TITLE 206 BEHAVIORAL HEALTH SERVICES

CHAPTER 6-000 STANDARDS OF CARE

6-001 CONSUMER RIGHTS: The following rights apply to consumers receiving behavioral health services through Nebraska's public behavioral health system. All consumers have the right to:

1. Be treated respectfully, impartially, and with dignity;
2. Communicate freely with individuals of their choice including, but not limited to, family, friends, legal counsel, and his/her private physician;
3. Have clinical records made available to themselves and individuals of their choice by his/her written request;
4. Actively and directly participate in decisions which incorporate independence, individuality, privacy, and dignity and to make decisions regarding care and treatment;
5. Refuse treatment or therapy, unless treatment or therapy was authorized by the consumer's legal guardian or was ordered by a mental health board or court;
6. Have privacy and confidentiality related to all aspects of care;
7. Be protected from neglect; physical, emotional or verbal abuse; and exploitation of any kind;
8. Actively and directly participate in developing an individual treatment, rehabilitation, and recovery plan and decision-making regarding his/her behavioral health care;
9. Receive care from providers who adhere to a strict policy of non-discrimination in the provision of services;
10. Be free of sexual exploitation and, harassment;
11. Voice complaints and file grievances without discrimination or reprisal and to have those complaints and grievances addressed in a timely manner (see 206 NAC 6-003); and
12. Receive behavioral health services in the most integrated setting appropriate for each consumer based on an individualized and person-centered assessment.

6-002 COMPLAINTS: Consumers must be able to freely voice complaints and recommend changes without being subject to coercion, discrimination, reprisal, or unreasonable interruption of care, treatment, and services.

6-003 CONSUMER GRIEVANCES: Each provider must establish a written consumer grievance policy with the following components:

1. Consumers and as applicable, their legal representative(s) and family of their choosing must be informed of and given a copy of written procedures for addressing and resolving grievances established by each provider (see consumer rights in 206 NAC 6-001);
2. Consumers, families, staff, and others must have access to the provider's grievance process;
3. The consumer's grievance must be responded to by the provider in a timely manner and the provider must document its response to the consumer;

4. If the consumer's grievance is not addressed satisfactorily through the provider's complaint process, the provider must give adequate information, including telephone numbers and addresses, to the consumer to enable the consumer to contact the Division of Behavioral Health, Office of Consumer Affairs; the Division of Public Health, Facility Complaint Intake and the Investigations Section, the designated Protection and Advocacy organization for Nebraska; the Consumer Specialist of the Regional Behavioral Health Authority (RBHA); the office of the Ombudsman; the Department's System Advocate, and the vendor who is contracted for system management. This information must also be readily available to consumers, families, staff, and others.

6-004 TRAUMA-INFORMED SERVICES: All state funded behavioral health providers must be knowledgeable about the effects of psychological trauma. Providers must consistently screen for trauma symptoms and history of traumatic events, provide ongoing review of trauma symptoms and problems related to that trauma, and offer services that are recovery-oriented and trauma-sensitive.

6-005 CONSUMER ELIGIBILITY AND PAYMENT FOR SERVICES: The Division will reimburse RBHA's for behavioral services for consumers who meet the following:

1. Clinical eligibility criteria for the services specified in the Behavioral Health Adult Services Definitions (attached and incorporated in these regulations by this reference); and
2. Financial eligibility criteria as specified in the Division of Behavioral Health Financial Eligibility Policy (attached and incorporated in these regulations by this reference) and fee schedule. The attached Financial Eligibility Policy is based on the 2012 United States Department of Health and Human Services (HHS) Federal Poverty Guidelines. For future fiscal years, the Financial Eligibility Policy and fee schedule will be adjusted based on changes to the annual United States Federal Poverty Guidelines and will not be specified in the regulations; and
3. Citizenship/lawful presence requirements set forth in Neb. Rev. Stat. §§ 4-108 to 4-114.
   a. An applicant for public benefits must attest that:
      i. S/he is a citizen of the United States of America; or
      ii. S/he is a qualified alien under the federal Immigration and Nationality Act 8 USC § 1101 et seq., as such existed on January 1, 2009, and is lawfully present in the United States.
   b. The attestation must be in the format prescribed by the Department of Administrative Services.

6-005.01 The assessment of a consumer's financial eligibility is an ongoing process. The consumer's financial eligibility status must be re-assessed annually or when known changes occur such as changes in current income or number of dependents. The re-assessment may increase or decrease the co-payment obligations of the consumer.

6-005.02 Consumers who refuse to provide financial information shall be charged the full cost of services. The provider may not bill the Department for any service for which

the consumer is responsible due to the failure to provide financial information or signed statement.

6-005.03 The RBHA shall adopt a policy for use in determining the financial eligibility of all consumers and shall adopt a uniform schedule of fees and copays, based on the Division of Behavioral Health Financial Eligibility Policy and Fee Schedules. The RBHA policy and schedule of fees and co-payments shall be approved by the Division. The RBHA shall assure that its policy and schedule of fees and copays are applied uniformly by the providers in the region.

6-005.04 For a consumer who meets the Division's clinical eligibility, citizenship/lawful presence, and financial eligibility criteria, the RBHA will be reimbursed:

1. The rate set by the Division for services provided which are pre-authorized with the Administrative Services Organization (ASO) or registered services that have a statewide rate established; or
2. A Region-determined rate or reimbursement for allowable uncompensated expenses for services provided which are registered with the ASO or otherwise documented as required by the Division.
    a. The payment shall not exceed the actual cost of the service less any copayment and third party payment received for the service.

6-005.05 The Division reserves the right to be the Payer of Last Resort for consumers who meet the Division's Clinical Criteria for an identified level of care and who are without the financial resources to pay for care. The Division will not reimburse:

1. For Medicaid reimbursable services (other than Medicaid Rehabilitation Option, Substance Abuse Waiver services, and room and board for consumers receiving Secure Residential treatment services) provided to Medicaid consumers. If the consumer has accrued personal needs allowance and created savings that disqualify him/her from a benefit such as Medicaid, the full cost of the service must be assessed to the consumer until he/she qualifies for the Medicaid benefit.
2. For any portion of services required to be paid by a Medicaid recipient to meet a share of cost obligation.
3. For services eligible for, or covered under, other health insurance benefits that were denied by an insurance company due to provider error or insufficient documentation, that were not submitted to the insurance company in accordance with the policy or that were not submitted to the insurance company at the request of the consumer.
4. For any service in which the consumer is deemed eligible to pay the cost of the service.

6-005.06 To determine if a consumer meets financial eligibility on the Financial Eligibility and Fee Schedule:

1. Complete the eligibility worksheet to determine the adjusted monthly income. To determine the adjusted monthly income:
   a. Add up wages, alimony, tips or other money received for a good or service in the past 12 month period. Divide this number by 12 to determine the "Taxable Monthly Income" of the individual.
   b. Determine the monthly amount for housing, utilities, transportation, or daycare paid by the individual. Actual cost claimed cannot exceed the maximum amounts listed on the worksheet for each item. Total the amounts listed for housing, utilities, transportation, and daycare to determine "Total Allowable Liabilities."
   c. Subtract the "Total Allowable Liabilities" from the "Taxable Monthly Income" amount to determine the "Adjusted Monthly Income" amount to be used to determine eligibility for funded services.
2. Locate the adjusted monthly income amount on the appropriate schedule;
   d. Financial eligibility fee schedule is used for consumers who do not meet the requirements for the Hardship or Emergency Access fee schedules.
   e. Hardship fee schedule is used for:
      i. Consumers who meet criteria for severe and persistent mental illness; or
      ii. Consumers who meet criteria for serious emotional disorder in youth 19 or under; or
      iii. Medical bills or medical debt in excess of 10% of the taxable annual income.
   f. Emergency Access Fee Schedule is used for:
      i. Consumers receiving assistance from crisis response team, emergency community support, housing related assistance; or
      ii. Hospital diversion programs where consumers stay less than 24 hours.
3. Locate the total number of family members dependent on the taxable income; and
4. Only those consumers who fall within the shaded areas on the fee schedules are eligible for services funded by the Division.

6-005.07 In addition to payments made by the Division, the RBHA may assess consumers a co-payment fee based upon the financial eligibility fee schedule. To determine the maximum copayment:

1. Locate the adjusted monthly income amount on the appropriate schedule.
2. Locate the total number of family members dependent on the taxable income.
3. Locate the box in which the column and row intersect is the maximum co-payment fee to be charged to the consumer for each appointment or unit of service.

6-005.08 Residential levels of care will receive payment based on the Department's established rates. In addition, room and board fees, a co-payment fee may also be assessed. The room and board fee may not be in excess of actual costs incurred for these services by the provider. All co-payments charged must be in compliance with the Division Financial Eligibility and Fee Schedules.

6-005.09 Fees and co-payments for Substance Abuse Education and Diversion programs are determined by the region or other providers and are not subject to provisions of the Division Financial Eligibility and Fee Schedules.

6-005.10 The Division and/or the RBHA may request from the provider verification of a consumer's eligibility for service.

6-006 RECORDS: Records must be maintained for all consumers admitted to a mental health or substance abuse treatment service funded by the Division. Documentation in the record must reflect the consumer's treatment/rehabilitation experience and be of the type and quality to facilitate service planning, evaluation, and continuity of care.

6-006.01 Policies and Procedures: Each organization/provider must have written policies and procedures regarding the maintenance of service records that:

1. Govern the compilation, storage, dissemination, and accessibility of the consumer's service records;
2. Are designed to ensure that the program fulfills its responsibility to safeguard and protect consumer records against loss and unauthorized alteration or disclosure that are compliant with HIPAA regulations and other relevant state and federal law;
3. Are designed to ensure that each record contains all information required by organizational policy and is consistent with professional practice;
4. Are designed to ensure uniformity in the format and forms used in consumer service records;
5. Require entries in the consumer service records to be legible, dated, and signed;
6. Include an explanatory legend approved by management staff for the abbreviations used;
7. Require maintenance of records at the Provider's site where the consumer is served to ensure that the records are directly accessible to the staff providing services. If only partial records are maintained at the program site, the policies and procedures must describe the information to be kept in each record, including a minimum of identifying information; current assessment; current individual treatment, rehabilitation, and recovery plan; emergency information; all applicable progress notes; legal information; and medical history;
   a. Providers of multiple services must indicate how significant consumer issues are shared between programs.
8. Specify time frames for the completion of assessments, assessment updates, emergency information updates, service plans, progress notes,

service plan reviews, discharge summaries, and any other standard treatment/rehabilitation/recovery documentation that are consistent with services as described in this chapter; and

9. Govern the disposal of consumer service records, including the following provisions:
   a. Records must be maintained for at least five years from the date the consumer is discharged from the program or until at last five years following the end of the contract year in which services were billed, whichever is longer; and
   b. Methods of disposal are designed to ensure the confidentiality of information.

6-006.02 Clinical Documentation: Behavioral health providers must maintain a clinical record that is confidential, complete, accurate, and contains up-to-date information relevant to the consumer's care and services. The record must sufficiently document assessments; individual treatment, rehabilitation, and recovery plans and plan reviews; and important provider discussion. The clinical record must document consumer contacts describing the nature and extent of the services provided, such that a clinician unfamiliar with the service can identify the consumer's service needs and services received. The documentation must reflect the rehabilitative services provided, and is consistent with the goals in the individual treatment, rehabilitation, and recovery plan, and based upon the comprehensive assessment. The absence of appropriate, legible, and complete records may result in the recoupment of previous payments for services. Each entry must identify the date, location of service, and the first name, last name, and title of the staff person providing the service.

Documentation requirements for day rehabilitation and for residential rehabilitation must provide a daily summary of the treatment describing consumer's condition, treatment and rehabilitation interventions provided and consumer's response to those interventions. Providers of multiple services must indicate how significant consumer issues are shared between providers.

Records must be kept in a locked file when not in use. For purposes of confidentiality, disclosure of treatment/rehabilitation/recovery information is subject to all the provisions of applicable State and Federal laws. The consumer's clinical record must be available for review by the consumer (and his/her guardian with appropriate consent) unless there is a specific clinically indicated reason to preclude this availability. The specific reason must be documented in the clinical record and reviewed periodically.

6-006.02A The clinical record must include, at a minimum:

1. Consumer identifying data, including demographic information and the consumer's legal status;
2. Assessment and Evaluations;
   a. Pre-Authorization/Referral Screening
   b. Comprehensive Assessment

c. Psychiatric assessment substantiating the consumer's diagnosis, and referral for treatment/rehabilitation/recovery service; and
d. Other appropriate assessments.

3. Consumer's Diagnostic Formulation (including all five axes);
4. Individual Treatment, Rehabilitation, and Recovery Plan and updates to plans;
5. Documentation of review of Consumer Rights with the consumer;
6. A chronological record of all services provided to the consumer. Each entry must include the staff member who performed the service received. Each entry includes the date the service was performed, the duration of the service, the place of the service, and the staff member's identity and legible signature, name, and title. All record entries must be dated, legible and indelibly verified. In the case of electronic records, signatures may be replaced by an approved, uniquely identifiable electronic equivalent.
7. Documentation of the level of participation of the consumer's participation in the service and involvement of family and significant others;
8. Documentation of treatment, rehabilitation, and recovery services and discharge planning;
9. A chronological listing of the medications prescribed (including dosages and schedule) for the consumer and the consumer's response to the medication;
10. Documentation of coordination with other services and treatment providers;
11. Discharge summaries from previous levels of care;
12. Discharge summary (when appropriate); and
13. Any clinical documentation requirements identified in the specific service.

6-006.02B The record must contain documentation that the consumer and guardian, as applicable, has participated in the program orientation.

6-006.02C The record must contain documentation of the consent of the consumer, and/or appropriate family members or guardians, as applicable, to treatment, rehabilitation, and/or recovery services, medication usage, and other services to be provided as stated in the individual treatment, rehabilitation, and recovery plan.

6-006.02D Consent to each of these services includes the concomitant right to refuse services, unless the treatment is court-ordered or required under the Nebraska Mental Health Commitment Act (Neb. Rev. Stat. §§ 71-901 to 71-962).

6-006.02E The risks and benefits of every service for which consent is sought and the right to refuse the service must be explained to the consumer at a level educationally appropriate to the individual.

6-006.02F The record must contain correspondence to and from the program regarding the services received. Signed and dated progress notes of all telephone calls concerning these services must also be present.

6-006.03 Medications: For each consumer who is receiving prescribed medication, the record must contain a medication use profile. This profile must include:

1. A listing of all medications and dosages currently prescribed by the psychiatric prescribing clinician (MD, APRN, or PA);
2. A listing of all medications and dosages currently prescribed by any other prescriber;
3. A listing of all over-the-counter medications, herbal preparations, or other alternative treatment being used by the consumer;
4. Documentation from the program's physician, including, upon discontinuation, the date and reason each drug is discontinued;
5. Documentation that medication education/health teaching has occurred and the consumer is informed regarding each medication prescribed during treatment and that the consumer understands the information; and
6. Documentation of the consumer's response to the teaching and medications prescribed (e.g. adverse effects, therapeutic effects, adherence issues).

6-007 ASSESSMENT: An assessment must be completed for each consumer upon entrance/admission of the consumer to the service, and on an ongoing basis as determined by the service description and the program's rehabilitation/clinical practice policy. The assessment must include a review of referral information, as applicable and, through appropriate evaluation procedures, must supplement this information as needed for initiation or continuation of treatment, rehabilitation, and recovery. Areas covered in the assessment must be consistent with program requirements, as specified in the service description, and determined by the needs of the consumer served as well as the service mission of the program. If the consumer demonstrates needs that fall outside the scope of the service, referral to and cooperation with other appropriate services/programs must be demonstrated and documented.

6-007.01 The assessment must be completed within the timeframe specified in the program's policies and procedures, however, no more than the timeframe prescribed in the Behavioral Health Adult Services Definitions. The assessment must include the following components:

1. Consumer name, Medicaid identification number, emergency contact (name, relationship and contact information), and other information of the consumer that is relevant;
2. Provider demographics including: provider name, address, phone, fax, and e-mail, and other contact information;
3. Individual strengths, presenting problem, and primary complaint including:
   a. Identification of the consumer's status, strengths, needs, and problem(s), resiliencies, experiences (including past trauma), cultural background, and preferences;

b. Determination of the consumer's strengths, weaknesses, resiliencies, experiences (including past trauma), cultural background, and preferences to address the identified problem(s);
c. Reason for referral to treatment, rehabilitation, and recovery services and referral source;
d. Name and title of the referral individual, such as MD, psychologist, APRN, or LIMHP;
e. Presenting problem from the consumer and provider's perspective;
f. External leverage to seek evaluation (courts, family and other).

4. Medical History:
   a. Dental history and current needs;
   b. Current medication list;
   c. Compliance with medication (historical and current);
   d. Current primary care physician (name and contact information);
   e. Date of last physical exam and physician providing that assessment;
   f. Recent hospitalizations; and
   g. Major health concerns (such as STD's, HIV, Tuberculosis, Hepatitis, pregnancy, diabetes, obesity, and nicotine dependency).
5. Employment/Education/Military History:
   a. History of employment;
   b. Educational history;
   c. Military involvement; and
   d. Strengths.
6. Alcohol/Drug History:
   a. Primary drug(s) of choice;
   b. Amount, frequency and duration of use;
   c. Prior treatment(s), location and length of stay;
   d. Current compliance with relapse prevention plan;
   e. Periods of abstinence (supports needed);
   f. Tolerance level/withdrawal/history of complications from withdrawal;
   g. Prior alcohol/drug evaluations/recommendations;
   h. Family history of alcohol/drug use; and
   i. Other addictive behaviors
7. Legal History (Information from Criminal Justice System):
   a. Criminal history and consequences of criminal involvement;
   b. Connection to alcohol/drug use; and
   c. Current legal charges/disposition of charges.
8. Family/Social/Peer
   a. People involved in the individual's life, including (1) Family members (age and level of involvement with consumer), (2) Adult or minor children (names, ages and level of involvement), and (3) other significant people and level of involvement;
   b. Parenting knowledge or skill level, history of system involvement (courts);
   c. Social supports utilized by consumer (previous and current);
   d. Housing (ability to maintain housing, type of current housing, need for assistance);

   e. Recreational activities (consumer's preference);
   f. Collateral information; and
   g. Consumer strengths as perceived by consumer and collateral contacts.
9. Psychiatric/Behavioral History:
   a. Current diagnosis(s);
   b. Previous treatment(s) and outcome(s) of treatment(s);
   c. Current mental health and substance use providers and treatment currently provided;
   d. Current psychiatric medication list;
   e. Compliance with medication (historical and current);
   f. History of self harm or threats to harm others;
   g. Board of mental health commitments (reason and dates of commitment);
   h. Abuse (to include sexual abuse, physical abuse, emotional abuse, neglect, witness domestic violence, victim/witness of community violence, physical assault); and
   i. Trauma (serious accident/injury, sexual assault/rape, life-threatening medical illness, traumatic loss of a loved one, terrorist act, war/political violence/torture, disasters [tornado, earthquakes], sanctuary trauma [trauma while institutionalized], prostitution/sex trafficking).
10. Clinical Impressions: (must be completed a licensed clinician whose scope of practice includes diagnosing major mental illness).
   a. This section should include the information that supports/justifies the recommendations in section J and must integrate mental health and substance use co-occurring disorders; and
   b. DSM-5 diagnosis.
11. Recommendations:
   a. Primary/ideal level of care;
   b. Available level of care/barriers to ideal level of care;
   c. Consumer/family's response to recommendations; and
   d. Goals consumer wants to accomplish.
12. Signature of fully licensed clinician approving this assessment.
13. Date of signature

<u>6-008 DISCHARGE PLANNING</u>: Discharge planning must occur in advance of a consumer's discharge from any service. The discharge plan must be strength-based, recovery-oriented, trauma-informed and include participation by the consumer and family/legal guardian as appropriate. The discharge plan must be documented in the consumer's record. The discharge plan must:

1. Begin on admission and be updated on an ongoing basis with <u>the direct and active</u> participation of the consumer and family/legal guardian, as appropriate and with the consumer's consent;
2. Be a component of the Individual Treatment, Rehabilitation, and Recovery plan and be consistent with the goals and objectives identified with the direct and active participation of the consumer, family, and guardian as appropriate;

3. Address the consumer's need for ongoing services to promote recovery. A crisis/safety/relapse prevention plan must be in place and address triggers, helpful intervention strategies, and contact information for resources useful in a crisis;
4. Document all referrals; and
5. Document pre-discharge planning, recommendations, and/or arrangements for a post-treatment/rehabilitation/recovery plan including but not limited to:
   a. Accessing and using medication
   b. Housing
   c. Employment
   d. Transportation
   e. Social connectedness – formal and informal support systems
   f. Plans to address unmet goals

6-009 INDIVIDUAL TREATMENT, REHABILITATION, AND RECOVERY PLAN: For treatment and rehabilitation services, a plan must be developed. Each record must contain a recovery-oriented individual treatment, rehabilitation, and recovery plan for all services provided in the program based on the individualized and person-centered assessment of the consumer and the Behavioral Health Adult Services Definitions. This plan must:

1. Be oriented to and apply the principles of recovery including but not limited to inclusion, direct and active participation, and a meaningful life in the community of one's choosing;
2. Incorporate and be consistent with best practices;
3. Include the consumer's individualized goals and expected outcomes;
4. Contain prioritized objectives that are measurable and time-limited;
5. Describe therapeutic interventions that are recovery-oriented, trauma-informed, and strength-based;
6. Identify staff responsible for implementing the therapeutic interventions;
7. Specify the planned frequency or duration of each therapeutic intervention;
8. Delineate the specific behavioral criteria to be met for discharge or transition to a lower level of care;
9. Include a component to avoid crises or admission to a higher level of care using principles of recovery and wellness;
10. Include the signature of the consumer and/or guardian to indicate agreement with the plan;
11. Document that the individual treatment, rehabilitation, and recovery plan is completed within the time frame specified in the policies and Behavioral Health Adult Service Definitions;
12. Document that the plan has been developed, reviewed, updated, and revised with the direct and active involvement of the consumer. If documentation shows that the consumer is not achieving his/her goals, timely revision of the plan must be documented; and
13. Be approved and signed by the licensed clinical supervisor.

6-010 PROGRESS NOTES: Each record must contain progress notes that document implementation of the individual treatment, rehabilitation, and recovery plan.

6-010.01 Progress notes must document:

1. All services provided,
2. How services provided relate specifically to goals and priorities identified in the individual treatment, rehabilitation, and recovery plan;
3. Consumer's participation in the review and revision of goals and treatment activities,
4. Consumer's opinion of progress being made (in consumer's own words, if possible).

6-010.02 Progress notes must be completed within the time frame specified in the program's policies and procedures.

6-010.03 Progress notes document the unit(s) provided to the consumer.

6-011 DISCHARGE SUMMARY: A discharge summary must be documented in the consumer's record and contain the signature of a licensed clinician and date of signature. The discharge summary must:

1. Be provided within the time frame specified in the program's policies and procedures which considers the prompt transfer of clinical records and information to ensure continuity of care;
2. Provide a summary of service provided;
3. Document the consumer's progress in relation to the individual treatment/rehabilitation/recovery plan, addressing recovery oriented goals identified by the consumer and how strengths have been utilized;
4. Describe the reason(s) for discharge;
5. Describe referral information; and
6. Include recommendations and/or arrangements not limited to:
   a. Accessing and using medication
   b. Housing
   c. Employment
   d. Transportation
   e. Social connectedness – formal and informal support systems.
   f. Financial resources

6-011.01 Documented telephone calls, collateral contacts or other outreach activities that demonstrate continuing treatment/rehabilitation responsibility are considered services for the purpose of this regulation.

6-011.02 The program must complete discharge process from the Division data system.

6-011.03 For consumers committed to a program by a board of mental health, the provider must notify the commitment board of the discharge.

6-012 STAFFING: All programs/services must be staffed according to standards in the Behavioral Health Adult Services Definitions by appropriately credentialed/licensed treatment professionals who are able to assess consumers for mental health and substance-related

issues. Staff must be able to assess the consumer's biopsychosocial needs and be knowledgeable about the biopsychosocial dimensions of mental illness, substance-related disorders, trauma-related issues, recovery, person-centered services, and co-occurring disorders. Staff must be capable of recognizing any instability of consumers with mental health and/or substance-related disorders and treat or make the appropriate referrals.

6-013 LENGTH OF STAY: The length of stay must be individualized according to the consumer's needs, the consumer's response to treatment and recovery, and the guidelines specified in the Behavioral Health Adult Service Definitions.

6-014 STANDARDS COMMON TO ALL MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT AND REHABILITATION PROGRAMS: Behavioral Health programs must meet the standards in 175 NAC 18, Licensure of Substance Abuse Treatment Centers; 175 NAC 19, Licensure of Mental Health Centers. Services to be covered by Medicaid must meet the requirements of 471 NAC 20, Psychiatric Services for Individuals Age 21 and Older (Medicaid); 471 NAC 32, Mental Health and Substance Abuse Treatment Services for Children and Adolescents; and 471 NAC 35, Rehabilitative Psychiatric Services.

6-015 BEHAVIORAL HEALTH SERVICES FOR ADULTS: Services funded by the Division must meet the service definitions listed in the Behavioral Health Adult Services Definitions.

6-016 BEHAVIORAL HEALTH SERVICES FOR CHILDREN AND YOUTH (Reserved)

6-017 PREVENTION SERVICES

6-017.01 Administration of Funded Community-Based Prevention Initiatives: The Department provides leadership and oversight to prevention systems by distributing funds received from the state and the federal government to Regional Behavioral Health Authorities.

1. 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. Prevention system activities are designed to prevent the onset and reduce the progression of substance abuse and mental illness, reduce substance abuse-related problems in communities, to promote protective factors and decrease risk factors, and build prevention capacity and infrastructure at the State/Tribal and community level.
2. Prevention initiatives funded through the State of Nebraska must follow the Strategic Prevention Framework and include the following:
   a. Universal Prevention: activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk;
   b. Selective Prevention: activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average;
   c. 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.

6-017.02 Accountability: Funded prevention initiatives will 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.

1. 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.
2. The Prevention Coordination staff of the RBHA 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.

6-018 HOUSING RELATED ASSISTANCE: For the Housing Related Assistance Program, the Division will contract with each RBHA for the provision of housing-related assistance in accordance with policies and procedures established by the Division implementing the State Housing-Related Assistance Program as authorized by Neb. Rev. Stat. §71-812(3). Each RBHA may contract with qualifying public or private nonprofit entities for the provision of housing-related assistance as specified in the policies and procedures.

6-018.01 Definitions: The following definitions apply to the Housing Related Assistance Program:

Adult with serious mental illness means a person age 18 or older who has, or at any time during the immediately preceding 12 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 the conditions exist concurrently with a diagnosable serious mental illness.

Extremely Low Income means a household income of between zero and 30 percent of the Median Family Income (MFI) as defined by the U. S. Department of Housing and Urban Development.

Very Low Income means a household income of 50 percent or less of the applicable median family income estimate as established defined by the U. S. Department of Housing and Urban Development.

Housing-related assistance means rental payments, utility payments, security and utility deposits, and other housing-related costs and payments.