBG population priorities and the agreement between the Division and RBHAs, a.k.a. the State and Region contract:
            (1) Pregnant women who are injecting drugs

(2) Pregnant women

*Priority Populations were discussed in the Network Operations Workgroup meeting on March 7, 2017

(3) IV Drug Users

(4) Women with dependent children, either having physical custody or attempting to regain custody.

6. Has an Individual Service/Treatment Plan (ISP) developed with their authorized behavioral health service provider that includes the identified goal of independent living. There should be written documentation showing:
    a. The consumer's goal of obtaining and maintaining independent housing;
    b. A contact person who is:
        i. Trained in identifying and assisting the consumer with the above goal, and
        ii. Who can be contacted by a landlord if there are any problems
    c. There is a plan of action to seek a stable income if the person is considered a "Zero Income Consumer".

7. If a person is found eligible, but is determined to have no income at the time of application for valid reasons, the following policies apply:
    a. There must be a plan of action in the consumer's ISP to document efforts to seek a stable income.
    b. If the consumer is able to seek employment, the ISP should specify how the consumer will obtain employment, including, but not limited to:
        i. Searching for employment independently,
        ii. Using the services of the Nebraska Department of Labor,
        iii. Seeking Supported Employment from a local behavioral health provider,
        iv. Applying for Vocational Rehabilitation services, or
        v. Other related strategies (identify).
    c. If the consumer is not able to seek employment due to a disability he/she must apply for disability benefits through any relevant programs including, but not limited to, SSI, SSDI, or Veteran's disability benefits.
        i. The ISP should include documentation from a behavioral health service provider that the consumer's mental illness is severe enough to prevent the consumer from doing any substantial gainful activity.
    d. The Housing Assistance Program Coordinator needs to review the case:
        i. Monthly to determine that the consumer is working to establish a stable income
        ii. If the consumer's application for disability benefits is under appeal, the case review may be done quarterly.

8. When a person served by the program has a job with earnings that exceed the Extremely Low Income requirements as defined under HUD Guidelines he/she will be transitioned from the program.
    a. The transition period begins upon verification that the consumer has been successfully employed with income over the Extremely Low Income level for one month (30 days).

b. Once the need for transition is identified, a Transition Plan is developed to allow from one (1) month up to a six (6) month process, depending on the consumer's situation.

c. Written notice is given to the consumer of the need to transition out of the Program.

d. The Program may hold Housing Assistance funds for this consumer for up to three (3) month(s) after successful transition out of the Program.

V. Housing Assistance

A. Housing Assistance - Rent

Upon determination of consumer eligibility, housing assistance may be used to pay for a housing unit that meets HQS and the local Fair Market Rent (FMR).

1. Each RBHA sets local standards on what is considered reasonable rent.
    a. The leased rent (not including utilities) should be equal to or less than the FMR as calculated, defined and published by HUD as much as possible.
    b. If it is documented that the eligible consumer cannot obtain safe, decent, and affordable housing in the local area using the FMR limit, the RBHA may approve a higher amount of rent.
        a. The RBHA must document the need for a higher amount of rent.
        b. The RHBA must make documentation available to the Division upon request.

2. The consumer is expected to contribute 30% of adjusted gross income for rent and utilities. To streamline transition to other programs, the adjusted gross income shall be calculated in a manner consistent with the appropriate local housing authority.

3. On-going rental assistance may only be provided to consumers who have a signed tenant lease agreement in place for their housing unit. The only exception for on-going rental assistance is the security deposit and first month rent due at the time of executing the lease.

4. On-going rental assistance needed for a consumer with zero income to live in public housing is authorized if the RBHA clearly documents a cost savings to the program.

5. The Housing Assistance Program may continue to pay the rent through a maximum of a ninety (90) day temporary consumer absence from the Housing Unit.
    a. After a ninety (90) day absence from the Housing Unit, or if the consumer is clearly determined to no longer be able to live independently, the consumer shall be discharged from the program.
    b. The ninety (90) day absence policy may be extended only:
        i. Upon recommendation of the consumer's treatment team or a written recommendation from the RBHA's Emergency Systems Coordinator; and,
        ii. With written approval from the Regional Administrator; and
        iii. The total extended absence is no longer than 180 days.

B. Housing Assistance – Other Related Costs

1. Housing Assistance Program funds may be used for one-time expenses to help an eligible consumer move into a housing unit that meets HQS and FMR, such as security and utility deposits and/or "Other Related Costs" as needed to provide housing.
    a. Upon sufficient documentation, the following “Other Related Costs” may be authorized:
        i. Allowance for stove and refrigerator consistent with the local housing authority’s standards.
        ii. One-time costs which may include
            1. RentWise or comparable consumer housing education program,
            2. Security and utility deposits,
            3. Reasonable moving expenses,
            4. Needed furniture such as couch, bed, table, and chairs,
            5. Items to make the consumer’s apartment suitable for living such as bedding, dishes, silverware, cookware, and general kitchen supplies.
            6. Housing Related Debt such as past due rent or utility payments may be paid if such payments allow the consumer to receive Section 8 and/or other local housing authority services.
        iii. “Other Related Costs” must be clearly documented by the RHBA and made available to the Division upon request.
        iv. “Other Related Costs” not listed here are unauthorized without written approval from the Division.

    b. Specifically excluded from “Other Related Costs” are:
        i. Cable television and telephone payments.
        ii. Food, cleaning products, or other related consumable products.
        iii. Funds to cover for damages the tenant made to the unit during tenancy.
        iv. To cover debt from previous utilizations of the program except as noted above.

2. Housing Assistance Program funds shall not be used to make payments on a mortgage against a consumer’s home unless advance approval has been provided in writing by a Deputy Director or Director of the Division.

VII. Program Fidelity

The principles of Permanent Supportive Housing as an Evidence-based Practice guide the implementation of this program.

Program Definitions

Adult with a Serious Mental Illness: A person eighteen years of age or older who has, or at any time during the immediately preceding twelve months has had, a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders and which has resulted in functional impairment that substantially interferes with or limits one or more major life functions. Serious mental illness does not include DSM V-codes, substance abuse disorders, or developmental disabilities unless such conditions exist concurrently with a diagnosable serious mental illness per Nebraska Revised Statute 71-812(3)(b)(i).

Adult with a Substance Use Disorder: A person eighteen years of age or older who has exhibited a maladaptive pattern of alcohol or substance use leading to clinically significant impairment or distress as manifested by one or more the following occurring at any time during the same twelve-month period: (1) Recurrent alcohol or substance use resulting in a failure to fulfill major role obligations at work, school, or home; (2) Recurrent alcohol or substance us in situations in which it is physically hazardous; (3) Recurrent legal problems related to alcohol or substance use; or (4) Continued alcohol or substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the alcohol or substance use. Nebraska Revised Statute 38-107.

Affordable: HUD defines affordable as paying no more than 30 percent of one's monthly income for housing, including basic utilities (not including phone or cable). People on Supplemental Security Income often pay 60% to 80% of their income toward their housing.

Behavioral Health (BH) services: Includes both mental health and substance abuse (alcoholism, drug abuse, and addiction) services. Behavioral health disorder means mental illness or alcoholism, drug abuse, or other addictive disorder.

Bridge subsidy: A short-term subsidy provided to a tenant who is waiting for a long-term or permanent subsidy, such as Section 8. *Bridge* refers to the fact that the subsidy helps bridge the gap in time from which tenants move into housing until they receive permanent or long-term subsidies.

Community based: Community-based behavioral health services means behavioral health services that are not provided at a regional center.

Continuum of Care: Both a planning process and an application for funding from HUD. The Continuum of Care brings together service providers in a geographic area to plan for providing housing and services for people who are homeless.

Department: The Nebraska Department of Health and Human Services (DHHS).

Director: The Director of the Division of Behavioral Health.

Division: The Division of Behavioral Health of the Nebraska Department of Health and Human Services.

Extremely low-income: A household income between 0 and 30 percent of the applicable Median Family Income (MFI) as defined by the HUD.

Fair Market Rent (FMR): A monetary amount that HUD determines represents a fair rent for a particular size rental unit in a particular community, based on statistical surveys. The United States Housing Act of 1937 (USHA) requires HUD to publish FMRs annually effective on October 1 of each year. FMRs provide a guide to the Regions on how much to expend for rental assistance per consumer.

Flexibility: Decent and affordable housing linked to flexible client-driven, community-based support services is desired by consumers as an essential ingredient to support their journey towards recovery, resiliency and self-determination.

Function separation of housing and supportive services: Assisting a resident to remain in the housing of his/her choice while the type and intensity of services vary to meet the changing needs of the individual.

Housing Choice Vouchers: Sometimes called *Section 8*, housing choice vouchers are administered by public housing authorities (PHAs) nationwide and make up the difference between 30 percent of a person's income and the fair market rent for a city or town. Housing choice vouchers are portable and allow tenants to choose where they live.

Housing First: A Permanent Supportive Housing model where people move directly into affordable rental housing in residential areas from shelters, streets, or institutions as quickly as possible. Receiving services, sobriety, and other conditions of readiness are eliminated or reduced.

Housing flex funds: Funds used for one-time expenses to help an eligible consumer move into a housing unit that meets HQS and Fair Market Rents in order to prevent homelessness. Funds may be HRA Program funds or state general funds available via the Housing Flex Fund or Consumer Flex Fund pools.

Housing related debt: Consumer housing debt to a Public Housing Agency, other leasehold landlord, or utility provider for which the consumer is responsible, including housing rental payments, utility service payments, security and utility deposits and late fees.

Housing Related Assistance: The State of Nebraska program authorized by Nebraska Revised State Statute 71-812(3) for adults with serious mental illness. Housing-related assistance includes rental payments, utility payments, security and utility deposits, and other related costs and payments. Utility deposits and payments are limited to tenant paid gas, electric, water, sewer, garbage. Specifically excluded are cable television and telephone. Other related costs and payments may also be covered.

Housing Quality Standards (HQS): Developed and mandated by the U.S. Department of Housing and Urban Development for safe and decent housing. HQS are specific standards for the physical aspects of a unit and include items like the number of windows, the number of light fixtures, how the plumbing functions, etc.

Integration: Means living independently in an individual's own home in the community; not consolidated in particular buildings or developments.

Low income housing tax credits (LIHTC): The main source of funding for affordable housing development in the United States. LIHTC is administered at the local level by each state's housing finance agency and provides a tax credit in exchange for providing affordable housing. Credits are sold to large corporations at a discount and the funds are used to build housing.

Median Family Income (MFI): Also referred to as Area Median Income (AMI). MFI represents the value at which one-half of all families have incomes above that value, and one-half have incomes below that value. MFI estimates are updated annually by HUD.

Olmstead: Refers to a legal case, *Olmstead v. L.C.*, which interpreted the *ADA's* antidiscrimination provision to mean that states and localities must provide services to people with disabilities in integrated settings.

Permanent Housing: Housing that is safe, decent, sanitary and meets all applicable federal, state, and local housing codes and licensing requirements. Permanent housing may or may not have established time limits for residency, with the expectation of long-term sustainability.

Project-based rental assistance (PRA): Assistance that lowers the cost of housing for tenants and is tied to a particular unit. Tenants who choose to live in those units pay a reduced rent.

Public housing agency (PHA): The local entity responsible for administering housing choice vouchers (Section 8), and which may own and operate public housing for low-income people.

Regional Behavioral Health Authority: A quasi-governmental agency organized in each behavioral health region established by the Nebraska Behavioral Health Services Act responsible for the development and coordination of publicly funded behavioral health services within the behavioral health region.

Regional Housing Coordinator: An individual appointed by the RBHA to provide leadership, planning activities and system problem solving for regional housing issues for eligible persons with extremely low incomes who have Behavioral Health disorders. This person cannot be a service provider.

Scattered-site housing: Housing located throughout the community; it can be agency-owned or privately owned.

Social Security Disability Income (SSDI): *SSDI* is for individuals who worked and are "insured" by the Social Security taxes (F.I.C.A.) that are withheld from their earnings to replace part of a person's earnings upon retirement, disability, or for survivors when a worker dies. If insured workers (and, in some cases, their dependents or survivors) become disabled, they may become eligible for SSDI benefits.

Supplemental Security Income (SSI): *SSI* is a federal income supplement program funded by general tax revenues. It provides cash to meet basic needs for food, clothing and shelter for older persons and persons with disabilities who have little or no income.

Supported Housing: Defined by the U.S. Department of Health and Human Services in the Community Mental Health Services Block Grant, it is a specific program model in which a consumer lives in a house, apartment or similar setting, alone or with others, and has considerable responsibility for residential maintenance but receives periodic visits from mental health staff or family for the purpose of monitoring and/or assisting with residential responsibilities. The objective of supported housing is to help obtain and maintain an independent living situation. It includes services that assist individuals in finding and maintaining appropriate housing arrangements.

Substantial Gainful Activity (SGA): Is an earnings limit established yearly by the Social Security Administration (SSA) at which point a consumer on SSI or SSDI loses their eligibility for Medicaid. For the purposes of this program, SGA means any paid employment whose remuneration is over the SGA limit as set by the SSA.

Tenant-based rental assistance: Housing assistance in which tenants receive funding assistance reducing their rent on any unit that meets affordability, quality, and size standards and for which the landlord agrees to a lease under which any leaseholder would be subject.

Very low-income: A household income of 50 percent or less of the applicable Median Family Income (MFI) as defined by the HUD.

Zero income consumer: PHAs calculate FMR in part on income and financial assistance received by a consumer but cannot base the calculated rent on amounts not received by a “zero income consumer.” However, PHAs are required to include imputed welfare income in the calculation of rent.

Supporting Documentation

Housing Related Assistance Program Statutes

Housing Related Assistance Program

Nebraska Revised Statute 71-812(3)(a)

71-812. Behavioral Health Services Fund; created; use; investment.

(3)(a) Money transferred to the fund under section 76-903 shall be used for housing-related assistance for very low-income adults with serious mental illness, except that if the division determines that all housing-related assistance obligations under this subsection have been fully satisfied, the division may distribute any excess, up to twenty percent of such money, to regional behavioral health authorities for acquisition or rehabilitation of housing to assist such persons. The division shall manage and distribute such funds based upon a formula established by the division, in consultation with regional behavioral health authorities and the department, in a manner consistent with and reasonably calculated to promote the purposes of the public behavioral health system enumerated in section 71-803. The division shall contract with each regional behavioral health authority for the provision of such assistance. Each regional behavioral health authority may contract with qualifying public, private, or nonprofit entities for the provision of such assistance.

(b) For purposes of this subsection:

(i) **Adult with serious mental illness** means a person eighteen years of age or older who has, or at any time during the immediately preceding twelve months has had, a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders and which has resulted in functional impairment that substantially interferes with or limits one or more major life functions. Serious mental illness does not include DSM V codes, substance abuse disorders, or developmental disabilities unless such conditions exist concurrently with a diagnosable serious mental illness;

(ii) **Housing-related assistance** includes rental payments, utility payments, security and utility deposits, and other related costs and payments; and

(iii) **Very low-income** means a household income of fifty percent or less of the applicable median family income estimate as established by the United States Department of Housing and Urban Development.

(4) Any money in the fund available for investment shall be invested by the state investment officer pursuant to the Nebraska Capital Expansion Act and the Nebraska State Funds Investment Act.

Source: Laws 2004, LB 1083, § 12; Laws 2005, LB 40, § 5; Laws 2007, LB296, § 459.

Documentary Stamp Tax

Nebraska Revised Statute 76-903

76-903. Design; collection of tax; refund; procedure; disbursement.

The Tax Commissioner shall design such stamps in such denominations as in his or her judgment will be the most advantageous to all persons concerned. When any deed subject to the tax imposed by section 76-901 is offered for recordation, the register of deeds shall ascertain and compute the amount of the tax due thereon and shall collect such amount as a prerequisite to acceptance of the deed for

recordation. If a dispute arises concerning the taxability of the transfer, the register of deeds shall not record the deed until the disputed tax is paid. If a disputed tax has been paid, the taxpayer may file for a refund pursuant to section 76-908. The taxpayer may also seek a declaratory ruling pursuant to rules and regulations adopted and promulgated by the Department of Revenue. From each two dollars and twenty-five cents of tax collected pursuant to section 76-901, the register of deeds shall retain fifty cents to be placed in the county general fund and shall remit the balance to the State Treasurer who shall credit ninety-five cents of such amount to the Affordable Housing Trust Fund, twenty-five cents of such amount to the Site and Building Development Fund, twenty-five cents of such amount to the Homeless Shelter Assistance Trust Fund, and thirty cents of such amount to the Behavioral Health Services Fund.

Source: **Laws 1965, c. 463, § 3, p. 1473;**
Laws 1969, c. 618, § 2, p. 2505;
Laws 1983, LB 194, § 3;
Laws 1985, LB 236, § 2;
Laws 1992, LB 1192, § 10;
Laws 1997, LB 864, § 16;
Laws 2001, LB 516, § 6;
Laws 2001, Spec. Sess., LB 3, § 5;
Laws 2005, LB 40, § 7;
Laws 2011, LB388, § 14.

The **NE BH All Hazards Disaster Response-Recovery Plan 2012** is available at:

http://www.disastermh.nebraska.edu/resources/currentplan.php

You may print/view individual sections or may download the entire PDF document under Complete Plan at the following direct link:

http://www.disastermh.nebraska.edu/files/currentplan/2012/appendices/CurrentPlan.pdf

The **NE BH All Hazards Disaster Response-Recovery Plan** is currently under review and will be updated for FY18.

Professional Partner Program

Program Manual

Approved August 26, 2015

Nebraska Department of Health & Human Services Division of Behavioral Health

TABLE OF CONTENTS

I. Professional Partner Introduction

A. Overview

The Nebraska Division of Behavioral Health Professional Partner Program is designed to serve youth/young adults and families who are experiencing behavioral health challenges. This level of care is appropriate for youth/young adult who are experiencing serious emotional disturbances and who have had a diagnosable mental, behavioral, or emotional disorder in the past year, which resulted in functional impairment(s) that substantially interferes with or limits the youth/young adult's role or functioning in family, school, or community activities.

The goals of the Professional Partner Program are to ensure the availability of an accountable individual to serve as an advocate, service broker, and liaison on behalf of the youth/young adult and his or her family when accessing needed services, to coordinate service components and all phases of treatment and support, and to ensure that the elements of treatment and supportive services are planned for and provided. An individualized service plan is developed for each youth/young adult and his or her family and is based upon the strengths and concerns of the youth/young adult and his or her family across life domains, including mental health, substance abuse, residential, family, education, vocational, financial, social/recreational, medical, legal, safety, and cultural.

B. The Wraparound Approach

Wraparound is an unconditional commitment to creating services to support normalized and inclusive options for youth with complex needs and their families. Through the wraparound process, youth/young adults and their families receive a customized blend of traditional and non-traditional services purchased through a flexible funding mechanism. The Nebraska Professional Partners Program embodies the Wraparound approach to service delivery, and consists of the following components:

- **Small caseloads**: a maximum of 15 youth/young adults per Professional Partner
- **Least restrictive**, least intrusive, developmentally appropriate interventions occur in accordance with youth and family needs within the most normalized environment.
- **Single point-of-access**: 24 hours per day, 7 days per week and a public information strategy to inform families how to access the Program.
- **Family-centered practice**: working with families as equal partners. Families with increasingly complex needs require individualized interventions, resources and supports but also rely on the natural support systems of the family in its own community. Professional Partners are unconditionally committed to helping families achieve their goals by working through their culture, values, preferences and strengths.
- **Culturally-competent and gender-sensitive** policies and processes as well as other policies and procedures that address the basic health and safety of the youth and family, and abides by all of the applicable federal, state, and local laws and regulations as they relate to equal employment opportunities and affirmative action.
- **Case Funded System, Flexibly funded** for traditional and non-traditional community-

based services and supports.

- **Unconditional care**: a "no reject, no eject" approach - youth are not excluded or terminated because of difficult behaviors
- **Interagency collaboration** for assessment, referral, service plan development, and coordination for supporting a System of Care by maintaining collaborative working relationships, and coordination with families, as well as public and private systems serving youth with emotional disorders.
- **Continuous Quality Improvement**: The meaningful involvement of parents, family members and youth in advisory and policy development capacities including the development and implementation of quality monitoring and program evaluation practices.
- **Family Choice:** The Program should be provided by an organization which does not provide other behavioral health treatment services to the target population. If the organization does provide other services, it must maintain safeguards to ensure families have independent choice of service providers. Professional Partners will ensure that a family's preferences are honored by addressing preferences in the assessment process and the continuing care plan.

II. Program Admission

A. ELIGIBILITY CRITERIA

The following three criteria are to be used in determining eligibility for acceptance into the Professional Partner Program (including short term and long term programs):
The Nebraska Professional Partner Program serves youth/young adults and their families who are experiencing behavioral health challenges. This level of care is appropriate for youth/young adults who are experiencing serious emotional disturbances and who have had a diagnosable mental, behavioral, or emotional disorder or serious mental illness in the past year, which resulted in functional impairment(s) that substantially interferes with or limits the youth/young/adult' role or functioning in family, school, or community activities.

The following admission guidelines apply to the Nebraska Division of Behavioral Health Professional Partner Program:

1. Youth/young adult must be between ages 3-25 years of age.
2. At admission, or as determined within 60 days of admission, the youth/young adult must be diagnosed with a mental health disorder under the current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association. Youth/young adults with Developmental Disorders or Psychoactive Substance Use Disorders may be included if they co-occur with the serious emotional disturbance/serious mental illness. This pattern has existed for 12 months or longer or is likely to endure for 12 months or longer;
   a. Documentation to support presence of DSM diagnosis must be signed by a licensed professional and updated annually.
3. Youth/young adult must demonstrate significant functional impairments due to their behavioral health diagnosis. Functional impairments are significant if as a result of the behavioral health diagnosis the youth/young adult consistently and persistently demonstrates behavioral abnormality in two or more spheres, to a significant degree, well outside normative developmental expectations, which cannot be attributed to intellectual, sensory, or health factors. The Child and Adolescent Functional Assessment Scale (CAFAS) OR Preschool and Early Childhood Functional Assessment (PECFAS) are used to determine degree of functional impairments. For eligibility purposes, the following score requirements apply
   a. CAFAS score of 80 or greater using the 8-point scale
   Or
   b. PECFAS score of 70 or greater using the 7-point scale,
   Or
   c. Moderate/severe score in at least two subscales of the CAFAS or PECFAS. Subscale scores are considered moderate at 20 and above*

* Subscales include:

School/Work Role Performance
Home Role Performance
Community Role Performance
Behavior Toward Others
Moods/Emotions
Self-Harmful Behavior
Substance Use
Thinking

B. Protocol and Procedures for Eligibility Screening

If a youth/young adult is considered potentially eligible for the traditional or transition-aged specific Professional Partner Program, the following procedures shall apply:

1. Within 30 (thirty) days, the following measures must be completed:
   - A Professional Partner Screening Form
     Note: A Screening Form must be completed on all youth/young adult and/or families who apply for services regardless of whether they are accepted into the program.
   - Child and Adolescent Functional Assessment Scale (CAFAS) OR Preschool and Early Childhood Functional Assessment (PECFAS) OR Young Adult CAFAS version, specific to transition aged youth/young adults. Use of the CAFAS/PECFAS is purposed to ensure eligibility and identify intake/discharge ranges. The Program is permitted to utilize other relevant and developmentally appropriate instruments purposed to further identify function, ability, readiness, clinical severity, etc.

2. The date of enrollment shall be designated as the date the youth/young adult and/or their family is orientated to the program. Regardless of enrollment date, a billable month of service must include a therapeutic intervention as defined in this manual.

3. If the youth/young adult is not eligible or not accepted for services then youth/family should be referred to a viable alternative within 30 calendar days of initial contact. Referrals shall be documented per agency requirements.

4. If the youth/young adult has not been previously diagnosed but diagnosis is considered likely, the Professional Partner may use information provided by the youth/family about the youth/young adult's biopsychosocial history as well as a CAFAS/PECAFAS score as evidence that a diagnosis is probable. In the presence of this evidence, the youth may be accepted into the program, contingent upon them receiving a formal evaluation resulting in documented diagnosis confirmation from a licensed professional within 60 calendar days. If an evaluation or a formal diagnosis meeting program criteria is not achieved within 60 days, the youth must be discharged from the program 30 days from that determination.

5. Multiple youth/young adults within the same family who individually meet the admission criteria, may be considered separate clients for the purpose of client load sizes. Youth/young adult within the same family that do not meet the admission criteria may not be individually served.

6. If a participant has not met the minimum score for admission on the Child and Adolescent Functional Assessment Scale (CAFAS) OR Preschool and Early Childhood Functional Assessment Scale (PECFAS), the Professional Partner Supervisor has the right to initiate a review process for the Division of Behavioral Health Network Administrator to consider an exception for admission into the program. See appendix for exception waiver.

C. POST ENROLLMENT REQUIREMENTS

Once enrolled in the Professional Partner Program, the following items will be completed within 30 days from date of enrollment:

1. An Intake and Interpretative Summary will be completed which will include a summary of information received from the youth, family and collateral providers to address the needs, abilities, strengths and preferences of the youth and family. The Interpretive Summary must contain a summary of the youth and family biopsychosocial dynamics as identified to include but not limited to the current diagnosis, current CAFAS score and current status of wellbeing.
2. The Professional Partner, youth/young adult and family will begin to identify team members who will contribute to the development of an individualized plan (Individual Family Service Plan (IFSP), Plan of Care, or Futures Plan) (hereinafter IFSP in the manual refers to an Individual Service Plan for both the youth/young adult). The IFSP must be a clear, outcome focused plan with time sensitive and measureable 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.
3. The format for the IFSP plan may vary but must include at a minimum:
   - Clear demonstration of youth/young adult/family partnership in the development of the plan
   - Youth/young adult and Family Strengths
   - Presenting Problems
   - Goals and Expected Outcomes/Pre-Discharge Plan
   - Objectives/Interventions must be measureable and timely
   - Team members, both formal and informal

   The IFSP will be a working document reflecting the services and supports established and/or coordinated by the team members and must be reviewed quarterly at a minimum and revised as appropriate to reflect progress and continued objectives to meet discharge goals.
4. The Descriptive Information Questionnaire (DIQ) will be completed at intake and entered into a database which is sent to DHHS quarterly per the data protocol found in this Manual.
5. All youth/young adults enrolled in PPP must be registered on the data system as identified by the Division of Behavioral Health (e.g., Authorized Service Organization/System, Division Centralized Data System)The program must ensure accurate entry of information including registration into the specific version of the program. All youth must be re-registered annually.
6. The admission criteria, outlined in Section II of this manual, and financial eligibility must be updated annually. An updated behavioral health diagnosis must be included in the annual update.

III. Program Requirements

A. Service Delivery

The Professional Partner will complete the following activities for each youth / young adult served:

1. Coordination of a comprehensive assessment of the youth/young adult and family needs within 30 days of enrollment. Development of an outcome-focused Individualized Family Service Plan (IFSP) using input from team members within 30 days of admission. Continuous monitoring and assessment of youth/young adult needs.
2. Screening for risk of suicide and other clinically relevant screenings.
3. Implementation of a quarterly review/revision of the IFSP and ongoing monitoring and evaluation of service provision to improve outcomes. For short term programs, IFSP plans should be reviewed no less frequently than once every 30 days.
4. Coordinating, purchasing and monitoring services and supports with service providers and families. All services purchased for the youth/young adult and/or family should be approved by the wraparound team and must be clearly indicated as directly supporting an IFSP goal and ultimately benefiting the improved function and well-being of the youth/young adult.
5. Proactively advocating for youth/young adult and family best interests and well-being, and equipping the youth/young adult and family with skills to continue self-advocacy.
6. Support and equip the youth/young adult and family to learn and utilize conflict resolution strategies.
7. Safety planning and emergency information as a standard component of each IFSP. *(Sample Safety Plan template in appendix)* The safety plan should be reviewed every 90 days at a minimum or more often as needed.
8. The establishment and maintenance of timely, appropriate and accurate service verification and documentation.
9. Provision of necessary data and reports to DHHS, in accordance with the current Policies and Procedures Manual or the most recently established procedures.
10. Other duties as necessary to fulfill the responsibilities of program management under the Professional Partner Program, including work groups as assigned.
11. Inclusion of progress notes and team meeting notes will provide documentation regarding the current status of the plan. Progress notes and team meeting notes must include records of all contacts with youth/young adult/family and relevant persons/professionals, progress/challenges, services purchased, team decisions, and youth/family desires. Progress notes/team meeting notes must provide demonstration of progress towards specific goals and the program is encouraged to utilize documentation that is easily identifiable to the consumer.

B. SPECIALIZED PROGRAMS

- Pilot programs: Any program funded by the Division of Behavioral Health must be approved by the State and therefore must be submitted for consideration.
- Short term programs: Wraparound has specific features that may be challenging to implement in a short term program. Eligibility for these programs would be generally the same as the traditional program although shorter term goals are expected. Regardless, the key features of wraparound must be present. Fidelity to wraparound is expected and utilization of the fidelity measurement tool, the Wraparound Fidelity Index- EZ (WFI-EZ), is mandated.
- Special populations: Wraparound is appropriate to special populations such as school based or early childhood. However any populations served must still demonstrate eligibility per the standard PPP requirements.
- Transition age programs: Wraparound also proves beneficial for adolescents/young adults who are in need of services and supports in the adult system to support their transition to adulthood. The purpose of programming to transition age youth is to assist in developing a clear course of transition for the variety of supportive needs related to their behavioral health and wellbeing. Transition age programs aim to empower participants to make informed choices about their care and equipt them with tools and ability to identify and implement an individual plan. Transition age youth programs utilize a Wraparound approach in combination with models such as the T*ransition to Independence Process (TIP) model*. The TIP model was developed for working with youth and young adults (14-29 years old) with emotional/behavioral difficulties (EBD) to: a) engage them in their own futures planning process; b) provide them with developmentally-appropriate, non-stigmatizing, culturally-competent, and appealing services and supports; and c) involve them and their families and other informal key players in a process that prepares and facilitates them in their movement toward greater self-sufficiency and successful achievement of their goals related to relevant transition domains (i.e., employment/career, educational opportunities, living situation, personal effectiveness/wellbeing, and community-life functioning). The TIP system is operationalized through seven guidelines and their associated practices that drive the work with young people and provide the framework for the program and community system to support these functions.

TIP Model Guidelines

1. Engage young people through relationship development, person-centered planning, and a focus on their futures.
2. Tailor services and supports to be accessible, coordinated, appealing, non-stigmatizing, and developmentally-appropriate - and building on strengths to enable the young people to pursue their goals across relevant transition domains.
3. Acknowledge and develop personal choice and social responsibility with young people.
4. Ensure a safety net of support by involving a young person's parents, family members, and other informal and formal key players.
5. Enhance young persons' competencies to assist them in achieving greater self-

sufficiency and confidence.

6. Maintain an outcome focus in the TIP system at the young person, program, and community levels.
7. Involve young people, parents, and other community partners in the TIP system at the practice, program, and community levels.

C. Professional Partner Staff Requirements

The Professional Partner Program shall provide a wraparound facilitator who will be referred to as a Professional Partner. A Professional Partner will have adequate training to provide quality, effective services for the benefit of the youth and family in the program.

- The program will ensure that new Professional Partner staff will have a minimum of forty (40) hours of core training and shadowing experience that develop the competency of the Professional Partner. Core training and shadowing experience topics include but are not limited to: the wraparound process, screening/ admission/discharge procedures, confidentiality, ethics, youth mental health/ substance abuse, CAFAS/PECFAS and other tool utilization, IFSP development, safety planning, and family centered practice.
- The program will ensure that Professional Partner staff receives no less than twelve (12) contact hours of continuing education every two years that benefit the competency of Professional Partners. Continuing education topics may include but are not limited to: cultural competency, diagnostic health/therapeutic interventions for youth, wraparound, trauma, evidence-based practices, and IEP process. Each Regional Behavioral Health Authority will provide access for all Professional Partners to attend a statewide Program conference at minimum once per year.
- Every Professional Partner will also experience frequent and routine direct supervision to ensure competency for the provision of program standards and service delivery. All Professional Partner staff will have access to clinical consultation as appropriate, to ensure quality and appropriate care and case planning. Access to clinical consultation must be available to staff in times of wraparound team emergency. This guidance is not meant to replace or substitute for the youth's medical care or exist as medically necessary interventions. Professional Partner staff should experience some form of individual or program supervision and/or consultation monthly at minimum to maintain program fidelity, effectiveness and quality of care.
- The program will ensure that mentors for youth whose services are funded by the program, have had sufficient background checks and receive no less than four (4) contact hours of orientation/training in topics that may include but are not limited to: program policies and procedures, wraparound process, goal setting, suicide screening/prevention, boundaries and ethics, youth behavioral health, etc.

IV. Program Discharge Guidelines

A. Professional Partner Program: Discharge Guidelines

A goal of the Professional Partner Program is to assist the youth/young adult and/or family to develop natural community supports to the point where they no longer need intensive wraparound/care coordination services offered by the Professional Partner Program. An essential element of the Program is the '*No Reject, No Eject'* Policy, which states that the youth/young adult will not be denied services or terminated from the program due to the challenging nature of their needs or the complexities of their behavior characteristics or histories. While maintaining accordance with this policy, there *are* instances in which discharge from the program may be the most appropriate course of action. The Professional Partner Program is committed to providing individualized services and care to youth and families. Therefore, the decision to discharge should not be based on a rigid set of *criteria*, but rather on a set of *guidelines* which can be interpreted and adapted by the youth/young adult and/or family and the Professional Partner to best suit the needs of each youth/young adult and family. The situations in which discharge should be considered and a set of guidelines for doing so are presented below.

Successful Completion of IFSP Goals

Please note that the following are only guidelines and not requirements, and are intended to help track the decision-making process only.

Indicators of Readiness or Reasons for Discharge:

- A collaborative and mutual agreement of the team members has been made to discharge and a collaborative transition plan is in place.
- The youth/ young adult and their family/caregiver/legal guardian has refused services; direct or indirect)
- Family and/or youth/young adult are satisfied with their progress towards the goals, and feel they no longer need intensive wraparound/care coordination services.
- Youth/young adult exhibits improved functioning, based on CAFAS scores and other assessments.
- Reduced crises and/or youth/young adult and family are able to maintain stability and safety on their own.
- Youth/young adult and/or their families are better able to meet their needs and continue progressing toward life goals. They are able to utilize the wraparound/care coordination process on their own when making decisions about their care.
- Maximum treatment and rehabilitation benefit and goals have been achieved. The youth/ young adult and their family/caregiver/legal guardian can function independently without intensive professional multidisciplinary supports.
- Long-term out-of-home facility based placement has occurred (long term is considered to be 3 months or longer)

- Youth/young adult or family relocates out of the region or moves so that providers are unable to locate youth/young adult or family.
- Youth/ young adult and their family are able to express their voice and choice and are able actively participate in decision making and can make decisions that positively impact their care and transition to adulthood.
- Youth/ young adult and their family/caregiver/legal guardian perceives improved overall health and well-being.
- Youth/ young adult and their family demonstrate the ability to identify their strengths, needs, access resources, and successfully navigate various systems to engage with those resources.
- Youth/ young adult and their family have formal services and informal supports in place as appropriate.
- youth/ young adult and their family has sustainable wellness skills/tools and is able to draw upon them in crisis situations
- Youth/ young adult and their family have progressed on goals to their personal satisfaction and/or the satisfaction of the team members.
- Youth/ young adult and their family have developed an IFSP. Marked reductions in school suspensions/vocational interrupts, no police contacts or court referrals, no abuse or neglect
- Youth/ young adult no longer meets age requirements
- Unplanned termination (e.g. death, incarceration or other crisis event).
- Found ineligible/no SED (or SMI adult) diagnosis.
- Youth/young adult becomes Medicaid eligible and obtains access to services and/or supports that reduce the need for intensive wraparound services via the Program.
- Direct or indirect refusal of services, as outlined below:
    - Youth/young adult and/ or family refuses to participate despite attempts to provide services. Young adult and/or family requests discharge.
    - Youth/young adult and/ or family refuses to participate or cooperate after enrolling, making service success unlikely.
    - Youth/young adult and/ or family engages only when in crisis (i.e. not attending meetings, continually canceling, not returning calls, only contacting when need the Program to solve a problem or provide a service).
    - Youth/young adult and/ or family is receiving financial assistance from PPP, but refuses to access other services or participate in other aspects of the program which might provide more long-term solutions.
    - Professional Partner is unable to make contact with the youth/ young adult or family or the youth/ young adult or family does not return calls.

Transition / Discharge Procedure Guidelines:

A discharge plan is an active component of the process and should be collaboratively developed by the wraparound team prior to a formal discharge. The family and/or youth/young adult should leave the program with a copy of their discharge plan to empower them for future self-determination

1. Plan for Transition/Discharge:
   Establish youth/young adult and family goals and pre-discharge/transition plan immediately after program admission, within the IFSP and review progress towards goals at every meeting. (i.e., ask youth/young adult and family how they will know when they are ready to leave this program?)
2. Prepare Youth/young adult and Family for Discharge:
   1. Review the goals established in the IFSP quarterly *at minimum* with the youth/young adult and family, and review the measurable progress/goal completion.
   2. Discuss with youth/young adult and family the role of the program and each team member after discharge.
   3. Empower youth/young adult and family, and prepare them for the discharge/transition from wraparound/care coordination services.
   4. Provide a 'reference guide' of services available in their community or county and assist them in identifying and connecting to other potential formal and/or informal services and supports.
   5. Discuss a collaborative discharge/transition plan with support from school and/or vocation, community, and team members, including:
      a. Loss of services that family and/or young adult may be unable to provide
      b. Supports to assist family and/or young adult in navigating through the multitude of services available
      c. Aftercare referrals to other services, supports, programs, and/or agencies.
   2. Discuss the possibility and process of readmission to the Professional Partner Program.

3. *Within 30 (thirty) days* from the date of discharge a summary of the formal plan for discharge must be *completed*. A discharge summary must include the following:
   - *A* summary of the youth/young adult CAFAS/PECFAS scoring from intake to discharge,
   - Description of progress over course of time in program,
   - Discharge Plan, inclusive of continued recommendations for safety and well-being of the youth/young adult and family after discharge.

4. The youth/young adult will be considered discharged from the program as of the date indicated on the Professional Partners Program Discharge Form. Discharge from the authorized service system, identified Division of Behavioral Health, must occur within 15 days of that date. Regardless of discharge date, as long as a valid therapeutic intervention has been provided during a calendar month, that month is considered an active month of service provision and may be reimbursed.

B. Direct or Indirect Refusal Service Guidelines:

- If refusal is indirect (e.g. no shows for appointments, not responding to letters, etc.), attempt to contact young adult or family for up to 30 days. Supervisory consultation is appropriate. Contact attempts should include frequent phone calls, home visits and/or letters.
- If refusal is direct (i.e. the youth/young adult/family refuses to interact, refuses to attend meetings, refuses to access services, etc. or the young adult or family requests discharge), the Professional Partner should explain clearly the possible outcomes of the decision to the client (i.e. loss of services, discharge, possibility of the need for restrictive care, not meeting court-ordered obligations, etc.).
- The final decision of the Professional Partner to discharge due to refusal should be based on the individual situation of the youth/young adult and/ or family, and should be a last resort option for the Professional Partner.

V. Program Evaluation and Reporting

A. Overview

The Program will submit programmatic outcome reports, as specified is this manual, which clearly reports service outcomes, both for the program, and for individual youth and families served in the program. Data will be submitted on a quarterly basis on the template provided by the Division or as otherwise specified below.

B. Demographics

Each youth/young adult will be registered in the Division's information management system.

C. Youth/Young Adult Outcomes

Regions will submit data for the CAFAS/PECAFAS and Protective Factors Survey (PFS) for DBH funded Wraparound Services only. Region database for PPP must be submitted by the 30th of the month following the fiscal year quarter. Suicide Prevention program data must be submitted by the 15th of the month following the fiscal year quarter. Data must be submitted to the Division designated individual or the Network Prevention, Treatment and Support Services Administrator.

*See appendix for SBQ-R and EIRF reporting due dates

**See appendix for program evaluation assessment administration chart

D. Program Fidelity

Each Region will use the Wraparound Fidelity Index EZ to assess program fidelity and report data as described below to the division. A Region must ensure the Wraparound Fidelity Index- EZ is performed in a neutral manner.

1. Regions shall utilize the forms for each Respondent-Type (Youth, Parent, Team Member and Wraparound Facilitator/Resource Coordinator).
2. Regions are not required to send surveys to those families who are discharged within sixty (60) days of entry to the program due to identified ineligibility or program refusal, etc. (This exception does not pertain to individuals who participate in short term programs and are only enrolled for short durations due to service type, not ineligibility.) However, Regions are required to perform fidelity measurement on all PPP programs, including short term services, therefore survey implementation will be necessary for such.
3. Each Region will specify a process for regular distribution and collection of the WFI-EZ, with the recommendation that it be administered within 3-9 months following enrollment in the program.

For the purpose of program continuous quality monitoring and improvement, Regions shall participate with the State in the review of data, reporting elements and processes to consider improvement processes that may contribute to the overall success and service effectiveness for the benefit of the youth and families.

VI. Program Financial Protocol

A. Youth/Young adult case Rate

In order for the traditional and transition aged PPP in each Region to receive full financial allocation, the program will need to serve a minimum number of youth/young adults each month for designated case rate. This case rate and/or expense reimbursement is established/approved by DHHS; refer to contract.

B. Program Income

The Professional Partner Program shall use income and/or funds which exceed the case rate per month per youth base to improve the Professional Partner Program and increase the number of youth/young adults and families served. Income is used in the Professional Partner Program shall be included in the financial reports submitted to DHHS *(see Monthly Wraparound Financial Report form in the Appendix)*.

C. Flexible Funds

The Program shall ensure that funds are used flexibly to purchase formal and/or informal services and supports for the youth/young adult and family based upon the needs identified in the IFSP. Each Region Program must comply with all current protocol, policy and/or regulations regarding allowable and unallowable costs. ***All* flex funds must directly benefit the behavioral health, safety and well-being of the admitted youth/young adult and be indicated in the IFSP and Wrap Reporting.**

If private insurance is present, the insurance would be considered the primary payor. All payor sources private and public will be exhausted before Professional Partner flexible funding is used to reimburse for those services or to subsidize insurance payments including Medicaid. Public funds provided in the Professional Partner Program shall only cover those services **not** covered by private insurance or other funding source.

D. Payment Process

The Program agrees to comply with the Contract and to the payment request, payment process, and financial data reporting for the Professional Partner System specified below.

- DHHS will require repayment of funds, which are used to pay for any service not identified by the IFSP or that is found to be reimbursable to another payor source such as family private insurance or Medicaid.

- A billable month of service will include at least one (1) contact with the youth/young adult and family and members of their team members that is therapeutic and meaningful in nature. For the purposes of this manual, meaningful contact with the youth/young adult and their family is defined as an interaction between the Professional Partner, and/or other formal and informal supports that is expected to further the accomplishment of the goals for the youth/young adult/family as identified in the IFSP (such as a family visit or team meeting), The intake screening is also included as a billable month of service.

- If contact with the youth/young adult is **not** made. The billable month of service must include one (1) therapeutic consultation contact with the Professional Partner Supervisor. In the event that one (1) therapeutic and meaningful contact was not made with the youth/young adult and family, detailed documentation must be kept to support all attempts to schedule meetings, cancellations, and collateral contact. For the purposes of this manual, therapeutic consultation is defined as consultation/supervision between the Professional Partner and the Professional Partner Supervisor that is expected to further the accomplishment of the goals for the youth/young adult/family as identified in the IFSP.

- Discharge and admission billable months of service: If there is at least one therapeutic contact within the month it is considered a billable month of service. If there is **not** a therapeutic contact during the month the following applies:
  - Discharge prior to the 15th- not able to bill for the month
  - Admitted after the 15th- able to bill for the month

E. Monthly Wraparound Financial Reports

A Monthly Wraparound Financial Report must be submitted to DHHS per protocol detailed in this Manual, and must provide record of how the funds are directly supporting the behavioral health, safety and well-being of the youth/young adult in the program. Flex funding must be tied directly to a goal/objective identified in the IFSP and indicated on the monthly report. Further detail must be demonstrated in the IFSP, progress notes and/or team meeting notes in the client file. The monthly financial report will account for program operations, fund expenditures and income; and indicate the specific goals/objectives in the IFSP that purchases supported for each youth/young adult in the program. The Program shall have a process for monitoring expenditures for: 1) each youth and family individually, and 2) all youth and families served. The Program shall have a process for managing service delivery to stay within the overall budget. The use of all funds shall be monitored and evaluated for cost effectiveness and most importantly to improve client outcomes.

The due date for each Monthly Wraparound Financial Report will be 30 days after the end of each reporting period with a 10 day grace period (e.g. the August report should be in by September 30th, but must be in by October 10th). These reports should be sent directly to the designated Division contact person who will review and approve all reports and maintain the data within DHHS.

REPORTING PROCESS

1. Wraparound Financial Reports: The Program agrees to the following reporting requirements:
   - The Program agrees to submit a Monthly Wrap Financial Report, as specified by DHHS, which clearly shows how the funds are serving the youth in the system.
   - The monthly wraparound financial report will account for fund expenditures, income and how the expenditures relate to the goals and objectives in the IFSP

for each youth in the program.

- The financial reports shall be received by DHHS on the schedule specified in below. The report shall be sent to the Division designated person who will review and approve it and maintain at DHHS. DHHS maintains the right to further inquire and deny any financial report or section therein if not deemed to meet program criteria.

Month	**Financial Report Due Date**
July	September 10th
August	October 10th
September	November 10th
October	December 10th
November	January 10th
December	February 10th
January	March 10th
February	April 10th
March	May 10th
April	June 10th
May	July 10th
June	August 10th

***Note: See Appendix for Wraparound Monthly Financial Report Form**

VII. Appendix

- **Definition of Funding Service Categories**
- **Wraparound Monthly Financial Reporting Form**
- **Wraparound Monthly Financial Reporting Form Guide**
- **Program Audit Tool**
- **Sample Safety Plan**
- **Annual Report Template**
- **Exception Waiver for Admission**
- **SBQ-R and EIRF Flow Chart**
- **Program Evaluation Assessment Administration Chart**
- **Frequently Used Acronyms**

Definitions of Funding Service Categories

Service Category	Definition
TREATMENT	
• **Assessment (MH/SA)**	A biopsychosocial evaluation and diagnostic interview to determine diagnosis and treatment needs
• **Youth Outpatient Therapy (MH/SA)**	Psychotherapy/counseling for mental health problems which disrupt a youth's home, school, family functioning; treatment focuses on changing behavior, modifying thought patterns, coping with problems, improving functioning and may include coordination to other services to achieve successful outcomes. Length of service varies depending on individual needs.
• **Day Treatment**	Facility based program serving children and adolescents with Severe Emotional Disturbance. Intensive, non-residential service providing counseling and family services, education, behavior modification and skill building, promoting reintegration back to the child's regular school.
NON-THERAPEUTIC SUPPORTS	
Crisis Prevention	Provision of funding towards emergency services focused specifically on prevention of crisis before they happen. Services may include educational programs in teaching youth how to handle crises and informing them of the services that are available to them (e.g. anger management). This service category should be used for youth only. For crisis prevention services for family refer to the parent empowerment category.

SERVICE CATEGORY	DEFINITION
NON-THERAPEUTIC SUPPORTS	
• **Psychotropic Medications**	Provision of funding towards assisting young adult or family financially to obtain prescribed behavioral health medication as deemed appropriate by a licensed physician.
• **Respite**	Temporary specialized care for youth with Severe Emotional Disturbance or their family in the absence of the primary caregiver. May be scheduled or unplanned due to crisis. Workers have specialized knowledge to care for youth with special needs and allow the parents to have some time away from the intensity of providing for the care of their child; assists in maintaining in-home placement for the youth.
• **Home Based Services**	Provision of funding towards assistance in the home purposed to strengthen youth and family well being, safety and permanency. Typical family support services include providing a trained para-professional (not necessarily a mental health provider) to work on an ongoing basis with the family (e.g. Community Treatment Aides for non Medicaid eligible children). These para-professionals may provide information, instruction, and encouragement on a variety of levels, (e.g. behavioral health interventions and supports, daily living skills, grocery shopping, caring for a new infant, reducing the likelihood of a parent abusing a child, general housekeeping, etc.).
• **Intensive Family Preservation**	Provision of funding towards short term (usually 1-3 months), in-home, intensive (10-20+ hours/week), crisis intervention services having an ecological perspective and a family-based focus (family is considered the client). Generally, these services are provided to children at imminent risk for out of home placement to a more restrictive setting. Services involve one or more therapists and are multi-faceted, which may include counseling, skills training, and assisting the family in obtaining and coordinating needed services, resources and supports. IFP may be based on multi-systemic therapy (MST) and/or Home Builders models of care.
PPP TEAM EXPENSES	Provision of funding towards wraparound team expenses which may include food for team meetings, transportation of team participants (not PPP) for meeting, celebrations, supplies for meeting, etc
INTERPRETATION	Provision of funding towards translation services utilizing a third party individual who speaks the non-English language of the consumer; may include live translation of service provision and/or indirect translation of documents necessary for the consumer's care in direct support of the IFSP.

SERVICE CATEGORY	DEFINITION
YOUTH SUPPORT	
• **Mentoring**	Provision of funding towards services designed to provide informal supports utilizing individuals from the community, agencies or organizations purposed to provide guidance, empowerment, encouragement, social enhancement, general skill building and/or assistance to a youth/young adult. These services are broad based in nature, while more specific services (e.g., tutoring) should be assigned to specific categories of services.
• **Behavioral Contracts**	Provision of funding towards services designed to provide incentive or celebrate the youths' involvement, successes and behavioral dedication to their own program.
• **Independent Living/Supported Employment**	Provision of funding towards specialized transition services intended to help youth/young adults live independently and prepare them for employment (via vocational training). Services focus on the information and social and trade skills required for individuals to successfully handle their daily needs when they are living on their own. Such skills relate to financial, medical, health (physical, mental/emotional, behavioral and social), housing, transportation, social/recreational, and other daily living needs. Independent living services can occur in a therapeutic group home situation, an apartment living situation with close supervision (i.e., usually daily contact with agency staff or mentors) and eventually graduating to apartment living with moderate supervision. A person, including a job coach, skilled in a particular area may provide mentoring, teaching and/or assistance to youth/ young adult in order to obtain skills required for meaningful employment. Services can also include vocational therapy, job training, career education, vocational assessment, job survival skills training, vocational skills training, work experiences, job finding, placement and retention services, etc.
• **Educational Support**	Provision of funding towards services originating within or created by the educational system and provided within the education setting to defray problematic emotional symptoms/behaviors as to ensure a proper education for the youth/young adult. Various components of educational services may include: assessment and planning, resource rooms, self-contained special education, special schools, home-bound instruction, residential schools, alternative programs, activity costs, and school supplies. These services originate from educational system or other outside agency as opposed to internal mentoring services provided by the PPP (see Mentoring Services).
• **Tutoring**	Provision of funding towards the assistance to the youth/ young adult with school work. Can include help with academics, study skills, organization, and motivation skills.

SERVICE CATEGORY	DEFINITION
YOUTH SUPPORT	
• **Recreational Programs/Services**	Provision of funding towards services which provide for the development of social skills and emotional well-being such as cooperation, team function and good sportsmanship. Recreational services may be arranged specifically and exclusively for SED children or efforts may be directed to gaining access to recreational services for these children. Some examples of recreational services include: general social activities, summer camps or day camps, special recreational projects or services, recreational therapy.
• **Health Services**	Provision of funding towards services related to the physical health of the youth/young adult as distinguished from services pertaining to any psychiatric or mental illness. Blood tests to monitor psychotropic medications or other medical procedures performed to assess the physical health of a child/adolescent, regardless of whether it has a psychiatric component (e.g., an upper GI to determine whether psychotropic drugs have caused an ulcer), would be included within this category. No professional partner system funds shall be used to pay for physical health needs above $500 per item. State funds shall not pay for abortions. A waiver of the $500 per item maximum may be available upon approval by the Division.
GENERAL FAMILY SUPPORT	
• **Parent Empowerment**	Provision of funding towards the services of empowering and educating parents/caregivers/family members on how to increase adaptive, pro-social and positive parenting skills and youth symptom management skills (e.g., educating about SED youth, symptom management and prevention, anger management, etc).
• **Family Peer Mentoring**	Family Peer Support Services provides families with a peer model/mentor to provide guidance, support, encouragement, education and training to the parent/caregiver/family with regard to interacting with their child/adolescent experiencing behavioral health challenges, interactions with the youth's education and/or treatment provider or other community resources. They will engage the parent/caregiver in recognizing the importance of self-care as a vital component of their parenting and their youth and family's overall well-being. These services may include a variety of supportive and empowering activities for parents/caregivers/families of a youth experiencing behavioral health challenges.
• **Money Management**	Provision of funding towards services by an entity other than PPP staff/Region employees that are designed to help the young adult and/or family review and manage their family finances and budget.

SERVICE CATEGORY	DEFINITION
GENERAL FAMILY SUPPORT	
• **Day Care**	Provision of funding towards caretaking service for the youth, by professional or para-professionals generally while the primary caretakers are at work.
• **Legal Services**	Provision of funding towards services to cover court related or other legal fees for the youth/young adult and/or family.
ECONOMIC SUPPORT	
• **Utilities**	Provision of funding towards the services associated with young adult or family utility bills (e.g. telephone service, calling cards, heating costs, etc.)
• **Housing**	Provision of funding towards the expenses related to the young adult or family's home, including rent and home maintenance.
• **Transportation**	Provision of funding towards the services associated with transportation of family and/or youth/young adult for therapeutic services and/or related events. (Transportation must not be provided by the Program unless the Program ensures it is in compliance with State requirements for transporting consumers.)
• **General Economic Support**	Provision of funding towards services designed to assist a young adult or a youth's family in basic needs. Includes the provision of assistance, groceries, and other supports as determined by the young adult or family as well as miscellaneous services which cannot be adequately described by the other service categories.

PROFESSIONAL PARTNER MONTHLY WRAPAROUND FINANICAL REPORT
(UPDATED 2015)

PROFESSIONAL PARTNER COST

EXPENDITURE CATEGORY	MONTHLY COSTS
PERSONNEL SERVICES	
OPERATING COSTS	
TRAVEL	
CAPITAL OUTLAYS	
OTHER	
TOTAL PPP COSTS	
SUBTOTAL	
TOTAL WRAPAROUND COSTS	
TOTAL EXPENDITURES	

FUNDS OUTSIDE PPP

MH/SA REGION FUNDING	
CPS/ PROVIDER	
SCHOOL	
MEDICAID	
PRIVATE (Insurance, client)	
DONATIONS/CONTRIBUTIONS	

CLIENT TRACKING

PRIOR MONTH CLIENT COUNT: _____

NEWLY ADMITTED CLIENTS: _____

DISCHARGED CLIENTS: _____

CURRENT CLIENT COUNT: _____

LB603 CLIENT TRACKING

NEWLY ADMITTED CLIENTS: _____

DISCHARGED CLIENTS: _____

CURRENT CLIENT COUNT: _____

TOTAL UNDUPLICATED SERVED TO DATE: _____

DBH APPROVAL:

_____

WRAP-AROUND SERVICE COSTS

SERVICE	CHECK		SUBTOTAL
TREATMENT	**MH**	**SA**	
ASSESSMENT			
YOUTH OP THERAPY			
FAMILY THERAPY			
INPATIENT RES			
DAY TREATMENT			
NON-THERAPEUTIC SUPPORTS			
CRISIS PREVENTION			
PSYCHOTROPIC MEDICATIONS			
MEDICATION MANAGEMENT			
RESPITE			
HOME-BASED SERVICES (CTA +)			
PPP TEAM EXPENSES			
INTERPRETATION			
YOUTH SUPPORT			
MENTORING			
BEHAVIORAL CONTRACTS			
IND LIVING/SUPP EMPLOYMENT			
EDUCATIONAL SUPPORT			
GENERAL YOUTH SUPPORT			
FAMILY SUPPORT			
PARENT EMPOWERMENT			
GENERAL FAMILY SUPPORT			
ECONOMIC SUPPORT			
UTILITIES			
HOUSING			
TRANSPORTATION			
GENERAL ECONOMIC SUPPORT			
TOTAL WRAPAROUND COSTS			

Region: _____

Submitted by: _____

Title: _____

SIGNATURE: _____

Date Prepared: _____

Month Ending: _____

Wraparound Monthly Financial Reporting Form Guide

New Form				Revisions matched to New Form categories
TREATMENT	**MH**	**SA**		**(Youth Treatment Services Domain)**
ASSESSMENT				Assessment – same, under Treatment
YOUTH OP THERAPY				*Individual* and *Group Therapy* = become one category of Youth Outpatient Therapy, under Treatment
FAMILY THERAPY				Family Therapy – same, under Treatment
INPATIENT RES				*Acute Inpatient* - Rolled into Inpatient Res, under Treatment (See definition for additional service types, including SA)
DAY TREATMENT				Day Treatment - same, under Treatment
Note: check box to identify MH and/or SA. Each service type may have been utilized for MH and/or SA. Just check which (or both) box and the Division will search into Detail Sheets to pull additional information				Substance Abuse = service types are broken out into same categories as Mental Health: Assessment, Youth OP Therapy, Family Therapy, Inpatient Res, Day Treatment, 24hr Res Fac
NON-THERAPEUTIC SUPPORTS				**(Youth Non-Therapeutic Supports Domain)**
CRISIS PREVENTION				Crisis Prevention – same, under Non-Therapeutic Supports
PSYCHOTROPIC MEDICATIONS				Medications = Psychotropic Medications, under Non-Therapeutic Supports
MEDICATION MANAGEMENT				Med Check = Med Mgt, under Non-Therapeutic Supports
RESPITE SERVICES				Respite Services – same, under Non-Therapeutic Supports
HOME-BASED SERVICES (see definition)				*Family Support Services* – rolled into Home Based Services, under Non-Therapeutic Supports *Intensive Family Pres.* – rolled into Home Based Services, under Non-Therapeutic Supports
PPP TEAM EXPENSES (see definition)				New category to capture expenses for Team meetings which may include travel, materials, food, celebrations, etc. (see definition)
INTERPRETATION				New break out category to specifically track interpretation/translation services (from old Supportive Services)
YOUTH SUPPORT				**(Youth Support Services Domain)**
MENTORING				Mentoring – same, under Youth Support
BEHAVIORAL CONTRACTS				Behavioral Contracts – same, under Youth Support
IND LIVING/SUPP EMPLOYMENT				*Independent Living* - rolled into Ind Liv/Supp Employ., under Youth Support *Supported Employment* - rolled into Ind Liv/Supp Employ., under Youth Support
EDUCATIONAL SUPPORT (see definition)				School Wraparound = revised to break out specific costs in other categories and remaining to be in Educational Support, under Youth Support *Tutoring* – rolled into Educational Support, under Youth Support
GENERAL YOUTH SUPPORT (see definition)				*Recreational Services* - Rolled into General Youth Support *Juvenile Justice* – rolled into General Youth *Health Services* – rolled into General Youth Support, under Youth Support (Supportive Services = revised categories with some broken out into General Youth Support, under Youth Support with remaining family economic support type services in General Economic Support, under Economic Support)
FAMILY SUPPORT				**(Family Support Services Domain)**
PARENT EMPOWERMENT				Parent Empowerment - same, under Family Support
GENERAL FAMILY SUPPORT				*Day Care* - Rolled into General Family Support, under Family Support *Money Management* - Rolled into General Family Support, under Family Support *Legal Services* – rolled into General Economic Support, under Economic Support
ECONOMIC SUPPORT				**(Economic Supports Domain)**
UTILITIES				Utilities – same, under Economic Support
HOUSING				Housing – same, under Economic Support
TRANSPORTATION				Transportation – same, under Economic Support
GENERAL ECONOMIC SUPPORT				(Supportive Services = revised categories with some broken out into General Youth Support, under Youth Support with remaining family economic support type services under General Economic Support)

PROFESSIONAL PARTNER PROGRAM
Program Fidelity and Unit Audit

Date: Agency: Review of FY:

Please place an X in the box next to the indicator if met. A blank space indicates that the requirement has not been met.

CLIENT:	**Enrollment Date:**		
INDICATOR	**COMPLIANT**	**NON-COMPLIANT**	**AUDITOR COMMENTS**
INTAKE AND ADMISSION			
1. Criteria for Admission			
1a. CAFAS score - 80 or above, PECFAS score of 70 or above, or moderate/ severe score in two subscales			
1b. DSM Diagnosis- Must be signed by licensed professional within 60 days of admission to program, and updated on a yearly basis			
1c. Indication of person whom provided diagnosis			
1d. Risk factors identified and prioritized			
1e. Intake assessment summary completed within 30 days			
1f. Signed financial eligibility worksheet			
ASSESSMENT			
2. Intake Assessment / Interpretative Summary Includes:			
2a. Presenting problems			
2b. Urgent needs			
2c. Strengths & Abilities			
2e. Preferences			
2f. Previous services/history			
3. Plan of Care (IFSP)			
3a. Goals written in the words of youth/young adult and family			
3b. Specify referrals for services			
- Clearly indicated, reference contacts			
- Documentation of unsuccessful referrals			
3c. Goals document address:			
- Utilize and build strengths			
- Identify and address needs			

INDICATOR	COMPLIANT	NON-COMPLIANT	AUDITOR COMMENTS
Plan of Care (IFSP)			
3f. Plan reviewed by team at least quarterly and modified as appropriate			
3g. Objectives are measurable, time specific and attainable			
3h. Signed documentation of participation of:			
- Formal supports (e.g., paid supports, professionals)			
- Informal supports (e.g., family members, volunteers)			
4. Wraparound			
4a. Team meetings occur frequently as designated in POC min: monthly			
4b. Family member or youth/ young adult present at all meetings			
4c. Presence of informal resources/supports documented			
4d. Information shared with those unable to attend meeting			
5. Progress Notes			
5a. Signed and dated by PPP			
5b. Reflective achievement of progress toward goals			
5c. Delivery of services: Is there documented follow-through on goals?			
5d. Supervisor signature/clinician signature			
6. Safety Domain			
6a. Addressed in separate plan or POC/IFSP			
6b. Family/youth centered includes protocol of informal/formal supports			
6c. Appropriate emergency services (formal/informal) identified and plan for accessing 24/7			
6d. Medications listed			
7. Discharge/Transition Plan			
7a. Identifies current progress and continued wellness plan			
7b. Plan for youth/young adult and family			
- Updated safety plan			
- Strengths/needs updated			
- Identified formal resources			
- Identified informal resources			
- Documentation of referral/contacts			
- Medication information included			

7c. Input and signature of youth/young adult and family team			
7d. Copy given to Y/F			
INDICATOR	**COMPLIANT**	**NON-COMPLIANT**	**AUDITOR COMMENTS**
8. Policy On			
8a. Orientation to program services			
8b. Confidentiality and consumer rights			
8c. Training and supervision of staff			
8d. Follow-up program: Information regarding post-discharge			
8e. Family-centered practice, philosophy to implementation			
10. Unit Audit	**MONTH 1**	**MONTH 2**	**MONTH 3**
10a. Unit billed for was provided			

SAMPLE SAFETY PLAN

Name:	**Emergency Contact (name, relation, phone):**
Address:	
Diagnosis:	**Allergies:**
Medications (dosage, reason, prescribing professional):	
EMERGENCY / CRISIS / SAFETY Situations:	
Situation 1. **Steps:** • • • **Situation 2.** **Steps:** • • •	**Situation 3.** **Steps:** • • • **Situation 4.** **Steps:** • • •
Support People (name, relation, phone): • • •	
Emergency Numbers:	
Police/Fire: 911 **Child Abuse Hotline: 1-800-652-1999** **Alegent Immanuel Mental Health: XXX-XXXX** **Girls & Boys Town Crisis Line: 1-800-XXX-XXXX** **Medical Questions: XXX-XXXX** **Crisis Center: 1-800-XXX-XXXX**	**Poison Control Center: 1-800-955-9119** **YWCA Crisis Line: XXX-XXXX** **Child Saving Institute Crisis Center: XXX-XXXX** **Happy Cab: XXX-XXXX** **PP Emergency After Hours: XXX-XXXX** **Nebraska Family Helpline: 1-888-866-8660**
Professional Supports (name, role, phone, address): • • • •	
Parent/Guardian Signature:	**Date:**
Person Served Signature:	**Date:**
Professional Partner Signature:	**Date:**

Annual Report Template

Overview of the Professional Partner Program

Eligibility Criteria

Adherence to the Wraparound Model

Youth Served in Fiscal Year

Total Number Served

Characteristics of Youths Discharged in Fiscal Year

Youth Psychiatric Diagnoses

Youth Problem Behaviors

Youth Risk Factors

Average Length of Stay

Age at Discharge

Gender

Race

Medicaid Eligibility

Family Characteristics of Youth Discharged in Fiscal Year

Family Risk Factors

Number of Dependents

Outcomes of Fiscal Year

CAFAS Results

PECFAS Results

Summary of Fiscal Year

References

PROFESSIONAL PARTNER PROGRAM
Exception Waiver for Admission

If a participant has not met the minimum score for admission on the Child and Adolescent Functional Assessment Scale (CAFAS) OR Preschool and Early Childhood Functional Assessment Scale (PECFAS), the Professional Partner Supervisor has the right to initiate a review process for the Division of Behavioral Health Network Administrator to consider an exception waiver for admission into the program.

The Nebraska Professional Partner Program serves youth and families who are experiencing behavioral health challenges. This level of care is appropriate for youth/young adults who are experiencing serious emotional disturbances and who have had a diagnosable mental, behavioral, or emotional disorder in the past year, which resulted in functional impairment(s) that substantially interferes with or limits the youth/young adult's role or functioning in family, school, or community activities.

The following admission guidelines apply to the Nebraska Division of Behavioral Health Professional Partner Program:

1. Youth/young adult must be between ages 3-25 years of age.
2. At admission, or as determined within 60 days of admission, the youth/young adult must be diagnosed with a mental health disorder under the current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association. Youth/young adults with Developmental Disorders or Psychoactive Substance Use Disorders may be included if they co-occur with the serious emotional disturbance/serious mental illness. This pattern has existed for 12 months or longer or is likely to endure for 12 months or longer;
    a. Documentation to support presence of DSM diagnosis must be signed by a licensed professional and updated annually.
3. Youth/young adult must demonstrate significant functional impairments due to their behavioral health diagnosis. Functional impairments are significant if as a result of the behavioral health diagnosis the youth/young adult consistently and persistently demonstrates behavioral abnormality in two or more spheres, to a significant degree, well outside normative developmental expectations, which cannot be attributed to intellectual, sensory, or health factors. The Child and Adolescent Functional Assessment Scale (CAFAS) OR Preschool and Early Childhood Functional Assessment (PECFAS) are used to determine degree of functional impairments. For eligibility purposes, the following score requirements apply:
    a. CAFAS score of 80 or greater using the 8-point scale
    Or
    b. PECFAS score of 70 or greater using the 7-point scale,
    Or
    c. Moderate/severe score in at least two subscales of the CAFAS or PECFAS. Subscale scores are considered moderate at 20 and above*

PROFESSIONAL PARTNER PROGRAM
Exception Waiver for Admission
Cover Page

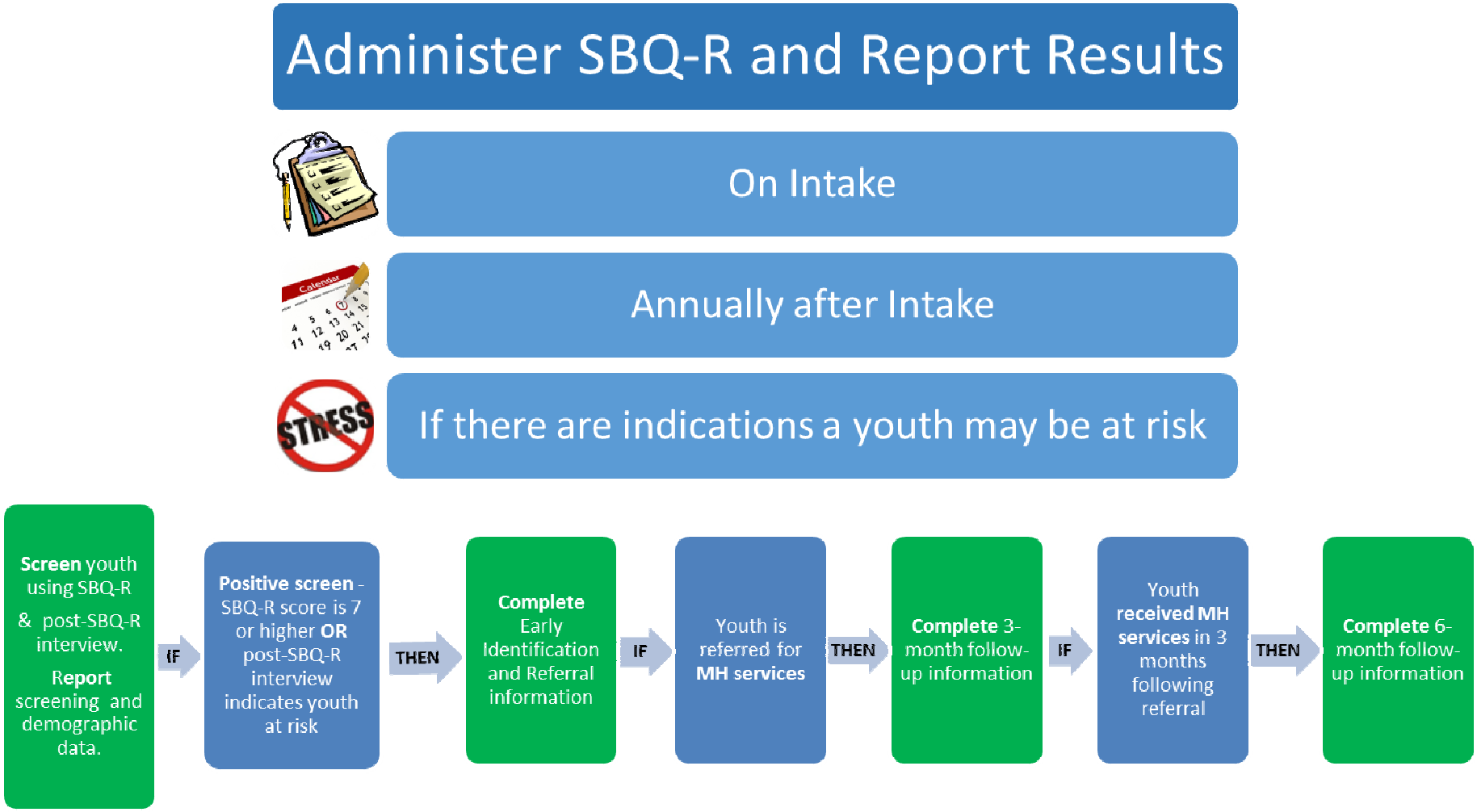
In separate documentation please be sure to include the following information along with this cover page when submitting waiver request to the DHHS Network Administrator for further review.

Date_____
Region _____
PP Supervisor _____
Date of eligibility screening_____

1. Descriptive Information Questionnaire.
2. The participant has met the following admission criteria:
   ___ DSM Diagnoses: _____
   ___ Financial Eligibility
   ___ Functional impairment as evidenced by
   ___CAFAS/PEFAS score
   Subscales
   ___School/Work Role Performance
   ___ Home Role Performance
   ___ Community Role Performance
   ___Behavior Toward Others
   ___ Moods/Emotions
   ___ Self-Harmful Behavior
   ___Substance Use
   ___ Thinking
   ___ Child Behavioral Checklist Score (if applicable)
   Internalizing _____
   Externalizing _____
   ___ Transitioning back into community from 3 (three) month or longer stay in higher level of care
   ___ Age of youth/young adult
3. Please explain in detail why the exception process has been initiated.
4. Is the participant at significant risk of any of the following, if so why?
   - Being placed out of the home or in a more restrictive level of care, or becoming a state ward specifically in order to access behavioral health services
   - Dropping or staying out of school (or vocation, specific to transition age youth).
   - Committing a criminal offense; becoming homeless;
5. What Professional Partner Program is being recommended and why is this program the most appropriate level of service?
6. What is the recommended Plan of Care?

To expedite the process, please submit all supporting documentation and assessments that support your request.
All documents should be submitted electronically to DHHS.DBHNetworkOperations@nebraska.gov
Once all documentation is submitted, requests will be answered within 3 (three) business days.

As of July 1, 2015, BH Regions report any new screening (SBQ-R) data whether it is from new admissions or screening of existing program participants (ages 10 through 24 are reported under the GLS Youth Suicide Prevention Grant).*



Use SBQ-R version for 6 to 12 years of age to screen ages 10 through 12; use SBQ-R version for 13 years and older to screen ages 13 through 24.

NOTE: *For evaluation purposes, if a youth is referred for MH services then 3-month follow-up data should be provided. If a youth receives MH services in the three months following the referral then 6-month follow-up data should be provided.*

SBQ-R and EIRF Reporting - Due Dates*					
	Year 1 (2014-15)	**Year 2 (2015-16)**	**Year 3 (2015–17)**	**Year 4 (2017–18)**	**Year 5 (2018–19)**
Qtr 1 (Oct – Dec)		**Jan 10**	**Jan 10**	**Jan 10**	**Jan 10**
Qtr 2 (Jan – Mar)		**April 10**	**April 10**	**April 10**	**April 10**
Qtr 3 (Apr – June)		**July 10**	**July 10**	**July 10**	**July 10**
Qtr 4 (July – Sept)	**October 10**	**October 10**	**October 10**	**October 10**	**October 10**
** If a due date falls on a weekend or holiday, the report is due the following work day. Submit data to DBH.*					

Send the quarterly Suicide grant data and the PPP data to the DBH Data Team at:
DHHS.DBHDataTeam@nebraska.gov

Program Evaluation Assessment Administration Chart

Time Frame	Assessment to Administer	What Each Assessment Measures	How Each Assessment is Administered
Intake/ Enrollment	DIQ	Gathers general descriptive and background information about the youth and family.	Data obtained at intake and entered into information system; process for ensuring data accuracy
	CAFAS/PECFAS	Assesses youth's functional limitations and assists in deciding level of intervention.	Completed by professional with certified completion of online CAFAS training who knows youth & family. To be administered if it has not been administered within the last 3 months.
	PFS	Assesses family functioning through multiple protective factors against abuse and neglect.	Administered by staff who have read manual - completed by caregiver with staff assistance. Not applicable for young adults in transition age programs.
	SBQ-R	Assess level of risk for suicide	No particular training needed, although efforts should be made to ensure consistency in obtaining and entering accurate information
Every 6 Months	CAFAS/PECFAS	Assesses youth's functional limitations and assists in deciding continued intervention.	See above
	PFS	Assesses family functioning through multiple protective factors against abuse and neglect.	See above
	WFI-EZ (just once at 6 months)	Measures fidelity to the Wraparound Model in the Professional Partner Program.	Administered by staff who have read quick guide and users-manual - completed by caregiver with staff assistance.
Every Year	SBQ-R	Assess level of risk for suicide	See above
Discharge	Discharge Summary	Summarizes youth's progress in the PP Program and reason for termination of services.	Data obtained at discharge and entered into information system; process for ensuring data accuracy
	CAFAS/PECFAS	Assesses youth's functional limitations and depicts progress made in the PP Program.	See above
	PFS	Assesses family functioning through multiple protective factors against abuse and neglect.	See above

Frequently used Acronyms

CAFAS - Child Adolescent Functional Assessment Scale
BH- Behavioral health
DBH- Division of Behavioral Health
DHHS – Department of Health and Human Services
DIQ- Descriptive Intake Questionnaire
DSM- Diagnostic Statistical Manual
EIRF- Early Identification Referral form
IEP- Individual Education Program
IFSP- Individual Family Service Plan
MH/SA- Mental health/ substance abuse
PECFAS- Preschool Early Childhood Functional Assessment Scale
PFS- Protective Factors survey
POC- Plan of Care
PPP- Professional Partner Program
SBQ-R- Suicidal Behaviors Questionnaire- Revised
SED- Serious Emotional Disturbance
SPMI- Serious and Persistent Mental Illness
SUD- Substance use disorder
TAY- Transition Age Youth
TIP- Transition to Independence Process
WFI-EZ - Wraparound Fidelity Index-EZ


Department of Health & Human Services
DHHS
NEBRASKA

PREVENTION SYSTEM MANUAL

DHHS Division of Behavioral Health

Issued February 2017

Contents

OUR PURPOSE

The DHHS Division of Behavioral Health is committed to the mission of broadening the behavioral health lens 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. Through our partnership with the six Regional Behavioral Health Authorities, we are dedicated to enhancing the capacity and collaboration of an effective and comprehensive prevention system that promotes overall wellness.

Vision

Develop a sustainable and effective prevention system that is committed to reducing the risk of developing a substance use disorder or mental illness.

Guiding Principles

In order to create population level change communities must be targeted with prevention initiatives that demonstrate measurable change in behaviors or in important risk factors that lead to behavior change.

- The Strategic Prevention Framework will be comprehensively utilized for all planning and decision making processes.
- All prevention activities will be culturally relevant.
- The DHHS Division of Behavioral Health will shape substance abuse prevention policy, quality improvement, and agency participation through cross-agency advisory groups.
- The DHHS Division of Behavioral Health will coordinate and support the work of the State's prevention advisory council, and will actively recruit and educate partners who can contribute to this important work.
- Each Regional Behavioral Health Authority will identify its highest risk subpopulations and will develop a plan to enhance or build community responses.

Performance Indicators

Like all strategies that the State, Regions and communities implement, key strategies involve:

- Increasing the perception of risk
- Increasing positive norms and policies associated with drug and alcohol free life choices
- Increasing positive attachments to family, school, neighborhood and community
- Reducing parental and peer group attitudes favorable toward the problem behavior or use

The State of Nebraska will prevent and reduce a wide range of behaviors including:

- Underage drinking
- Binge drinking
- Prescription drug abuse
- Marijuana use
- Suicidal ideation
- Illegal sale of tobacco products to minors

PREVENTION DEFINED

What is Prevention?

"Prevention is the active process of creating conditions or attributes that promote the well-being of people". William Lofquist

Primary Prevention

Programs and services that are directed at individuals who have not been determined to require treatment for substance abuse.

Substance Abuse Prevention

Interventions that are delivered prior to the onset of a disorder and are intended to prevent or reduce the risk of developing a substance abuse problem, such as underage alcohol use, prescription drug misuse and abuse, and illicit drug use.

Mental Health Promotion

Any action taken to maximize mental health and well-being among populations and individuals.

Mental Illness Prevention

Interventions that are designed to directly reduce the incidence of mental disorders, high risk precursors of disorders, and adverse consequences of precursors and/or early manifestations of the disorders themselves.

Community Coalition

A community-based organization of individuals representing diverse organizations, factions or constituencies who agree to work together in order to achieve a common goal. The coalition's work includes identification of prevention services and/or strategies designed to specifically reduce or delay the onset of substance abuse.

Prevention Provider

An individual or agency who directly provides a specific community population or target group with prevention information, resources and expertise.

Promising Practice

Programs that have been assigned either a Proven or a Promising rating, depending on whether they have met certain evidence criteria.

Evidence Based Practices

Refers to a set of prevention activities that evaluation research has shown to be effective and one that has been included in one or more of the three categories:

- Included in Federal registries of evidence-based interventions;
- Reported (with positive effects on the primary targeted outcome) in peer-reviewed journals; or
- Documented effectiveness supported by other sources of information and the consensus judgment of informed experts.

PREVENTION STRATEGIES

The state is mandated to report to the federal government on who is being served, and what approaches are being utilized. All funded prevention activities must fall within the *Institute of Medicine Prevention Classification* (IOM) categories:

Universal Prevention - activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk.

- **Universal Direct** – directly serve an identifiable group of participant but who have not been identified on the basis of individual risk. (e.g., school curriculum, parenting class). This also could include interventions involving interpersonal and ongoing/repeated contact (e.g., coalitions).
- **Universal Indirect** – support population-based programs and environmental strategies (e.g., establishing ATOD policies). This could also include programs and policies implemented by coalitions.

Selective Prevention - activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
Indicated Prevention - activities targeted to individuals in high-risk environments, identified as having minimal but detectable signs or symptoms foreshadowing disorder or having biological markers indicating predisposition for disorder but not yet meeting diagnostic levels.

All funded prevention activities must fall also within the following *6 Primary Prevention Strategies.* The SAMHSA Center for Substance Abuse Prevention requires that all prevention strategies be identified as fitting into the framework of one of these six, overarching strategies. One way to think of these 6 strategies is that they represent the array of services that are provided to specific target populations.

- In a broad sense, the **3 IOM's** answer: Who your target population is
- The **6 strategies** answer: How the activity is used to address the population

(1) Information Dissemination:
This strategy provides awareness and knowledge of the nature and extent of alcohol, tobacco and drug use, abuse and addiction and their effects on individuals, families and communities. It also provides knowledge and awareness of available prevention programs and services. Information dissemination is characterized by one-way communication from the source to the audience, with limited contact between the two. Examples of activities conducted and methods used for this strategy include (but are not limited to) the following:

- Clearinghouse/information resource center(s)
- Resource directories
- Media campaigns
- Brochures
- Radio/TV public service announcements
- Speaking engagements
- Health fairs and other health promotion e.g., conferences, meetings, seminars
- Information lines/Hot lines

(2) Education:
This strategy involves two-way communication and is distinguished from the Information Dissemination strategy by the fact that interaction between the educator/facilitator and the participants is the basis of its activities. Activities under this strategy aim to affect critical life and social skills, including decision-making, refusal skills, critical analysis (e.g., of media messages) and systematic judgment abilities.
Examples of Educational activities conducted and methods used for this strategy include (but are not limited to) the following:

- Parenting and family management classes
- Ongoing classroom and/or small group sessions
- Peer leader/helper programs
- Education programs for youth groups
- Mentors
- Preschool ATOD prevention programs

(3) Alternative Activities:
This strategy provides for the participation of target populations in activities that exclude alcohol, tobacco and other drug use. The assumption is that constructive and healthy activities offset the attraction to, or otherwise meet the needs usually filled by alcohol, tobacco and other drugs and would, therefore, minimize or prevent resorting to the latter.
Examples of activities conducted and methods used for this strategy include (but are not limited to) the following:

- Drug free dances and parties
- Youth/adult leadership activities
- Community drop-in centers
- Community service activities
- Outward Bound
- Recreation activities

(4) Problem Identification and Referral:
This strategy aims at identification of those who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs in order to assess if their behavior can be reversed through education. It should be noted, however, that this strategy does not include any activity designed to determine if a person is in need of treatment. Examples of activities conducted and methods used for this strategy include (but are not limited to) the following:

- Employee assistance programs
- Student assistance programs
- Driving while under the influence/driving while intoxicated education program

(5) Community-Based Process:
This strategy aims to enhance the ability of the community to more effectively provide prevention and treatment services for alcohol, tobacco and drug abuse disorders. Activities in this strategy include organizing, planning, enhancing efficiency and effectiveness of

services implementation, interagency collaboration, coalition building and networking. Examples of activities conducted and methods used for this strategy include (but are not limited to) the following:

- Community and volunteer training, e.g., neighborhood action training, impact or
- Training of key people in the system, staff/officials training
- Systematic planning
- Multi-agency coordination and collaboration/coalition
- Accessing services and funding
- Community team-building

(6) Environmental:

This strategy establishes or changes 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. This strategy is divided into two subcategories to permit distinction between activities which center on legal and regulatory initiatives and those that relate to the service and action oriented initiatives. Examples of activities conducted and methods used for this strategy include (but are not limited to) the following:

- Promoting the establishment or review of alcohol, tobacco and drug use policies in schools
- Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drugs
- Modifying alcohol and tobacco advertising practices
- Product pricing strategies

Population

Strategies that focus on altering and improving the environment rather than focusing on the individual. Some examples include working to: change social norms or attitudes relating to the use of illicit drugs or alcohol, control the availability of these substances, or create/strengthen enforcement of laws and regulations affecting their use.

Individual

Prevention approaches focus on helping people develop the knowledge, attitudes, and skills they need to influence their future behavior. Many of these strategies are classroom-based, though some are presented in the form of community activities. Generally, programming focuses on life and skill development. This may include alcohol and other drug refusal skills, processing substance abuse messaging in the media, understanding and changing norms, among other skills.

STRATEGIC PREVENTION FRAMEWORK

SAMHSA's **Strategic Prevention Framework** (SPF) is a planning process for preventing substance use and misuse.

The purpose of the SPF is to better understand substance use and related problems in a state or community as well as how to determine the resources and the readiness of the state or community to address these problems

The five steps and two guiding principles of the SPF offer **prevention** professionals a comprehensive process for addressing the substance misuse and related behavioral health problems facing their communities.

The SPF's elements assist coalitions to develop the infrastructure needed to successfully implement community-based approaches organized around the **public health model**, that lead to effective and sustainable reductions in alcohol, tobacco, and other drug (ATOD) use and abuse. The SPF is considered "**data-driven**" because it requires every step in prevention planning to be supported by the collection and analysis of objective data.

The SPF also includes these guiding principles through each step:

Cultural competence: The ability to interact effectively with members of diverse population.

Sustainability: The process of achieving and maintaining long-term results.

Step 1: ASSESSMENT *- Profile population needs, resources, and readiness to address needs and gaps.*
Collection of data to identify and prioritize problems, as well as an assessment of resources and readiness within the community to address needs and gaps.

Step 2: CAPACITY BUILDING *- Mobilize and/or build capacity to address needs*
Mobilization of resources within a community. A key aspect of capacity building is convening key stakeholders, coalitions, and service providers to implement all five steps of the SPF and to plan for sustainability.

Step 3: STRATEGIC PLANNING *- Develop a comprehensive strategic plan.*
The development of a strategic plan that utilizes policies, programs, and practices to address the evidence-identified factors that contribute to a community issue.

Step 4: IMPLEMENTATION *- Implement evidence-based prevention programs, policies, and practices*
The implementation of strategies or programs identified in the strategic plan.

Step 5: EVALUATION *- Monitor, evaluate, sustain, and improve or replace failing entities, systems, or strategies*
Measuring the overall impact of the SPF and the specific programs, policies, and practices implemented on the selected outcomes, as well as an assessment of the actual implementation of strategies.

For more information on the Strategic Prevention Framework, please visit:
http://captus.samhsa.gov/prevention-practice/strategic-prevention-framework

SUBSTANCE ABUSE PREVENTION SKILLS TRAINING

The Substance Abuse Prevention Skills training (SAPST) is a face-to-face 3.5-day training that was developed by SAMHSA's Center for the Application of Prevention Technologies to prepare prevention professionals for work in their community in a proven effective way.

The SAPST offers a comprehensive introduction to the substance abuse prevention field and interactive activities to apply key skills grounded in current prevention science research.

Each step of the Strategic Prevention Framework is put to use through interactive activities to help develop the knowledge and skills needed to implement effective, data-driven prevention that reduces behavioral health disparities and improves wellness.

SESSION 1
AN INTRODUCTION TO THE SAPST
• Training Overview and Logistics

SETTING THE FOUNDATION: FROM THEORY TO PRACTICE
• Behavioral Health
• Continuum of Care
• Public Health Approach
• Risk and Protective Factors
• Developmental Perspective
• Introduction to the Strategic Prevention Framework

SESSION 2
STRATEGIC PREVENTION FRAMEWORK
• Step 1: Assessment
• Step 2: Capacity (Assessing)

SESSION 3
STRATEGIC PREVENTION FRAMEWORK
• Step 2: Capacity (Building)
• Cultural Competence
• Step 3: Planning

SESSION 4
STRATEGIC PREVENTION FRAMEWORK
• Sustainability
• Step 4: Implementation
• Step 5: Evaluation

PREVENTION COORDINATION

Prevention Systems are purposeful partnerships of agencies, organizations, and individuals who come together with a shared commitment of supporting wellness in their community. Activities led by Prevention Systems seek to produce sustained outcomes in preventing the onset and reducing the progression of substance use disorders and mental illness and related consequences among communities. Furthermore, Prevention systems are designed to operate at the community level embracing the local culture while leading the development of strong, sustainable, community-based prevention activities focused on pro-social and normative changes.

The Regional Behavioral Health Authority will support local community coalitions and other community activities within the Region's Prevention System to ensure that prevention services are available, accessible and that duplication of efforts are minimized. The prevention systems funded must comply with requirements set forth by the state and federal government in the attainment and continuation of federal prevention funding.

A. Standing Expectations:
    1. Prevention system activities shall promote protective factors and decrease risk factors, and build prevention capacity and infrastructure at the State/Tribal and community level.
    2. Ensure funded prevention initiatives include strategies that address the targeted audience and desired outcome and ensure expenditures for prevention initiatives reflect objective analysis of data, evidence-based or promising practices, and alignment with the community's strategic prevention plan.
    3. Ensure that all funds utilized from the primary prevention set-aside are only for activities directed at individuals not identified to be in need of treatment.
    4. Plan for comprehensive strategies that address both mental health promotion and substance use prevention when applicable.
    5. Ensure that the Region funds a comprehensive prevention program that includes activities in all six Primary Prevention Strategies as identified in 45 CFR §96.125.
        a. Activities are to be provided in a variety of settings for both the general population as well as targeting sub-groups who are at high risk for substance use.
        b. Activities should support DBH strategic plan priorities.
        c. It is permissible to use primary prevention set-aside funds for strategies that address shared risk and protective factors as long as the desired outcome is expected to reduce both substance abuse and mental health problems.
    6. Ensure that all funded prevention activities emphasize and utilize a mix of evidence based program, practices and/or policies for prevention efforts whenever possible.
    7. Promote the use of environmental strategies, which are considered those that focus on altering societal influences rather than focusing on the individual.

8. Promote the alignment and leveraging of prevention resources and priorities, to include State discretionary prevention grants, Suicide Prevention and Mental Health Promotion at the Regional and community levels in partnership and coordination within state.
9. Ensure compliance with all federal funding requirements (e.g., not for inpatient services, inherently religious activities or religious services, or lobbying) – see also Federal Mandates section.
10. It is allowable to use federal funds to support local Synar tobacco compliance checks being conducted. However, any time spent toward enforcement (issuing a citation) is not reimbursable through federal funds.
11. Ensure that the goals of DBH's Strategic Plan for Prevention are prioritized for use of primary prevention set-aside whenever possible.
12. Ensure that funded initiatives will include an evaluation plan that describes the plan to collect, analyze, and disseminate process, outcome, and impact evaluation data, including plans to monitor for continuous improvement and plans to use lessons learned from evaluation to improve the performance of the funded initiative.
13. The Prevention Coordination staff will be responsible for providing technical assistance to funded prevention initiatives in the region and organizing and preparing any supporting documentation required by the Department.
14. Ensure sufficient funds are available for travel to attend and participate in statewide meetings and trainings.
15. Adhere to the Prevention Code of Conduct, promotion of minimum standards for community coalitions, and advancement of Prevention Professional Core Competencies.
16. Ensure that all paid Prevention staff (both Regional and community coalitions) complete 12 hours of continuing education relevant to the prevention of mental illness and/or substance use disorders and support proficiency across the Prevention Professional Core Competencies.
    a. These hours are to include at least one professional development training opportunity each year for Regional Prevention Coordination staff.
    b. New Prevention staff shall complete the Substance Abuse Prevention Skills Training within the first year of employment which meets the 12 hour requirement.
17. Up to $20,000 of the Region's allocation for primary prevention set-aside may be requested and applied as "training funds" in support of community coalition and regional prevention staff receiving continuing education hours and professional development.
    a. The Training Outline form must be completed and submitted with the annual Regional Budget Plan.
    b. Priorities for use of training dollars shall be toward travel, hotel, per diem for meals and incidentals, registration fee, training materials, facility fees.
    c. Priorities for training topics include but are not limited to, substance abuse prevention outcome or evidence based practices, prevention strategic planning,

workforce development, and sustainability of local coalitions.

   d. If requested as part of the $20,000, trainings conducted or attended by regional prevention staff, should be reflected in the Prevention Coordination System budget.

18. Assist local prevention coalitions to develop sustainability plans, identify outcomes, and prioritize SPF initiatives to continue.
19. Assist local prevention coalitions to increase understanding common risk and protective factors for substance use and mental health problems.
20. Submit a Regional work-plan detailing activities that will address priority areas for training and technical assistance efforts to be completed during the contract year.
21. Report annual progress to DBH on all applicable Prevention Strategic Planning and Results Based Accountability (RBA) performance indicators at the Regional level.
22. Submit Regional guidelines for awarding mini-grants, to include scoring criteria if applicable.
23. Participate in reporting National Outcome Measures via the use of Nebraska Prevention Information Reporting System (NPIRS), or other data recording processes required by DBH, to record prevention activities.
24. Ensure that all funded prevention providers and community coalitions enter data into the NPIRS system and/or other data reporting system as required by DBH.
25. If offered, mini-grants must be awarded per the following parameters:
    a. No more than $3,000 each; awards over this threshold shall be captured in contract.
    b. Must have a formal process for awarding mini-grants, including scoring and standardized criteria developed by the Region.

NEBRASKA PREVENTION CORE COMPENTENCIES

Provide competent, professional services in keeping with prevention standards by demonstrating knowledge, skills, and abilities in each of the Prevention Specialist Domains:

Planning & Evaluation

A. *Assess community needs by collecting the most current local data through systematic assessment methods in order to provide relevant data for the planning process*
B. *Develop a prevention plan by facilitating a planning process that considers the findings of the needs assessment in order to prioritize needs and guide program selection.*
C. *Select strategies by reviewing professional literature for effective programs and practices in order to meet the needs of the target population, implementing adaptations as necessary.*
D. *Identify financial sources through networking, workshops, and research in order to fund prevention projects.*
E. *Review evaluation options through consultation and research in order to determine an appropriate evaluation method.*
F. *Conduct quality improvement analysis of the prevention program using the selected measurement tools to determine program effectiveness.*
G. *Document project activities and outcomes using an appropriate reporting system in order to demonstrate accountability.*
H. *Refine the prevention program reviewing and incorporating findings of the evaluation in order to enhance program effectiveness.*

Education & Skill Development

A. *Tailor education and skill development activities by gathering information about the knowledge and skill levels of the intended audient in order to maximize program effectiveness.*
B. *Connect prevention theory and practice by using current research and program models in order to prepare effective education and skill development activities.*
C. *Maintain fidelity when replicating research-based prevention programs only making adaptations that do not compromise program integrity in order to ensure program effectiveness.*
D. *Deliver culturally competent education and training by working with representatives from the intended audience to identify appropriate content, methods, resources, materials, and evaluation tools.*
E. *Conduct education and skills development activities by employing appropriate training techniques in order to address the educational needs of the intended audience.*
F. *Educate intended audiences by providing accurate, relevant and appropriate information about ATOD abuse and related problems in order to encourage health lifestyles.*
G. *Disseminate appropriate information by identifying prevention materials for education and training activities.*
H. *Provide prevention information to professionals in related fields through appropriate means to increase their understanding of prevention and ATOD-related problems.*

I. *Gain the support of decision makers/stakeholders by informing them about effective prevention practice in order to influence policy development.*
J. *Establish working relationships with media by serving as a credible resource in order to develop public support for effective prevention policy.*
K. *Promote advocacy for prevention by conducting prevention awareness campaigns to strengthen public and organizational policy and norms.*

Community Organization

Define the community by identifying its demographic characteristics and core values for the purpose of providing appropriate prevention services.

A. *Engage community leaders by including them in the planning process in order to foster participation and ownership in achieving prevention goals.*
B. *Identify prevention needs and resources within the community by collecting relevant information in order to provide a foundation for a sound and culturally appropriate plan.*
C. *Develop a prevention plan in accordance with appropriate prevention theory by collaborating with community member to achieve the identified goals.*
D. *Support the community by providing technical assistance in order to implement a plan for achieving prevention goals.*
E. *Develop the capacity of the community through ongoing mentoring and training to sustain positive change resulting from the prevention project.*

Public Policy & Environmental Change

A. *Identify decision makers/stakeholders using formal and informal processes in order to influence prevention policies and cultural and social norms.*
B. *Plan policy initiatives working in collaboration with appropriate community groups and other organizations in order to implement policy change.*
C. *Gain the support of decision makers/stakeholders by informing them about effective prevention practice in order to influence policy development.*
D. *Establish working relationships with media by serving as a credible resource in order to develop public support for effective prevention policy.*

Professional Growth & Responsibility

A. *Attain knowledge of current research-based prevention theory and practice by participating in appropriate educational opportunities and reviewing current literature in order to provide effective prevention services.*
B. *Model collaboration by networking with colleagues, other professional, individuals, and community organizations to ensure effective prevention services.*
C. *Practice ethical behavior by adhering to legal and professional standards to protect the consumer and promote the integrity of the profession.*
D. *Recognize norms & develop cultural competence through education, training, guided practice, and life experience to ensure sensitivity & inclusion of diverse populations to achieve the highest level of professional skill relative to the community.*
E. *Develop a comprehensive Professional Development Plan to include, as appropriate, professional training and education; certification; personal wellness.*

PROFESSIONAL CODE OF ETHICAL CONDUCT FOR PREVENTIONISTS

The practice of alcohol, tobacco, and other drug (ATOD) prevention is based on shared knowledge, skills, and values. The following ethical standards shall govern the professional's daily involvement in prevention activities and emphasize the professional concern for the rights and interests of the consumer/client:

RESPONSIBILITIES

Preventionists have a responsibility to maintain objectivity, integrity, and the highest standards in delivering prevention services. Preventionists shall:

- Operate at the highest level of honesty and professionalism and will strive to deliver high quality services, holding the best interest of the public above all
- Recognize his/her primary obligation to promote the health and well-being of individuals, families, and communities in order to prevent chemical abuse and dependency
- Recognize his/her personal competence and not operate beyond their skill or training level
- Amenably refer to another individual or program when appropriate.
- Be committed to advancing their knowledge and skills through ongoing education and training
- Understand and appreciate varying cultures and demonstrate sensitivity to cultural differences in professional practices

NON-DISCRIMINATION

Preventionists shall not discriminate against individuals, the public, or others in the delivery of services on the basis of: race, color, national origin, ancestry, gender, gender identity, sexual orientation, religion, socioeconomic status, age or mental/physical disabilities.
Preventionists shall not engage in any behavior involving professional conduct that encourages, condones, or promotes discrimination and will strive to protect the rights of all individuals.

ADHERENCE TO STATE AND FEDERAL LAWS AND RULES

Preventionists shall protect client rights and insure confidentiality by adhering to all state and federal laws and rules. Preventionists:

- Will not participate in or condone any illegal activity, including the use of illegal chemicals, or the possession, sale or distribution of illegal chemicals
- Shall not participate in, condone, or be an accessory to dishonesty, fraud, deceit, or misrepresentation
- Will adhere to mandatory reporting procedures related to abuse, neglect, or misconduct by individuals and/or agencies in accordance with state and federal laws and regulations
- Shall assume responsibility to report the incompetent and unethical practices of other professionals

PERSONAL CONDUCT AND PROFESSIONAL COMPETENCY

Preventionists have a duty to maintain a healthy lifestyle and wellbeing to prevent the impairment of professional judgment and performance. Furthermore, Preventionists shall actively work to identify and eliminate actual or potential conflicts of interest, commitments, or conscience ("conflicts") that may prohibit or limit their ability to provide objective, effective, and efficient services. Preventionists:

- Will not exhibit gross incompetence, unprofessional, or dishonorable conduct or any other act that would be a substantial deviation from the standards ordinarily possessed by professional peers
- Shall not fail to recognize the personal boundaries and limitations of their professional competence
- Shall not offer services beyond the scope of their personal competencies or expertise
- Will utilize resources for support, growth, and professional development
  Will strive to maintain and promote the advancement of the Preventionists profession

PUBLIC WELFARE

Preventionists will maintain an objective, non-possessive relationship with those they serve and will not exploit them sexually, financially, or emotionally. Preventionists:

- Will actively discourage any dependency upon themselves for the personal satisfaction of any physical, psychological, emotional, or spiritual need
- Shall accurately represent their qualifications and affiliations
- Shall discontinue services when they are no longer appropriate and will refer the client to programs or other practitioners based on the client's needs
- Shall not impede an individual's access to competent, professional care
- Will respect the rights and views of other professionals and agencies and should treat colleagues with respect, courtesy, and fairness
- Will not promote personal gain or the profit of an agency or commercial enterprise of any kind
- Will adhere to professional remuneration and financial arrangement practices and standards that safeguard the best interests of the public and profession

PROFESSIONAL PUBLICATIONS AND PUBLIC STATEMENTS

Preventionists will respect the limits of present knowledge and shall assign credit to all who have contributed to published materials, professional papers, videos/films, pamphlets, or books. Preventionists will:

- Act to preserve the integrity of the profession by acknowledging and documenting any materials, techniques, or people used in creating their opinions, papers, books, etc.
- Adhere to copyright laws and seek approval for the use of such materials

PUBLIC POLICY TO MAINTAIN AND IMPROVE ALCOHOL, TOBACCO AND OTHER DRUGS CONTINUUM OF CARE

Preventionists will take the initiative to support, promote, and improve the delivery of high quality services in the professional continuum of care (prevention, intervention, treatment, and aftercare). Preventionists:

- Shall advocate for changes in public policy and legislation to afford opportunities and choices for all persons whose lives are impaired or impacted by the disease of alcoholism, tobacco use, and other drug abuse and addictions, which promotes the well-being of all human beings
- Will actively participate in developing the public awareness of the effects of tobacco, alcoholism, and other drug addictions and should act to ensure all persons, especially the disadvantaged, have access to the necessary resources and services

I hereby agree to the above Professional Code of Ethical Conduct. I will uphold and promote the integrity of the profession by adhering to and reporting violations of the preceding Code of Ethical Conduct. I understand that violations of the principles will be grounds for disciplinary action and sanctions.

_____ _____

Signature of Preventionist Date

COMMONLY ASKED QUESTIONS ABOUT THE SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

1. **What should Primary Prevention activities include?**
   - Comprehensive primary prevention programs should give priority to target population sub-groups that are at risk of developing a pattern of substance abuse. Programs should include activities and services provided in a variety of settings, that address specific risk factors, and that may be broken down by age, race/ethnicity, gender, and other characteristics of the population being served. Unallowable activities in SAPTBG primary prevention programs are any activities that were provided to clients who have a diagnosis of substance abuse or dependence.

2. **Can primary prevention set-aside funds be used to fund mental health promotion or mental disorder prevention strategies?**
   - Primary prevention set-aside funds can only be used to fund strategies that are intended to prevent substance use and abuse. However, we know that many strategies that prevent substance abuse also positively impact mental health because they target risk and protective factors that are common to both issues. Specifically, substance abuse and mental illness share many of the same modifiable risk and protective factors. For example, poor academic achievement and a family history of substance use disorders are risk factors for both substance abuse and mental health problems. Similarly, parental support and bonding and participation in social activities are protective factors for both substance abuse and mental health problems. This means that strategies that target those risk and protective factors would be expected to reduce both substance abuse and mental health problems.

   - SAMHSA encourages grantees to fund strategies that address shared risk and protective factors (the star area) AND those that are specific to substance abuse prevention.
   - Some examples of strategies that address shared risk and protective factors include:
     - School-based substance abuse prevention education programs that promote positive self-esteem and work to decrease bullying, which are risk factors for both substance abuse and mental health problems; and

    - Parenting and family management classes that increase the ability of parents to bond with their children and discipline effectively, which are protective factors common to both substance abuse and mental health.
- Some examples of strategies that are specific to substance abuse prevention include:
    - Promoting the establishment or review of alcohol, tobacco, and drug use policies in schools
    - Guidance and technical assistance on monitoring enforcement governing the availability and distribution of alcohol, tobacco, and other drugs, and
    - Modifying alcohol and tobacco advertising practices

3. Do states have to spend SABG primary prevention set-aside funds in all six strategies?

- Yes, the SABG regulation requires states to use the set-aside to fund a comprehensive prevention program that includes activities in all six primary prevention strategies. While states have the option to report expenditures by either the six strategies, IOM categories, or both, states are required by regulation to use SABG dollars to fund all six strategies. For this reason, in the Prevention Strategy Report in the SABG Report, CSAP State Project Officers expect to see primary prevention activity codes in all six prevention strategies. It is also important to note that the six strategies and IOM categories are not mutually exclusive. Strategy classification indicates the type of activity, while IOM category indicates the populations served by the strategy.

4. Can SBIRT be funded with primary prevention set-aside funds?

- While states can use the treatment portion of the SABG to fund Screening, Brief Intervention and Referral to Treatment, primary prevention set-aside funds cannot be used to fund SBIRT. Because SBIRT is a billable service that can be provided in a health care setting, SAMHSA also encourages states to work with their State Medicaid Agencies and Health Insurance Marketplaces to include SBIRT as a covered service delivery benefit. SAMHSA's SBIRT website provides further information about health insurance reimbursement for SBIRT, including the billing codes and reimbursement rates. These can be found at: http://beta.samhsa.gov/sbirt/coding-reimbursement.

5. What is the difference between SBIRT and Problem Identification and Referral?

- Problem Identification and Referral is one of the six primary prevention strategies states are required to fund with prevention set-aside funds. The SABG regulation defines Problem Identification and Referral as a strategy aimed at the identification of those who have experimented with tobacco, alcohol, or illicit drug use, in order to assess if their behavior can be reversed through education. The SABG regulation specifically notes that Problem Identification and Referral does not include any activity designed to determine if a person is in need of treatment. In this way, it is different than SBIRT, which is intended to assess the severity of substance use and identify the appropriate level of treatment.
- Examples of activities that can be funded under Problem Identification and Referral include employee and student assistance programs and driving while intoxicated education programs that provide education aimed at preventing further use.

6. **Can enforcement of alcohol, tobacco and drug laws be funded with the primary prevention set-aside of the Substance Abuse Prevention and Treatment Block Grant (SABG)?**
   - Grantees may not use primary prevention set-aside funds to fund the enforcement of alcohol, tobacco or drug laws.
   - Grantees may use primary prevention set-aside funds to provide technical assistance to communities to maximize local enforcement procedures governing the availability and distribution of alcohol, tobacco and other drugs. This would include, for example, educating community members, including law enforcement officials, about the benefits of enforcing alcohol, tobacco and drug laws.
   - Additionally, states may utilize state funds and other applicable prevention discretionary funds to pay for the costs associated with enforcing these laws.
   - Based on the statutory limitations placed on primary prevention funds and the Department of Health and Human Services (DHHS) pronouncement of what activities would fall within the scope of primary prevention programs, enforcement of alcohol, tobacco and drug laws are not permissible SABG primary prevention activities.
   - Additionally, the Synar regulation specifically forbids states from using the primary prevention set-aside to fund enforcement of youth tobacco access laws.
     a. Any billing statement from a law enforcement agency must clearly separate the payment request between their **administrative time** and the time spent on the actual inspection (compliance check).
     b. Administrative time is defined as time spent on enforcement actions resulting from the issuance of a citation including writing up the report, making court appearances, further investigation, subsequent evidence collection or handling, or other similar activities that may be required in the enforcement or prosecution related to the citation.

7. **Does the SABG have any unallowable expenses? For example, is food served as part of a family meal in an evidence-based prevention curriculum such as Strengthening Families an allowable expense? How about gift cards provided to recipients of prevention services as an incentive for their participation?**
   - The SABG statute and regulation outline allowable and unallowable grant expenditures. Specifically, SABG funds may be used to provide for a wide range of activities to prevent and treat substance abuse and may be expended to deal with the abuse of alcohol, the use or abuse of illicit drugs, the abuse of licit drugs and the use or abuse of tobacco products.
   - The regulation also lists specific restrictions on the use of SABG funds. Specifically, grantees may not expend SABG funds on the following activities:
     c. To provide inpatient hospital services, except in specific circumstances outlined in the regulation;
     d. To make cash payments to intended recipients of health services. (This includes gift cards used as an incentive for participation in activities);
     e. To purchase or improve land;

f. To purchase, construct or permanently improve a building (other than minor re-modeling);
g. To purchase major medical equipment;
h. To satisfy any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds;
i. To provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs (unless the Surgeon General of the Public Health Service determines that a demonstration needle exchange program would be effective in reducing drug abuse and the risk that the public will become infected with HIV/AIDS); or
j. To provide financial assistance to any entity other than a public or nonprofit private entity. This means that if the grantee provides sub-grants to community-based or intermediary organizations, these organizations cannot be for-profit entities. However, SABG grantees and sub-recipients, including states/territories, local governments, and non-profit organizations, may award contracts, but not grants, to for-profit organizations serving as either sub-recipients or vendors under the grant.

- Except where otherwise required by federal law or regulation, a state must obligate and expend SABG funds in accordance with the laws and procedures applicable to the obligation and expenditure of its own funds.
- Since food served as part of a family meal in an evidence-based prevention curriculum is one example of an activity that is not specifically prohibited in the SABG regulation and is also part of an authorized activity, states must consult with their own procurement rules and regulations to determine if the activity it allowable.

8. Can the purchase of naloxone be funded with the primary prevention set-aside of the SABG?

- No, primary prevention funds cannot be used to purchase naloxone. However, primary prevention set-aside funds may be utilized to support overdose prevention education and training.
- SABG funds other than primary prevention set-aside funds may be utilized to purchase naloxone and the necessary materials to assemble overdose kits and to cover the costs associated with the dissemination of such kits.

9. Can Early or Problem Identification activities be counted as part of the SABG primary prevention set-aside?

- Yes, if the activities are considered those that are aimed at detecting and screening for alcohol (or drug) use and include the individual receiving intervention before the onset of major problems.
- These interventions are defined as being a brief, short-duration counseling or educational session that is not provided on an ongoing basis but to raise awareness and motivate change in individual's use patterns.

Pass through Funding:
It is important to keep in mind that **federal funds never lose their identity** regardless of how many times the dollars are sub granted or subcontracted. The original provisions for use of the dollars are applicable to each recipient. For example, if the state passes federal funds to an agency, which are in turn passed to subcontractor, the subcontractor must also follow the same guidance to ensure that federal funds are used for authorized purposes in compliance with laws, regulations, and provisions of the contract or grant agreements are met.

Use of Federal Funding for Food/Meals:
The rules on using federal funds for food purchases may depend on whether you are an individual travelling to or attending a training, or if you are the sponsor of a training or conference event. As the rules for use are often conditional, the following categories are suggested.

Travel:
In general, federal funds can be used to reimburse for meals when in travel status, but the reimbursement amount is restricted to the maximum allowed by Federal *per diem* guidelines, see (http://www.gsa.gov/portal/category/21287).

The Substance Abuse and Mental Health Services Administration's general rules are:

- Travel other than local mileage must be pre-approved;
- Travel must be reasonable and there must be a description of how this is determined; mileage, meals and incidentals, and lodging charged to federal programs are limited to the rates published in the Federal Travel Regulations, unless otherwise justified;
- Airfare is limited to coach and car rental to mid-sized, unless otherwise justified; and
- Travel costs are reimbursed based on expenditures reports or the like listing each cost individually along with original receipts.
- If federal funds are used by the grantee to attend a meeting, conference, etc. and meal(s) are provided as part of the program, then the per diem applied to the Federal travel costs (M&IE allowance) must be reduced by the allotted meal cost(s).

Additionally:

- You must also adhere to your own agency's policy.
- Regardless of which policy is followed, at no time may federal (or state) funds be used to purchase alcohol.
- If attending training and a meal is provided as part of the event, an individual cannot claim reimbursement for that meal.

Hosting a Conference/Training:
To determine if federal funds can be used to purchase snacks, light refreshments and/or meals for participants the agency must first review the conditions associated with that particular funding source.

Acknowledgement Requirements:
It is a standard Nebraska Department of Health and Human Services contractual agreement that any **federal funds** used for a project, training event or activity etc. require all publications resulting from the work under the contract acknowledge that the project was supported by "Grant No. XXXX" from "*Federal Agency*" **and** the *Nebraska Department of Health and Human Services* to support such work.

- Substance Abuse Prevention and Treatment Block Grant "training dollars" would be considered federal funds.
- This requirement also applies to any project funded by federal dollars via DHHS through a *subcontract or mini grant* (i.e. community collations) with the Regional Behavioral Health Authority.

Using the Substance Abuse Prevention and Treatment Block Grant as an example, the standard contract language should read as follows:

"*This project was supported in whole or part by Grant No. XXX under the Substance Abuse Prevention and Treatment Block Grant from the Substance Abuse and Mental Health Services Administration Center for Substance Abuse Prevention and the Nebraska Department of Health and Human Services."*

Abbreviations for a funding source within the advertisement should be avoided whenever possible:

- Advertisement refers to a printed brochure, flyer, program, or other specialty material designed to promote the project. This also includes text for radio, billboard, or social media.
- If limited by space or time air time restrictions, the following shall serve as a guide for abbreviation:
    - This *(ad)* is sponsored by Region XX, the Substance Abuse and Mental Health Services Administration, and Nebraska DHHS, Division of Behavioral Health

The above requirements also apply to any project, training event or activity etc. funded by **State General funds**, therefore, all published material, press releases, and documents describing the project shall contain the following acknowledgement:

"This project was supported in whole or part, from state funds received from the Division of Behavioral Health of the Nebraska Department of Health and Human Services."

NEBRASKA PREVENTION INFORMATION REPORTING SYSTEM

The Nebraska Prevention Information Reporting System (NPIRS) is an internet based reporting system designed to collect prevention activity data in the State of Nebraska. Recipients of the state and federal substance abuse fund through the DHHS Division of Behavioral Health use the system to report data per federal requirements. Subsequently, the State of Nebraska uses NPIRS to manage the Nebraska Behavioral Health Prevention System funded in whole or part by the Federal Block Grant. Entities reporting include community coalitions, private not for profit agencies conducting prevention efforts, Regional Behavioral Health Authorities, and other funded entities. The Nebraska Behavioral Health system collaborates with a variety of entities to create a comprehensive system of prevention services statewide.

Key features of NPIRS include:

1. Internet based reporting.
2. Reporting at multiple levels.
3. Coordinated reporting between various funding sources, schools and communities, etc.

Coalition Coordinators and members enter the key information used to measure progress toward meeting community goals and for reporting state progress in meeting National Outcome Measures (NOMs).

The reports provide numbers served by individual-based programs or population based programs by and strategies, by intervention type, and use of evidence-based programs.

Login and additional instructions can be accessed through this link **http://www.NPIRS.org.**

Supported Employment Payment Protocol Manual

DIVISION OF BEHAVIORAL HEALTH
NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
FINAL - REVISED 01/31/17

Table of Contents

THE NEW SUPPORTED EMPLOYMENT PAYMENT SYSTEM
Milestones and Payment Protocols

BACKGROUND

The Division of Behavioral Health and Nebraska Vocational Rehabilitation (VR) have partnered to provide Supported Employment (SE) services as effectively and efficiently as possible for to Nebraskans with serious mental illness and/or substance use disorders. New joint SE Milestones and Payment Protocols were implemented beginning October 1, 2014. Both agencies have signed a Memorandum of Understanding (October 2014) agreeing to partner in the development of these processes to improve Supported Employment services in Nebraska. [Note: The MOU for SE Services is included at the end of this protocol manual.]

A pilot study was undertaken in March 2014 – May 2014 to test the new milestones and measure the revenues that would be secured by providers with the new milestone payment system. The data from the pilot study was compiled, compared to the previous funding method and reported to the BH Regions and providers in August 2014. Behavioral Health Regions and SE providers participated in a survey to report financial and personnel data in order to develop a cost model that would determine a rate for long term support staff hours in Milestone 5.

A series of statewide group and individual region/provider conference calls were held from February through September 2014 to allow for stakeholder feedback, discussion, clarifications and questions about the operation of the new payment system. Based on the feedback and discussion, adjustments were made to the process to pay for SE and final decisions were made to move forward with implementation of the new Milestones and Payment System beginning October 1, 2014.

FEDERAL SUPPORTED EMPLOYMENT DEFINITION

Rehabilitation Act of 1973 as Amended
Title I - Vocational Rehabilitation Services
Section 7 (35-36) - Definitions.
*Nebraska VR and DBH will be working under the Rehabilitation Act of 1973 as Amended with the caveat of possible changes coming from the Workforce Investment Opportunity Act of August 2014.

Basic Definition

(A) In General

The term "supported employment" means competitive work in integrated work settings, or employment in integrated work settings in which individuals are working toward competitive work, consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individuals, for individuals with the most significant disabilities -- for whom competitive employment has not traditionally occurred; or for whom competitive employment has been interrupted or intermittent as a result of a significant disability; and who, because of the nature and severity of their disability, need intensive supported employment services for the period, and any extension, and extended services after the transition in order to perform such work.

(B) Certain transitional employment

Such term includes transitional employment for persons who are individuals with the most significant disabilities due to mental illness.

Service Expectations

The term "supported employment services" means ongoing support services and other appropriate services needed to support and maintain an individual with a most significant disability in supported employment, that:

(A) Are provided singly or in combination and are organized and made available in such a way as to assist an eligible individual to achieve competitive employment;

(B) Are based on a determination of the needs of an eligible individual, as specified in an individualized plan for employment; and

(C) Are provided by the designated State unit *for a period of time not to extend beyond 24 months post job stabilization*, unless under special circumstances the eligible individual and the rehabilitation counselor or coordinator involved jointly agree to extend the time in order to achieve the employment outcome identified in the individualized plan for employment.

STATE OF NEBRASKA SUPPORTED EMPLOYMENT DEFINITION

Basic Definition

Supported Employment is designed to provide recovery and rehabilitation services and supports to consumers engaged in community-based competitive employment-related activities in normalized settings. A Supported Employment team provides assistance with all aspects of employment development as requested and needed by the consumer. The intent of the service is to support the consumer in the recovery process so the consumer's employment goals can be successfully obtained.

Service Expectations

- Initial employment assessment completed within one week of program entry.
- Individualized Employment Plan developed with consumer within two weeks of program entry.
- Assistance with benefits counseling through Vocational Rehabilitation or other individual to do such work for consumers who are eligible for or potentially eligible but not receiving benefits from Supplemental Security Income (SSI) and/or Social Security Disability Insurance (SDDI). The Division of Behavioral Health will not reimburse funds for benefits analysis for consumers regardless of Nebraska VR eligibility.
- Individualized and customized job search with consumer.
- Employer contacts based on consumer's job preferences and needs and typically provided within one month of program entry.
- On-site job support and job skill development as needed and requested by consumer.
- Provide diversity in job options based on consumer preference including self-employment options.
- Follow-along supports provided to employer and consumer.
- Participation on consumer's treatment/rehabilitation/recovery team as needed and requested by consumer including crisis relapse prevention planning.
- Employment Plan reviewed and updated with consumer as needed but not less than every six months.
- Services reflect consumer preferences with competitive employment as the goal and are integrated with other services and supports as requested by consumer.
- Frequency of face-to-face contacts based upon need of the consumer and the employer.
- Job Development activities.
- All services must be culturally sensitive.

Supported Employment Consumer Referral Process

And

Milestones 1-5

PROCESS FOR CONSUMER REFERRAL TO SUPPORTED EMPLOYMENT

Step 1: A consumer is referred to VR for services.

- VR will do an initial interview and complete an application.
- VR determines eligibility for the VR program.
- VR provides a Benefits Orientation.
- VR develops an individual Plan of Employment.
- Other services may include:
  - career exploration
  - identification of needed community supports
  - paid work experience.

Step 2: A referral is made by the VR Specialist to the Supported Employment Provider, if the consumer and VR Specialist agree that Supported Employment is needed for her/him to be successfully employed. The referral information includes:

- a copy of the Plan of Employment,
- any VR exploration materials,
- a copy of the career notebook if used,
- a job history,
- a summary of the Benefits Orientation,
- VR Service Authorization
- All pertinent records.

Step 3: VR will make a referral for Benefits Analysis to the VR Benefits Partner (Easter Seals). The Benefits Analysis by the VR Benefits Partner will occur during work on Milestone 1. The provider may only bill the Region/Division for Benefits Analysis in the event that 1) the individual is NOT VR eligible and 2) the individual is currently receiving SSI/SSDI benefits or other benefit which may be impacted by employment/income.

WORK TO BE ACCOMPLISHED IN MILESTONES

PRE-SUPPORTED EMPLOYMENT (by VR - see Process for Consumer Referral to SE above)

- A consumer is referred to VR for services.
- VR works with consumer to develop an Individual Plan of Employment (IPE) for SE.
- The employment plan is developed and approved.
- If VR identifies an individual with most significant disabilities and who needs Supported Employment, the consumer is referred to a Supported Employment Provider.

MILESTONE 1: PLAN FOR EMPLOYMENT AND JOB DEVELOPMENT

SERVICES EXPECTED

- SE provider reviews all documentation from VR, completes Intake and services are initiated.
- SE provider notifies VR SE liaison of consumer's acceptance to SE program.
- The SE program staff develop the Job Search Plan with the Consumer and approval of the plan is verified by the Consumer and SE program staff signature.

NOTE: *Benefits Analysis will be provided by the VR Benefits Partner at the same time the consumer and SE Employment Specialist are working on Milestone 1 as appropriate based on VR eligibility. The provider may only bill the Region/Division for Benefits Analysis in the event that 1) the individual is NOT VR eligible and 2) the individual is currently receiving SSI/SSDI benefits or other benefit which may be impacted by employment/income.*

DOCUMENTATION REQUIRED (in consumer file and/or on M-1 Form)

- A written Job Search plan is signed by the consumer.
- The plan includes the following:
  - Consumer's strengths
  - Consumer's job preferences
  - IPE goal (and other acceptable options for employment)
  - Benefits orientation was completed – documentation from VR in consumer file.
  - If needed, VR refers the consumer to their Benefits Partner (Easter Seals) for detailed Benefits Counseling.
- Job expectations include:
  - Time status (part/full time),
  - Wage expected, and
  - Benefits needed.
- Supports needed include: transportation, coaching, assistive technology, job accommodations
- Barriers to employment (poor job record, criminal justice history, medical impairments).
- Approach to document satisfaction by consumer & employer.
- Plan signed by the consumer for Job Development services to begin.

PAYMENT SOURCE AND TRIGGER FOR PAYMENT

VR

SE Milestone-1 Form is completed

MILESTONE 1 Alternative: Job Retention Supports

If a consumer is competitively employed and the consumer wants the support of a SE provider to aid them in keeping the job, the VR counselor will follow the section entitled "Process of Consumer Referral to SE", as needed, for job retention services.

SERVICES EXPECTED

- SE provider reviews all documentation from VR, completes intake and services are initiated.
- SE provider notifies VR counselor of consumer's acceptance to SE program.
- The SE program staff develop the Job Retention Agreement with the Consumer and approval of the plan is verified by the Consumer and SE program staff signature.

NOTE: *Benefits Analysis will be provided by the VR Benefits Partner. A referral for these services will be initiated by the VR counselor prior to the referral to the SE provider. The provider may only bill the Region/Division for Benefits Analysis in the event that 1) the individual is NOT VR eligible and 2) the individual is currently receiving SSI/SSDI benefits or other benefit which may be impacted by employment/income.*

DOCUMENTATION REQUIRED (in consumer file and/or on M-1 Alternative Job Retention Form)

- A written Job Retention Agreement is signed by the consumer for Job Retention services to begin.
- IPE Job Goal
- Name and address of employer
- Job title and job duties
- Start date
- Hours per week
- Pay rate
- Benefits consumer is receiving
- Accommodations

- Supports needed for job retention services

PAYMENT SOURCE AND TRIGGER FOR PAYMENT

VR

SE Milestone-1 Alternative Form Job Retention Agreement is completed

MILESTONE 2: JOB SEARCH AND PLACEMENT

SERVICES EXPECTED AND TRIGGER FOR PAYMENT

- SE staff assist consumer in finding a job.
- Consumer is hired by an employer.
- There is one "start job" payment per consumer per year. If an additional payment is needed for a consumer, a written request explaining why it is needed must be sent to DHHS/DBH.
- Services to receive the start job payment include implementation of the Job Search Plan.
  → The goal matches the original IPE. If not, follow the process to notify the VR counselor and obtain signature from the consumer for the change.

DOCUMENTATION REQUIRED (in consumer file and/or on M-2 Form)

(Must be completed by SE Employment Specialist no later than 5 business days after consumer starts new job):

- Name and address of employer
- Job title and job duties
- Start date
- Hours per week
- Pay rate
- Benefits consumer is receiving
- Accommodations
- Revised Employment Plan based on job placement.
  → If IPE is different and/or has changed, an amendment will be obtained after job start and prior to successful job outcome. The amendment will contain the consumer's signature. VR will supply the SE provider with a copy of the signed document.

PAYMENT SOURCE AND TRIGGER FOR PAYMENT

DHHS/DBH

SE Milestone-2 Form is completed

- Only <u>one</u> SE M-2 payment will be made per consumer per 12-month period.
- If an additional payment is needed or a consumer, the SE Provider must submit a written request to DHHS/DBH explaining why it is needed an included documentation of all agency activity taken to assist the consumer in retaining the job. The written request must document the circumstance of the job loss, any determination of initial job appropriateness for the consumer, skills and activities taught or completed that may have mitigated events that lead to the job loss, and summarize any other activities by the SE Provider to support the consumer's success with employment. DHHS may approve or deny the additional payment at its discretion.

<u>Note:</u> For consumers who are competitively employed and are seeking help in maintaining the job (Milestone 1-Alternative Job Retention Agreement), DHHS will not pay for Milestone 2 services. However, should the consumer lose the job during the Milestone 1 time period, with DBH approval, the consumer can move into Milestone 2 and DHHS will provide payment.

MILESTONE 3: JOB STABILIZATION AND COACHING

SERVICES EXPECTED

- Job stabilization means the consumer is working at the job, and coaching time has leveled off becoming predictable.
- There is agreement between the consumer, Employment Specialist and Nebraska Vocational Rehabilitation Counselor on achieving job stabilization.
- Consumer must be on job at least 30 days.

DOCUMENTATION REQUIRED (in consumer file and/or on M-3 Form)

- Feedback from employer on 30 days job satisfaction or documentation of why feedback is not available.
- Feedback from consumer on 30 days job satisfaction
- Employment Plan is updated by Employment Specialist, as needed. Plan documents any identified training and supports needed to continue successful employment.

PAYMENT SOURCE AND TRIGGER FOR PAYMENT

VR

SE Milestone-3 Form is completed

MILESTONE 4: VR CLOSURE AND JOB RETENTION PLAN

SERVICES EXPECTED

- The VR Counselor, Employment Specialist, the consumer, and others (agreed to by consumer) start preparing the Job Retention plan.
- The focus of the Job Retention Plan is on identifying specific long term supports that will be needed. The Job Retention Plan should have the following items:
    - Consumer Contact: (projected number of times per month) specify face to face, email, phone or text.
    - Employer Contact: (projected number of times per month) specify face to face, email, phone or text.
    - Develop Natural Supports
    - Job Retention & Maintenance Skills
    - Symptom Management
    - Benefits Monitoring (Social Security, Medicaid, housing, food stamps)
    - Anticipated Discharge Date from SE
    - Consumer's Signature
- Work on this plan starts 60 days into a consumer successfully working a job.
- The job retention plan describes the long term support strategy needed to help the consumer keep the job into the future.
- The Job Retention Plan is submitted to VR and DBH within a minimum of 90 days after starting new job, upon agreement of provider and VR.
- The Job Retention Plan is on file with VR and DBH.
- VR closes the case.

DOCUMENTATION REQUIRED (in consumer file and/or on M-4 Form)

- Written plan signed by the consumer, VR Counselor, and SE Employment Specialist.
- Feedback from employer on 90 day job satisfaction or documentation of why feedback is not available.
- Feedback from consumer on 90 day job satisfaction.
- List specific follow-along supports needed by employer & consumer.

- The use of natural supports and/or other DBH funded services as needed. The plan does not necessarily require the use of an Employment Specialist.
- A crisis relapse prevention plan as specified in the job retention plan.
- Update on wages and hours.
- An anticipated discharge date from SE is noted on the M-4 (24 months from job stabilization per federal requirement).

PAYMENT SOURCE AND TRIGGER FOR PAYMENT

VR

SE Milestone-4 Form is completed

MILESTONE 5: LONG TERM SUPPORTS

SERVICES EXPECTED

- The Job Retention Plan is implemented.
- The consumer continues to work.
- The consumer may continue to receive rehab and/or treatment services, based on the service plan, to assist in managing symptoms of the behavioral health disorder and retaining employment.
- There are ongoing DBH funded supports after VR closes the case.
- A consumer may be in SE (including Long Term Supports) up to 24 months from date of job stabilization (see federal definition and requirement).
- Notify DBH at 22 months if more time is needed for Long Term Supports. DBH approval for any extension is required. To be submitted to the DBH Network Services Administrator, this request must be in writing, thoroughly describes the consumer's need for additional supports, and, includes an anticipated date that supports will no longer be needed. An updated M-5 form is to accompany the request.
  --DBH will respond to the request for extension within 30 days.
- Clinical coordination continues.
- Discharge as soon as possible when consumer is independent on a job.

DOCUMENTATION REQUIRED (in consumer file and/or on M-5 Form)

- Monthly feedback from employer or documentation of why feedback is not available.
- Monthly feedback from consumer
- Behavioral health supports are continued as needed per the Job Retention Plan.
- The plan does not require the use of an SE Employment Specialist to provide ongoing long term support.
- Describe specific supports from Job Retention Plan that are used and billed by SE program staff.
- Support work carried out by the SE provider staff is documented in the consumer file.
- Supported Employment Providers should enter the number of units (hours) of long term supports into the Central Data System (CDS) and the TAD will serve as supportive documentation for reimbursement for the number of units (hours) provided during the month. Providers should document the types of long term support provided and the amount of time for each service in the consumer file as designated in the following list:

☐ Work Performance Skills	☐ Symptom Management	☐ Natural Supports
☐ Work Related Social Skills	☐ Work / Life Balance	☐ Problem Solving
☐ Job Attendance	☐ Conflict Resolution	☐ Worksite Accommodations
☐ Coping Skills	☐ Personal Appearance	☐ Transportation
☐ Interpersonal Relationships (employer, supervisor, co-workers)	☐ Benefits Monitoring (Social Security, Medicaid, housing, food stamps)	
☐ Other	☐ Other:	☐ Other:

PAYMENT SOURCE AND TRIGGER FOR PAYMENT

DBH – FY hourly SE rate per *BH Rates Sheet* times Staff Hour

SE Milestone-5 Form is completed

SUMMARY CHART OF MILESTONE PAYMENT SYSTEM

Milestone	Funding Source	Amount	Phase of Supported Employment Service
1	**VR**	$1000	VR REFERRAL, INITIATE SERVICES, SE INTAKE, PLAN FOR EMPLOYMENT AND JOB DEVELOPMENT
2	**DBH**	See FY rate, BH Rates Sheet	JOB SEARCH AND PLACEMENT • *Note: For consumers who are competitively employed and are seeking help in maintaining the job (Milestone 1-Alternative Job Retention Agreement), DHHS will not pay for Milestone 2 services. However, should the consumer lose the job during the Milestone 1 – Alternative Job Retention Agreement time period, the consumer can move into Milestone 2 and DHHS will provide payment*.
3	**VR**	$1500	JOB STABILIZATION AND COACHING
4	**VR**	$1500	VR CLOSURE AND JOB RETENTION PLAN
5	**DBH**	See FY rate, BH Rates Sheet	LONG TERM SUPPORTS

Milestone Quick Reference

Milestones Payments Quick Reference Chart

Nebraska VR-DHHS/DBH Behavioral Health Supported Employment

MILESTONE	DESCRIPTION/ACTIVITIES	PAYMENT	AGENCY PAYING
MILESTONE 1 – Referral-Initiate SE Services-Individual Employment Plan **Note:** *There is **no cap** on the number of consumers referred to the SE Program each year.*	• VR staff develops *Individual Employment Plan (IPE)* and refers consumer to SE Program, providing all pertinent re-releasable records with referral. • SE program staff completes program intake, notifies VR SE liaison of consumer's acceptance to program. • SE program staff develops and **submits Job Search Plan** with invoice for Milestone 1.	$1,000 - Payment upon receipt of invoice for Milestone 1	Voc Rehab
MILESTONE 2 - Job Search and Placement	• SE Program staff implements Job Search Plan activities. • Develops resume and assists with applications matching consumer to job(s) consistent with IPE goal, • Contacts employer, places consumer on job, • Teaches job seeking skills and provides employer education as needed. • SE Program staff meets with VR liaison monthly to review progress. • Notifies VR immediately with Job information. • **Submits Milestone 2 Report** form to BH and sends VR a copy of report. *Note: For consumers who are competitively employed and are seeking help in maintaining the job (Milestone 1-Alternative Job Retention Agreement), DHHS will not pay for Milestone 2 services. However, should the consumer lose the job during the Milestone 1-Alternative Job Retention Agreement time period, the consumer can move into Milestone 2 and DHHS will provide payment.*	Per FY BH Rates Sheet - Payment upon receipt of invoice for Milestone 2	DHHS/ Division of Behavioral Health
MILESTONE 3 - Job Coaching and Stabilization	• SE Program staff and consumer jointly develop job-specific strategies and accommodations. • SE Program staff provides on/off-site job coaching and supports to stabilize consumer on the job. • Maintains regular contact with employer. • SE Program staff & VR liaison agree to the job stabilization. • Amend the IPE, as needed. • SE Program staff completes and **submits Milestone 3 Job Stabilization Report 30-days after job start date** with invoice for Milestone 3.	$1,500 - Payment upon receipt of invoice for Milestone 3	Voc Rehab
MILESTONE 4 - VR Closure & Job Retention Plan	• SE Program staff maintains regular contact with consumer and employer, building long-term natural supports for job retention. • The consumer, the SE provider and the VR liaison must agree to closure at minimum of 60 days post stabilization date. • A meeting is held to agree on successful employment outcome and plan for long-term support needs. • SE Program staff **submits Milestone 4 VR Closure and Job Retention Plan** with invoice for Milestone 4.	$1,500 - Payment upon receipt of invoice for Milestone 4	Voc Rehab
MILESTONE 5 - Long Term Support	• SE Program staff maintains regular contact with consumer and employer. • Provides long-term job supports. • **Submits invoice for ongoing long term supports** while gradually reducing contact as consumer becomes more independent. • SE provided is for a period of time not to extend beyond 24 months from job stabilization (see federal service definition requirement).	Hourly Rate: Per FY BH Rates Sheet to be paid upon receipt of invoice for Milestone 5	DHHS/ Division of Behavioral Health

Milestone Payment/Reporting Forms

SE MILESTONE-1

MILESTONE/SERVICE DATES: START: _____ END_____

Consumer Name:	Address:	Phone Number:	Email:

M-1 SUPPORTED EMPLOYMENT JOB SEARCH AGREEMENT

VR Counselor:	VR IPE Job Goal:	Date Submitted:

Strengths/Abilities/Contributions:	Requirements (things you must have to accept a job):
Companies you would like to explore:	Environments / Jobs to Avoid:
Employment Barriers: 1. 2. 3.	Possible Solutions to Barriers: 1. 2. 3.

Here is a list of job search skills and activities that a person will need to have the ability to do to successfully obtain employment. Please mark the activities that would be most helpful for you and the Supported Employment Specialist to do together during the job development process.

☐ Weekly Contact	☐ Worksite Accommodation Needs
☐ Interview Skills	☐ Internet Search Training / Computer Access
☐ Job Leads / Information	☐ Discuss Appropriate Job Fit (ie duties, locations, hrs)
☐ Networking	☐ Symptom Management
☐ Personal / Appearance Needs	☐ Application Assistance
☐ Cover Letter/Resume	☐ Permission to Contact Employers on Behalf of Consumer for Employer Advocacy/Job Retention/Employer Follow-up
☐ Benefits Monitoring (Social Security, Medicaid, housing, food stamps)	☐ Take to Job Interviews (when available)
☐ Current Transportation Plan:	☐ Other:
☐ Problem Solving	

Consumer Expectations/Work Expectation Skills:

☐ Arrive on Time ☐Keep Scheduled Appointments ☐Return Calls

Comments (include explanation of why Benefits Analysis was needed and person/agency who did it)

X _____ _____

Consumer Signature Date

X _____ _____

Supported Employment Specialist Signature Date

SE MILESTONE 1-ALTERNATIVE (RETENTION of Current Employment)

MILESTONE/SERVICE DATES: START:_____ END_____

Consumer Name:	Address:	Phone Number:	Email:

M-1 SUPPORTED EMPLOYMENT JOB RETENTION AGREEMENT

VR COUNSELOR:		VR IPE JOB GOAL:
JOB START DATE:		DATE SUBMITTED:
NAME OF EMPLOYER:		JOB TITLE:
EMPLOYER ADDRESS:		JOB DUTIES:
TELEPHONE #:		BENEFITS: ☐ HEALTH INSURANCE ☐ PAID SICK LEAVE ☐ RETIREMENT PLAN ☐ NONE ☐ DENTAL ☐ PAID VACATION ☐ OTHER
SUPERVISOR:		
HOURLY WAGE:	HOURS PER WEEK:	

Here is a list of job retention skills and activities that a person could need to have the ability to successfully maintain employment. Please mark the activities that would be most helpful for you and the Supported Employment Specialist to do together to help you keep your job.

☐ Job Coaching - ☐ On Site ☐ Off Site	**EMPLOYER INVOLVEMENT (CHECK ALL THAT APPLY)** ☐ We may contact employer/supervisor about work performance ☐ Employer is aware of disability ☐ Employer is aware of SE involvement ☐ Employer Contact – _____(# times per month) ☐ No Employer contact per consumer request
☐ Consumer contact- (times per week): ☐ face to face: ☐ phone, email text:	
☐ Assistance learning the job	
☐ Develop transportation plan	
☐ Problem solving	
☐ Conflict resolution	☐ Personal/Appearance
☐ Coordinate with mental health provider(s)/Symptom Management	☐ Coping Skills
☐ Attendance Skills	☐ Other:
☐ Benefits Education/Reporting (Social Security, Housing, HHS)	☐ Other:
☐ Worksite Accommodations	☐ Other:
☐ Develop work/life balance	☐ Other:
Comments (include explanation of why Benefits Analysis was needed and person/agency who did it):	

I verify that the information above is correct. I understand that I have a right to revoke this consent in writing if I so desire in the future.

_____ _____

Client Signature Date

_____ _____

Supported Employment Specialist Signature Date

SE MILESTONE-2

MILESTONE/SERVICE DATES: START: _____ END_____

Consumer Name:	Address:	Phone Number:	Email:

M-2 SUPPORTED EMPLOYMENT JOB PLACEMENT REPORT

VR Counselor:		Job Start Date:
Name of Employer:		Job Title:
Employer Address:		Job Duties:
Telephone #:		Benefits: ☐ None ☐ Health Insurance ☐ Dental ☐ Paid Sick Leave ☐ Paid Vacation ☐ Retirement Plan ☐ Other
Supervisor:		
Hourly Wage:	Hours per Week:	

JOB SEARCH SUPPORTS PROVIDED:

☐ Weekly Contact	☐ Application Assistance
☐ Interview Skills	☐ Symptom Management/Coordinate with Mental Health Providers
☐ Job Leads / Information	☐ Personal / Appearance Needs
☐ Networking	☐ Problem Solving
☐ Employer Advocacy / Follow-up	☐ Worksite Accommodation Needs
☐ Cover Letter/Resume	☐ We may contact you at work
☐ Internet Search Training / Computer Access	☐ We have reviewed possible risks involved in job
☐ Transportation Assistance	☐ Other:
☐ Benefits Monitoring (Social Security, Medicaid, housing, food stamps)	

PROJECTED INTERVENTIONS:

☐ Job Coaching - ☐ On Site ☐ Off Site	**EMPLOYER INVOLVEMENT (CHECK ALL THAT APPLY)** ☐ We may contact employer/supervisor about work performance ☐ Employer is aware of disability ☐ Employer is aware of SE involvement ☐ Employer Contact – _____ (# of times per month): ☐ No Employer contact per client requests
☐ Consumer Contact- _____ (times per week) ☐ Face to Face: ☐ Phone, Email, Text:	
☐ Assistance Learning the Job	
☐ Develop Transportation Plan	
☐ Problem Solving	☐ Personal/Appearance
☐ Conflict Resolution	☐ Coping Skills
☐ Coordinate with Mental Health Providers / Symptom Management	☐ Develop Work/Life Balance
☐ Attendance Skills	☐ Other:
☐ Benefits Monitoring (Social Security, Medicaid, housing, food stamps)	**Comments:**
☐ Worksite Accommodations	

I verify that the information above is correct. I understand that I have a right to revoke this consent in writing if I so desire in the future.

X_____ _____

Consumer Signature Date

X_____ _____

Supported Employment Specialist Signature Date

SE MILESTONE-3

MILESTONE/SERVICE DATES: START: _____ END_____

Consumer Name:	Address:	Phone Number:	Email:

M-3 SUPPORTED EMPLOYMENT JOB STABILIZATION REPORT

VR Counselor:		Job Start Date:	Stabilization Date:
Name of Employer:		Job Title:	
Hourly Wage:	Hours per Week:	Job Duties:	

STABILIZATION CRITERIA:

☐ Consumer satisfied with job & progress

☐ On the job minimum of 30 days

☐ Consumer performance meets employer expectations

☐ Supports are sufficient to maintain job

Benefits: ☐ Dental ☐ Paid Vacation ☐ Health Insurance ☐ None ☐ Other ☐ Paid Sick Leave ☐ Retirement Plan

Employer Feedback: ☐ No Employer contact per consumer request

Name of Employer Contact:

SUPPORTS PROVIDED THROUGH STABILIZATION:	**PROJECTED INTERVENTIONS:**
☐ Job Coaching - ☐ On Site ☐ Off Site	☐ Job Coaching - ☐ On Site ☐ Off Site
☐ Consumer Contact- _____ (number of contacts for this period) ☐ Face to Face: ☐ Phone, Email, Text:	☐ Consumer Contact- _____ (number of contacts for this period) ☐ Face to Face: ☐ Phone, Email, Text:
☐ Employer Contact – _____ (times per month): ☐ NA	☐ Employer Contact – _____ (times per month): ☐ NA
☐ Assistance Learning the Job	☐ Job Retention Skills
☐ Problem Solving	☐ Problem Solving
☐ Conflict Resolution	☐ Conflict Resolution
☐ Coordinate with Mental Health Providers / Symptom Management	☐ Coordinate with Mental Health Providers / Symptom Management
☐ Attendance Skills	☐ Attendance Skills
☐ Coordinate Benefits Monitoring (Social Security, Medicaid, housing, food stamps)	☐ Coordinate Benefits Monitoring (Social Security, Medicaid, housing, food stamps)
☐ Worksite Accommodations	☐ Develop Natural Supports
☐ Develop Work/Life Balance	☐ Work / Life Balance
☐ Develop Transportation Plan	☐ Transportation Assistance
☐ Personal / Appearance	☐ Personal / Appearance
☐ Coping Skills	☐ Coping Skills
☐ Other:	☐ We may contact you at work
Comments:	☐ We have reviewed possible risks involved in job
	☐ Other:
	Comments:

X_____ _____

Supported Employment Specialist Signature Date

X_____ _____

Nebraska VR Specialist Signature Date

SE MILESTONE-4

MILESTONE/SERVICE DATES: START: _____ END_____

Consumer Name:	Address:	Phone Number:	Email:

M-4 VR CLOSURE AND SE JOB RETENTION PLAN

VR Counselor:	Possible outcome date:
IPE Job Goal:	Job Title:
Name of Employer:	Job Duties:
Hourly Wage: / Hours per Week:	

CLOSURE CRITERIA:

☐ Consumer Satisfaction

☐ On the Job at least 90 days

☐ Employer Satisfaction

☐ Long Term Supports Identified

Benefits:

☐ None ☐ Health Insurance ☐ Dental ☐ Paid Sick Leave ☐ Paid Vacation ☐ Retirement Plan ☐ Other

EMPLOYER FEEDBACK: ☐ NA Per Consumer Request

NAME OF CONTACT:

SUPPORTED EMPLOYMENT SERVICES PROVIDED	JOB RETENTION PLAN (projected long term supports)
☐ Employment Advocacy	☐ Consumer Contact: (projected number of times per month) ☐ Face to Face: ☐ Phone, Email, Text:
☐ Job Search Activities	
☐ Job Seeking Skills	☐ Employer Contact (projected number of times per month) ☐ NA ☐ On-Site: ☐ Emails, Phone:
☐ Job Coaching: ☐ On-Site ☐ Off-Site	
☐ Consumer Contact: (Avg # of times per week) ☐ Face to Face: ☐ Phone, Email, Text:	
☐ Employer Contact: Face-Face, Calls ☐ NA	☐ Develop Natural Supports
☐ Work Performance Skills	☐ Job Retention & Maintenance Skills
☐ Transportation	☐ Symptom Management
☐ Benefits Monitoring (Social Security, Medicaid, housing, food stamps)	☐ Benefits Monitoring (Social Security, Medicaid, housing, food stamps)
☐ Symptom Management	☐ Other (Describe)
☐ Work / Life Balance	☐ Other (Describe)
☐ Work Related Social Skills	**Anticipated Discharge Goal Date from SE: _____**
☐ Problem Solving	**COMMENTS:**

X_____ _____

Consumer Signature Date

X_____ _____

Supported Employment Specialist Signature Date

X_____ _____

Nebraska VR Specialist Signature Date of Closure

MILESTONE REPORT FORMS PAYMENT PROCESS

Submission of Forms
When submitting the Milestone Form for payment, send a copy of EACH Milestone Form to both Vocational Rehabilitation and to the Regional Behavioral Health Authority, irrespective of which agency will pay for the completion of the Milestone. The correct entity will then process payment for the Milestone completion.

Benefits Analysis
The provider may only bill the Region/Division for Benefits Analysis in the event that 1) the individual is NOT VR eligible and 2) the individual is currently receiving SSI/SSDI benefits or other benefit which may be impacted by employment/income.

Nebraska Vocational Rehabilitation Process
When submitting the copy of **Milestone 1, 3 & 4 Forms**, send the VR copy to the appropriate VR payment processing location. Milestones 1, 3 and 4 will be paid by VR.

DHHS/DBH Process
When submitting the copy of **Milestone 2 Form,** send the DHHS/ Division of Behavioral Health copy to the Region. The Region will then submit the form to DHHS/DBH with the monthly billing. Milestones 2 and 5 will be paid by DHHS/DBH.

BH-SE1
Supported Employment Milestone Summary Billing Form

NE Department of Health and Human Services
Division of Behavioral Health

Effective 10-1-14

PROVIDER/REGION: _____
BILLING FOR MONTH/YEAR: _____
DATE SUBMITTED: _____

SERVICES	UNITS	RATES		DBH FUNDS	VR FUNDS	TOTAL
MH – SUPPORTED EMPLOYMENT						
Milestone 1		$1,000			$	$
Milestone 2		FY BH Rate		$		$
Milestone 3		$1,500			$	$
Milestone 4		$1,500			$	$
Milestone 5		FY BH Rate		$		$
Supported Employment Flex Funds	**NA**	**NA**		$		$
Benefits Analysis (attached BH-4)						
TOTAL MH Supported Employment $				$	$	$

ATTACH ALL MILESTONE REPORT FORMS TO THIS BILLING FORM.

X
ORIGINAL SIGNATURE – AGENCY DIRECTOR DATE

X
ORIGINAL SIGNATURE – REGIONAL AUTHORITY DATE

*Unit = unduplicated number of consumers

BH - 4 SE-Benefits Analysis

EXPENSE REIMBURSEMENT DOCUMENT

Behavioral Health Services Reimbursement Report

Division of Behavioral Health

AGENCY: _____

MONTH/YEAR SERVICES PRODUCED: _____

DATE OF BILL: _____

A EXPENSE CATEGORIES	B CURRENT MONTH'S EXPENSES +	C TOTAL OF PRIOR EXPENSES BILLED =	D TOTAL EXPENSES BILLED TO DATE
Personal Services			
General Operations			
Travel			
Capital Outlays			
Other Expenses			
Indirect Administration Expenses			
Subtotal			
Minus Revenue received			
TOTALS			

The # of consumers receiving initial Benefits Analysis			
The # of consumers with follow-up Benefit Analysis			

_____

Signature: Agency Director

_____

Date

10/01/2014

SUPPORTED EMPLOYMENT FLEX FUNDS GUIDANCE

Division of Behavioral Health FLEX FUNDS GUIDANCE

The SE Flexible Funds will be paid according to DBH guidance and must be directly related to job and IPE. Behavioral Health Region will determine whether they wish to use Supported Employment dollars for flexible funding. DBH Flex Funds may be used anytime during Milestones 1-5. These funds are from DBH and not paid by VR.

Purpose

Supported Employment Flex Funds (SEFF) are available to each consumer enrolled in Supported Employment Services to provide the necessary resources to address identified employment needs in implementing an approved Individual Plan of Employment (IPE).

Applicability

The Behavioral Health Supported Employment (BHSE) Provider can use SEFF resources to assist with the implementation of an IPE.

- The BHSE is responsible to maintain all supporting documentation needed to substantiate any SEFF claims.
- There is documentation showing the items purchased **cannot** be provided through Nebraska Vocational Rehabilitation, Department of Labor, other funding mechanisms or more traditional service provision modalities.
- Authorized use includes the following: transportation (gas, auto repair), tools, uniforms, medications, lab work, and related areas that are directly related to job attainment or retention.

Accountability

- If the Region choose to, they shall determine whether they want to use Supported Employment funding for SEFF.
- If the Region is willing to use its Supported Employment allocation for SEFF, each BHSE provider designates an allocation of Flexible Funds which is then approved by the Regional Behavioral Health Authority. Region may choose to increase Supported Employment allocation for Flex Fund purposes.
- The Regional Behavioral Health Authority shall ensure these Flexible Funds are used to purchase goods and services for eligible consumers based on needs identified in the IPE.
- Use of SEFF resources needs to comply with State requirements pertaining to allowable and unallowable costs.
- The funds are subject to additional restrictions as may be imposed by the Region.

Financial Reporting

- The Region shall have a process for authorizing, monitoring, and accounting for the expenditures of SEFF resources.
- The Region shall insure the provider's SEFF expenditures do not exceed budgeted amounts.
- A monthly financial report must be submitted by the Region to the Division of Behavioral Health for the utilization of SEFF resources.
- The use of all Supported Employment Flexible Funds will be monitored by the Department to evaluate cost effectiveness and the impact of SEFF resources on consumer outcomes.

BH-SE1 Flex Funds
Supported Employment Consumer Billing Form

NE Department of Health and Human Services
Division of Behavioral Health

Effective 10-1-14

PROVIDER/REGION: _____
BILLING FOR MONTH/YEAR: _____
DATE SUBMITTED: _____

CONSUMER NAME:	DATE:

1. DBH Flex Funds may not be used for any item, service or expense that can be paid for in full by Nebraska Vocational Rehabilitation or other source.

2. DBH Flex Funds may be in combination with other sources with permission from DHHS.

3. Flex Funds may only be used to purchase goods or services for SE eligible consumers based up the individual's Plan of Employment.

CONSUMER NEED FOR FLEX FUNDS (as documented in the IEP)

Items Eligible for Flex Funds	***Cost:***
Transportation to/from residence and work only (gas, bus tickets, taxi) during job search and until person can pay for cost through earnings	$0.00
One-time Car Repairs	$0.00
Tools required for performance of job not provided by employer (most economical set available)	$0.00
Required clothing, uniforms, work shoes, or other required apparel not provided by employer or Nebraska Vocational Rehabilitation	$0.00
License or permit fees required for employment (one time)	$0.00
Medications for the consumer	$0.00
Lab work or testing required for employment & not paid for by employer	$0.00
Other (pre-approved by DBH):	$0.00
Other (pre-approved by DBH):	$0.00
Other (pre-approved by DBH):	$0.00
TOTAL - SE Flex Funds $	**$0.00**

<u>Attach documentation</u> showing that items purchased cannot be provided through Nebraska Vocational Rehabilitation, Department of Labor, and other funding mechanisms, OR through more traditional services. If documentation is not available, explain below.

DOCUMENTATION EXPLANATION (as needed):

X
ORIGINAL SIGNATURE: Supported Employment Staff Date

X
ORIGINAL SIGNATURE: Agency Fiscal Manager/Director Date

Memorandum of Understanding

MEMORANDUM OF UNDERSTANDING FOR SUPPORTED EMPLOYMENT SERVICES

INTERAGENCY AGREEMENT
BETWEEN THE

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF BEHAVIORAL HEALTH
AND
NEBRASKA DEPARTMENT OF EDUCATION
VOCATIONAL REHABILITATION

This agreement is entered into by and between the Nebraska Department of Health and Human Services, **DIVISION OF BEHAVIORAL HEALTH** (hereinafter "DHHS"), and Nebraska Department of Education, **NEBRASKA VR** (hereinafter "Agency").

NO JOINT ENTITY. This agreement does not create a joint entity. Each party retains their statutory authority, maintains separate administration, and will not have jointly held property.

PURPOSE. The purpose of this agreement is for the DHHS and the Agency to work together to contract for Supported Employment services for persons with mental illness and/or substance use disorders in Nebraska.

I. TERM AND TERMINATION

A. TERM. This agreement is in effect from October 1, 2014 until October 30, 2017.

B. TERMINATION. This agreement may be terminated at any time upon mutual written consent or by either party for any reason upon submission of written notice to the other party at least Thirty (30) days prior to the effective date of termination. DHHS may also terminate this contract in accord with the provisions designated "FUNDING AVAILABILITY" and "BREACH OF AGREEMENT." In the event either party terminates this agreement, the Agency shall provide to DHHS all work in progress, work completed, and materials provided to it by DHHS in connection with this agreement.

II. SCOPE OF SERVICES

A. The Agency shall do the following:
   a. Implement and maintain the Behavioral Health Supported Employment Braided Funding Model.
      i. Will be responsible to pay for Milestones 1, 3 & 4 as specified in Attachment 1.
   b. Commit in writing to provide funding as necessary to implement the agreed to Supported Employment milestone payments (Attachment 1) for the period of this agreement with no reduction in the payment amounts except by the agreement of both DHHS and the Agency.
   c. Meet periodically, on a mutually agreed upon date/time, to review and discuss implemented Behavioral Health Supported Employment Braided Funding

Model.

d. Provide information on funding levels, persons served, and related content in order to monitor and evaluate the implementation of the Supported Employment programs for persons with mental illness and/or substance use disorders in Nebraska.

B. DHHS shall do the following:

a. Implement and maintain the Behavioral Health Supported Employment Braided Funding Model.
   i. Will be responsible to pay for Milestones 2 & 5 as specified in Attachment 1.

b. Commit in writing to provide funding as necessary to implement the agreed to Supported Employment milestone payments (Attachment 1) for the period of this agreement with no reduction in the payment amounts except by the agreement of both DHHS and the Agency.

c. Will schedule the meetings between DHHS and the Agency, on a mutually agreed upon date/time, to review and discuss implemented Behavioral Health Supported Employment Braided Funding Model.

d. Provide information on funding levels, persons served, and related content in order to monitor and evaluate the implementation of the Supported Employment programs for persons with mental illness and/or substance use disorders in Nebraska.

IV. GENERAL PROVISIONS

A. AMENDMENT. This agreement may be modified only by written amendment, executed by both DHHS and the Agency. No alteration or variation of the terms and conditions of this agreement shall be valid unless made in writing and signed by DHHS and the Agency.

B. ANTI-DISCRIMINATION. DHHS and the Agency shall comply with all applicable local, state and federal statutes and regulations regarding civil rights and equal opportunity employment, including Title VI of the Civil Rights Act of 1964; the Rehabilitation Act of 1973, Public Law 93-112; the Americans With Disabilities Act of 1990, Public Law 101-336; and the Nebraska Fair Employment Practice Act, NEB. REV. STAT. §§ 48-1101 to 48-1125. Violation of said statutes and regulations will constitute a material breach of agreement. DHHS and the Agency shall insert this provision in all subcontracts.

C. ASSIGNMENT. The Agency shall not assign or transfer any interest, rights, or duties under this agreement to any person, firm, or corporation without prior written consent of DHHS. In the absence of such written consent, any assignment or attempt to assign shall constitute a breach of this agreement.

judicial forums as defined by Nebraska State law. DHHS and the Agency shall comply with all Nebraska statutory and regulatory law.

K. HOLD HARMLESS.

1. DHHS and the Agency liability is limited to the extent provided by the Nebraska Tort Claims Act, the Nebraska Contract Claims Act, the Nebraska Miscellaneous Claims Act, and any other applicable provisions of law. DHHS and the Agency do not assume liability for the action of its Contractors.

2. The above provisions shall survive termination of the agreement.

L. NEW EMPLOYEE WORK ELIGIBILITY STATUS. DHHS and the Agency shall use a federal immigration verification system to determine the work eligibility status of new employees physically performing services within the State of Nebraska. A federal immigration verification system means the electronic verification of the work authorization program authorized by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. § 1324a, known as the E-Verify Program, or an equivalent federal program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work eligibility status of a newly hired employee.

If the Party is an individual or sole proprietorship, the following applies:

1. The Party must complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at www.das.state.ne.us.

2. If the Party indicates on such attestation form that he or she is a qualified alien, the Party agrees to provide the U.S. Citizenship and Immigration Services documentation required to verify the Party's lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.

3. The Party understands and agrees that lawful presence in the United States is required and the Party may be disqualified or the agreement terminated if such lawful presence cannot be verified as required by NEB. REV. STAT. § 4-108.

M. PUBLIC COUNSEL. In the event Agency provides health and human services to individuals on behalf of DHHS under the terms of this agreement, Agency shall submit to the jurisdiction of the Public Counsel under NEB. REV. STAT. §§ 81-8,240 through 81-8,254 with respect to the provision of services under this agreement. This provision shall not apply to agreements between DHHS and long-term care facilities subject to the jurisdiction of the state long-term care ombudsman pursuant to the Long-Term Care Ombudsman Act. This provision shall survive termination of the agreement.

N. SEVERABILITY. If any term or condition of this agreement is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and conditions shall not be affected, and the rights and obligations of the Agency shall be construed and enforced as if this agreement did not contain the particular provision held to be invalid.

O. SUBCONTRACTORS. The Agency shall not subcontract any portion of this agreement without prior written consent of DHHS. The Agency shall ensure that all subcontractors comply with all requirements of this agreement and applicable federal, state, county and municipal laws, ordinances, rules and regulations.

NOTICES. Notices shall be in writing and shall be effective upon receipt. Written notices, including all reports and other written communications required by this agreement shall be sent to the following addresses:

FOR DHHS:

Scot Adams
Division of Behavioral Health
PO Box 95026
Lincoln, NE, 68509
402-471-8553

FOR AGENCY:

Mark Schultz
Vocational Rehabiliation
PO Box 94987
Lincoln, NE, 68509
402-471-0788

IN WITNESS THEREOF, the parties have duly executed this agreement, and each party acknowledges the receipt of a duly executed copy of this agreement with original signatures.

FOR DHHS:

Scot Adams
Director
Department of Health and Human Services
Division of Behavorial

DATE: 10/6/2014

FOR AGENCY:

Mark Schultz
Director
Department of Education
Nebraska VR

DATE: 10/3/14