Response to Nebraska Olmstead Plan Request for Proposals

Solicitation Number 125999 O3
July 2026

Prepared For:
Nebraska Department of Health and Human Services

From:
Partners for Insightful Evaluation (PIE)

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CORPORATE OVERVIEW

A. Bidder Identification & Information

Partners for Insightful Evaluation Inc.
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www.pievaluation.com

Partners for Insightful Evaluation Inc. was first incorporated in 2006 as Schmeeckle Research Inc. When Mindy Anderson-Knott assumed ownership of the organization in 2022, the name was changed to Partners for Insightful Evaluation Inc. The company has operated continuously since inception as an S-Corporation, maintaining financial stability and a strong reputation for evaluation services throughout Nebraska.

B. Financial Statements

Partners for Insightful Evaluation Inc. (PIE) is not a publicly held company. However, PIE has been financially stable since its inception, when it began as Schmeeckle Research in 2006. Key financial indicators include.

- Average annual revenue of approximately $630,000 over the past ten years
- An average of 28 contracts served per year
- No financial liabilities held by the company
- Consistent growth and positive cash flow throughout company history

The company originally banked with Great Western Bank since its inception. After Great Western Bank was acquired by First Interstate Bank, the company transitioned its banking to First Interstate Bank. There have never been any judgments or litigations against Schmeeckle Research Inc. or Partners for Insightful Evaluation Inc. by any client or contractor.

Banking Reference:
First Interstate Bank
3410 N. 27th St., Lincoln, NE 68521
402-743-6460

C. Change of Ownership

No change in ownership or control of the company is anticipated in the twelve months following the submission of this RFP response.

D. Office Location

PIE's office is in Lincoln, NE at the following address:

Partners for Insightful Evaluation
1701 South 17th Street, Suite 2A
Lincoln, NE 68502

This Lincoln location provides PIE with direct access to Nebraska Department of Health and Human Services staff and the ability to facilitate and/or participate in any meetings held in person with NDHHS or key partners. Our Nebraska-based location ensures we understand the unique landscape, demographics, and challenges faced as they pertain to the Olmstead Plan implementation.

E. Relationship with the State

In the previous ten (10) years, Partners for Insightful Evaluation has had extensive work with the State of Nebraska, including direct contracts and subcontracts with multiple state agencies. Our experience includes a variety of contracts with the Nebraska Department of Health and Human Services (see Table 1) as well as the State of Nebraska (see Table 2). The tables are organized by program or office within that state agency, with projects listed in chronological order. They include contracts and subawards that were active on or after August 2016.

Table 1: PIE's Contracts with NDHHS

Division/Program	Project/Topic	Duration	Contract Number/ Identification
Division of Developmental Disabilities	Olmstead Plan Evaluation	9/1/23 – 6/30/25	85402 O4 DocuSign Envelope ID: 140FB423-40CC-4FBD-A4DB-ADDE9975EE35
Division of Public Health – Chronic Disease Prevention & Control Program	1815 Centers for Disease Control & Prevention (CDC) Grant – EPMP revisions and onboarding	2/4/21 – 6/29/21	DocuSign Envelope ID: DD935EA5-AD01-4DBE-828B-2A118C5E50A5
	1815 CDC Grant – Y3 Evaluation Reporting	7/28/21-9/30/21	DocuSign Envelope ID: 39E04B90-FA88-49D4-BA1C-BDDDDFF08123
	Living Well Leader Trainings	5/23/22 – 6/29/22	DocuSign Envelope ID: C37FEC48-BCC4-4681-80F6-744C6B488EE7
	Living Well Leader Training & Sustainability Evaluation	7/3/23 – 4/30/24	104963 O4
	Living Well Workshops	10/1/24 – 3/3125	DocuSign Envelope ID: BC967E42-1BD7-4DB4-95CC-616608767D18
	Living Well Leader Training Facilitation	3/1/26 – 9/30/26	115756 O4
Division of Public Health – Comprehensive Cancer Control Program	Nebraska Comprehensive Cancer Control Program Grant Year-End Success Story Development	3/1/22 – 6/29/22	99481 O4
	Comprehensive Cancer Control Evaluation Plan Development	9/15/22 – 3/31/23	101412 O4
	Comprehensive Cancer Control Evaluation and Facilitation/Development of 5-year Cancer Plan	4/1/23[1] – 9/30/27	85402 O4 DocuSign Envelope ID: 58B13DEF-AEA8-42E8-B59E-E7F4F2D14B2E
Division of Public Health – Drug Overdose	Overdose Data to Action (OD2A) Evaluation – Year 1 Services	9/1/23 – 12/31/24	106761-O4

[1] Date when project began. Official date listed on service contract award shows 3/15/19 as the start date.

Prevention Program	OD2A-S Program Performance Measurement and Evaluation	2/7/25 – 2/6/29	112074 O4
Division of Public Health – Injury Prevention Program	Core State Injury Prevention Program (SIPP) Evaluation – 2016-2021	7/9/2019 – 6/30/2021	85402 O4 awarded through an RFQ
	CDC Core State Injury Prevention Program (SIPP) Evaluation – 2021-2026	2/2/22 – 9/30/26	85402 O4 DocuSign Envelope ID: 9D3DFDF1-1EEE-435F-9EF1-5D2FF0E2C3D8
Division of Public Health – Office of Health Disparities & Health Equity	Scan and Plan Tool for Minority Health Initiative (MHI) Projects for State FY 2026-2027	10/18/24 – 12/31/24	DocuSign Envelope ID: 03690EA2-D42B-4084-AC1B-6F736C0F25D7
Division of Public Health – Tobacco Free Nebraska (TFN)	TFN Program Evaluation, Survey Data Collection & Reporting	2/14/22 – 9/30/26	85402 O4 DocuSign Envelope ID: CB1CFACF-130D-49D1-8DD0-EA561E7DC355
	TFN Strategic Planning Services	2/28/23 – 4/28/24 with 4 additional one-year renewals	103371 O4

Table 2: State Contracts with Nebraska Department of Education

Office/Program	Project	Duration	Contract Number/ Identification
Nebraska Vocational Rehabilitation (VR)	Traumatic Brain Injury State Partnership Program Mentor State Grant	7/1/20 – 6/30/21	#41054
	Traumatic Brain Injury State Demonstration Grant Program Evaluation	9/1/21 – 8/31/25 (annual awards)	#45074
	Nebraska VR's Supplemental TBI Public Health Workforce Grant	5/1/22 – 9/30/24	#43414
Office of Coordinated Student Support Services	Youth Risk Behavior Survey (YRBS) Infographics	8/1/20 – 7/31/21	#41087
	1801 CDC Grant – Healthy Schools	7/31/21 – 8/31/22	#42102
	1801 CDC Grant – Healthy Schools	3/31/23 – 8/31/23	#43381
	1807 CDC Grant – School Health Profiles	3/31/23 – 8/31/23	#43140
	1807 CDC Grant – School Health Profiles	10/25/23 – 9/30/24	#44155
	YRBS Infographics - 13902234 CDC Health Surveillance & ESSER Funding	6/17/24 – 9/30/24	#44393
	School Health Profiles Infographics, Nebraska Adolescent Health Report	6/17/24 – 9/30/24	#44393

	Nebraska 21st Century Community Learning Centers (CCLCs)	1/2/2026 – 1/1/27 with 4 additional one-year renewals	#46214

The projects in Table 3 were funded by NDHHS to the University of Nebraska Lincoln, with PIE included as a subcontractor. It is also organized by division or program, with contracts listed in chronological order.

Table 3: State Contracts with UNL that Include Subawards to PIE

Division/Program	Project	Duration	Contract Number/ Identification
NDHHS – Division of Behavioral Health	Nebraska Strategic Prevention Framework Partnerships for Success (SPF-PFS) 2018	1/7/19 – 9/29/23 (annul awards)	70279 Y3
	Substance Abuse Prevention & Treatment Block Grant Evaluation	8/1/20 – 5/31/25 (annul awards)	DocuSign Envelope ID: 95CF6B05-4ACC-4467-B8BE-DCF431FE1943
	Nebraska Strategic Prevention Framework Partnerships for Success (SPF-PFS) 2023	10/1/23 – 9/30/24 (pending new award through 9/30/25)	77287 Y3 3453 CLMS
NDHHS – Division of Public Health – Chronic Disease Prevention & Control Program	1817 Innovative State and Local Public Health Strategies to Prevent and Manage Diabetes and Heart Disease and Stroke Grant	3/25/19 – 2/15/24	98033-O4
	Chronic Disease Prevention and Control Program 2320/2304 Evaluation	3/1/24 – 6/30/24 with 3 additional one-year renewals	107891-O4
NDHHS – Division of Public Health – Office of Performance Management	State Health Assessment and Improvement Redesign	9/19/22 – 4/30/24	101394-O4

PIE also has contracts with the University of Nebraska, which is generally classified as a state entity. These are direct contracts between PIE and the University of Nebraska (outlined in Table 4) that do not necessarily pertain to projects being coordinated by NDE or NDHHS.

Table 4: PIE Contracts with University of Nebraska

University Campus	Project	Duration
UNL	Rural Drug Addiction Research Center Grant	2024 – 2029
	Nebraska Center for the Prevention of Obesity Diseases through Dietary Molecules	2024 – 2029

	Effectiveness of a Multilevel Rural Community Engagement model for Improving Children's Dietary Intake in Family Child Care Homes	2024 – 2029
	Fostering Student Successes in STEM through Early Course-based Undergraduate Research Experience	2023 – 2026
UNMC	Cognitive Neuroscience of Development & Aging Center (CoNDA) CoBRE	2023 – 2025

PIE has maintained exemplary performance on all state contracts, with no instances of contract default, termination for cause, or negative performance evaluations. Our long-standing relationship with NDE makes us uniquely qualified to continue and enhance the evaluation services required by this solicitation.

F. Bidder's Employee Relations to State

Mindy Anderson-Knott, the owner and President of PIE, is employed with the University of Nebraska-Lincoln's (UNL's) Research Compliance Services on a part-time, on-call basis (<10 hours/month). Her responsibilities at UNL consist of reviewing UNL research protocols and are completely unrelated to this proposed project. Her role for the proposed Nebraska Olmstead Plan Evaluation is to provide oversight, quality assurance, and evaluation consultation to the PIE team. She may also assist with replicating a similar data collection and analysis process to the previous evaluation of the Nebraska Olmstead Plan. This part-time UNL role does not create any conflict of interest with the proposed NDHHS contract.

No other PIE employees named in this proposal have current or past employment relationships with NDHHS or any other Nebraska state agency within the previous 24 months. No NDHHS employees or employees of any Nebraska state agency are currently employed by PIE or serve as subcontractors to PIE.

G. Contract Performance

Partners for Insightful Evaluation Inc. has never had a contract terminated for default, either in the past five (10) years or at any time in the company's history. The company has never had a contract terminated for convenience, non-performance, non-allocation of funds, or any other reason.

PIE maintains an exemplary record of contract performance, consistently meeting or exceeding deliverable requirements and deadlines. Our reputation for quality, reliability, and professional service has resulted in multiple contract renewals and expansions with existing clients, including our long-standing relationship with Nebraska Department of Health and Human.

H. Summary of Bidder's Corporate Experience

PIE has extensive experience conducting evaluations and monitoring related to state strategic plans. The three projects described below were chosen for their similarity to this solicitation in size, scope, and complexity. PIE served as the prime vendor on all the projects.

Project 1: Olmstead Plan Evaluation

PIE coordinated and led the evaluation of Nebraska's 2023 – 2025 Olmstead Plan. The scope of work was similar that outlined in this RFP. During the 21-month project, PIE's team conducted a comprehensive evaluation and offered recommendations not only based on what

was assessed regarding Nebraska's progress, but also a literature review and analysis of Olmstead Plans from 22 other states and the District of Columbia.

Table 5: Summary of 2023-2025 Olmstead Plan Evaluation

Time Period	9/1/23 – 6/30/25
Scheduled and Actual Completion Dates	The following deliverables were completed by their scheduled due date and within the proposed budget: • Data Collection and Evaluation Plan (January 15, 2024) • Olmstead Plan Evaluation Report One-Time (October 15, 2024) • Communications Plan and Supporting Materials (December 15, 2025) • Olmstead Plan revision recommendation draft language (January 15, 2025) • Summary of Technical Assistance and Final Recommendations for Plan Revisions
Bidder's Responsibilities	The scope of work for PIE included five deliverables with a total budget of $88,000. Key responsibilities included: • Developing an evaluation plan in consultation with NDHHS, including the collection and monitoring of evaluation indicators, providing updates on activities and assessments completed, and survey and assessment tool development and revision. • Conducting interviews and focus groups with program staff, partners, and stakeholders to evaluate plan successes, systemic challenges, and opportunities for plan revision. • Providing a draft evaluation report to NDHHS for consultation and coordinated revisions prior to submission. • Developing an analysis of the strategic plan and a report on the progress of the strategic plan and recommended changes or revisions for the Legislature. • Developing a communication plan and supporting materials to disseminate evaluation findings, including presentations, infographics, and fact sheets. • Providing technical assistance to NDHHS and Olmstead advisory committee in making recommended changes and revisions to the plan. • Attending and facilitating meetings with program staff, partner agencies, and stakeholders, as determined by NDHHS staff, as well as attending regular meetings with NDHHS to share insights and progress on project.
Customer Name	Colin Large Policy Administrator II NDHHS – Division of Developmental Disabilities Office: 402.853.1452 Colin.Large@nebraska.gov

Project 2: Traumatic Brain Injury (TBI) Grant Evaluation

PIE has been the evaluator for Nebraska VR (Vocational Rehab) through the Nebraska Department of Education as part of their TBI Grant for more than 15 years. In more recent years, PIE has taken on an expanded role with the Brain Injury State Plan, including a revision process in 2023 that revamped the structure and language used in the plan. PIE is currently

working collaboratively with Nebraska VR to update and transition the two-year state plan into a five-year plan.

Table 6: Summary of TBI Grant Evaluation

Time Period	The initial contract for the current five-year grant was 9/1/21 – 8/31/22 and was renewed each year for the same fiscal year range.
Scheduled and Actual Completion Dates	All evaluation deliverables for the current five-year grant were completed on time, including: • Annual evaluation reports, documenting successes, progress, and barriers during each fiscal year. • All required data submission for the federal semi-annual reports, which were due in February and August each year. • Data collection activities, including the ongoing collection of the TBI Registry mailing caller survey. Current evaluation activities are proceeding on schedule with established timelines for data collection in the final year of the grant.
Bidder's Responsibilities	The scope of work for PIE included five deliverables with a total budget of $32,000. It included the following: • Act as the central point of contact for all of Nebraska VR's TBI grant data collection activities, including: 1) Semi-annual performance report data; 2) Key outcomes and indicators for each project activity as described in the grant documents and evaluation plan. • Implement the evaluation plan developed for each of the project activity teams and meet as needed to discuss data collection efforts and results. • Create secure and user-friendly data collection tools as needed, which may include training evaluations or surveys to solicit feedback from workgroups, advisory councils and/or committees. • Perform data analysis on Nebraska VR ABI Interviews to produce a brief report for each semi-annual performance report to ACL and a comprehensive annual report for Nebraska VR purposes. Provide a brief progress report to the Brain Injury Advisory Council twice per year. • Collaborate with Nebraska VR and the Brain Injury Advisory Council to assist with updating the Brain Injury State Plan to reflect the five-year time period and monitoring indicators. PIE will coordinate the implementation of State Plan activities assigned to the Brain Injury Data Workgroup. • Produce reports, infographics, and data handouts as needed to highlight project data and outcomes, including key results from the evaluation plan. • Meet quarterly to review and document progress toward outcomes.
Customer Name	Keri Bennett Program Director for Acquired Brain Injury Nebraska VR (Vocational Rehabilitation) – NDE Office: 308-224-7571 Keri.Bennett@nebraska.gov

Project 3: Evaluation of Nebraska Comprehensive Cancer Control Program (NECCCP)

The evaluation work carried out for the NECCCP includes federal reporting for the CDC grant as well as annual updates as part of the State Cancer Plan.

Table 7: Summary of NECCCP Evaluation

Time Period	4/1/23 – 6/29/27
Scheduled and Actual Completion Dates	Each year the scheduled deliverables were completed by the anticipated due dates. This included: • Evaluation report, due at the end of September. • Annual performance measurement report, due at the end of September. • Annual evaluation and performance measurement plan, due at the end of each September. • Annual review of the Nebraska State Cancer Plan, done through the facilitation of a meeting in June or July depending on the meeting cadence of the Nebraska Cancer Alliance.
Bidder's Responsibilities	The scope of work and budget varied slightly each fiscal year based on the federal reporting requirements. The budget is generally around $52,000 each year. The key responsibilities include: • Implementation and revision of an annual evaluation plan, to include evaluation of partnerships and the state cancer plan • Conducting interviews and focus groups with program staff, partners, and coalition members • Survey and tool development and revision (as needed) • Conducting data collection and analysis • Performance measure monitoring and reporting • Reviewing program records and subrecipient reports • Preparing reports and dissemination documents for publication, and for Centers for Disease Control and Prevention (CDC) grant reporting • Conducting quality improvement on the implementation of assessment and reporting tools and processes to ensure information collected is contributing to the positive advancement of the grant outcomes
Customer Name	Julie Chytil Comprehensive Cancer Control Program Coordinator NDHHS – Division of Public Health Office: 402-670-4854 Julie.Chytil@nebraska.gov

I. Summary of Bidder's Proposed Personnel/Management Approach

Management Approach

PIE's management approach for the Olmstead Plan evaluation is based on our proven model refined over the past several years of successful performance on similar work implemented, including in collaboration with NDHHS. Our approach emphasizes:

- **Dedicated Project Leadership**. One senior PIE staff member serves as project lead with primary responsibility for all deliverables, coordination, and collaboration with NDHHS.

- **Team Support Structure.** The project lead is supported by other PIE staff members with specialized skills and expertise in data analysis, qualitative research, and continuous quality improvement.
- **Regular Internal Coordination.** The team holds weekly meetings to review all projects to identify support needs and ensure quality and timeliness of products.
- **Proactive Communication.** Regular check-ins are facilitated with NDHHS staff, prioritizing prompt response to requests and transparent reporting of progress and challenges.
- **Quality Assurance.** Multiple reviews of all deliverables are conducted before submission to ensure accuracy, completeness, and professional quality.

Proposed Team Structure & Personnel

The proposed team structure for this project builds on our existing successful model used for other projects, including the most recent Olmstead Plan evaluation. There are three PIE staff members who will be regularly involved with the project if awarded the contract, with other PIE staff available to assist as needed (see Table 8). Resumes for those three individuals are submitted as attachments to further demonstrate the skill for carrying out the project requirements.

Table 8: Proposed Staffing and Expertise of PIE for Project

Professional	Title	Education, Credentials & Relevant Experience
Liz Gebhart-Morgan	Vice President	• Master of Public Health (MPH), University of Missouri • Master of Public Administration (MPA), University of Missouri • Served as lead for the 2023 Olmstead Plan evaluation project • Expert in mixed-methods evaluation approaches combining quantitative and qualitative data • Extensive experience with continuous quality improvement and monitoring state plan progress • Adept at creating user-friendly data visualizations
Catherine Brown	Evaluator	• PhD, Public Administration, University of Nebraska at Omaha • Master of Arts (MA) in Anthropology, University of Kentucky • Nebraska Children and Families Foundation Vice President of Research & Evaluation, overseeing the evaluative component of $18M+ in federal and state grants spanning cradle to career (2015–2021) • US Government Accountability Office (GAO) Senior Analyst, producing reports for Congress and related testimony (2004-2009) • Catherine Brown Evaluation Services, LLC Founder and CEO, providing evaluation, project management, data visualization, and facilitation services to clients who are committed to advancing the public interest, value inclusion, and appreciate the power of data (2021-Present) • Expert in mixed-methods evaluation, including interviews, focus groups, surveys, content analysis, outcomes harvesting, and social network analysis
Mindy Anderson-Knott	President	• Master of Arts (MA) in Sociology, University of Nebraska Lincoln

		• Certificate of Evaluation Practice (CEP), George Washington University • 20+ years conducting evaluation research for government, education, and nonprofit clients • Expertise in research design, quantitative and qualitative methods, data analysis and reporting • 10+ years of experience with substance abuse programs including opioid initiatives

To ensure effective implementation of the project, initial division of roles and responsibilities have been outlined among the PIE team. Table 9 outlines the anticipated scope of work for each team member. Additional PIE staff may assist as needed.

Table 9: Proposed Roles of PIE Staff for Project

PIE Staff Member	Olmstead Plan Evaluation Roles & Tasks
Liz Gebhart-Morgan	Liz, committing an estimated 15 hours/month throughout the two-year contract, will serve as the project lead. In this role, she will maintain overall responsibility for project management, coordinate with NDHHS, and ensure all deliverables meet requirements and deadlines. Her key roles will include: • Overall project management and communication with NDHHS staff • Oversight of data collection and analysis plan • Leading the development of all evaluation and communication products, including the evaluation report • Oversight and delivery of technical assistance
Catherine Brown	Catherine, committing an estimated 13 hours, will serve as the qualitative data expert. She brings the ideal blend of technical rigor, strategic insight, and relationship-centered leadership needed for this project. Her key roles will include: • Internal coordination, facilitation and analysis of interviews and focus groups • Assistance with reviewing subrecipient reports and administrative records • Integrating qualitative data results into evaluation report and development of recommendations based on data • Assistance with developing supporting materials as part of the Communications Plan, ensuring ADA and/or 508 compliance
Mindy Anderson-Knott	As PIE's President, Mindy provides strategic oversight, quality assurance, and expert evaluation consultation for the project. She is estimated to commit 75 hours to the project throughout the contract period. Her key roles on this project include: • Quality assurance review of all deliverables • Advanced data analysis support including qualitative analysis • Review of data collection tools, survey instruments and evaluation processes • Conducting interviews and focus groups as needed • Strategic guidance and problem-solving support

J. Subcontractors

PIE does not intend to subcontract any portions of the performance required by the contract.

TECHNICAL RESPONSE

Partners for Insightful Evaluation Inc. is uniquely qualified and prepared to lead the Nebraska Olmstead Plan evaluation. Our previous experience with evaluating the Olmstead Plan, combined with our deep understanding of developing, reviewing, and monitoring state strategic plans, positions us to strategically and intentionally evaluate the 2026-2031 Olmstead Plan to drive meaningful reporting and recommendations.

A. Understanding of Project Requirements

Based on the Request for Proposal and subsequent clarifications from NDHHS, our team understands that this contract encompasses comprehensive evaluation services for the Olmstead Plan.

Data Collection and Evaluation Plan

PIE is prepared to develop an evaluation plan in conjunction with NDHHS to systematically and effectively assess progress on the Olmstead Plan. The plan will be created within the first 90 days of the contract and based on experience with the previous Olmstead Plan evaluation. It will focus on the compilation of information for pertinent evaluation indicators and a goal of summarizing updates within each of the goal areas. The plan will focus on a mixed methods approach to integrate quantitative and qualitative data, including interviews and focus group with staff, partners and stakeholders. This will allow for a more comprehensive assessment of successes, barriers, and opportunities for improvement related to the current Olmstead Plan. This deliverable also encompasses the collection of data, which will include focus groups, interviews and/or surveys to ensure consistent evaluation approaches.

Evaluation Report

A thorough analysis of a range of data – including program records, subrecipient reports, performance measure monitoring, transcripts, etc. – will be conducted to aid in the development of a comprehensive evaluation report. The analysis plan will be outlined through the evaluation plan to ensure buy-in from NDHHS staff. A full draft of the report will be provided a few months prior to the final deliverable being due to allow ample time for NDHHS staff to review and provide input. The final report will be available by May 2028 for submission to the legislature.

Communications Plan and Supporting Materials

Using the Communications Plan from the previous Olmstead Plan evaluation as a basis, PIE will work collaboratively with NDHHS to craft a comprehensive Communications Plan for this project. This may include success stories, presentations, infographics, fact sheets, and other summary reports to highlight and effectively disseminate evaluation findings. During the development of the plan and supporting materials, PIE will ensure final products meet ADA and/or 508 compliance. This has been a requirement of PIE's work with Nebraska VR on the TBI Grant, which makes the team prepared to meet the some requirements for the Olmstead Plan evaluation.

Plan Revision Recommendation Draft Language

Once the evaluation report and recommendations are developed, PIE will offer technical assistance to NDHHS and the Olmstead Advisory Committee to begin making recommended changes and revisions to the plan.

Technical Assistance and Final Recommendations

Similar to other projects at NDHHS, the project lead at Partners for Insightful Evaluation will facilitate regular check-in meetings with NDHHS staff. This will include developing an agenda and providing minutes for each meeting. Beyond meeting with staff, PIE is committed to attending Omstead Advisory Committee and workgroup meetings as needed. Being in Lincoln provides an opportunity for participating in meetings in person as needed. A final report summarizing all meetings, presentations and support provided to NDHHS and partners will be submitted at the end of the project.

B. Proposed Development Approach

Partners for Insightful Evaluation is exceptionally prepared to meet the requirements as outlined in the solicitation. The proposed development approach is based on the experience gained through the evaluation of the previous Olmstead Plan. To ensure PIE can meet the requirements as outlined, PIE staff reviewed the request for proposal, assessed capacity of each PIE team member, and discussed expected deadlines for the project. The workplan was developed with those elements in mind and can be modified as needed in conjunction with NDHHS.

If awarded, PIE will facilitate a kickoff meeting with NDHHS to review the proposed work plan and discuss any additional project expectations. Through internal PIE meetings and monthly meetings with NDHHS, there will be ample opportunity to troubleshoot barriers, discuss data collection efforts, and ensure reporting deliverables sufficiently met. All products and tools developed will be shared with NDHHS in advance to ensure approval before materials are disseminated publicly.

C. Technical Requirements

Below are the responses to the technical requirements included in Attachment A of the RFP.

1. Provide a narrative of the bidder's experience evaluating state Olmstead plans or similar, including the use of quantitative and qualitative methods as well as using continuous quality improvement approaches or processes to achieve better results.

The team at Partners for Insightful Evaluation (PIE) has ample experience with state and strategic plans, including the development, implementation, monitoring, and evaluation of state plans. This includes the evaluation of the 2023-2025 Nebraska Olmstead Plan. In addition to collecting and analyzing data from NDHHS and key partners, the Olmstead Plans from other states were also reviewed to guide the evaluation and recommendations of Nebraska's plan.

PIE's experiences with evaluating Nebraska's Olmstead Plan was based on, among other projects, the development and monitoring of the five-year Nebraska Tobacco Control State Plan. This was done in partnership with the Tobacco Free Nebraska (TFN) program in the Division of Public Health (DPH) at NDHHS. As part of that process, quantitative and qualitative data was collected and analyzed by PIE to assess progress on the previous five-year state plan. This was done through the development and dissemination of a survey among key partners, analyzing secondary data from sources such as the Youth Tobacco Survey, and conducting and coding 10 interviews. Key results were presented during the first strategic planning session to help inform the development of the new state plan. Data and findings focused on elements such as progress on previous state plan objectives, barriers and challenges within each of the four priority areas, key drivers for success, and recommendations on what should be included in the new state plan. PIE provides an annual update to key stakeholders. They were also approached

by the Nebraska Comprehensive Cancer Control Program to carry out similar work for the Nebraska Cancer Plan.

Another key state plan that is assessed using quantitative and qualitative methods is the Nebraska Brain Injury State Plan, which is done in conjunction with the Brain Injury Advisory Council (BIAC) through Nebraska VR (Vocational Rehab). To make the Brain Injury State Plan more user-friendly and actionable, PIE lead a quality improvement effort by coordinating a small workgroup of BIAC members to revise the state plan. This included updating activities as well as identifying process indicators to ensure progress can be measured on at least a bi-annual basis. It was also determined that, to achieve better results, there would be two documents for the state plan. One document will serve as a public-facing file that provides a high-level overview of the state plan for all partners and stakeholders to understand what the plan entails. The second file is a working document primarily for the BIAC, which outlines the key entities responsible for each activity, the process indicators within each goal area, and a status update for each of the state plan activities.

Beyond state plans and evaluation plans for state or federal grants, the PIE team has more than a decade of experience with using continuous quality improvement (CQI) approaches and processes to achieve better results. Nearly all projects have a CQI component, which is driven by evaluation results. One such project is being done as part of two CDC-funded grants (CDC-RFA-DP18-1815 and CDC-RFA-DP18-1817) with the Chronic Disease Prevention and Control Program at NDHHS. A data collection tool being used for both grants is the Scan & Plan Tool, which is an interactive excel file meant to help health care organizations and community-based organizations carry out a self-assessment and develop an action plan. Beyond evaluating the impact of the work carried out by the agencies, the PIE team is also evaluating the tool. Throughout the last four years, the PIE team has conducted more than 30 interviews and focus groups as well as reviewed administrative records (such as progress reports and check-in calls notes) to assess the utility of the tool. This has led to significant enhancements of the Scan & Plan Tool, which is still used for their most recent CDC funding cycles. Deliverables of these analyses have included writing up results in a case study, evaluation reports, health impact statements, and drafts of manuscripts.

In addition to using evaluation results through PIE to facilitate continuous quality improvement, the staff focus on developing tools, templates, and frameworks for other organizations to lead their own CQI work. A key example of that, which was based on the initial work with the Scan & Plan Tool noted above, is with the U.S. Department of Education's 21st Century Community Learning Centers (CCLC) program. The PIE team developed and recently launched an Action+ Tool, which serves as a resource that helps grantees turn data into actionable plans for continuous improvement. This will be utilized by nearly 125 sites across Nebraska to ensure data is being used to identify and guide quality improvement efforts.

2. Describe the bidder's experience evaluating partnerships, including identifying partners and stakeholders not currently represented.

Partnerships are a key component of nearly all evaluation projects carried out by PIE. The team has many years of experience in developing and implementing tools to track partnership outcomes, including partner surveys and stakeholder or key partner interviews.

The Nebraska Injury Prevention Program (NIPP) within Division of Public Health at NDHHS is finishing a five-year CDC grant (CDC-RFA-CE21-2101) where strengthening strategic collaborations and partnerships is one of three grant objectives. During the first year, PIE

worked with NIPP to develop a partnership log to monitor efforts throughout the five-year period. On an annual basis, PIE utilizes data and feedback from NIPP to track the level of engagement, amount of funding, and what role each partnering organization has with grant efforts. Additional descriptive data is included in the partnership log, such as the type of organization and number of years the entity has been a partner. There is also a section to monitor which partners or stakeholders are missing and to what degree outreach has been done to engage those organizations. All this data is analyzed for annual reporting to CDC.

Another component of NIPP's partnership evaluation is conducting a partner survey, which included questions related to partner satisfaction, level of engagement, and needs. A baseline survey was disseminated early in the second year of the grant and will be conducted again during the final year of the grant. Data collected from the partners is compared to the partnership log data as a way to triangulate the information and enhance the understanding of the partnerships. Findings from the survey were shared with NIPP to discuss recommendations for enhancing relationships and develop a plan for outreach among partners or sectors that are missing.

The evaluation efforts utilized with NIPP are similar to approaches utilized by PIE to evaluate partnerships within the Chronic Disease Prevention and Control Program (CDPCP) and Comprehensive Cancer Control Program. One tool that has been used for a variety of projects within the CDPCP is the Circle of Involvement. This allows partners to self-identify their role within certain programs or plans, after which PIE can assess changes and impacts throughout the implementation period. This also prompts focused conversations with the CDPCP regarding where there are gaps, either in terms of partnerships or levels of involvement for work to be successful. RACI (Responsible, Accountable, Consult, and Inform) Charts, while typically used for project management, have also been used as evaluation tools to determine where there may be misalignment among partners.

In addition, PIE has conducted coalition capacity surveys over the past 10 years for the NDHHS's Division of Behavioral Health (DBH). Assessing the strengths of partnerships and identifying stakeholders not represented on the coalition are key aspects of the capacity survey. Those results are shared with each coalition and DBH through user-friendly infographic reports to show how their partnerships and coalition memberships have changed over time.

3. Provide a narrative of the bidder's experience with evaluating the quality and implementation of strategic plan objectives and activities (e.g., state cancer plan, organizational strategic plan).

The PIE team has extensive experience evaluating the quality and implementation of objectives, goals, and activities across a wide variety of projects, including many with NDHHS and other state agencies. PIE begins projects by developing evaluation plans so that a structured and objective approach can be utilized to assess progress and quality of efforts. This includes identifying appropriate evaluation questions, indicators, and data sources in conjunction with the partnering organization(s). To carry out the evaluation plans, PIE has developed and implemented several data collection tools, including surveys, interviews, progress report templates, surveys, and facilitated discussions. In addition to understanding to what degree efforts have been implemented, that data also helps identify barriers and facilitators that occurred during implementation efforts, helping programs revise and adapt plans to better fit their current needs.

As noted, PIE has been involved with Tobacco Free Nebraska's state plan efforts. That included data collection and reporting on the progress made on four priority areas included in the 2016 –

2020 plan, which covered 10 objectives and more than 12 strategies. Data briefs were developed for each of the four priorities areas to highlight accomplishments and potential areas for additional or expanded work. For the 2023 – 2028 plan, PIE provides annual updates to the Nebraska Tobacco Control Program on the 15 objectives. This is complemented by process indicators that are developed by PIE to provide context on the progress, such as outputs, deliverables, barriers, and facilitators to strategy implementation.

Another DPH program where PIE serves as the lead evaluator is the Nebraska Comprehensive Cancer Control Program (NECCCP). In addition to leading the evaluation efforts for their current federal funding (CDC-RFA-DP22-2022), PIE coordinated the development of and continued monitoring of the State Cancer Plan. Each year, PIE facilitates a portion of an annual update meeting for the Nebraska Cancer Alliance to share updates on the state plan objectives and report on results from an annual partner survey.

PIE has also been involved with the development and implementation of DBH's strategic plan. Staff were actively engaged in providing input on the recent plan developed and are currently evaluating many of the objectives and activities through the evaluation of the Substance Abuse Prevention & Treatment Block Grant project.

As mentioned in the first technical response questions, a project through the TBI grant with Nebraska VR was the revision of Nebraska's Brain Injury State Plan. PIE facilitated recurring meetings for a small team to review and revise (as needed) each state plan activity to ensure a "SMART" (specific, measurable, achievable, relevant, and time-bound) goal format was used. As part of the revision process, PIE used coding technique to ensure all SMART components were achieved. PIE also helped develop a scale to create a consistent way of reporting on the status of each of the activities on a quarterly basis, ranging from not started to complete. This is supplemented by progress indicators to further evaluate the implementation of the state plan activities and goals.

5. Describe how the bidder proposes to produce evaluation reports using existing and programmatic data. Provide an example of reports completed for previous work.

To first ensure the evaluation is designed to collect appropriate data and answer relevant questions, the PIE team will work with NDHHS to develop an evaluation plan within the first 90 days of the contract. The plan will outline pertinent evaluation indicators and data collection approaches, which will include interviews and/or focus groups. Potential indicators may include the number and type of barriers to implementation, perceived level of progress on goals and focus areas, and key successes or impacts identified among partners.

A formal report summarizing all evaluation activities and key findings will be produced by the specified time frame. The report will be in direct response to the evaluation plan and developed by PIE with input and consultation from NDHHS. It will be inclusive of all data collection efforts and denote any changes to the initial timelines and workplan activities to denote how implementation may have deviated from the original approach.

Although a formal report is anticipated, there will also be informal reporting will be done by PIE in a variety of ways, including: 1) updates during the regular check-in meetings with NDHHS and 2) presentations and sharing updates during partnership meetings. Results for the informal reporting may be shared verbally, via PowerPoint slides, infographics, or other visuals.

Beyond that, additional materials will be developed as needed and requested by NDHHS. These documents will include, but are not limited to, success stories, presentations, infographics, fact sheets, and impact statements. All dissemination documents will be developed in conjunction with and at the request of NDHHS. Samples of such reports are included with PIE's submission as part of the Evaluation Reports attachment (File 8 of 10):

- Nebraska Olmstead Plan Evaluation Report
- FY24-25 Brain Injury Assistance Act Report
- Maine BI Pilot Project Eval Report
- 2024 Nebraska Brain Injury Needs Assessment Executive Summary
- 2025 Adolescent Health Report

The PIE team utilizes data visualization techniques to develop evaluation reports that are easy to understand by a wide range of audiences. All PIE staff have participated in Stephanie Evergreen's Data Visualization Trainings.

Provide a narrative of how the bidder will work with NDHHS to provide technical assistance and support the revision of the Olmstead plan. The bidder may provide an example of previous work

As an external evaluation consultant, PIE has served in technical assistance and support roles for a variety of projects. Staff have a strong background with project management as well as facilitation, including Technology of Participation (ToP) Facilitation and HueLife trainings on strategic planning. The PIE team will draw on their experience with projects done to date, including the previous revision process for Nebraska's Olmstead Plan. In PIE's role in serving as the evaluator for the previous Olmstead Evaluation, PIE presented the evaluation results to the Olmstead Advisory Committee and facilitated two meetings with each of the five workgroups. Content and slides presented to the Transportation workgroup are included as a sample (File 9 of 10).

In 2023, PIE also supported the development of the Nebraska Tobacco Control State Plan. Throughout the project, PIE met regularly with Tobacco Free Nebraska to plan the strategic planning process and the development of the state plan, including a sustainability plan. To lead the work, PIE facilitated two half-day sessions with partners and stakeholders to obtain input on the state plan. PIE also conducted a half-day in-person meeting with TFN staff to facilitate the development of the sustainability plan. Preliminary drafts were provided to the TFN team for revisions, and the plan was finalized through a collaborative process. This process was then replicated with the Nebraska Comprehensive Cancer Control Program two years later after seeing the success of the process with the state tobacco plan.

In 2026, PIE began evaluating Nebraska's 21st Century Community Learning Centers (CCLC). A key component of launching this project was a strategic review of the state's current policies and evaluation processes, which included an intensive data collection effort drawing on input from a variety of project stakeholders. Building on this review, PIE provided the Nebraska Department of Education with technical assistance to revise and update its state policies and evaluation processes. In addition, PIE developed a novel process and tool to provide CCLC grantees with user-friendly infographic reports, enabling them to translate the data into actionable, data-driven decisions for continuous improvement

With all projects, the level and type of technical assistance provided will be determined by the contractor. Although PIE coordinates and leads the development of products, resources, processes, and/or document revisions, it is all done in conjunction with the partner. Technical

assistance and support for the revision of the Olmstead plan would be done in the same manner, working with NDHHS to determine the most appropriate method and approaches.

Describe the bidder's experience identifying systemic issues and developing inter-agency and statewide solutions.

There are a variety of projects where PIE has a focus on identifying systemic issues and developing interagency and statewide solutions. A unique project was carrying out a statewide brain injury needs assessment in Kansas. To carry out the needs assessment, three surveys were conducted: one for individuals with brain injury, one for family members and unpaid caregivers, and one for service providers. More than 30 people were also invited to participate in interviews, including individuals with brain injury, service providers, and advocates. This data was paired with other programmatic and statewide data provided as part of the project to triangulate information and identify key themes and systematic issues. Recommendations were developed by PIE based on a literature review and best practices outlined by the Administration for Community Living (ACL) and Traumatic Brain Injury Technical Assistance and Resource Center on building successful TBI systems. Recommendations focused on key areas such as state system/infrastructure, awareness and training opportunities, addressing gaps and barriers to services, and future data collection efforts. A similar approach was used in 2024 to carry out Nebraska's statewide brain injury needs assessment. Following the development of the report, PIE coordinated a workgroup to take a more in-depth look at the results to identify solutions that could be addressed through the Brain Injury Advisory Council.

PIE also played a key role in the redesign of the State Health Assessment (SHA) and State Health Improvement Plan (SHIP). PIE collaborated with the NDHHS's Division of Public Health as well as other evaluation experts to carry out a developmental evaluation to determine what has worked with the SHA/SHIP process in the past, what could be improved, and what recommendations should be explored to enhance the process in the future. A variety of data collection has been done to guide the project, including two surveys (one with DPH staff and another with previous and future users of the SHA/SHIP), three interviews with tribal entities, and 10 focus groups. This was paired with an extensive literature review, a review of all publicly available SHIPs from other states, and a review of Nebraska Community Health Improvement Plans (CHIPs). Key deliverables from the project included guidance documents to aid NDHHS in implementing statewide solutions based on systemic issues discovered through the data collection process. Given health priorities cross many divisions within NDHHS (in fact, the most common health priority among local health departments is mental health), the guidance documents being developed for DPH will also address inter-agency collaboration.

PIE's long-term relationship with the Division of Behavioral Health (DBH) has played an essential role in identifying systemic issues and statewide solutions as the Division has evolved over time. A key example is the guidance PIE provided to support DBH in restructuring its Prevention Advisory Council (PAC). When new administrators assumed responsibility for DBH, they turned to PIE for guidance on restructuring the PAC. Drawing on nearly 20 years of involvement with the PAC, PIE summarized the council's organizational structure, how it had evolved, and the challenges encountered over that time in a digestible format for leadership. Leadership used this information to establish a new structure for the PAC moving forward.

Provide a narrative of the bidder's experience with creating documentation for disseminating results for a variety of audiences. This could include but is not limited to success stories, presentations, infographics, fact sheets, and health impact statements. Provide an example completed for previous work.

The PIE team has experience with creating a wide variety of dissemination materials, including success stories, presentations, infographics, fact sheets, and manuscripts. The following is a sampling of products the PIE team has developed within just the last year, highlighting the range of experience the team has sharing results.

- An adolescent health report and nine fact sheets addressing multiple data sources on a variety of topics, including mental health, physical activity, substance use, and nutrition.
- A report and infographic summarizing the results of a Nebraska Community Health Worker Assessment. The infographic is being included as an example for this technical response question (File 10 of 10).
- A comprehensive brain injury statewide needs assessment report, along with three infographics summarizing the aggregate results from surveys conducted.
- Focus on Fremont, which is a web resource of key social indicators impacting quality of life for Fremont residents (available here: https://focusonfremont.org/).
- Data briefs summarizing tobacco-related outcome data to inform TFN's 2023-2028 strategic planning efforts and process.
- An action-oriented evaluation report of a pilot project conducted by the Brain Injury Association of America – Maine Chapter on the integration of brain injury screening and training in substance use and behavioral health settings. This is also included as a sample submitted through File 8 of 10.
- An evaluation report and three infographics summarizing the efforts implemented and impacts on vaping, alcohol use, and mental health.
- Nebraska Epidemiological Profile describing prevalence, consequences, and perceptions surrounding alcohol, tobacco, mental health, and illicit drugs.
- Presentations to statewide advisory groups to showcase statewide impacts and needs related to substance use prevention.
- An evaluation report and infographic summarizing efforts implemented and outcomes of Nebraska 21st Century Community Learning Centers (CCLC).
- More than 115 site-level data infographics for recipients of CCLC funding to drive continuous improvement.

Our team works collaboratively with partners to ensure appropriate dissemination of evaluation findings, with a goal of ensuring the final product best meets the needs of the audience. In some cases, a dissemination or communications plan is developed to ensure the appropriate medium and documentation is developed for the appropriate audience and in a timely manner.

Describe bidder's experience with survey / assessment tool development and focus group design. The bidder may provide an example of previous work.

The staff at PIE has years of training and experience with survey development and focus group design. Mindy Anderson-Knott previously served as the Assistant Director of the Penn State University Survey Research Center and as the Director of the Methodology and Evaluation Research Core Facility at the University of Nebraska-Lincoln, where she directed the development and collection of surveys, interviews, and focus groups. She has been active in the survey research discipline, presenting at American Association of Public Opinion Research Conferences and other related conferences, and publishing in the Sage Encyclopedia of Survey Research Methods.

The PIE team works collaboratively with clients to develop data collection tools – including surveys and interview/focus group protocols – to answer evaluation questions and gather relevant data for reporting purposes. While surveys are often administered online using SurveyMonkey or Qualtrics (PIE staff have experience with and access to both platforms), tools have also been formatted to disseminate via paper. This includes having materials available in other languages as needed and also offering opportunities for participants to complete surveys via the telephone to ensure accessibility.

Examples of the data collection tools used for the previous Olmstead Plan evaluation are included in the appendix of the Olmstead Plan Evaluation Report (File 10 of 12 of this submission). This includes a survey for individuals with disabilities and family members/caregivers, a survey for workgroup members, partners and advocates, and focus group protocols for 1) caregivers; 2) individuals with disabilities; 3) Olmstead Plan staff; and 4) workgroup members. With PIE's focus on continuous quality improvement, the team also monitors the success and challenges with data collection tools. Included in the previous Olmstead Plan Evaluation Report are lessons learned from implementing the survey for individuals with disabilities and family members/caregivers.

As part of the annual review of the Nebraska Tobacco Control State Plan, PIE developed and administered a stakeholder survey prior to the annual review meeting. The survey assessed implementation, perceived impact, and the successes and challenges of each strategy within the plan. This feedback guided the modifications needed to the plan. A similar survey was conducted for the Nebraska Cancer Plan. Because these surveys are triangulated with other data and information to assess progress on the state plan, the development of the survey intentionally captures information from partners to complement existing information or to fill in any gaps of information.

An example of PIE's experience in collecting qualitative data was in planning, coordinating, and implementing focus groups and interviews that were conducted as part of the SHA/SHIP Redesign Project. As part of the data collection efforts, interviews were conducted with tribal entities while focus groups were carried out with local health departments to solicit feedback from those entities on public health priorities and the SHA/SHIP process. The methodology was slightly different given the intended participants. Protocols for the focus groups and interviews were designed through a collaborative process where PIE staff discussed the concepts with the client and then drafted an initial protocol, which then went through several revisions as part of the collaborative process. Similar questions were later asked of DPH staff through a series of five focus groups, all conducted by the PIE team. Protocols for each interview/focus group were aligned to ensure data could be triangulated to inform recommendations.

For any focus group or interview conducted by PIE, notes are taken during the data collection. Since most are conducted virtually, they are recorded via Zoom, which also ensures an initial transcript is created. As needed, recordings are also transcribed through an online service to ensure accurate quotes are utilized. Thematic coding is typically used to identify key themes across all interviews/focus groups.

D. Detailed Project Workplan

The work plan below outlines PIE's approach for meeting the project requirements.

Proposed Workplan

Outlined below is the anticipated approach for the Olmstead Plan evaluation project. This would be reviewed and modified with NDHHS as needed. The timeline assumes a start date of September 1, 2026 and is broken down by quarters (i.e., Q1 is September 1, 2026 through November 30, 2026) to show progression of the work.

Key Task/ Deliverable	**Action Steps**	**Timeline**							
1. Evaluation Plan		Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8
1. Develop Evaluation Plan	Hold kickoff meeting with NDHHS within first 30 days to determine key priorities and data collection preferences								
	Provide draft evaluation plan to NDHHS; make revisions based on feedback								
	Provide final evaluation plan within 90 days of the contract start date								
	Monitor progress of evaluation plan implementation								
2. Data collection with program staff, partners, and stakeholders	Based on evaluation plan, determine data collection approach based on the type of information and feedback needed. This may include interviews, key partner survey, surveys for individuals with disabilities, etc.								
	Generate list of program staff, partners and stakeholders to capture feedback from and what method is most appropriate for that audience								
	Develop data collection tools, which may include interview or focus group protocols and/or surveys. Review recommendation from evaluation report								

	regarding potential data collection modifications								
	Collect data as outlined in the evaluation plan; inform DHHS of progress with gathering data. Aim to have all data collected by June 30, 2027 to align with end of state fiscal year (second complete year of Olmstead Plan).				6/30/27				
2. Evaluation Report		Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8
1. Review program records and subrecipient reports; conduct outcome and performance measure monitoring and reporting	Collaborate with NDHHS to develop list of all data/reports pertinent to the evaluation plan								
	Compile and gather data to be included as part of the outcome and performance measure monitoring and reporting. Aim to have all data collected by August 30, 2027 to allow partners to supply data for the entirety of Year 2 of the Olmstead Plan.				8/30/27				
	Analyze data from program records, subrecipient reports, and other data from partners based on analysis approach outlined in the evaluation plan								
	Share preliminary results with NDHHS to identify any gaps or discrepancies with data; integrate final results into the draft evaluation plan								
2. Develop analysis of strategic plan;	Conduct quantitative and qualitive data analysis on all data gathered as part of evaluation								

report on progress of plan	Triangulate and summarize all data (interviews, program records, partner data, previously reported data, etc.) into sections based on the Olmstead goal area								
3. Provide draft evaluation report to NDHHS	Create outline for evaluation report structure to get feedback from NDHHS								
	Develop initial evaluation report; share with NDHHS for preliminary edits and revisions								
	Send first full draft of evaluation report to NDHHS for review by the end of 2027						12/30/27		
	Revise evaluation report based on feedback from NDHHS and other key partners								
	Provide final report to DHHS for submission to legislature by May 1, 2028							5/1/28	
3. Communications Plan & Supporting Materials		Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8
1. Develop Communications Plan	Draft first portion of the communications plan to outlines how the evaluation approach/plan will be shared out with key partners (one-pager about evaluation plan, communications about data collection efforts, etc.)								
	Draft remainder of the communications plan to describe how the evaluation results will be shared out with key partners, general public, workgroups, etc.								
2. Develop Supporting Materials	Create communication materials (one-page handout, talking points for meetings) to share information about								

	the proposed evaluation plan with key partners								
	Develop materials outlined in the communications plan and based on requests/input from key partners regarding the results of the evaluation								
	Send final deliverables and summary of all communication plan efforts by July 1, 2028								7/1/28
4. Olmstead Plan Revision Recommendations Draft Language		Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8
Provide TA to NDHHS and Olmstead Advisory Committee (due by 8/31/28)	Present preliminary results from evaluation to NDHHS and Olmstead Advisory Committee, including draft recommendations								
	Share final results and recommendations from evaluation with Advisory Committee								
	Develop plan with NDHHS to work with advisory committee and/or workgroups to being implementing recommendations								
	Work with advisory committee and/or workgroups to implement recommendations and/or revisions								
4. Summary of TA & Final Recommendations		Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8
1. Participate in Meetings and Presentations	Schedule recurring meetings with NDHHS throughout the contract period; determine key partner meetings to attend as way to introduce evaluation approach								
	Discuss and determine need for ad hoc evaluation workgroup to help guide data collection efforts								

	Participate in monthly meetings with NDHHS to discuss project progress; join partner and committee meetings as needed								
	Submit summary of technical assistance provided throughout project by Aug. 31, 2028								8/31/28
2. Final report with structural and language changes	Capture notes during the revision recommendation process to document the final modifications anticipated								
	Submit final report								8/31/28

E. Deliverables & Due Dates

As outlined in the workplan, PIE is prepared to meet the requirements of the project in accordance with the timeframes included in the request for proposals. PIE will work with NDHHS to set mutually agreeable due dates. Below are the anticipated deliverables and deadlines, which were used to determine staffing capacity needed, the workplan, and the budget for the cost sheet.

Deliverable	Due Date
Data Collection and Evaluation Plan	**Within first 90 days** of contract (by December 1, 2026)
Olmstead Plan Evaluation Report	• Initial draft for NDHHS by December 31, 2027 • Final report submitted **by May 1, 2028**
Communications Plan & Supporting Materials	Supporting materials will be developed throughout the contract, with a final communications plan and pertinent materials being submitted **by July 1, 2028**
Olmstead Plan Revision Recommendation Draft Language	Following the initial list of recommendations provided through the evaluation report, PIE will offer guidance and TA on implementing the recommendations and revisions **by August 1, 2028**
Summary of TA and Final Recommendations for Plan Revisions	TA will be provided on an ongoing basis throughout the contract, with a summary of all TA, presentations and final recommendations **by Aug. 31, 2028**

ADDITIONAL FILES FOR APPLICATION

Along with this document, which includes the Corporate Overview and Technical Response, PIE is submitting the Cost Sheet and other required documents as part of the solicitation response. The following outlines the files that are being submitted as part of the response, including the file name.

Description of File	File Name
Cost Sheet	125999 O3 PIE File 2 of 10
Signed Contractual Agreement Form	125999 O3 PIE File 3 of 10
Signed RFP Files (Sections II through IV)	125999 O3 PIE File 4 of 10
Resume for Liz Gebhart-Morgan	125999 O3 PIE File 5 of 10
Resume for Mindy Anderson-Knott	125999 O3 PIE File 6 of 10
Resume for Catherine Brown	125999 O3 PIE File 7 of 10
Examples of Previous Evaluation Reports	125999 O3 PIE File 8 of 10
Example of Previous TA Work	125999 O3 PIE File 9 of 10
Example of Previous Dissemination	125999 O3 PIE File 10 of 10

Cost sheet
RFP 125999 O3
Nebraska Olmstead Plan Evaluation

Bidder Name: Partners for Insightful Evaluation (PIE)

Important Instructions: Bidders are to complete all fields highlighted in yellow.

Do not alter existing format or content within the Cost Sheet. However, if Bidder identifies that other items are essential in Part I to create full functionality, and meet the requirements as outlined in the RFP document and any related attachments, then additional lines may be inserted as needed. **Important**: In case of a mathematical error in extension of price, unit price shall govern.

All prices, costs, and terms and conditions submitted in the solicitation response shall remain fixed and valid commencing on the opening date of the solicitation until the contract terminates or expires.

Basis for award of points is the "Total Project Cost" for the Nebraska Olmstead Plan Evaluation $ $96,000
This amount shall equal the sum of Deliverables 1-5 for **Part I**.

Part I: Project section requirements as outlined in Section (V) of the Request for Proposal (RFP) document and Attachment A – Technical Requirements. Bidder to provide pricing for each of the project deliverable categories listed as fixed price per deliverable.

Description	Cost per completed deliverable
Deliverable 1: Data Collection and Evaluation Plan	$29,000
Deliverable 2: Olmstead Plan Evaluation Report	$36,000
Deliverable 3: Communications Plan and Supporting Materials	$11,000
Deliverable 4: Olmstead Plan revision recommendation draft language	$7,500
Deliverable 5: Summary of Technical Assistance and Final Recommendations for Plan Revisions	$12,500
TOTAL PROEJCT COST:	**$96,000**

CONTRACTUAL AGREEMENT FORM

BIDDER MUST COMPLETE THE FOLLOWING

By signing this Contractual Agreement Form, the bidder guarantees compliance with the provisions stated in this solicitation and agrees to the terms and conditions unless otherwise indicated in writing and certifies that bidder is not owned by the Chinese Communist Party.

Per Nebraska's Transparency in Government Procurement Act, Neb. Rev Stat § 73-603, DAS is required to collect statistical information regarding the number of contracts awarded to Nebraska Vendors. This information is for statistical purposes only and will not be considered for contract award purposes.

MM NEBRASKA VENDOR AFFIDAVIT: Bidder hereby attests that bidder is a Nebraska Vendor. "Nebraska Vendor" shall mean any bidder who has maintained a bona fide place of business and at least one employee within this state for at least the six (6) months immediately preceding the posting date of this Solicitation. All vendors who are not a Nebraska Vendor are considered Foreign Vendors under Neb. Rev Stat § 73-603 (c).

_____ I hereby certify that I am a Resident disabled veteran or business located in a designated enterprise zone in accordance with Neb. Rev. Stat. § 73-107 and wish to have preference, if applicable, considered in the award of this contract.

_____ I hereby certify that I am a blind person licensed by the Commission for the Blind & Visually Impaired in accordance with Neb. Rev. Stat. § 71-8611 and wish to have preference considered in the award of this contract.

THIS FORM MUST BE SIGNED MANUALLY IN INK OR BY DOCUSIGN

COMPANY:	Partners for Insightful Evaluation
ADDRESS:	1701 S. 17th St. Ste 2A, Lincoln, NE 68502
PHONE:	402-477-5407
EMAIL:	mindy@pievaluation.com
BIDDER NAME & TITLE:	Mindy Anderson-Knott, President
SIGNATURE:	
DATE:	7/27/26

VENDOR COMMUNICATION WITH THE STATE CONTACT INFORMATION (IF DIFFERENT FROM ABOVE)	
NAME:	
TITLE:	
PHONE:	
EMAIL:	

II. TERMS AND CONDITIONS

Bidder should read the Terms and Conditions within this section and must initial either "Accept All Terms and Conditions Within Section as Written" or "Exceptions Taken to Terms and Conditions Within Section as Written" in the table below. If exception is not taken to a provision, it is deemed accepted as stated. If the bidder takes any exceptions, they must provide the following within the "Exceptions" field of the table below (Bidder may provide responses in separate attachment if multiple exceptions are taken):

1. The specific clause, including section reference, to which an exception has been taken;
2. An explanation of why the bidder took exception to the clause; and
3. Provide alternative language to the specific clause within the solicitation response.

By signing the solicitation, bidder agrees to be legally bound by all the accepted terms and conditions, and any proposed alternative terms and conditions submitted with the solicitation response. The State reserves the right to negotiate rejected or proposed alternative language. If the State and bidder fail to agree on the final Terms and Conditions, the State reserves the right to reject the solicitation response. The State reserves the right to reject solicitation responses that attempt to substitute the bidder's commercial contracts and/or documents for this solicitation.

Accept All Terms and Conditions Within Section as Written (Initial)	Exceptions Taken to Terms and Conditions Within Section as Written (Initial)	**Exceptions:** (Bidder must note the specific clause, including section reference, to which an exception has been taken, an explanation of why the bidder took exception to the clause, and provide alternative language to the specific clause within the solicitation response.)
		

The bidders should submit with their solicitation response any license, user agreement, service level agreement, or similar documents that the bidder wants incorporated in the Contract. The State will not consider incorporation of any document not submitted with the solicitation response as the document will not have been included in the evaluation process. These documents shall be subject to negotiation and will be incorporated as addendums if agreed to by the Parties.

If a conflict or ambiguity arises after the Addendum to Contract Award has been negotiated and agreed to, the Addendum to Contract Award shall be interpreted as follows:

1. If only one (1) Party has a particular clause, then that clause shall control,
2. If both Parties have a similar clause, but the clauses do not conflict, the clauses shall be read together,
3. If both Parties have a similar clause, but the clauses conflict, the State's clause shall control.

A. GENERAL

1. The contract resulting from this Solicitation shall incorporate the following documents:

    a. Solicitation, including any attachments and addenda;
    b. Questions and Answers;
    c. Bidder's properly submitted solicitation response, including any terms and conditions or agreements submitted by the bidder;
    d. Addendum to Contract Award (if applicable); and
    e. Amendments to the Contract. (if applicable)

These documents constitute the entirety of the contract.

Unless otherwise specifically stated in a future contract amendment, in case of any conflict between the incorporated documents, the documents shall govern in the following order of preference with number one (1) receiving preference over all other documents and with each lower numbered document having preference over any higher numbered document: 1) Amendment to the executed Contract with the most recent dated amendment having the highest priority, 2) Executed Contract and any attached Addenda 3) Addendums to the solicitation and any Questions and Answers, 4) the original solicitation document and any Addenda or attachments, and 5) the Vendor's submitted solicitation response, including any terms and conditions or agreements that are accepted by the State.

Unless otherwise specifically agreed to in writing by the State, the State's standard terms and conditions, as executed by the State, shall always control over any terms and conditions or agreements submitted or included by the Vendor.

Any ambiguity or conflict in the contract discovered after its execution, not otherwise addressed herein, shall be resolved in accordance with the rules of contract interpretation as established in the State of Nebraska.

B. NOTIFICATION

Bidder and State shall identify the contract manager who shall serve as the point of contact for the executed contract.

Communications regarding the executed contract shall be in writing and shall be deemed to have been given if delivered personally; electronically, return receipt requested; or mailed, return receipt requested. All notices, requests, or communications shall be deemed effective upon receipt.

Either party may change its address for notification purposes by giving notice of the change and setting forth the new address and an effective date.

C. BUYER'S REPRESENTATIVE

The State reserves the right to appoint a Buyer's Representative to manage or assist the Buyer in managing the contract on behalf of the State. The Buyer's Representative will be appointed in writing, and the appointment document will specify the extent of the Buyer's Representative authority and responsibilities. If a Buyer's Representative is appointed, the bidder will be provided a copy of the appointment document and is expected to cooperate accordingly with the Buyer's Representative. The Buyer's Representative has no authority to bind the State to a contract, amendment, addendum, or other change or addition to the contract.

D. GOVERNING LAW (Nonnegotiable)

Notwithstanding any other provision of this contract, or any amendment or addendum(s) entered into contemporaneously or at a later time, the parties understand and agree that, (1) the State of Nebraska is a sovereign state and its authority to contract is therefore subject to limitation by the State's Constitution, statutes, common law, and regulation; (2) this contract will be interpreted and enforced under the laws of the State of Nebraska; (3) any action to enforce the provisions of this agreement must be brought in the State of Nebraska per state law; (4) the person signing this contract on behalf of the State of Nebraska does not have the authority to waive the State's sovereign immunity, statutes, common law, or regulations; (5) the indemnity, limitation of liability, remedy, and other similar provisions of the final contract, if any, are entered into subject to the State's Constitution, statutes, common law, regulations, and sovereign immunity; and, (6) all terms and conditions of the final contract, including but not limited to the clauses concerning third party use, licenses, warranties, limitations of liability, governing law and venue, usage verification, indemnity, liability, remedy or other similar provisions of the final contract are entered into specifically subject to the State's Constitution, statutes, common law, regulations, and sovereign immunity.

The Parties must comply with all applicable local, state, and federal laws, ordinances, rules, orders, and regulations.

E. BEGINNING OF WORK & SUSPENSION OF SERVICES

The bidder shall not commence any billable work until a valid contract has been fully executed by the State and the successful Vendor. The Vendor will be notified in writing when work may begin.

The State may, at any time and without advance notice, require the Vendor to suspend any or all performance or deliverables provided under this Contract. In the event of such suspension, the Contract Manager or POC, or their designee, will issue a written order to stop work. The written order will specify which activities are to be immediately suspended and the reason(s) for the suspension. Upon receipt of such order, the Vendor shall immediately comply with its terms and take all necessary steps to mitigate and eliminate the incurrence of costs allocable to the work affected by the order during the period of suspension. The suspended performance or deliverables may only resume when the State provides the Vendor with written notice that such performance or deliverables may resume, in whole or in part.

F. AMENDMENT

This Contract may be amended in writing, within scope, upon the agreement of both parties.

G. CHANGE ORDERS OR SUBSTITUTIONS

The State and the Vendor, upon the written agreement, may make changes to the contract within the general scope of the solicitation. Changes may involve specifications, the quantity of work, or such other items as the State may find necessary or desirable. Corrections of any deliverable, service, or work required pursuant to the contract shall not be deemed a change. The Vendor may not claim forfeiture of the contract by reasons of such changes.

The Vendor shall prepare a written description of the work required due to the change and an itemized cost sheet for the change. Changes in work and the amount of compensation to be paid to the Vendor shall be determined in accordance with applicable unit prices if any, a pro-rated value, or through negotiations. The State shall not incur a price increase for changes that should have been included in the Vendor's solicitation response, were foreseeable, or result from difficulties with or failure of the Vendor's solicitation response or performance.

No change shall be implemented by the Vendor until approved by the State, and the Contract is amended to reflect the change and associated costs, if any. If there is a dispute regarding the cost, but both parties agree that immediate implementation is necessary, the change may be implemented, and cost negotiations may continue with both Parties retaining all remedies under the contract and law.

In the event any good or service is discontinued or replaced upon mutual consent during the contract period or prior to delivery, the State reserves the right to amend the contract to include the alternate product at the same price.

*****Vendor will not substitute any item that has been awarded without prior written approval of DHHS*****

H. RECORD OF VENDOR PERFORMANCE

The State may document the vendor's performance, which may include, but is not limited to, the customer service provided by the vendor, the ability of the vendor, the skill of the vendor, and any instance(s) of products or services delivered or performed which fail to meet the terms of the purchase order, contract, and/or specifications. In addition to other remedies and options available to the State, the State may issue one or more notices to the vendor outlining any issues the State has regarding the vendor's performance for a specific contract ("Contract Compliance Request"). The State may also document the Vendor's performance in a report, which may or may not be provided to the vendor ("Contract Non-Compliance Notice"). The Vendor shall respond to any Contract Compliance Request or Contract Non-Compliance Notice in accordance with such notice or request. At the sole discretion of the State, such Contract Compliance Requests and Contract Non-Compliance Notices may be placed in the State's records regarding the vendor and may be considered by the State and held against the vendor in any future contract or award opportunity. The record of vendor performance will be considered in any suspension or debarment action.

I. NOTICE OF POTENTIAL VENDOR BREACH

If Vendor breaches the contract or anticipates breaching the contract, the Vendor shall immediately give written notice to the State. The notice shall explain the breach or potential breach, a proposed cure, and may include a request for a waiver of the breach if so desired. The State may, in its discretion, temporarily or permanently waive the breach. By granting a waiver, the State does not forfeit any rights or remedies to which the State is entitled by law or equity, or pursuant to the provisions of the contract. Failure to give immediate notice, however, may be grounds for denial of any request for a waiver of a breach.

J. BREACH

Either Party may terminate the contract, in whole or in part, if the other Party breaches its duty to perform its obligations under the contract in a timely and proper manner. Termination requires written notice of default and a thirty (30) calendar day (or longer at the non-breaching Party's discretion considering the gravity and nature of the default) cure period. Said notice shall be delivered by email, delivery receipt requested; certified mail, return receipt requested; or in person with proof of delivery. Allowing time to cure a failure or breach of contract does not waive the right to immediately terminate the contract for the same or different contract breach which may occur at a different time.

The State's failure to make payment shall not be a breach, and the Vendor shall retain all available statutory remedies.

K. NON-WAIVER OF BREACH

The acceptance of late performance with or without objection or reservation by a Party shall not waive any rights of the Party nor constitute a waiver of the requirement of timely performance of any obligations remaining to be performed.

L. SEVERABILITY

If any term or condition of the contract 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 parties shall be construed and enforced as if the contract did not contain the provision held to be invalid or illegal.

M. INDEMNIFICATION

1. **GENERAL**

The Vendor agrees to defend, indemnify, and hold harmless the State and its employees, volunteers, agents, and its elected and appointed officials ("the indemnified parties") from and against any and all third party claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, and attorney fees and

expenses ("the claims"), sustained or asserted against the State for personal injury, death, or property loss or damage, arising out of, resulting from, or attributable to the willful misconduct, negligence, error, or omission of the Vendor, its employees, Subcontractors, consultants, representatives, and agents, resulting from this contract, except to the extent such Vendor liability is attenuated by any action of the State which directly and proximately contributed to the claims.

2. **INTELLECTUAL PROPERTY**

The Vendor agrees it will, at its sole cost and expense, defend, indemnify, and hold harmless the indemnified parties from and against any and all claims, to the extent such claims arise out of, result from, or are attributable to, the actual or alleged infringement or misappropriation of any patent, copyright, trade secret, trademark, or confidential information of any third party by the Vendor or its employees, Subcontractors, consultants, representatives, and agents; provided, however, the State gives the Vendor prompt notice in writing of the claim. The Vendor may not settle any infringement claim that will affect the State's use of the Licensed Software without the State's prior written consent, which consent may be withheld for any reason.

If a judgment or settlement is obtained or reasonably anticipated against the State's use of any intellectual property for which the Vendor has indemnified the State, the Vendor shall, at the Vendor's sole cost and expense, promptly modify the item or items which were determined to be infringing, acquire a license or licenses on the State's behalf to provide the necessary rights to the State to eliminate the infringement, or provide the State with a non-infringing substitute that provides the State the same functionality. At the State's election, the actual or anticipated judgment may be treated as a breach of warranty by the Vendor, and the State may receive the remedies provided under this Solicitation.

3. **PERSONNEL**

The Vendor shall, at its expense, indemnify and hold harmless the indemnified parties from and against any claim with respect to withholding taxes, worker's compensation, employee benefits, or any other claim, demand, liability, damage, or loss of any nature relating to any of the personnel, including subcontractor's and their employees, provided by the Vendor.

4. **SELF-INSURANCE**

The State of Nebraska is self-insured for any loss and purchases excess insurance coverage pursuant to Neb. Rev. Stat. § 81-8,239.01. If there is a presumed loss under the provisions of this agreement, Vendor may file a claim with the Office of Risk Management pursuant to Neb. Rev. Stat. §§ 81-8,239.01 to 81-8,306 for review by the State Claims Board. The State retains all rights and immunities under the State Miscellaneous (Neb. Rev. Stat. § 81-8,294), Tort (Neb. Rev. Stat. § 81-8,209), and Contract Claim Acts (Neb. Rev. Stat. § 81-8,302), as outlined in state law and accepts liability under this agreement only to the extent provided by law.

5. The Parties acknowledge that Attorney General for the State of Nebraska is required by statute to represent the legal interests of the State, and that any provision of this indemnity clause is subject to the statutory authority of the Attorney General.

N. ATTORNEY'S FEES

In the event of any litigation, appeal, or other legal action to enforce any provision of the contract, the Parties agree to pay all expenses of such action, as permitted by law and if ordered by the court, including attorney's fees and costs, if the other Party prevails.

O. ASSIGNMENT, SALE, OR MERGER

Either Party may assign the contract upon mutual written agreement of the other Party. Such agreement shall not be unreasonably withheld.

The Vendor retains the right to enter into a sale, merger, acquisition, internal reorganization, or similar transaction involving Vendor's business. Vendor agrees to cooperate with the State in executing amendments to the contract to allow for the transaction. If a third party or entity is involved in the transaction, the Vendor will remain responsible for performance of the contract until such time as the person or entity involved in the transaction agrees in writing to be contractually bound by this contract and perform all obligations of the contract.

P. CONTRACTING WITH OTHER NEBRASKA POLITICAL SUBDIVISIONS OF THE STATE OR ANOTHER STATE

The Vendor may, but shall not be required to, allow agencies, as defined in Neb. Rev. Stat. § 81-145(2), to use this contract. The terms and conditions, including price, of the contract may not be amended. The State shall not be contractually obligated or liable for any contract entered into pursuant to this clause. A listing of Nebraska political subdivisions may be found at the website of the Nebraska Auditor of Public Accounts.

The Vendor may, but shall not be required to, allow other states, agencies or divisions of other states, or political subdivisions of other states to use this contract. The terms and conditions, including price, of this contract shall apply to any such contract, but may be amended upon mutual consent of the Parties. The State of Nebraska shall not be contractually or otherwise obligated or liable under any contract entered into pursuant to this clause. The State shall be notified if a contract is executed based upon this contract.

Q. FORCE MAJEURE

Neither Party shall be liable for any costs or damages, or for default resulting from its inability to perform any of its obligations under the contract due to a natural or manmade event outside the control and not the fault of the affected Party ("Force Majeure Event") that was not foreseeable at the time the Contract was executed. The Party so affected shall immediately make a written request for relief to the other Party and shall have the burden of proof to justify the request. The other Party may grant the relief requested; relief may not be unreasonably withheld. Labor disputes with the impacted Party's own employees will not be considered a Force Majeure Event.

R. COMPLIANCE WITH PRESIDENTIAL EXECUTIVE ORDERS 14151 AND 14173

Executive Order 14151, issued by President Donald Trump on January 20, 2025, and Executive Order 14173, issued by President Donald Trump on January 21, 2025, prohibit discriminatory "diversity, equity, and inclusion" (DEI) programs and "diversity, equity, inclusion, and accessibility" (DEIA) mandates, policies, programs, preferences, and activities in the federal government. If the Contract involves federal funds, Contractor shall not use contract funds for any DEI program or for any DEIA mandate, policy, program, or preference. Contractor shall assure its compliance and the compliance of any subcontractors with all requirements of Executive orders 14151 and 14173.

S. CONFIDENTIALITY

All materials and information provided by the Parties or acquired by a Party on behalf of the other Party shall be regarded as confidential information. All materials and information provided or acquired shall be handled in accordance with federal and state law, and ethical standards. Should said confidentiality be breached by a Party, the Party shall notify the other Party immediately of said breach and take immediate corrective action.

It is incumbent upon the Parties to inform their officers and employees of the penalties for improper disclosure imposed by the Privacy Act of 1974, 5 U.S.C. 552a. Specifically, 5 U.S.C. 552a (i)(1), which is made applicable by 5 U.S.C. 552a (m)(1), provides that any officer or employee, who by virtue of his/her employment or official position has possession of or access to agency records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established thereunder, and who knowing that disclosure of the specific material is prohibited, willfully discloses the material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than $5,000.

T. EARLY TERMINATION

The contract may be terminated as follows:

1. The State and the Vendor, by mutual written agreement, may terminate the contract, in whole or in part, at any time.
2. The State, in its sole discretion, may terminate the contract, in whole or in part, for any reason upon thirty (30) calendar day's written notice shall be delivered by email, delivery receipt requested; certified mail, return receipt requested; or in person with proof of delivery to the Vendor. Such termination shall not relieve the Vendor of warranty or other service obligations incurred under the terms of the contract. In the event of termination, the Vendor shall be entitled to payment, determined on a pro rata basis, for products or services satisfactorily performed or provided.
3. The State may terminate the contract, in whole or in part, immediately for the following reasons:

    a. if directed to do so by statute,
    b. Vendor has made an assignment for the benefit of creditors, has admitted in writing its inability to pay debts as they mature, or has ceased operating in the normal course of business,
    c. a trustee or receiver of the Vendor or of any substantial part of the Vendor's assets has been appointed by a court,
    d. fraud, misappropriation, embezzlement, malfeasance, misfeasance, or illegal conduct pertaining to performance under the contract by its Vendor, its employees, officers, directors, or shareholders,
    e. an involuntary proceeding has been commenced by any Party against the Vendor under any one of the chapters of Title 11 of the United States Code and (i) the proceeding has been pending for at least sixty (60) calendar days; or (ii) the Vendor has consented, either expressly or by operation of law, to the entry of an order for relief; or (iii) the Vendor has been decreed or adjudged a debtor,
    f. a voluntary petition has been filed by the Vendor under any of the chapters of Title 11 of the United States Code,
    g. Vendor intentionally discloses confidential information,
    h. Vendor has or announces it will discontinue support of the deliverable; and,

i. In the event funding is no longer available.

U. CONTRACT CLOSEOUT

Upon termination of the contract for any reason the Vendor shall within thirty (30) days, unless stated otherwise herein:

1. Transfer all completed or partially completed deliverables to the State,
2. Transfer ownership and title to all completed or partially completed deliverables to the State,
3. Return to the State all information and data unless the Vendor is permitted to keep the information or data by contract or rule of law. Vendor may retain one copy of any information or data as required to comply with applicable work product documentation standards or as are automatically retained in the course of Vendor's routine back up procedures,
4. Cooperate with any successor Vendor, person, or entity in the assumption of any or all of the obligations of this contract,
5. Cooperate with any successor Vendor, person, or entity with the transfer of information or data related to this contract,
6. Return or vacate any state owned real or personal property; and,
7. Return all data in a mutually acceptable format and manner.

Nothing in this section should be construed to require the Vendor to surrender intellectual property, real or personal property, or information or data owned by the Vendor for which the State has no legal claim.

V. AMERICANS WITH DISABILITIES ACT

Vendor shall comply with all applicable provisions of the Americans with Disabilities Act of 1990 (42 U.S.C. 12131–12134), as amended by the ADA Amendments Act of 2008 (ADA Amendments Act) (Pub.L. 110–325, 122 Stat. 3553 (2008)), which prohibits discrimination on the basis of disability by public entities.

W. LONG-TERM CARE OMBUDSMAN (Nonnegotiable)

Vendor must comply with the Long-Term Care Ombudsman Act, per Neb. Rev. Stat. § 81-2237 et seq. This section shall survive the termination of this contract.

X. OFFICE OF PUBLIC COUNSEL (Nonnegotiable)

If it provides, under the terms of this contract and on behalf of the State of Nebraska, health and human services to individuals; service delivery; service coordination; or case management, Vendor shall submit to the jurisdiction of the Office of Public Counsel, pursuant to Neb. Rev. Stat. § 81-8,240 et seq. This section shall survive the termination of this contract.

Y. LOBBYING

1. No federal or state funds paid under this RFP shall be paid for any lobbying costs as set forth herein.

2. Lobbying Prohibited by 31 U.S.C. § 1352 and 45 CFR §§ 93 et seq, and Required Disclosures.

   a. Contractor certifies that no federal or state appropriated funds shall be paid, by or on behalf of Contractor, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this award for: (a) the awarding of any federal agreement; (b) the making of any federal grant; (c) the entering into of any cooperative agreement; and (d) the extension, continuation, renewal, amendment, or modification of any federal agreement, grant, loan, or cooperative agreement.

   b. If any funds, other than federal appropriated funds, have been paid or will be paid to any person for influencing or attempting to influence: an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with Contractor, Contractor shall complete and submit Federal Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

3. Lobbying Activities Prohibited under Federal Appropriations Bills.

   a. No funds paid under this RFP shall be used, other than for normal and recognized executive-legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, electronic communication, radio, television, or video presentation designed to support or defeat the enactment of legislation before the Congress or any State or local legislature or legislative body, except in presentation of the Congress or any State or local legislature itself, or designed to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any state or local government itself.

b. No funds paid under this RFP shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before the Congress or any State government, State legislature or local legislature or legislative body, other than normal and recognized executive legislative relationships or participation by an agency or officer of an State, local or tribal government in policymaking and administrative processes within the executive branch of that government.

c. The prohibitions in the two sections immediately above shall include any activity to advocate or promote any proposed, pending, or future federal, state or local tax increase, or any proposed, pending, or future requirement or restriction on any legal consumer product, including its sale of marketing, including but not limited to the advocacy or promotion of gun control.

4. Lobbying Costs Unallowable Under the Cost Principles. In addition to the above, no funds shall be paid for executive lobbying costs as set forth in 45 CFR § 75.450(b). If Contractor is a nonprofit organization or an Institute of Higher Education, other costs of lobbying are also unallowable as set forth in 45 CFR § 75.450(c).

III. VENDOR DUTIES

Bidder should read the Vendor Duties within this section and must initial either "Accept All Terms and Conditions Within Section as Written" or "Exceptions Taken to Vendor Duties Within Section as Written" in the table below. If exception is not taken to a provision, it is deemed accepted as stated. If the bidder takes any exceptions, they must provide the following within the "Exceptions" field of the table below (Bidder may provide responses in separate attachment if multiple exceptions are taken):

1. The specific clause, including section reference, to which an exception has been taken;
2. An explanation of why the bidder took exception to the clause; and
3. Provide alternative language to the specific clause within the solicitation response.

By signing the solicitation, bidder agrees to be legally bound by all the accepted terms and conditions, and any proposed alternative terms and conditions submitted with the solicitation response. The State reserves the right to negotiate rejected or proposed alternative language. If the State and bidder fail to agree on the final Terms and Conditions, the State reserves the right to reject the solicitation response. The State reserves the right to reject solicitation responses that attempt to substitute the bidder's commercial contracts and/or documents for this solicitation.

Accept All Vendor Duties Within Section as Written (Initial)	**Exceptions Taken to Vendor Duties Within Section as Written (Initial)**	**Exceptions:** (Bidder must note the specific clause, including section reference, to which an exception has been taken, an explanation of why the bidder took exception to the clause, and provide alternative language to the specific clause within the solicitation response.)
		

A. INDEPENDENT VENDOR / OBLIGATIONS

It is agreed that the Vendor is an independent Vendor and that nothing contained herein is intended or should be construed as creating or establishing a relationship of employment, agency, or a partnership.

The Vendor is solely responsible for fulfilling the contract. The Vendor or the Vendor's representative shall be the sole point of contact regarding all contractual matters.

The Vendor shall secure, at its own expense, all personnel required to perform the services under the contract. The personnel the Vendor uses to fulfill the contract shall have no contractual or other legal relationship with the State; they shall not be considered employees of the State and shall not be entitled to any compensation, rights or benefits from the State, including but not limited to, tenure rights, medical and hospital care, sick and vacation leave, severance pay, or retirement benefits.

By-name personnel commitments made in the bidder's solicitation response shall not be changed without the prior written approval of the State. Replacement of these personnel, if approved by the State, shall be with personnel of equal or greater ability and qualifications.

All personnel assigned by the Vendor to the contract shall be employees of the Vendor or a subcontractor and shall be fully qualified to perform the work required herein. Personnel employed by the Vendor or a subcontractor to fulfill the terms of the contract shall remain under the sole direction and control of the Vendor or the subcontractor respectively.

With respect to its employees, the Vendor agrees to be solely responsible for the following:

1. Any and all pay, benefits, employment taxes and/or other payroll withholding,
2. Any and all vehicles used by the Vendor's employees, including all insurance required by state law,
3. Damages incurred by Vendor's employees within the scope of their duties under the contract,
4. Maintaining Workers' Compensation and health insurance that complies with state and federal law and submitting any reports on such insurance to the extent required by governing law,
5. Determining the hours to be worked and the duties to be performed by the Vendor's employees; and,
6. All claims on behalf of any person arising out of employment or alleged employment (including without limit claims of discrimination alleged against the Vendor, its officers, agents, or subcontractors or subcontractor's employees).

If the Vendor intends to utilize any subcontractor, the subcontractor's level of effort, tasks, and time allocation should be clearly defined in the solicitation response. The Vendor shall agree that it will not utilize any subcontractors not specifically included in its solicitation response in the performance of the contract without the prior written authorization of the State. If the Vendor subcontracts any of the work, the Vendor agrees to pay any and all subcontractors in accordance with the Vendor's agreement with the respective subcontractor(s).

The State reserves the right to require the Vendor to reassign or remove from the project any Vendor or subcontractor employee.

Vendor shall ensure that the terms and conditions contained in any contract with a subcontractor does not conflict with the terms and conditions of this contract.

The Vendor shall include a similar provision, for the protection of the State, in the contract with any Subcontractor engaged to perform work on this contract.

B. FOREIGN ADVERSARY CONTRACTING PROHIBITION ACT CERTIFICATION (Nonnegotiable)

The Vendor certifies that it is not a scrutinized company as defined under the Foreign Adversary Contracting Prohibition Act, Neb. Rev. Stat. Sec. § 73-903 (5); that it will not subcontract with any scrutinized company for any aspect of performance of the contemplated contract; and that any products or services to be provided do not originate with a scrutinized company.

C. EMPLOYEE WORK ELIGIBILITY STATUS

The Vendor is required and hereby agrees to use a federal immigration verification system to determine the work eligibility status of 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 an employee.

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

1. The Vendor must complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at https://das.nebraska.gov/materiel/docs/pdf/Individual%20or%20Sole%20Proprietor%20United%20States%20Attestation%20Form%20English%20and%20Spanish.pdf
2. The completed United States Attestation Form should be submitted with the Solicitation response.
3. If the Vendor indicates on such attestation form that he or she is a qualified alien, the Vendor agrees to provide the US Citizenship and Immigration Services documentation required to verify the Vendor's lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.
4. The Vendor understands and agrees that lawful presence in the United States is required, and the Vendor may be disqualified or the contract terminated if such lawful presence cannot be verified as required by Neb. Rev. Stat. § 4-108.

D. COMPLIANCE WITH CIVIL RIGHTS LAWS AND EQUAL OPPORTUNITY EMPLOYMENT / NONDISCRIMINATION (Nonnegotiable)

The Vendor shall comply with all applicable local, state, and federal statutes and regulations regarding civil rights laws and equal opportunity employment. The Nebraska Fair Employment Practice Act prohibits Vendors of the State of Nebraska, and their Subcontractors, from discriminating against any employee or applicant for employment, with respect to hire, tenure, terms, conditions, compensation, or privileges of employment because of race, color, religion, sex, disability, marital status, or national origin (Neb. Rev. Stat. §§ 48-1101 to 48-1125). The Vendor guarantees compliance with the Nebraska Fair Employment Practice Act, and breach of this provision shall be regarded as a material breach of contract. The Vendor shall insert a similar provision in all Subcontracts for goods and services to be covered by any contract resulting from this Solicitation.

E. COOPERATION WITH OTHER VENDORS

Vendor may be required to work with or in close proximity to other Vendors or individuals that may be working on same or different projects. The Vendor shall agree to cooperate with such other Vendors or individuals and shall not commit or permit any act which may interfere with the performance of work by any other Vendor or individual. Vendor is not required to compromise Vendor's intellectual property or proprietary information unless expressly required to do so by this contract.

F. DISCOUNTS

Prices quoted shall be inclusive of ALL trade discounts. Cash discount terms of less than thirty (30) days will not be considered as part of the solicitation response. Cash discount periods will be computed from the date of receipt of a properly executed claim voucher or the date of completion of delivery of all items in a satisfactory condition, whichever is later.

G. PRICES

Prices quoted shall be net, including transportation and delivery charges fully prepaid by the bidder, F.O.B. destination named in the Solicitation. No additional charges will be allowed for packing, packages, or partial delivery costs. When an arithmetic error has been made in the extended total, the unit price will govern.

Fixed Price Contract All prices, costs, and terms and conditions submitted in the solicitation response shall remain fixed and valid commencing on the opening date of the solicitation until the contract terminates or expires.

DHHS reserves the right to deny any requested price increase. No price increases are to be billed to any State Agencies prior to written amendment of the contract by the parties.

DHHS will be given full proportionate benefit of any decreases for the term of the contract.

H. PERMITS, REGULATIONS, LAWS

The contract price shall include the cost of all royalties, licenses, permits, and approvals, whether arising from patents, trademarks, copyrights or otherwise, that are in any way involved in the contract. The Vendor shall obtain and pay for all royalties, licenses, and permits, and approvals necessary for the execution of the contract. The Vendor must guarantee that it has the full legal right to the materials, supplies, equipment, software, and other items used to execute this contract.

I. OWNERSHIP OF INFORMATION AND DATA / DELIVERABLES

The State shall have the unlimited right to publish, duplicate, use, and disclose all information and data developed or obtained by the Vendor on behalf of the State pursuant to this contract.

The State shall own and hold exclusive title to any deliverable developed as a result of this contract. Vendor shall have no ownership interest or title, and shall not patent, license, or copyright, duplicate, transfer, sell, or exchange, the design, specifications, concept, or deliverable.

J. INSURANCE REQUIREMENTS

The Vendor shall throughout the term of the contract maintain insurance as specified herein and provide the State a current Certificate of Insurance/Acord Form (COI) verifying the coverage. The Vendor shall not commence work on the contract until the insurance is in place. If Vendor subcontracts any portion of the Contract the Vendor must, throughout the term of the contract, either:

1. Provide equivalent insurance for each subcontractor and provide a COI verifying the coverage for the subcontractor,
2. Require each subcontractor to have equivalent insurance and provide written notice to the State that the Vendor has verified that each subcontractor has the required coverage; or,
3. Provide the State with copies of each subcontractor's Certificate of Insurance evidencing the required coverage.

The Vendor shall not allow any Subcontractor to commence work until the Subcontractor has equivalent insurance. The failure of the State to require a COI, or the failure of the Vendor to provide a COI or require subcontractor insurance shall not limit, relieve, or decrease the liability of the Vendor hereunder.

In the event that any policy written on a claims-made basis terminates or is canceled during the term of the contract or within four (4) year of termination or expiration of the contract, the Vendor shall obtain an extended discovery or reporting period, or a new insurance policy, providing coverage required by this contract for the term of the contract and four (4) year following termination or expiration of the contract.

If by the terms of any insurance a mandatory deductible is required, or if the Vendor elects to increase the mandatory deductible amount, the Vendor shall be responsible for payment of the amount of the deductible in the event of a paid claim.

Notwithstanding any other clause in this Contract, the State may recover up to the liability limits of the insurance policies required herein.

1. **WORKERS' COMPENSATION INSURANCE**

The Vendor shall take out and maintain during the life of this contract the statutory Workers' Compensation and Employer's Liability Insurance for all of the contactors' employees to be engaged in work on the project under this contract and, in case any such work is sublet, the Vendor shall require the Subcontractor similarly to provide Worker's Compensation and Employer's Liability Insurance for all of the Subcontractor's employees to be engaged in such work. This policy shall be written to meet the statutory requirements for the state in which the work is to be performed, including Occupational Disease. **The policy shall include a waiver of subrogation in favor of the State. The COI shall contain the mandatory COI subrogation waiver language found hereinafter.** The amounts of such insurance shall not be less than the limits stated hereinafter. For employees working in the State of Nebraska, the policy must be written by an entity authorized by the State of Nebraska Department of Insurance to write Workers' Compensation and Employer's Liability Insurance for Nebraska employees.

2. **COMMERCIAL GENERAL LIABILITY INSURANCE AND COMMERCIAL AUTOMOBILE LIABILITY INSURANCE**

The Vendor shall take out and maintain during the life of this contract such Commercial General Liability Insurance and Commercial Automobile Liability Insurance as shall protect Vendor and any Subcontractor performing work covered by this contract from claims for damages for bodily injury, including death, as well as from claims for property damage, which may arise from operations under this contract, whether such operation be by the Vendor or by any Subcontractor or by anyone directly or indirectly employed by either of them, and the amounts of such insurance shall not be less than limits stated hereinafter.

The Commercial General Liability Insurance shall be written on an **occurrence basis**, and provide Premises/Operations, Products/Completed Operations, Independent Vendors, Personal Injury, and Contractual Liability coverage. **The policy shall include the State, and others as required by the contract documents, as Additional Insured(s). This policy shall be primary, and any insurance or self-insurance carried by the State shall be considered secondary and non-contributory. The COI shall contain the mandatory COI liability waiver language found hereinafter.** The Commercial Automobile Liability Insurance shall be written to cover all Owned, Non-owned, and Hired vehicles.

REQUIRED INSURANCE COVERAGE	
COMMERCIAL GENERAL LIABILITY	
General Aggregate	$2,000,000
Products/Completed Operations Aggregate	$2,000,000
Personal/Advertising Injury	$1,000,000 per occurrence
Bodily Injury/Property Damage	$1,000,000 per occurrence
Medical Payments	$10,000 any one person
Damage to Rented Premises (Fire)	$300,000 each occurrence
Contractual	Included
XCU Liability (Explosion, Collapse, and Underground Damage)	Included
Independent Vendors	Included
Abuse & Molestation	Included
If higher limits are required, the Umbrella/Excess Liability limits are allowed to satisfy the higher limit.	
WORKER'S COMPENSATION	
Employers Liability Limits	$500K/$500K/$500K
Statutory Limits- All States	Statutory - State of Nebraska
Voluntary Compensation	Statutory
COMMERCIAL AUTOMOBILE LIABILITY	
Bodily Injury/Property Damage	$1,000,000 combined single limit
Include All Owned, Hired & Non-Owned Automobile liability	Included
Motor Carrier Act Endorsement	Where Applicable
UMBRELLA/EXCESS LIABILITY	
Over Primary Insurance	$5,000,000 per occurrence
PROFESSIONAL LIABILITY	
All Other Professional Liability (Errors & Omissions)	$1,000,000 Per Claim / Aggregate
COMMERCIAL CRIME	
Crime/Employee Dishonesty Including 3rd Party Fidelity	$1,000,000
CYBER LIABILITY	
Breach of Privacy, Security Breach, Denial of Service, Remediation, Fines and Penalties	$5,000,000
MANDATORY COI SUBROGATION WAIVER LANGUAGE	
"Workers' Compensation policy shall include a waiver of subrogation in favor of the State of Nebraska."	
MANDATORY COI LIABILITY WAIVER LANGUAGE	
"Commercial General Liability & Commercial Automobile Liability policies shall name the State of Nebraska as an Additional Insured and the policies shall be primary and any insurance or self-insurance carried by the State shall be considered secondary and non-contributory as additionally insured."	

3. **EVIDENCE OF COVERAGE**

The Vendor shall furnish the Contract Manager, via email, with a certificate of insurance coverage complying with the above requirements prior to beginning work at:

125999 O3

Department of Health and Human Services
Attn: Angellica Shasteen, Procurement Contracts Officer
301 Centennial Mall South, 5th Floor
Lincoln, NE 68509
dhhs.rfpquestions@nebraska.gov

These certificates or the cover sheet shall reference the solicitation number, and the certificates shall include the name of the company, policy numbers, effective dates, dates of expiration, and amounts and types of coverage afforded. If the State is damaged by the failure of the Vendor to maintain such insurance, then the Vendor shall be responsible for all reasonable costs properly attributable thereto.

Reasonable notice of cancellation of any required insurance policy must be submitted to the contract manager as listed above when issued and a new coverage binder shall be submitted immediately to ensure no break in coverage.

4. **DEVIATIONS**

The insurance requirements are subject to limited negotiation. Negotiation typically includes, but is not necessarily limited to, the correct type of coverage, necessity for Workers' Compensation, and the type of automobile coverage carried by the Vendor.

K. ANTITRUST

The Vendor hereby assigns to the State any and all claims for overcharges as to goods and/or services provided in connection with this contract resulting from antitrust violations which arise under antitrust laws of the United States and the antitrust laws of the State.

L. CONFLICT OF INTEREST

By submitting a solicitation response, vendor certifies that no relationship exists between the vendor and any person or entity which either is, or gives the appearance of, a conflict of interest related to this solicitation or project.

Vendor further certifies that vendor will not employ any individual known by vendor to have a conflict of interest nor shall vendor take any action or acquire any interest, either directly or indirectly, which will conflict in any manner or degree with the performance of its contractual obligations hereunder or which creates an actual or appearance of conflict of interest.

If there is an actual or perceived conflict of interest, vendor shall provide with its solicitation response a full disclosure of the facts describing such actual or perceived conflict of interest and a proposed mitigation plan for consideration. The State will then consider such disclosure and proposed mitigation plan and either approve or reject as part of the overall solicitation response evaluation.

M. ADVERTISING

The Vendor agrees not to refer to the contract award in advertising in such a manner as to state or imply that the company or its goods or services are endorsed or preferred by the State. Any publicity releases pertaining to the project shall not be issued without prior written approval from the State.

N. DISASTER RECOVERY/BACK UP PLAN

The Vendor shall have a disaster recovery and back-up plan, of which a copy should be provided upon request to the State, which includes, but is not limited to equipment, personnel, facilities, and transportation, in order to continue delivery of goods and services as specified under the specifications in the contract in the event of a disaster.

O. DRUG POLICY

Vendor certifies it maintains a drug free workplace environment to ensure worker safety and workplace integrity. Vendor agrees to provide a copy of its drug free workplace policy at any time upon request by the State.

P. WARRANTY

Despite any clause to the contrary, the Vendor represents and warrants that its services hereunder shall be performed by competent personnel and shall be of professional quality consistent with generally accepted industry standards for the performance of such services and shall comply in all respects with the requirements of this Agreement. For any breach of this warranty, the Vendor shall, for a period of ninety (90) days from performance of the service, perform the services again, at no cost to the State, or if Vendor is unable to perform the services as warranted, Vendor shall reimburse the State all fees paid to Vendor for the unsatisfactory services. The rights and remedies of the parties under this warranty are in addition to any other rights and remedies of the parties provided by law or equity, including, without limitation actual damages, and, as applicable and awarded under the law, to a prevailing party, reasonable attorneys' fees and costs.

Q. TIME IS OF THE ESSENCE

Time is of the essence with respect to Vendor's performance and deliverables pursuant to this Contract.

IV. PAYMENT

Bidder should read the Payment clauses within this section and must initial either "Accept All Terms and Conditions Within Section as Written" or "Exceptions Taken to Payment clauses Within Section as Written" in the table below. If exception is not taken to a provision, it is deemed accepted as stated. If the bidder takes any exceptions, they must provide the following within the "Exceptions" field of the table below (Bidder may provide responses in separate attachment if multiple exceptions are taken):

1. The specific clause, including section reference, to which an exception has been taken;
2. An explanation of why the bidder took exception to the clause; and
3. Provide alternative language to the specific clause within the solicitation response.

By signing the solicitation, bidder agrees to be legally bound by all the accepted terms and conditions, and any proposed alternative terms and conditions submitted with the solicitation response. The State reserves the right to negotiate rejected or proposed alternative language. If the State and bidder fail to agree on the final Terms and Conditions, the State reserves the right to reject the solicitation response. The State reserves the right to reject solicitation responses that attempt to substitute the bidder's commercial contracts and/or documents for this solicitation.

Accept All Payment Clauses Within Section as Written (Initial)	Exceptions Taken to Payment Clauses Within Section as Written (Initial)	**Exceptions:** (Bidder must note the specific clause, including section reference, to which an exception has been taken, an explanation of why the bidder took exception to the clause, and provide alternative language to the specific clause within the solicitation response.)
MAK		

A. PROHIBITION AGAINST ADVANCE PAYMENT (Nonnegotiable)

Neb. Rev. Stat. § 81-2403 states "[n]o goods or services shall be deemed to be received by an agency until all such goods or services are completely delivered and finally accepted by the agency" The standard term is to pay after deliverables and that any alteration of that standard term should be carefully considered and used only when absolutely necessary to accommodate certain critical exceptions, i.e. insurance premiums, etc. that must be paid in advance.)

Pursuant to Neb. Rev. Stat. § 81-2403, "[n]o goods or services shall be deemed to be received by an agency until all such goods or services are completely delivered and finally accepted by the agency."

B. TAXES (Nonnegotiable)

The State is not required to pay taxes and assumes no such liability as a result of this Solicitation. The Vendor may request a copy of the Nebraska Department of Revenue, Nebraska Resale or Exempt Sale Certificate for Sales Tax Exemption, Form 13 for their records. Any property tax payable on the Vendor's equipment which may be installed in a state-owned facility is the responsibility of the Vendor.

C. INVOICES

Invoices for payments must be submitted by the Vendor to the agency requesting the services with sufficient detail to support payment.

Invoices shall be submitted to: DHHS
Nebraska Division of Developmental Disabilities
Attn: Policy Administrator II
301 Centennial Mall South, 4th Floor
Lincoln, NE 68509-2529

The terms and conditions included in the Vendor's invoice shall be deemed to be solely for the convenience of the parties. No terms or conditions of any such invoice shall be binding upon the State, and no action by the State, including without limitation the payment of any such invoice in whole or in part, shall be construed as binding or estopping the State with respect to any such term or condition, unless the invoice term or condition has been

previously agreed to by the State as an amendment to the contract. **The State shall have forty-five (45) calendar days to pay after a valid and accurate invoice is received by the State.**

D. INSPECTION AND APPROVAL

Final inspection and approval of all work required under the contract shall be performed by the designated State officials.

E. PAYMENT (Nonnegotiable)

Payment will be made by the responsible agency in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. § 81-2403). The State may require the Vendor to accept payment by electronic means such as ACH deposit. In no event shall the State be responsible or liable to pay for any goods and services provided by the Vendor prior to the Effective Date of the contract, and the Vendor hereby waives any claim or cause of action for any such goods or services.

F. LATE PAYMENT (Nonnegotiable)

The Vendor may charge the responsible agency interest for late payment in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §§ 81-2401 through 81-2408).

G. SUBJECT TO FUNDING / FUNDING OUT CLAUSE FOR LOSS OF APPROPRIATIONS (Nonnegotiable)

The State's obligation to pay amounts due on the Contract for fiscal years following the current fiscal year is contingent upon legislative or federal appropriation of funds. Should said funds not be appropriated, the State may terminate the contract with respect to those payments for the fiscal year(s) for which such funds are not appropriated. The State will give the Vendor reasonable written notice prior to the effective date of termination. All obligations of the State to make payments after the termination date will cease. The Vendor shall be entitled to receive just and equitable compensation for any authorized work which has been satisfactorily completed as of the termination date. In no event shall the Vendor be paid for a loss of anticipated profit.

H. RIGHT TO AUDIT (First Paragraph is Nonnegotiable)

The State shall have the right to audit the Vendor's performance of this contract upon a thirty (30) days' written notice. Vendor shall utilize generally accepted accounting principles, and shall maintain the accounting records, and other records and information relevant to the contract (Information) to enable the State to audit the contract. (Neb. Rev. Stat. § 84-304 et seq.) The State may audit, and the Vendor shall maintain, the Information during the term of the contract and for a period of five (5) years after the completion of this contract or until all issues or litigation are resolved, whichever is later. The Vendor shall make the Information available to the State at Vendor's place of business or a location acceptable to both Parties during normal business hours. If this is not practical or the Vendor so elects, the Vendor may provide electronic or paper copies of the Information. The State reserves the right to examine, make copies of, and take notes on any Information relevant to this contract, regardless of the form or the Information, how it is stored, or who possesses the Information. Under no circumstance will the Vendor be required to create or maintain documents not kept in the ordinary course of Vendor's business operations, nor will Vendor be required to disclose any information, including but not limited to product cost data, which is confidential or proprietary to Vendor.

The Parties shall pay their own costs of the audit unless the audit finds a previously undisclosed overpayment by the State. If a previously undisclosed overpayment exceeds one percent (1%) of the total contract billings, or if fraud, material misrepresentations, or non-performance is discovered on the part of the Vendor, the Vendor shall reimburse the State for the total costs of the audit. Overpayments and audit costs owed to the State shall be paid within ninety (90) days of written notice of the claim. The Vendor agrees to correct any material weaknesses or conditions found as a result of the audit.

DR. CATHERINE BROWN

c.humphries.brown@gmail.com
Omaha, Nebraska
703-819-4585

SUMMARY

- More than two decades of experience leading applied research and evaluation efforts in mission-driven organizations
- Expertise in qualitative data collection and analysis
- Outstanding ability to facilitate strategic, meaningful, data-focused collaboration with partners at the local, state, and national levels

EDUCATION

University of Nebraska at Omaha, *PhD, Public Administration* **2014**
US Naval War College, *MA, National Security* **2010**
University of Kentucky, *MA, Anthropology* **2004**
University of Kentucky, *MA, International Relations, Cum Laude* **2003**
Mount Holyoke College, *BA, Anthropology and English, Cum Laude* **2000**

PROFESSIONAL EXPERIENCE

Catherine Brown Evaluation Services, LLC Omaha, NE
2021-Present
Founder and CEO

- Support clients including the Omaha Community Foundation, Children's Nebraska, and the Nebraska Department of Health and Human Services in building a more sustainable future by supporting approaches to collecting, analyzing, and using data that are grounded in our innate human capacities for compassion and curiosity
- Enhance the surge capacity of nonprofit and public organizations by providing quick-turn quantitative and qualitative evaluation services including evaluation design, data collection, analysis, report preparation, and data visualization
- Build the evaluation capacity of organizations and collaboratives

University of Nebraska at Omaha, Omaha, NE 2009-2014 & 2022-Present
Part-Time Faculty

- Design and teach both undergraduate and graduate courses, including Masters of Public Administration (MPA) program courses such as Planning and Evaluation, Advanced Leadership and Management in the Public and Nonprofit Sector, and Grantwriting
- Demonstrate the ability to work with a student population that diverse in age, cultural background, ethnicity, primary language and academic preparation while teaching courses relevant to nonprofit management and public administration both online and in-person

Nebraska Children and Families Foundation, Lincoln, NE 2016-2021
Vice President, Research and Evaluation

- Supported the development and execution of grants for Nebraska totaling more than $18 million, including Community Collaborations to Strengthen and Preserve Families ($2 million), the Pregnancy Assistance Fund ($1 million), and the Social Innovation Fund ($15 million)
- Managed complex evaluation projects and budgets, including external evaluation contracts valued at approximately $200 thousand annually
- Provided leadership to Nebraska Children's and Research Evaluation Team, while continuing to play an active role in external technical assistance provision and internal continuous quality improvement (CQI) efforts
- Liaised extensively in a leadership capacity with partners both internally and externally to ensure data quality, identify and implement best practices, co-create new insights through collaborative approaches, and disseminate research and evaluation findings

Nebraska Children and Families Foundation, Lincoln, NE 2015
Data Director

- Managed the development, analysis, and dissemination of the foundation's Community Well-Being Indicators, a data set used to inform investments and communicate about the status of health in Nebraska's 93 counties
- Handled multiple tasks and projects simultaneously to ensure successful and timely project completion

University of Nebraska at Omaha, Omaha, NE 2009-2014
Graduate Assistant

- Contributed to the University of Nebraska's Government Engagement Group by analyzing proposing state legislation and providing direct administrative support
- Designed and conducted evaluations for multiple philanthropic organizations

US Government Accountability Office (GAO), Washington, DC 2004-2009
Senior Analyst

- Led and managed multidisciplinary engagement teams to equip Congress. executive agencies, and the public with timely, fact-based, non-partisan information to improve government-funded efforts
- Produced seven reports, multiple briefings, and Congressional testimony
- Supervised and mentored analysts, provided technical assistance, and conducted performance evaluations
- Contributed to the design and execution evaluative research to obtain relevant, in-depth information and develop policy recommendations for Congressional committees and staff

Smithsonian Institution 2002
Researcher

- Secured funding and independently designed data collection and analysis methodology to study the Smithsonian's collection of Inca ceremonial artifacts; used statistical software to identify previously unknown correlations between artifact dimensions and the dissolution of the Inca empire

The Advisory Board Company 2000-2001
Research Associate

- Conducted and presented quick-turnover primary and secondary research on healthcare topics

SKILLS

- Expertise in inclusive practices both in evaluation settings and in community settings, including but not limited to accessible design
- Expertise in qualitative and quantitative research methods, including mixed methods, multiple methods, and participatory designs
- Expertise in data-related facilitation, drawing on Technology of Participation (ToP) training to communicate complex findings into clear, actionable insights for diverse audiences
- Expertise in collaboration with a range of internal and external partners at the local, state, and national levels

PROFESSIONAL ASSOCIATIONS & RECENT AWARDS

- Board Member: Nebraska Evaluation Network (NEN), the state-level affiliate for the American Evaluation Association (AEA)
- Member: American Evaluation Association (AEA)
- Member & Training Provider: Nonprofit Association of the Midlands (NAM)
- Award: Excellence in Part-Time Faculty Teaching Award, University of Nebraska at Omaha, 2025

PIE Samples of Evaluation Reports

The following files are included in this document as previous examples of evaluation reports produced and disseminated by Partners for Insightful Evaluation. They are samples provided in response to question four (4) of the Technical Requirements included in Attachment A of the RFP.

1. Nebraska Olmstead Plan Evaluation Report
2. FY24-25 Assistance Act Report for BIA-NE
3. Maine Brain Injury Pilot Project Evaluation Report
4. 2024 NE Brain Injury Needs Assessment Executive Summary
5. 2025 Adolescent Health Report

Nebraska Olmstead Plan Evaluation Report

Developed by: Partners for Insightful Evaluation
Date: November 2024

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Partners for Insightful Evaluation

Nebraska Olmstead Plan Evaluation Report
November 2024

If you have any questions or concerns regarding the information reported within, please contact us at:

Partners for Insightful Evaluation
1701 S. 17th St, Suite 2A
Lincoln, NE 68502
402-477-5407
hello@pievaluation.com
http://pievaluation.com

Contents

Executive Summary

The Nebraska Department of Health and Human Services (DHHS) conducted an evaluation of the state's Olmstead Plan in 2023-2024, as required by legislation. The evaluation was conducted by Partners for Insightful Evaluation (PIE) and explored five key questions. One core goal of the evaluation was to assess progress on the plan's seven goal areas and gather input on the plan's content to inform future iterations of Nebraska's Olmstead Plan. With the evaluation report being finalized in November 2024, results include efforts carried out in Fiscal Year (FY) 2023 (July 2022 – June 2023) and FY24 (July 2023 – June 2024).

Key Findings

1 To what degree has progress been made among the seven goals of the Olmstead Plan?

Progress across the seven goals has varied. There are 41 outcomes included in the plan, each of which has a benchmark for FY23, FY24, and FY25. According to the Olmstead outcomes monitoring system monitored by DHHS, 71% of the benchmarks set for FY23 and 56% set for FY24 were achieved.

Goal		FY23 Benchmarks Achieved	FY24 Benchmarks Achieved
1	Community-Based Services (7 outcomes)	71%	71%
2	Housing (6 outcomes)	67%	50%
3	Services in Appropriate Settings (6 outcomes)	83%	67%
4	Education & Employment (7 outcomes)	57%	29%
5	Transportation (4 outcomes)	25%	0%
6	Data-Driven Decision Making (6 outcomes)	83%	100%
7	High Quality Workforce (5 outcomes)	100%	60%

On average, 10% of partner survey respondents felt a great deal of progress had been made across the six goal area workgroups, while 23% reported no progress. The most progress was perceived in data, education, and community supports.

2 What improvements and impacts have resulted from the Olmstead Plan?

Key improvements include increased advocacy for individuals with disabilities, enhanced collaboration among state agencies, and policy changes such as the elimination of the Developmental Disabilities (DD) Registry waitlist. The plan has fostered stronger partnerships between state entities and new collaborations with nonprofits, particularly in the housing sector. Implementation of the 9-8-8 crisis line and increased access to transportation in rural counties were also noted as significant impacts.

3 What activities and outcomes should be included in the next iteration of the Plan?

Although Nebraska's plan includes most of the topics that partners and stakeholders felt it should, there are additional activities for consideration. The evaluation suggests adding new goals or activities related to health/medical care and collaboration/service coordination. It is also recommended to include efforts for increasing public awareness and enhancing inter-agency collaboration. For clarity, it would be important to separate out the education and employment efforts, which are currently under Goal 4. Reducing the total number of outcomes in the plan may assist with the effective implementation, though many noted it would be beneficial to have more outcome-focused measures alongside the process ones, particularly for community services and housing.

4 What are the barriers/challenges and facilitators/successes for implementing the Plan?

Key facilitators included strong partnerships and collaborations among stakeholders, and active involvement of advocates. The diversity of partners involved in workgroups was seen as a strength. Major barriers include limited funding, lack of comprehensive data on needs and gaps, workforce shortages across various sectors, and limited public awareness of the plan. Inconsistent workgroup leadership and the slow pace of change were also identified as challenges.

5 To what degree do the metrics in the Olmstead Plan support the goals and outcomes? How could they better align?

On average, over 80% of partner survey respondents felt the metrics were moderately or very well aligned, though it varied by goal. The evaluation found that alignment was higher in areas where more data is available to understand the problem. Key partners noted that while outcomes generally aligned well, it is primarily because the plan includes outcomes that agencies are already addressing. To improve alignment, recommendations include defining key terms more clearly, developing more outcome-focused measures, and ensuring agencies can report on metrics before finalizing plan objectives. Setting longer-term benchmarks that align with the length of the evaluation cycle (rather than being annual benchmarks) and integrating outcomes that stretch beyond what agencies are already doing were also suggested to better support progress toward the plan's overall vision.

Recommendations

The recommendations offer a comprehensive approach to refining the plan to enhance support for individuals with disabilities. While a full list of detailed recommendations and rationale is in the report, some key suggestions include:

- Transitioning to a six-year plan rather than having an Olmstead Plan that covers three fiscal years. This would allow for more meaningful development, implementation, monitoring, and evaluation of the plan.
- Improving the plan development process by having each workgroup start by identifying high-level priorities for that topic. Once the vision is established, agencies that would implement activities during the plan's timeframe could determine what outcomes and/or benchmarks are achievable and measurable.
    - While the plan should include benchmarks to assess progress, annual benchmarks are challenging to monitor. The frequency of the benchmarks can be determined based on the length the plan (i.e. six years rather than three) and availability of data.
- Adding health/medical care and collaboration/service coordination efforts to the plan.
- Prioritizing specific communities, populations, or areas that would benefit most from targeted interventions within key goal areas rather than aiming to do statewide implementation, as the latter has many challenges. This focused approach could lead to more significant impacts in areas of greatest need.
- Reducing the number of outcomes to create a more manageable and effective plan. Some of this could be done by streamlining some of the context in the plan, such as:
    - Combining Goal 3 (Appropriate Settings) with Goal 1 (Community Services), since an individual's ability to receive services in appropriate settings is closely tied to their access to such services.
    - Integrating data activities (currently Goal 6) across pertinent areas of the plan rather than being a stand-alone goal.

Background

Nebraska's first Olmstead Plan was submitted to the state legislature by the Nebraska Department of Health and Human Services (DHHS) in December 2019. The plan is intended to be a roadmap to guide laws, regulations, and planning to ensure consistency with the 1999 Supreme Court *Olmstead v L.C.* decision. The first plan outlined objectives between July 2019 and June 2022. Updates and revisions were made for the second iteration, which covered July 2022 through June 2025. Both plans focused on seven key goals (Figure 1).

Figure 1. There are seven goals included in Nebraska's Olmstead Plan

Goal	Goal Topic	Description
1	Community-Based Services	Nebraskans with disabilities will have access to individualized community-based services and supports that meet their needs and preferences.
2	Housing	Nebraskans with disabilities will have access to safe, affordable, accessible housing in the communities in which they choose to live.
3	Services in Settings Most Appropriate	Nebraskans with disabilities will receive services in the settings most appropriate to meet their needs and preferences.
4	Education & Employment	Nebraskans with disabilities will have increased access to education and choice in competitive, integrated employment opportunities.
5	Transportation	Nebraskans with disabilities will have access to affordable and accessible transportation statewide.
6	Data-Driven Decision Making	Individuals with disabilities will receive services and supports that reflect data-driven decision-making, improvement in the quality of services, and enhanced accountability across systems.
7	High Quality Workforce	Nebraskans with disabilities will receive services and supports from a high-quality workforce.

DHHS is required through a legislative bill (LB570) passed in May 2019 to conduct an evaluation of the Olmstead Plan every three years.[1] The bill specifies that an independent consultant should provide an analysis, along with suggested revisions to the Plan, to determine whether the benchmarks and timeline are in compliance with the plan.

The first Olmstead Plan evaluation was conducted by Technical Assistance Collaborative, Inc. (TAC), with the report made available in December 2021. The second Olmstead Plan was evaluated by Partners for Insightful Evaluation (PIE). That project began in the fall of 2023 and the final report was available in October 2024. The core intent of the evaluation, as noted in the legislation, is to ensure that Nebraska is in substantial compliance with the strategic plan.

[1] L.B. 570 – 106th Legislature (2019-2020): Change transfers to the Nebraska Health Care Cash Fund and provisions regarding the strategic plan for providing services to persons with disabilities. https://nebraskalegislature.gov/bills/view_bill.php?DocumentID=37197

Currently there is not a requirement regarding how frequently Nebraska's Olmstead Plan must be updated or revised. There is also no guidance or requirement on what length of time the Plan should cover. When reviewing plans and progress reports from other states (see methodology), there were only seven (29%) that specified a date range for which their plan covered. Two of the seven, however, were annual plans required as part of the consent decrees. Although one state (North Carolina) had a two-year plan, the remaining four covered a four-to-six-year time frame.

Structure of Report

The methodology section provides a high-level overview of the data collected, compiled, and used in the evaluation. More specific details are outlined in Appendix A, including the methodology used for conducting the surveys and focus groups.

The results section has two parts. The first portion highlights the findings and recommendations related to the overall Olmstead Plan. This includes feedback about the goal areas included, the information and content contained in the plan, and how efforts with implementing the plan have been going. For the remainder of the results section, findings are presented for each of the seven goal areas. For each goal, there is a summary of what the vision is for that topic area, including an overview of what workgroup members would view as success. It then highlights the progress toward annual benchmarks and outcomes, and barriers to addressing that goal area, and recommendations based on feedback from Nebraska partners and a review of Olmstead Plans from other states. Some of the recommendations for one goal may be applicable to other goals as well. Throughout the results section, key findings and/or considerations for the next iteration of the plan are in bold font.

The conclusions provide a high-level summary of the findings for each of the five evaluation questions. Although recommendations are included throughout the results section, they are also listed in the recommendations section of the report. Infographic reports are also available for each of the six workgroups and for the overall Olmstead Plan to better allow key partners and stakeholders to review and utilize the evaluation results. Additional documents are available through DHHS and on Nebraska's Olmstead Plan website, including the preliminary results that were presented to the Olmstead Advisory Committee in July 2024.[2]

Methodology

Per the legislative bill, a key aspect of the evaluation is assessing progress toward goals. However, the evaluation also provides an opportunity to understand the successes and challenges of implementing the Olmstead Plan, providing additional context for progress and potential revisions.

The evaluation conducted by PIE focused on five key questions:

1. To what degree has progress been made among the seven goals of the Olmstead Plan?
2. What improvements and impacts have resulted from the Olmstead Plan, including collaborations between state agencies?
3. What activities and outcomes should be included in the next iteration of the Plan?
4. What are the barriers/challenges and facilitators/successes for implementing the Plan?

[2] Partners for Insightful Evaluation. *Nebraska Olmstead Plan evaluation update*. July 2021. PowerPoint Presentation. https://dhhs.ne.gov/Olmstead/Olmstead%20Evaluation%20Slides_07.16.24.pdf

5. To what degree do the metrics in the Olmstead Plan support the goals and outcomes? How could they better align?

A variety of data was used for the evaluation (Figure 2). A summary of the data sources, including methodology, is in Appendix A.

Figure 2. Primary and secondary data were used to carry out the Olmstead Plan evaluation

Surveys	Two surveys were developed and administered: • An online and paper survey for individuals with disabilities (which could be completed by the person with disabilities or their family members and caregivers), made available in English and Spanish • An online survey for workgroup members, key partners, and advocates. Note: this is referred to throughout the report as the key partner survey for ease
Interviews with Key Partners	Interviews were conducted virtually with 18 individuals reflecting 9 unique agencies
Focus Groups	Four focus groups were held virtually, each with a specific audience: • Individuals with disabilities • Family members/caregivers • Workgroup members • DHHS Olmstead Plan staff
Administrative Data	• Meeting minutes • Workgroup reports/updates • Olmstead outcomes monitoring system
Other State Olmstead Plans	Olmstead Plans and/or related documents were compiled from 22 states and the District of Columbia to review content regarding priorities, strategies, and partners[3]

Results

Overall Olmstead Plan

There were mixed reactions among partners and workgroup members regarding how they perceive Nebraska's Olmstead Plan. At the start of most focus groups and interviews, participants were asked what word they would use to describe the Olmstead Plan. Responses (n=26) ranged from "living document" to "ongoing" or "evolving" and "needs improvement."

[3] Not all states have an Olmstead Plan. In addition to compiling plans that were publicly available, PIE conducted outreach to states for obtaining pertinent documents. One state had two plans in response to consent decrees, so a total of 24 plans were reviewed.

Given few individuals used the exact same word or words, some were grouped together based on similar concepts. Within Figure 3, the color of the word indicates whether it had a positive (green), neutral (light blue), or negative (orange) association to the plan.

Figure 3. Of the 22 words used to describe the Olmstead Plan, 45% were considered positive

Areas of Focus (Goals)

In general, the seven goals included in Nebraska's Olmstead Plan address the core areas that focus group participants (individuals with disabilities, family members/caregivers and workgroup members) felt the plan should include. Focus group participants identified eight common things they felt a person with disabilities should be able to access or have. Those included:

1. A safe and secure place to live.
2. Access to the medical care that they need, including home health.
3. Access to integrated services for complex needs, such as brain injury and mental health treatment.
4. Employment of some kind with or without supports, if desired.
5. Educational settings with accommodations, if needed.
6. Community-based social and recreational opportunities.
7. Access to all spaces where people without disabilities can go, including restrooms, walkways, and public spaces.
8. Access to transportation to live, work, and play within their communities without relying on family and friends.

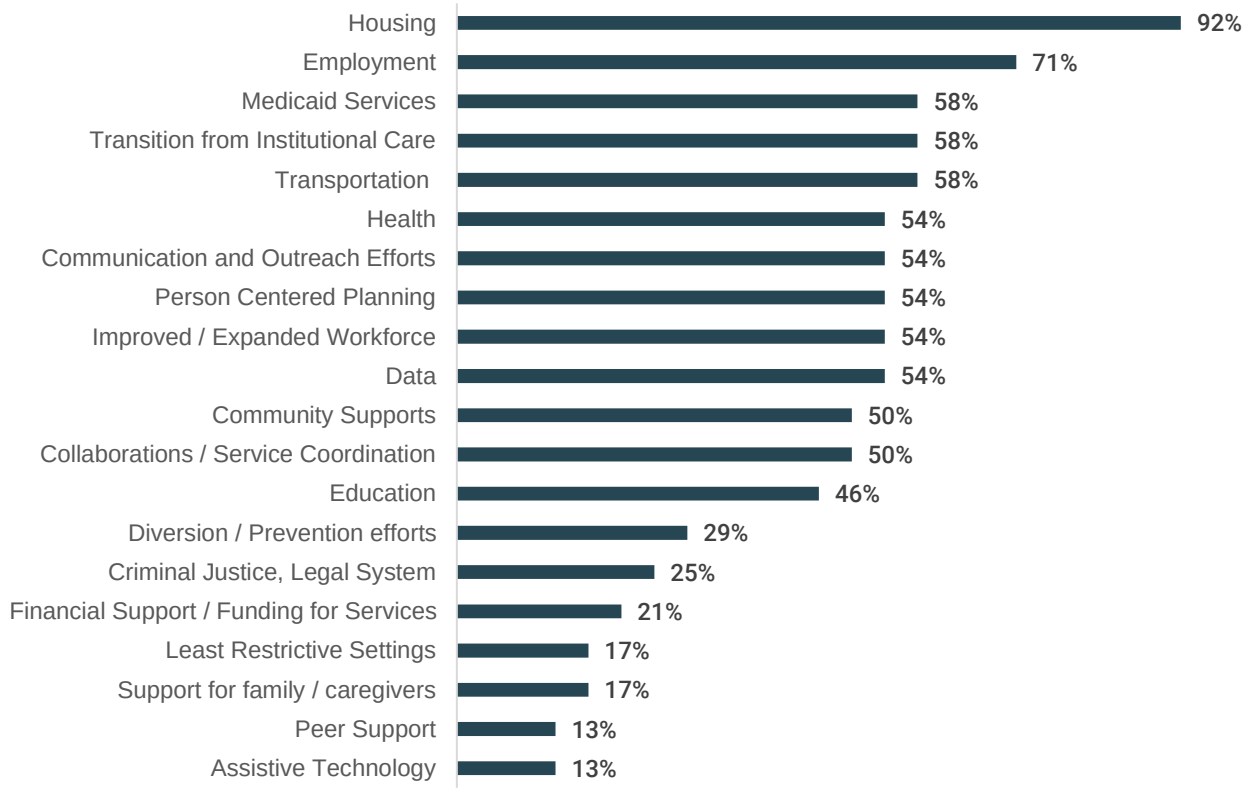
With the exception of medical care and mental health, nearly all those aspects are addressed through Nebraska's Olmstead Plan. Ultimately the vision expressed by focus group participants was seeing respect and dignity for those with disabilities. For many, that means full integration into society, which includes being able to access housing, transportation, jobs, and other services that are not separate from services that people who are not disabled receive. Ideally this would lead to acceptance, where all individuals are considered a valuable part of the community. It would also mean freedom of choice – people having the opportunity to go where they want, when they want without having to make plans well in advance. It would also mean not arriving somewhere – an apartment, business, etc. – and finding they cannot get into the building. This aligns well with Nebraska's vision of *"People with disabilities living, learning, working, and enjoying life in the most integrated setting."*

Comparison to Other States' Olmstead Plans

Among the 24 Olmstead documents reviewed from other states and the District of Columbia, there were an average of 7.3 priorities or key topic areas per plan.[4] This is comparable to the 7 goal areas that Nebraska has in its Olmstead Plan. At the high end was Georgia (20), Vermont (14), and Minnesota (13). In contrast, two entities (Virginia and the District of Columbia) had three priorities while Massachusetts and Pennsylvania had four.

Across the 24 documents reviewed, there were a total of 176 priorities or key topic areas (these are called goals in Nebraska's Olmstead Plan). Twenty of these areas were identified in at least three plans, of which housing (addressed in 92% of the plans) and employment (71%) were most frequently mentioned (Figure 4). Both of those topics are included in Nebraska's Plan. This was followed closely by Medicaid services (primarily related to home and community-based services), transition from institutional care, and transportation (each included in 14 plans). Although Nebraska's Plan does contain some outcomes related to Medicaid, there is not a specific goal related to collaboration/service coordination.

Figure 4. There were 20 common topics addressed through Olmstead efforts in ohter states, with the most common being housing, employment, and Medicaid services (n=24)



[4] The findings summarized in the evaluation report do not include Nebraska's Olmstead Plan, primarily so comparisons could be made to Nebraska's plan.

In addition to the topics shown in Figure 4, there were 17 state plans that included at least one goal that was only shared with one other state or not at all. These included goals related to emergency planning and preparedness, supporting local grassroots initiatives, implementing quality assurance practices, voting, trauma-informed services, and more.

The health priorities were further coded to identify specific health conditions or topics being addressed by other states. Although there were 23 priorities that were coded as being health-related, some of those priorities addressed more than one health condition. The most common health topics included behavioral health (n=6), mental health (n=4), substance use/abuse (n=3), and policies specific to discharging patients from a hospital (n=3).

Health was a topic noted among focus group participants as something that would be important to include in Nebraska's Plan. In addition to trying to advocate for access to certain medical services – focus group attendees specifically noted assisted outpatient therapy – there was also a push to include an outcome or activity around education for medical providers.

> *"It seems there should be some way to educate the medical community about all developmental disabilities. It would be great if there could be a medical spokesperson included in the Olmstead planning.*

They also noted it would be an important priority to include for two additional reasons:

1. The mental health care system can be a revolving door for some patients. Often people are moved from one system to another and back again without a way to break the cycle. There are no long-term safety net options that allow people with mental health concerns or challenges to fully stabilize, beyond the Lincoln Regional Center.
2. Some medical systems are dismissive of what patients need to thrive. Physicians don't always take a patient's pain, illness, or concerns seriously, or they may not be prescribing the medication that is needed.

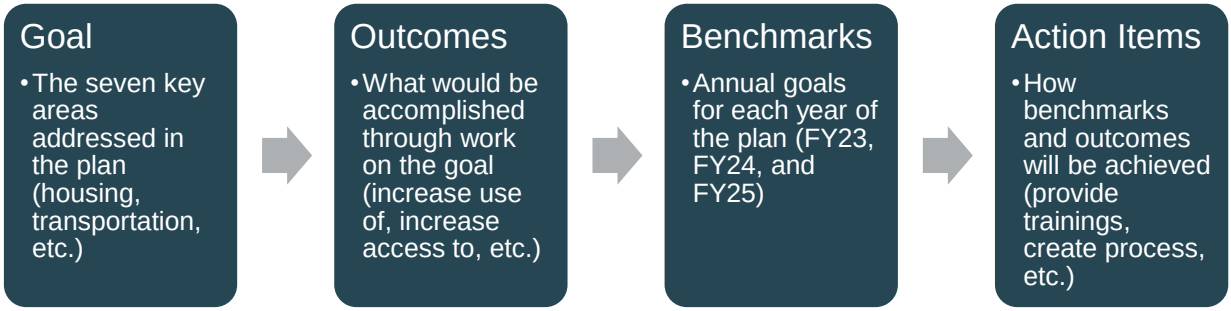
Another goal that Nebraska may want to consider is related to collaboration and service coordination. There are 12 states that had at least one priority focused on enhancing partnerships, particularly among state agencies, to better ensure they can address the comprehensive needs of individuals with disabilities more effectively. Although Nebraska has a variety of state entities noted in the plan, there is not necessarily a priority or goal related to leveraging and aligning services among partners.

Although data was a topic area addressed by nearly 9% of the priorities, a distinction from Nebraska is that in many cases, data was not a stand-alone goal. Rather, data was a component of other priority or goal areas. For example, among Colorado's nine priorities, five of them include an aspect related to data collection or utilization. Additional information is included in the results for Goal 7, but **Nebraska could remove Goal 7 (data-driven decision making) and instead integrate data-related objectives into the other goals.**

A more general change that may be worth considering in the next iteration of the Olmstead Plan is the terminology used throughout the plan. Or, at the very least, **it may be helpful for Nebraska to define the key terms used at the start of the plan.** This could be similar to what Iowa does in their Olmstead Plan and what Minnesota does through their plain language

document.[5] Currently Nebraska uses the terms goal, outcome, baseline data, benchmark, and action items (Figure 5).

Figure 5. There are four key terms that are used in Nebraska's Olmstead Plan structure



Not surprisingly, each state uses a different set of terminology within their plans (Figure 6). This will be helpful to keep in mind as results related to Olmstead Plans from other states are presented, as priorities will often be used in place of goals.

Figure 6. Terminology used in each Olmstead Plan varied by state

Nebraska's Terminology	Terminology from Other States	
Goal	• Priority • Priority Area • Strategic Goal	• Outcome Goal • Issue
Outcomes	• Goal • Measurable Goal	• Objectives • Strategy
Benchmarks	• Targeted Measure • Performance Targets • Indicators of Progress	• Measurable Outcomes • Metrics
Action Items	• Strategy • Activity	• Actions • Programs

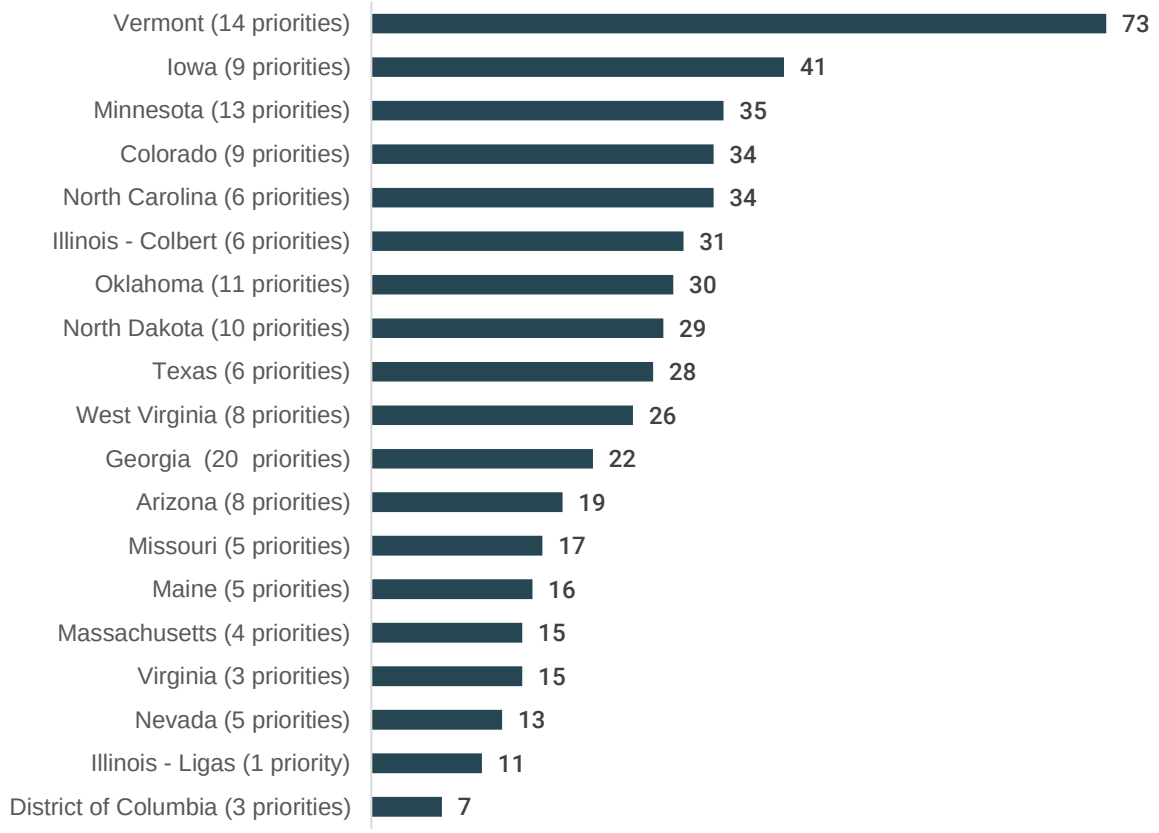
Outcomes

There are 41 outcomes included in Nebraska's Olmstead Plan for the seven goals. Among the 24 Olmstead Plan documents reviewed, there were 19 that listed specific objectives or strategies for each of their goals/priorities. On average, those 19 plans included 26 objectives, which is fewer than the 41 that Nebraska has.

States varied in how many strategies or objectives they had. Vermont had the highest number of strategies (which they call "actions needed") with 73 total (Figure 7). The District of Columbia had the lowest number with seven. For plans that had 6 to 8 priorities (about the number included in Nebraska's plan), the average number of objectives was 28 (n=5 plans).

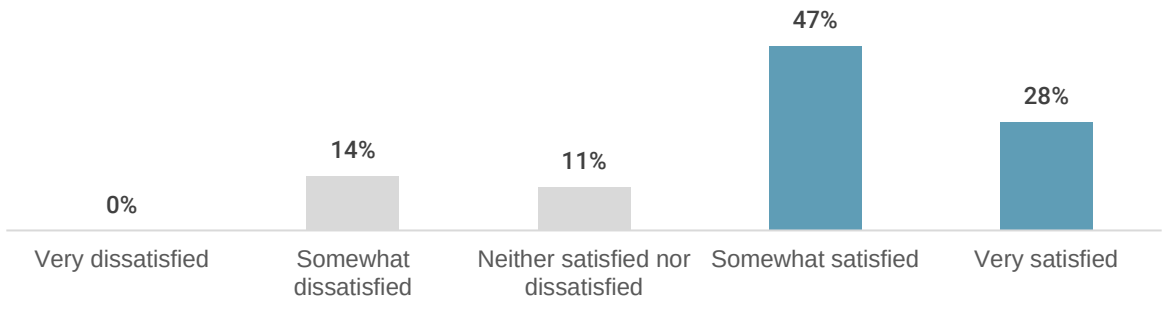
[5] Minnesota Olmstead Plan Implementation Office. (December 2020). *Minnesota Olmstead plan: Plain language version.* https://mn.gov/olmstead/assets/Minnesota%20Olmstead%20Plan%20-%20Plain%20Language%20Version_tcm1143-539438.pdf

Figure 7. The plans that included outcomes for their priority areas had an average of 4 outcomes per priority



Results from the key partner survey indicate that most were satisfied with the outcomes currently included in Nebraska's Plan. In fact, a majority (75%) reported they were "somewhat satisfied" or "very satisfied" with the objectives (Figure 8).

Figure 8. About 75% of survey respondents reported they were somewhat or very satisifed with the objectives included in the Olmstead Plan (n=36)

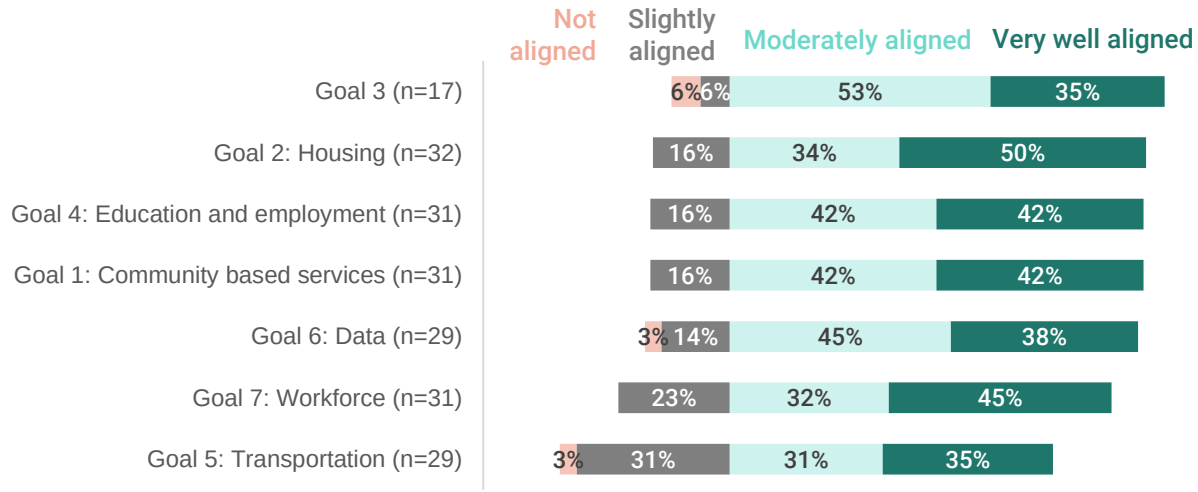


There were five who included a description for why they were dissatisfied[6]:

- The objectives need to go deeper and target individuals with disabilities who are at risk of institutionalization and also individuals who currently live institutional lives because of a lack of supports and services available.
- A low process for change.
- There needs to be consideration of a continuum of care including the [Intermediate Care Facilities] ICF option for individuals with mental illness and [intellectual and developmental disabilities] IDD/DD.
- Without studying the plans and hearing from people affected, it is hard to judge whether the plan is effective or not.
- No current needs assessment that lends to indications of improvement in the data. The correct areas are cited to be addressed, there's just no way to know if improvement has occurred as there is no baseline. The strategies for improvement are lacking as well.

The degree to which people felt the outcomes were aligned with each goal area was also assessed through the key partner survey. For the most part, people felt like the outcomes align, though it did vary by goal area (Figure 9). People were less likely to perceive alignment with Goal 5, Goal 7 and Goal 6. Although Goal 3 had the highest amount of "moderately aligned" and "very well aligned" response (88% total), it also had the largest percentage of respondents noting the objectives were not aligned.

Figure 9. Survey respondents felt objectives were most aligned with Goal 3 and least well aligned with Goal 5



To gain more context about the perceived alignment, results from the key partner survey were presented during two of the focus groups. One stakeholder noted that it seemed that alignment is higher in areas where there is more data available to understand the problem. For example, the education workgroup knew how many people in the school system had 504 plans and individualized education plans (IEPs), but there was not much knowledge about how many people in Nebraska have a disability or can't access services. This prevents Nebraska from

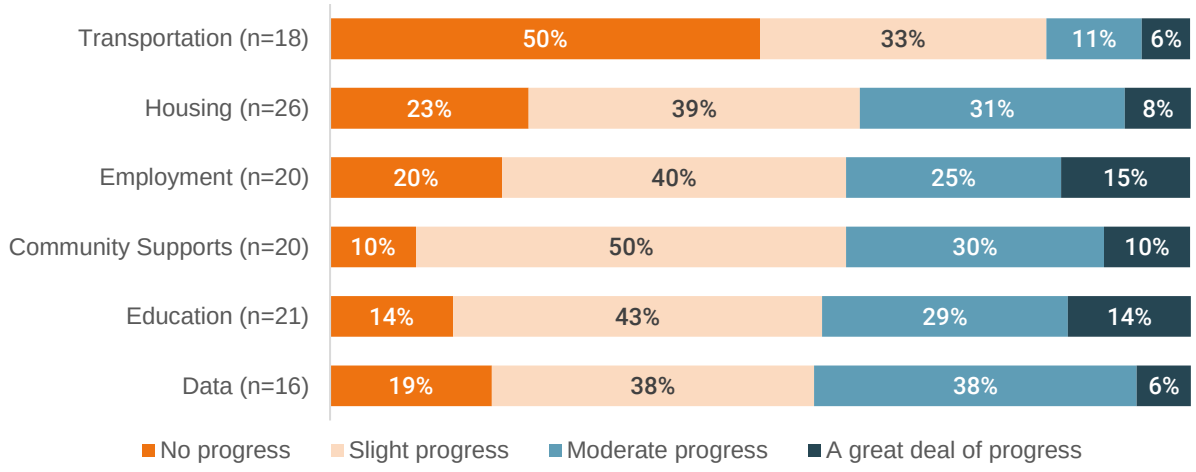
[6] The open-ended responses are included as they were written on the survey, except for text in brackets to spell out the acronyms.

having a strong sense for what objectives or outcomes should be included within each goal area.

Progress and Impacts

On average, based on the key partner survey, 10% of respondents felt there was "a great deal of progress" made among the seven goal areas. Conversely, about 23% reported "no progress" among the goal areas. Transportation was the area where people were more likely to report "no progress" (Figure 10). There was no statistically significant difference in the respondent's perception based on 1) how long they have been working on Olmstead Plan efforts or 2) what their level of involvement in each topic area is, likely due to the low number of survey participants. That means that people who have been involved in the Olmstead Plan efforts were not more likely to report a specific level of progress than those who were less involved.

Figure 10. The perceived amount of progress varied by goal, though on average, a great deal of progress was reported by 10% of respondents



> *"We may not have solved housing or transportation, but there's momentum and progress being made. Every time we expand a service, or every time we secure a new grant, we're working towards that ultimate goal of everybody should be able to have a safe and affordable and accessible home.*

In some ways, many felt that **Nebraska having a written plan was in and of itself a success for the state.** Although some were unsure of how much had occurred because of the plan, at least having something written and publicly available was a start.

While it is not directly related to the Olmstead Plan, some respondents noted that a key success was the elimination of the Developmental Disabilities (DD) Registry, which served as a wait list of people wanting to be enrolled in the DD Waiver program.[7] Many advocates have been pushing for increased funding to ensure people can get services. *"The governor just said, 'we're*

[7] Nebraska Department of Health and Human Services. (2024, March 29). *Governor Pillen announces elimination of developmental disabilities registry* [Press release]. https://dhhs.ne.gov/Pages/Governor-Pillen-Announces-Elimination-of-Developmental-Disabilities-Registry.aspx

just going to get rid of it and create a different pathway for folks to get services and support.'" This helps address one of the outcomes in Nebraska's Olmstead Plan (under Goal 1) to decrease the number of individuals on the DD Waiver Registry.

Another success that is not directly due to the Olmstead Plan but relates to it is the Katie Beckett Program through Nebraska DHHS. This support is intended for families who are not eligible for Medicaid but have a child or children who meet the level of care for living in a nursing facility, hospital, or intermediate care facility for individuals with intellectual disabilities.[8]

Workgroup members felt another success was individuals becoming more vocal in their advocacy: *"I think one of the biggest impacts is [that] all of us that you're talking to have gotten louder in our advocacy."* Many noted that there's active participation from people with disabilities and advocates who have come to the table to champion the cause. Over time, workgroup members felt this also led to having more champions within DHHS and the legislature. Though there is still progress to be made, the legislative mandate ensures efforts remain in place and *"to the extent that the Department of Health and Human Services and partners have attempted to live up to the requirements of the legislative mandate, I'm grateful."*

> *I think the successes that we see is the fact that we're still gathering and still building and still have folks engaged.*

To help articulate or show successes related to the Olmstead Plan, **Nebraska could add a section to the next iteration of the Olmstead Plan highlighting progress and successes.** This could be similar to North Carolina's Olmstead Plan where they highlight "priority area efforts to date" to provide context on what has been done within each priority area up to that point.

Public Experiences and Perceptions

To get a sense for how people – and more specifically, individuals with disabilities – experience life within the seven goals areas, input was sought through a survey (the methodology is outlined in Appendix A). The survey could be completed by individuals with disabilities or family members/caregivers (see Appendix C). A total of 310 individuals answered at least one question on the survey. Among those, 35% reported being an individual with a disability and 12% reported completing it on behalf of someone with a disability. The remaining participants were family members or caregivers to someone with a disability.

A core set of questions allowed people to indicate to what degree they had access to certain services related to the seven goals. People could indicate whether they 1) currently have or receive; 2) don't have but could get; 3) don't have and could not get; or 4) felt it was not applicable. In most cases, the "not applicable" responses were taken out of the analysis to get a better sense of access to services. In the future, it may be helpful to differentiate between those who feel a certain service is not applicable (such as employment or education for someone who is retired) and a service that is not desired by the individual.

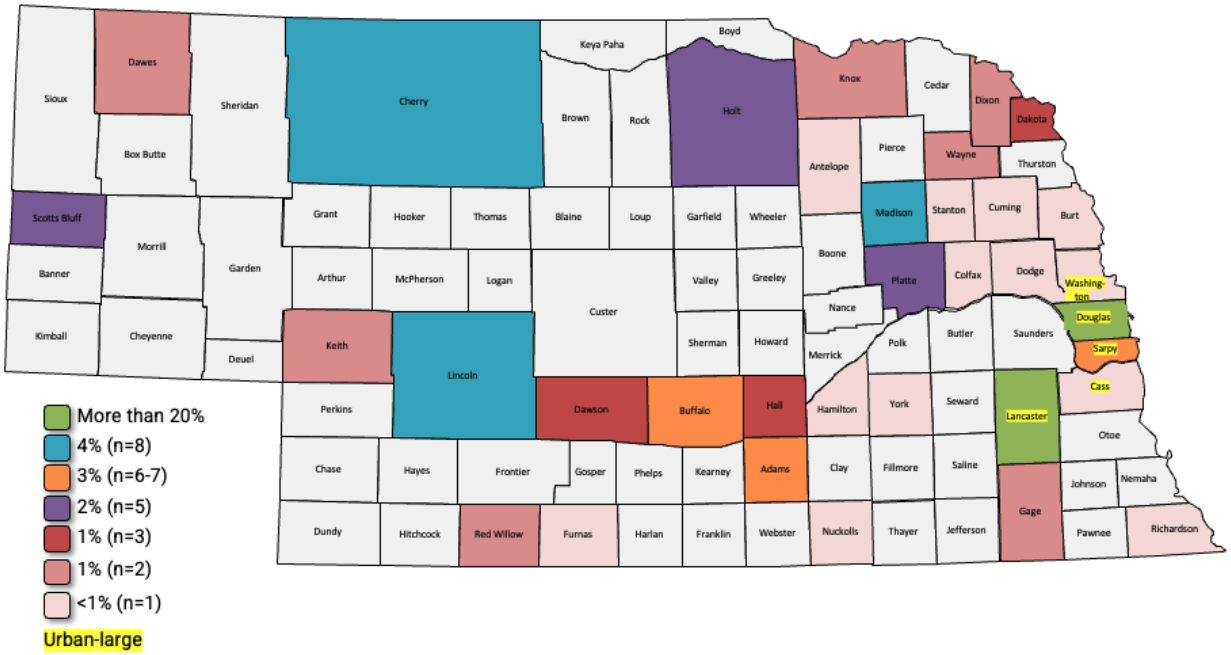
Although results shared are at the aggregate level, additional analysis was done for many of the survey questions based on where the respondent lived and how far they typically had to travel to get disability-related services and support. Survey respondents reported being from 34

[8] Nebraska Department of Health and Human Services. (n. dat). *Nebraska DHHS Katie Beckett program* [Info sheet]. https://dhhs.ne.gov/DD%20Documents/Katie%20Beckett%20Program%20Info%20Sheet.pdf

counties, with most being in Douglas and Lancaster County. There was also a high number of respondents from Cherry, Lincoln, and Madison counties (Figure 11). No weighting was done with the analysis because it was a convenience sample, meaning those who received and completed the survey were easy to access (i.e. clients of organizations sharing the survey).

The county of each respondent was coded into three categories based on the rural/urban classifications provided by DHHS's Division of Public Health Disparities Demographic Data Recommendations.[9] Two of the categories (urban-small and non-urban) were combined for analysis and compared to those in urban-large[10] counties. Of the 34 counties where survey respondents resided, there were five counties classified as the urban-large areas. They are highlighted in yellow in Figure 11.

Figure 11. Percentage of respondents by county of the individuals with disabilities survey

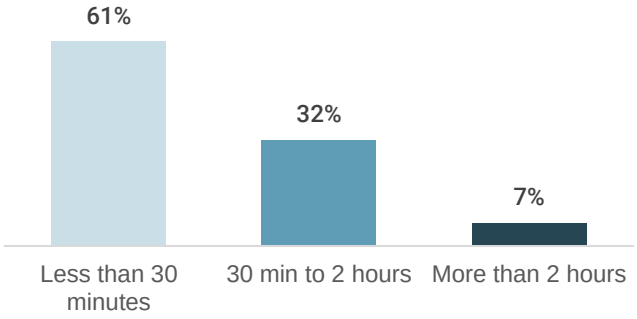


[9] Division of Public Health, Nebraska Department of Health and Human Services. *Disparities demographic data recommendations.* (Nov. 2016). https://dhhs.ne.gov/Reports/DHHS%20Demographic%20Data%20Recommendations%20Report.pdf

[10] Urban-large includes Douglas, Sarpy, Lancaster, Washington, Saunders, Seward, and Cass Counties. Urban-small and Rural includes all other Nebraska counties.

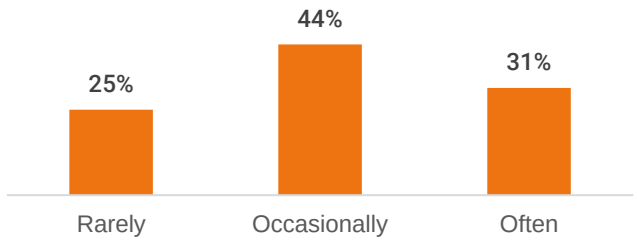
As mentioned, additional analysis was also done based on the amount of time it took individuals to get disability-related services and supports. It is important to note that the survey did not provide a definition or description for what disability-related services or supports entailed; that was left up to the discretion of the individual taking the survey. A majority (61%) of respondents indicated that they traveled 30 minutes or less (Figure 12). When doing the additional analysis, those who traveled “30 minutes to 2 hours” and “more than 2 hours” were grouped together. This was because individuals within those two groups responded similarly and grouping them together made it better to test for statistical significance.

Figure 12. More than half the survey respondents reported traveling less than 30 minutes to get disability-related services and supports (n=220)



Through the survey, feedback was obtained regarding how difficult people felt it was to access disability-related services and support. Slightly less than half (44%) reported it was “occasionally” difficult while 31% reported it was “often” difficult (Figure 13).

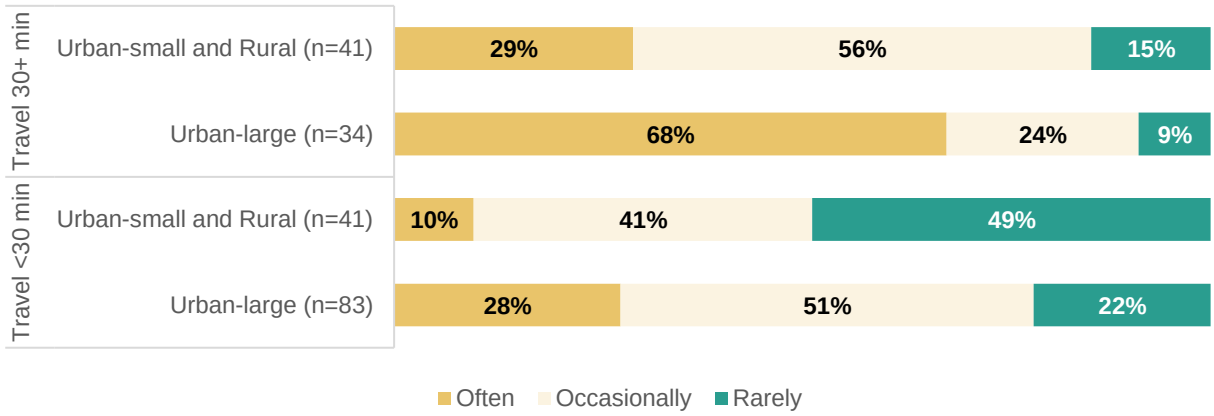
Figure 13. About one-fourth of the survey respondents "rarely" had difficulties getting access to disability-related services and supports (n=221)



Additional analysis was done to determine whether there were any statistically significant differences based on where the respondent lived and/or how far they had to travel to get to services. Being statistically significant means that there is confidence that the results are unlikely to be due to chance.

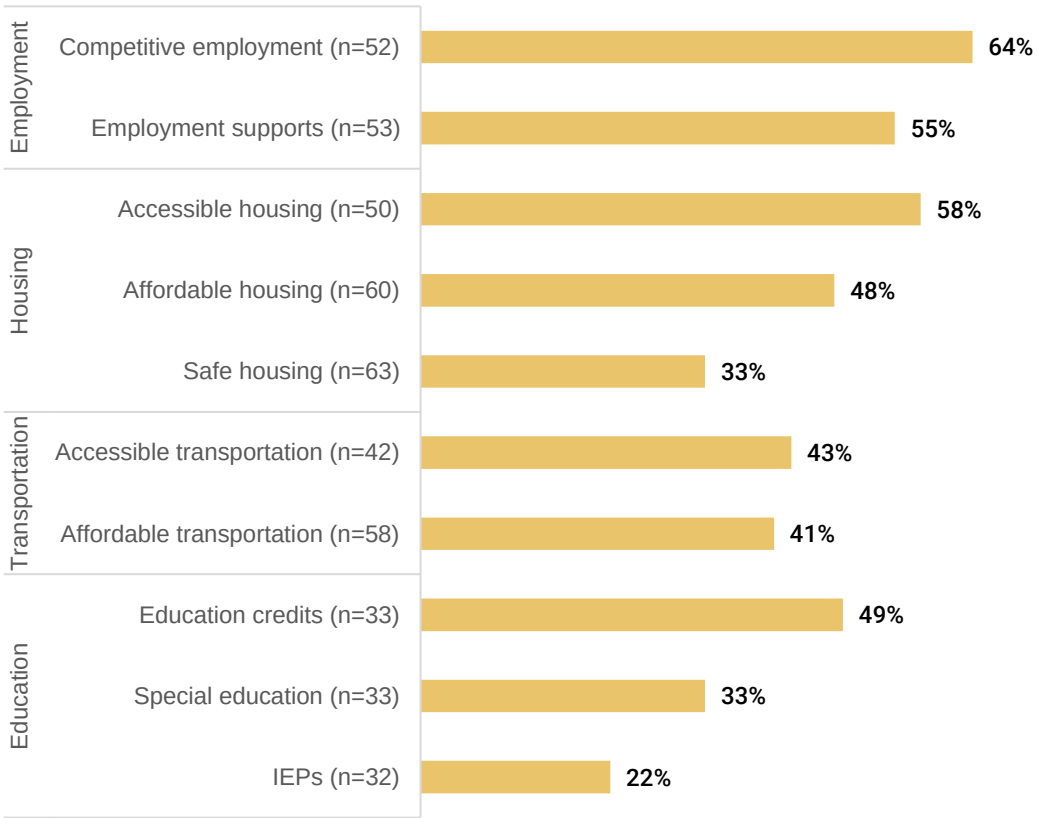
Among those who live in an urban-large county and who reported having to travel 30 minutes or more to get disability-related services and supports, 68% reported they “often” have difficulties getting access to disability-related services and supports (Figure 14). There were 28% of respondents in urban-large county areas who travel less than 30 minutes that reported they “often” had difficulties getting access to services. Interestingly, those who were from urban-small and rural counites were less likely to report “often” having difficulties accessing services, particularly if they travel less than 30 minutes for disability-related services and supports.

Figure 14. Those in urban-large counties were more likely to report "often" having difficulties getting access to disability-related services and supports



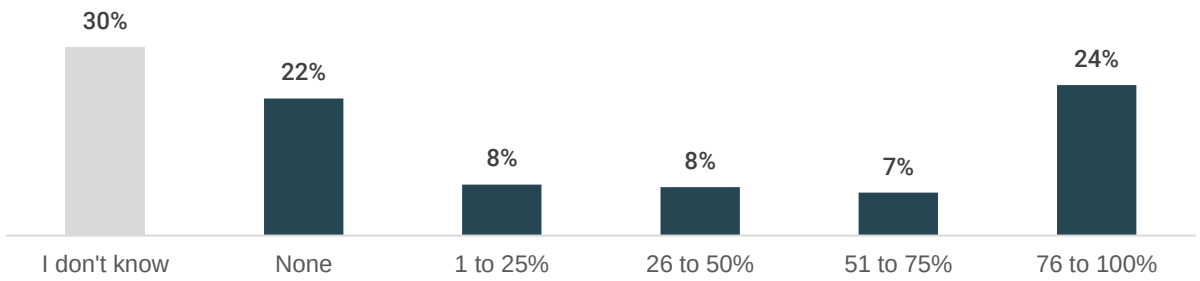
For those who reported they did not have or could not get access to certain services, analysis explored what those services might be. Results show that the areas where people were more likely to report not having access was in the areas of employment and housing (Figure 15).

Figure 15. Among those who reported they did not have or could not get access to services, the most common were in the area of employment and housing



The survey also captured input on whether the services used required some type of eligibility determination, qualification, or special request. This was primarily to explore to what degree services were inclusive. Although 30% reported they were not sure, about one-fourth (24%) noted that 76% or more of the services they receive or use require some type of eligibility determination, qualification, or special request (Figure 16). Slightly less than one-fourth (22%) reported that none of the services they used required that.

Figure 16. While 30% of respondents were unsure if the services they used required some type of eligibility determination or special request, 24% noted that a majoirty of the services utilized did (n=230)



Long-Term Vision

Although the Olmstead Plan is geared toward ensuring individuals with disabilities are fully integrated into their communities, there are other overarching goals that partners would like to see accomplished. One of those is working toward a more integrated adoption of the Plan. Success, for one workgroup member, would be when "*the plan becomes infused into the work of the different programs and supports for persons with disabilities in the state and their families."* **Rather than separately defining Olmstead work and Agency or Division work, advocates want Olmstead activities to drive day to day activities and planning**.

Several partners and workgroup members noted the plan seems to be a summary of what agencies are already doing rather than outcomes that agencies should collectively work toward achieving. That may be why partners feel the outcomes align well – many of the outcomes selected are based on things agencies are already working to address. *"I don't know how we pivot [from] a place of this [being] the plan we just report out on every year and it's comfortable and it's the minimum of what we need to do in order to comply with the obligations. Are we eventually going to get to a place where we're driving new initiatives and new areas of innovation through Olmstead?"* That being said, there are a handful of states that do use their Olmstead Plans as a way to outline what services and programs are available to be in alignment with the Olmstead decision.

> *Sometimes I think we may struggle just by how we've structured it within DHHS and sometimes wonder would we be better off as a state if this was a project or a plan that was managed at a higher level [and] truly crossed over multiple agencies, entities, both public and private.*

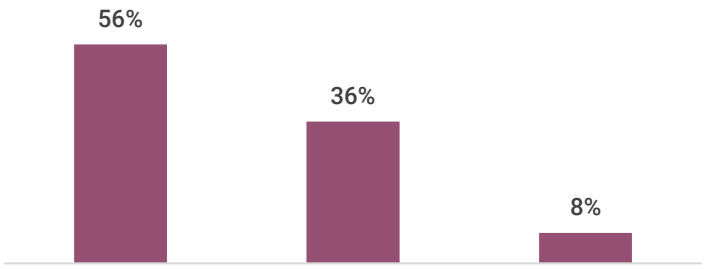
A related long-term hope for Nebraska's Plan is to have ownership across different entities. Some perceive that while agencies and advocates come together to attend meetings and provide feedback, the key coordination and action is taken by Nebraska DHHS. Over time, **efforts may be more successful if different agencies and advocates took on key pieces of the plan to ensure they move forward**. In doing so, it may lead to more sustained change and fewer challenges with implementing the plan.

To work toward achieving that vision, **Nebraska could consider adding a priority within the Olmstead Plan around creating or enhancing the governance structure for the Olmstead Plan.** Colorado has something similar through their ninth priority, which focuses on ensuring successful plan implementation and enhancements by creating a governance structure and supportive workgroups.[11] Although Nebraska has workgroups and committees in place, it may be beneficial to outline the specific responsibilities of state partners and define the roles of each group clearly to ensure it is a collaborative, effective approach for the state. This would also create an opportunity to go beyond DHHS for plan implementation.

Public Awareness

Based on results from the individuals with disabilities and family members/caregivers survey, there is not a strong level of awareness about the Olmstead Plan. In fact, more than half the respondents reported being "not at all familiar" with the Plan (Figure 17).

Figure 17. More than half the survey respondents were "not at all familiar" with Nebraska's Olmstead Plan (n=309)



Participants in two of the focus groups were not surprised by the survey results: *"I did not know about the Olmstead Plan until I was contacted for the survey. I don't know how I would have learned about the plan otherwise."* Part of the challenge may be that there hasn't been a marketing push to help people know what it is or why the state has one. A participant also noted that many may not read the plan given it is full of data and is a single-spaced document, making it a lot of information to digest. A key partner also reiterated that message, noting that it may be helpful to **have a one to two page "scorecard" that could summarize each goal area, what has**

[11] Colorado Department of Health Care Policy and Financing, Colorado Department of Human Services, Colorado Department of Local Affairs. (July 2014). *Colorado's community living plan: Colorado's response to the Olmstead decision.* https://hcpf.colorado.gov/sites/hcpf/files/Colorado%20Community%20Living%20Plan-July%202014.pdf

occurred, and what is planned to meet the measures, as many people won't read a long document.

During the focus groups, suggestions were given on how to generate better awareness about the plan. Many of the ideas focused on making information about the plan easier to understand and creating new avenues for people to learn about it (Figure 18).

Figure 18. There were 10 key suggestions offered during focus groups regarding how to increase awareness about the Olmstead Plan

01	Create a one-pager of what the plan is about and highlight the key goals.
02	Have a website with access to good information and resources, including materials that are easy to read.
03	Have public service announcements (PSAs) to help people understand and drive them to the website. This could include short informational videos in plain language.
04	Provide a way that people can offer feedback on the Olmstead Plan.
05	Reach out to TV news and newspaper reporters to do interviews.
06	Get information to local organizations through posters or their own communication departments.
07	Use regional and statewide systems to push information out, such as through Disability Rights Nebraska.
08	Incorporate information into trainings and events that are already occurring, such as trainings that teach parents how to be advocates, disability pride events, Special Olympics, etc.
09	Connect with schools and educate parents/guardians about how they can help be engaged in the Olmstead Plan. Trainings should be done in a family-friendly, culturally and linguistically appropriate manner so families feel connected to and understand the importance of the Olmstead Plan.
10	Explore a way to better connect disabled community parents, care providers, and DHHS. This could include a safe blog, newsletter, or Facebook page that people and interested community members could subscribe to and use to share concerns and ideas. A monthly newsletter would also be beneficial.

To ensure this is a priority in the future, **Nebraska could work toward increasing communication and outreach around the Olmstead Plan.** At least 13 plans from other states (two from Illinois) have priorities that include an element of resource sharing, communication strategies, and outreach. Part of this also relates to the state's ability to ensure individuals with disabilities are informed and aware about their ability to make informed choices. Nebraska could work with partner agencies and outreach organizations to help spread information about the Olmstead Plan to those who are directly impacted.

Prioritizing communication and awareness could also be an opportunity to address another key barrier noted among individuals with disabilities and family members/caregivers. One focus group participant noted it is not uncommon for people to group individuals with disabilities together. As an example, people with intellectual and developmental disabilities (IDD) are often grouped together with people with brain injuries despite having different functional and social

skill sets. This creates misunderstanding around the breadth of disabilities and the treatment options that people with different disabilities need. Working to generate awareness about the nuance of disabilities and the Olmstead Plan may lead to better impact, particularly with service providers.

Content Generation

The initial Olmstead Plan evaluation, as previously mentioned, was conducted by TAC.[12] This informed the revision process for the second iteration of the Olmstead Plan. By and large, workgroup members and partners felt the changes to the plan were relatively positive. Many reported that it was a more readable format and made it easier to track information.

That being said, there are still components that could be enhanced, particularly when it comes to the revision process. Some stakeholders noted that there was a disconnect between the people putting the plan together and those from the agencies that were editing, reviewing, or approving. Partner agencies reported not having the opportunity to edit their action steps or benchmarks, which was frustrating. *"I think maybe [we should be] taking some more time and having each agency responsible for the goals officially approve at least the wording of the benchmarks and action items."* The suggestion from a handful of partners was to **ensure agencies listed as being responsible for an action step or benchmark are responsible for the drafting of those steps and give approval before the plan is finalized.** This would allow agencies to draft outcomes that are meaningful, aligned, and achievable for themselves, while the committees and workgroups could serve in an advisory role to provide feedback.

The challenge, though, is that there are 41 different outcomes, giving workgroups quite a bit of content to wade through: *"There was a lot of time spent on each and every one of the outcomes and on each and every one of the benchmarks."* Many workgroup discussions became bogged down in specific details, such as what percentage change should be set. Those types of conversations didn't always lend themselves to setting realistic outcomes. To counter this in the future, one suggestion was to **have workgroups identify the appropriate high-level goals (currently called outcomes in the plan), and then have the relevant and appropriate entities determine how they could best measure that progress and change (currently listed as benchmarks in the plan)**.

To better guide the process for workgroups – either in terms of identifying the high-level priorities or more specific benchmark and outcomes – a recommendation offered by a handful of partners was to share and/or review examples of how other states have been successful or how they've structured their Olmstead Plan goals and implementation. Knowing what has worked for other states and who has been successful may help Nebraska model meaningful outcomes and benchmarks. In addition, a lack of expertise for Olmstead Planning was something that workgroup members noted may be missing, with some expressing the value in having a technical assistance partner that could provide technical assistance to the state and help it move forward. While resources to provide technical assistance are not available, a review of other state Olmstead Plans was conducted as part of this evaluation report and recommendations are made where appropriate based on this review.

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[12] Technical Assistance Collaborative. (2021, December 15). *Nebraska Olmstead Plan Evaluation: Report on progress with plan implementation – June 2020 to December 2021.* https://nebraskalegislature.gov/FloorDocs/107/PDF/Agencies/Health_and_Human_Services__Department_of/708_20211215-142757.pdf

Another recommendation was to **make the statement of need clearer in the plan**. One participant noted that they were working on a grant application and they looked at the Olmstead Plan to articulate the need and could not find it. If data is not necessarily available to demonstrate the need, there are other ways to integrate that type of content in the plan. For example, North Carolina has a summary under each priority within their Olmstead Plan describing what it means and why it remains a focus within their plan.[13] Minnesota also has a plain language document that summarizes why each of their priority areas is important. That may help with showcasing the need for the state to pursue a particular priority or goal.

It may also be important to ensure the accessibility of the document, particularly given the focus of the Plan on serving people with disabilities. Currently the Olmstead Plan is available as a PDF on the DHHS website. One partner noted it may help to have it in a more interactive online format so that it's searchable, which would make it easier for stakeholders to find and use key information. Other ways to make the document more accessible include a plain language version (which is something Minnesota does for their plan) or including an accessible PDF to ensure screen readers can be used more effectively. The plan is currently 501 compliant, so partners who are recommending this change may simply not know that the document is already accessible.

One key partner noted they would like to see **more information added about who has what data**. When writing a grant application, they found it difficult to find who had data on certain goal areas. This barrier may be due in part to how data is collected and shared by Olmstead Plan partners. Among the interviews conducted, at least 12 partners discussed their agency's ability to pull data for benchmarks and other Olmstead reporting. Among those:

- Six were already collecting the data and found it easy to supply to DHHS. However, one did note that they are reliant on others to report the data into their system, so although it is easy to pull, it doesn't guarantee all data is submitted or submitted accurately.
- Two had the data, but noted it was time-consuming to pull together.
- Two were somewhat monitoring it but did not have a set system or process to report effectively to DHHS.
- Two noted they have not been asked for or supplied data recently.

One way Iowa addresses data challenges through their Olmstead Plan is including links to the data sources used within each of their priorities as well as a summary at the end of their plan with the list of data sources and outcomes included in the plan. This could be an option for Nebraska for data that is publicly available. Unfortunately, as a result of how the Olmstead outcomes and benchmarks were written in the current plan, there is not always a data source available to track the change in that benchmark. By having agencies write their own outcomes and benchmarks in future iterations of the plan, they can ensure that they have existing data sources and/or can develop data sources to track the process of their goals.

SMART Goals & Benchmarks

A key focus during the most recent revision process was on integrating SMART activities and metrics, primarily based on recommendations from the evaluation conducted by TAC. In the current iteration of the plan, each outcome specifies the baseline data (if available), benchmarks for each fiscal year, action items that will be taken, and the agency responsible for that

[13] North Carolina Department of Health and Human Services. (April 2024). *North Carolina Olmstead plan: 2024 – 2025).* https://www.ncdhhs.gov/2024-25-olmstead-plan/open

outcome. Previously Nebraska's Plan outlined strategies that would be taken to achieve each goal, with a series of measurable outcomes they hoped to achieve.

Partners noted through interviews and focus groups that the benchmarks included in the most recent iteration of the plan didn't always help them understand what was really happening and what progress was being made. It also doesn't accurately conceptualize a meaningful impact: *"That's where our plan struggles, figur[ing] out what those meaningful indicators are in some of those areas."*

Among the 24 Olmstead Plan documents reviewed, 9 (38%) of the plans include specific indicators. The small percentage of plans that include indicators may be due to states trying to write their objectives as SMART goals, which includes what they will measure or what they aim to achieve. They do not include a separate list of indicators or measures.

One unique aspect of Nebraska's plan is the use of annual benchmarks. The other plans reviewed included indicators for what they wanted to achieve by the end of their Olmstead Plan period. **It may help Nebraska to set indicators based on what they would like to see accomplished at the end of the plan period instead of the current structure of annual goals or benchmarks.** The annual progress could still be tracked and reported, but that way the focus is on the long-term goals of the plan.

> *"We're now in a position where when any program changes, when funding comes in or goes away, or a contract doesn't go through... then that goal falls apart.*

Taking a broader approach to goals and benchmarks may also help staff, partners, and stakeholders focus on the larger picture. Some noted during interviews that by making the plan more specific for the second iteration, it was unclear if the "very specific action steps" would lead to the changes the Olmstead Plan is aiming to achieve. As noted, rather than having a set of strategies that would be implemented to achieve the goal, the updated plan has action steps provided for each of the outcomes listed under the goal. The slight challenge with that level of specificity, at least from the perspective of some partners, is that there is no longer enough flexibility in the plan to account for natural changes that may occur, such as funding, programs, or policies.

It was also difficult to set benchmarks – particularly annual ones – without having clear baselines. Many workgroup members noted that even now, because there are not clear baselines, it is difficult to determine whether goals have been met or progress is being made. A handful of partners suggested that when creating benchmarks, it is important to set ones that are within the control of the agencies implementing the work rather than being issues or topics that are outside of their control. For example, an agency might not be able to control how many referrals they receive or how much funding they have, but they can streamline their processes to reduce wait time.

More broadly, many stakeholders discussed a need for gathering data to understand the needs and priorities in Nebraska related to disabilities. Currently there is not a comprehensive assessment or set of data that allows the state to look at each of the goal areas to get a sense for the current status of things like transportation, housing, etc. Given data collection can be time-consuming and costly, there may be an opportunity for **key partners to identify data sources already available that can give stakeholders a sense for where Nebraska is within each of the goal areas**. Iowa, for example, uses the Iowa Participant Experience Survey

(IPES) through their Medicaid program to capture personal experiences across all their priority areas.

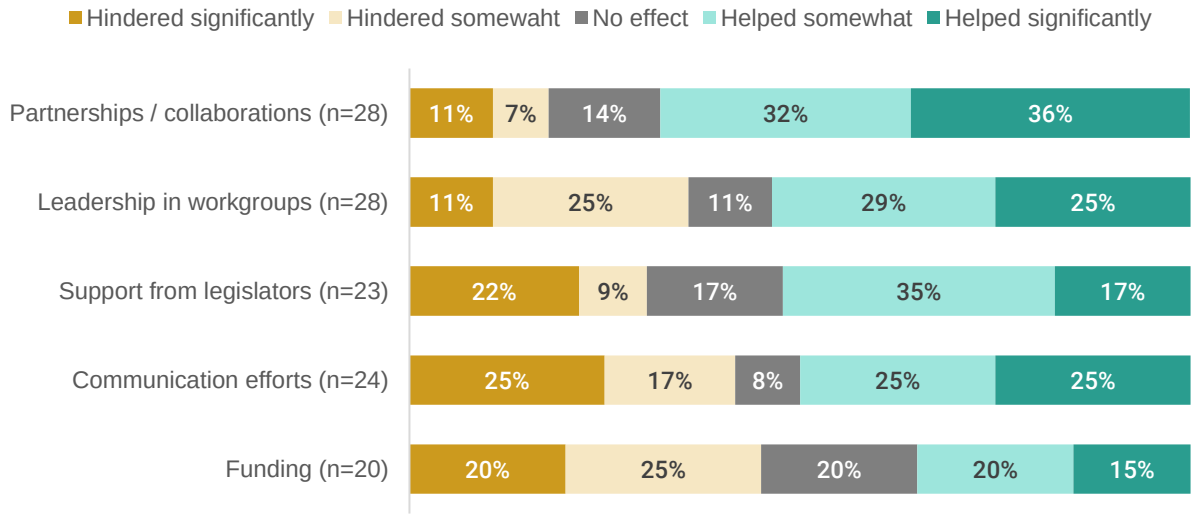
Another stakeholder noted that it would be helpful to collect data from all stakeholders to get a better sense of who is being served and who is not. *"It's hard to make those decisions without that documentation or information, but a lot of times we don't gather it."* However, the need for data must be balanced with ensuring the burden of collecting the data is not too high. *"[We want to be] tracking enough information to be able to make sound decisions without having this gigantic list of things [they're] checking off for everybody that comes in, where they're filling out this huge form."*

Gathering additional data is particularly helpful to knowing where different needs may exist in the state. A solution for one community or region of the state may not be applicable to another area. *"When we talk about transportation in Omaha, that's very different than transportation in Valentine, Nebraska."* In addition to capturing needs, it's also important to understand or assess the level of capacity and interest. While the outcome may be to have public transportation everywhere, it may not be as realistic in rural areas or there may be limitations that need to be factored into the solution.

Implementation Efforts

There are a variety of factors that help and prevent Nebraska with effectively implementing the Olmstead Plan. Based on feedback from the key partner survey, the biggest area facilitating progress was related to partnerships and collaborations (Figure 19). More than half the respondents also felt leadership in workgroups and support from legislators facilitated success. It is important to note that "leadership in workgroups" was not defined on the survey, so it is unknown to what degree that may be DHHS's leadership versus leadership from other workgroup members.

Figure 19. A majority of respondents to the partner survey viewed partnerships and collaborations as a key factor for helping move the Olmstead Plan forward



Beyond the five topics included in the survey questions, additional factors that helped and hindered progress were noted by workgroup members, key partners, and advocates through various data collection efforts (Figure 20).

Figure 20. A variety of other factors have helped and hindered progress for Nebraska's Plan

Factors that Helped Progress	Factors that Hindered Progress
• Active involvement of community and advocates (n=4) • DHHS staff (n=4) • Collaboration with partners (n=4) • N/A or Don't know (n=3) • Active involvement of workgroup or committee members (n=3) • Knowledge / expertise (n=2) • Overall leadership (n=1) • In-person meetings (n=1) • Consistent meeting facilitators (n=1) • Advocacy (n=1) • DD system evaluation (n=1)	• Lack of communication (n=3) • Unproductive meetings / low attendance (n=3) • No support from governor's office or legislature (n=3) • Lack of high-level / agency leadership support (n=3) • Funding (n=2) • Lack of awareness about plan (n=2) • Lack of direction for workgroups (n=2) • Limited involvement to implement plan (n=2) • Feels like the plan is a box to check (n=2) • Inexperience / jargon (n=1) • Translating plan objectives to other stakeholders (n=1) • Not having a finished plan (n=1) • Delays with posting updated plan (n=1) • Political issues (n=1) • Staffing (n=1) • Plan not being a priority (n=1) • Restriction on membership (n=1) • DHHS turnover (n=1) • Lack of coordination among partners (n=1) • No continuum of services (n=1) • Lack of housing developments (n=1)

Workgroup members echoed the challenges of having limited funding. *"In order to truly fix things, we need some funding to be able to do it."* Additional funding could also help with managing, administering, and coordinating the Plan at the state level to better enhance collaboration and create cross-system engagement.

Partners also noted that a barrier for Olmstead efforts in general was the slow speed. Although Olmstead was passed in 1999, there wasn't a push for Nebraska to have a plan. There was a long period of time where advocates and champions felt like a plan was needed, but it was not being developed. Even now that the plan exists, many advocates reported that working toward the goals continues to be slow.

Committees and Workgroup Structure

There are currently six workgroups that help implement the Olmstead Plan: Community-based Supports, Housing, Education, Employment, Transportation, and Data. Community Supports is a newer workgroup, with their first meeting occurring in November 2023. Although Education and Employment were previously one workgroup (because Goal 4 focuses on both), they became two separate workgroups to more effectively address their activities.

In addition, there is also an Advisory Committee and Steering Group (Figure 21). This role is to have a higher-level focus, though one partner noted: *"One of the things, as we look forward, that the steering committee and the advisory committee really need to focus on is how we create that systems change without becoming so stuck down in the weeds that we can't see the system that we're supposed to be improving."*

Figure 21. There are three types of groups that help with the implementation and oversight of Nebraska's Olmstead Plan

A handful of partners noted that it **would be beneficial to have greater delineation between the roles and responsibilities of the advisory committee, the steering committee, and the workgroups** to ensure that each level knows what they are tasked with doing. As noted, this is something Colorado addressed through the ninth goal in their Olmstead Plan, which is based on creating a governance structure for Olmstead efforts in the state.

Although the Advisory Committee has bylaws and the Steering Group has a charter to outline the expectations, there may be a need for a less formal description or reference for the role each group plays and what their core focus should be.[14,15] This may also provide an opportunity to look for any duplication or opportunities to streamline decision-making and information sharing. Although most have a set of core partners committed to participating in meetings and moving the work forward, as one partner noted, "*I think we have a bit of death by committee."*

Throughout the interviews, many workgroup members and key partners noted some of the challenges related to the workgroup structure and functionality. Among them were:

- Workgroup leadership has been inconsistent. Although most of the facilitators have had a positive influence, the turnover makes it hard to progress. *"They do a good job, it's just they never seem to last long enough to keep the momentum going, and the second we get somebody else it's like starting all over again."* It was also noted that it would be beneficial to have someone with lived experience not only at the table, but also in leadership roles.

[14] https://dhhs.ne.gov/Pages/Olmstead.aspx
[15] Nebraska Department of Health and Human Services (n. dat). *Nebraska Olmstead Steering Group Charter*. https://dhhs.ne.gov/Olmstead/FINAL%20Olmstead%20Steering%20Group%20Charter.pdf

- Although a strength of workgroups is the diversity of partners, it can be challenging when each individual or agency seems to "have their own thing." At times it can feel like members aren't all working toward a common goal. *"We're not on the same page. You're getting a whole group of people that want to help, and everybody means well, but they're kind of in their own little bubble and so their ideas are focused on that."* This can make it feel like the workgroup has a lack of a shared vision to work toward collaboratively.
    - Some felt this may be caused by a lack of level-setting. Without a common understanding of the key terminology and data, it was hard to feel like there is a cohesive group addressing each goal.
    - A handful of workgroup members noted it would also be beneficial to ensure that all workgroup members have a shared understanding of what is expected of them. This could relate to their participation in Olmstead efforts, but also other tasks such as supplying data.
- Varied attendance, and to some degree the lack of a shared vision within workgroups, often made it so meetings were spent recapping what had previously been discussed. *"I felt like, between the meetings, there wasn't a lot of carryover, so I never knew, each time I came to a meeting, what we were going to discuss…I would participate in each meeting I went to, but I didn't necessarily feel like there was a cohesive link between the meetings and maybe some of it is the time in between."*

> *We keep going to these meetings, we spend an hour and nothing happens, and here we are, four years into it, and what has happened other than we keep rewriting this plan? I think it'd be fun to have some wins and be able to showcase that and say, 'look what we've accomplished.'*

When workgroups were initially formed, each one met monthly. This transitioned to quarterly, in part due to low attendance and DHHS being cognizant of the workload of agencies who needed to be at the table. *"It takes up a lot of their time to maintain their presence at all of these meetings. It was those folks that were saying, 'This just isn't working…we can't do this.'"* Given monthly meetings are a substantial time commitment – not only for DHHS staff, but also those who were participating in the workgroups – the decision was made to meet less frequently. Nebraska looks to formalize or enhance their workgroup and committee structures, including meetings, the following suggestions were offered by key partners:

- **Create greater structure or focus for workgroup meetings.** It was noted by a partner that because of the nature of the groups that have been formed and the level of passion that many have, it can be easy for members to be sidetracked or want to talk about a variety of disability concerns, regardless of whether it relates to the workgroup topic. Although the stakeholder mentioned the state does a good job of trying to bring the focus back to the Olmstead Plan, it's challenging to redirect that passion to ensure the discussion gets back to plan itself.
- **Have ad hoc or subcommittees as needed to address specific issues.** This might be a more effective way to stay focused on specific areas of the plan, particularly if there are sections that need to be prioritized or perhaps haven't seen a lot of movement.
- **Look for ways to increase attendance.** Members from a variety of workgroups noted that meeting attendance and lack of participation was a barrier to progressing on the plan. One suggestion was to integrate team-building opportunities. That might help build cohesiveness and emphasize the value that each person brings to the workgroup.
- **Integrate opportunities for information sharing.** Several workgroup members noted they would like to have different agencies report the status of their outcomes on a

regular basis. In addition to promoting more accountability, it may spark discussion among members about efforts happening within other agencies. This would include hearing updates from DHHS, as many aren't aware of efforts that are happening within the various divisions of the agency.

Partnerships & Collaboration

As noted, partnerships and collaboration have been a key facilitator for moving the Olmstead Plan forward. Most felt the right partners were at the table: *"What works well is that I think we have, for the most part, a well-rounded group of members on steering committee or advisory committee… housing partners, funding entities… It's a good mix of all the folks that need to be at the table."*

However, it did not necessarily start that way and there is still room for improvement. Some workgroup members noted that it took a lot of time for some divisions, departments and agencies to get involved. *"They didn't show up at meetings, they didn't have reports, we didn't get data from them. I get that they're busy, but this is important."* Others agreed, noting that some partners attended meetings only because they were written into the statute and may not have understood their role or how Olmstead would affect their work.

One partner noted that while DHHS, Medicaid, and disability services have a clear role, beyond that, others do not necessarily understand how the work would impact them. This is why it may be beneficial to 1) focus on level-setting among the group and creating a shared vision and 2) increasing awareness regarding the Olmstead Plan to further showcase the value and role it plays for Nebraska.

Respondents to the key partner survey noted that they either didn't know or weren't sure who else should be involved in implementing the Olmstead Plan, in part since they weren't fully aware of who currently is involved. However, there were suggestions offered from other partners and workgroup members:

- Adults experiencing multiple disabilities
- Businesses
- General Public
- Public K-12
- Colleges and universities
- Someone from Housing and Urban Development (HUD)
- Housing authorities
- Tribal representatives
- Staff from the Governor's Administration policy office
- Representative from the Nebraska Legislature
- Regional Behavioral Health Authorities

It's important to consider that some of the suggested groups may have expertise to guide the conversation but do not have capacity to work toward solutions or provide resources to the Olmstead efforts. This can sometimes lead to meetings where progress is impeded by attendees sharing advise, but no one being able to make final decisions about moving forward. While having some members of committees and workgroups that bring expertise to the table is essential, limiting membership to those that have both expertise and capacity to make change may make the workgroups more effective in their efforts to make progress on the goals of the plan.

Given the input, **it may be beneficial for the Olmstead groups to prioritize how the missing entities fit – whether they are suited for the advisory committee or a particular workgroup**. A representative from a housing authority, for example, may be well suited for the housing workgroup.

Progress Toward Goals

As shown previously in Figure 10, on average, 10% of respondents perceived that there was "a great deal of progress" among the seven topic areas in the Olmstead Plan while about 23% felt there was "no progress." That does vary by goal, with the most progress being perceived in the areas of data and education, and the least amount of progress reported in transportation.

Each priority in the Olmstead Plan has annual benchmarks that DHHS uses to monitor progress toward outcomes. Updates are compiled by DHHS and shared with the workgroups and advisory committee. Results were also utilized in the evaluation to assess progress, particularly in relation to the other data collected. Within each of the goal areas, symbols are used to show the progress made during the first two fiscal years of the current Olmstead Plan. Figure 22 shows the symbols used to describe Nebraska's progress on each benchmark, based on information received from DHHS as of September 25, 2024.

Figure 22. Four symbols are used to describe Nebraska's progress on each benchmark

Symbol	Description
✓	Benchmark for the fiscal year was met
➤	Benchmark for the fiscal year was in progress
▲	Progress is delayed or pending for this benchmark
■	Benchmark for the fiscal year was not met
No Report	Data was not available to determine whether benchmark was met

Goal 1 – Community Services

The first Olmstead Plan goal is focused on ensuring that individuals with disabilities can access individualized community-based services and supports that meet their needs and preferences. Long-term, many partners and stakeholders noted they would like to see consumers being aware of and having access to services, but also have a better understanding of how it improved their lives over time to know whether the services are working. Success within this goal area would mean:

> *They would report that their life is better, not just, 'I like my services' but 'I feel my life condition has improved.'*

1. Consumers have access to training about services and are aware of what services are available.
    a. This includes knowing about and actively using crisis services as needed, including the 9-8-8 crisis line.
2. Consumers have access to supports they need regardless of their circumstances.
3. Community members have service options that are an alternative to law enforcement involvement or recidivism.

Progress Toward and Perceptions of Outcomes

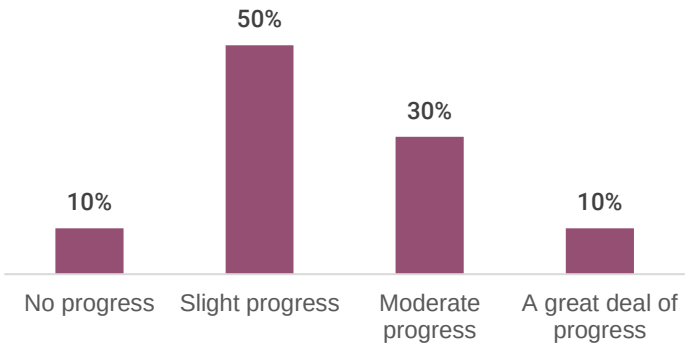
There are seven outcomes for the first goal. While five are addressed through the newly formed Community Supports workgroup, one (#7) is led by the housing workgroup and another (#3) is through the education workgroup. Based on the Olmstead outcomes monitoring system maintained by DHHS, all but two of the benchmarks set for Fiscal Year (FY) 2023 (July 2022 – June 2023) were completed (Figure 23). Five benchmarks were also completed in FY24 (July 2023 – June 2024), including one that was not met the previous fiscal year.

Figure 23. Five of the seven benchmarks for the Goal 1 outcomes in the Olmstead Plan were completed in both FY23 and FY24.

Outcome	Description	FY23 Status	FY24 Status
1	Increase utilization of crisis intervention through the implementation of the 9-8-8 plan and the National Suicide Prevention Lifeline.	✓	✓
2	Increase usage of the "No Wrong Door"/2-1-1 system.	✓	✓
3	The Commission for the Deaf and Hard of Hearing (NCDHH) will increase educational outreach on the services available to support integrated community living.	■	✓
4	The Division of Developmental Disabilities will make sufficient offers to individuals on the HCBS DD Waiver Registry to not exceed the baseline with a goal to decrease the number of individuals on the registry.	✓	✓
5	Increase access to medication-assisted treatment (MAT) for adults with Opioid Use Disorders (OUD).	✓	✓
6	Increase usage of telehealth to support patient-provider relationships and minimize barriers to service for Nebraskans with disabilities.	✓	■
7	Decrease in the average amount of days between when an Aged and Disabled Waiver referral is entered into the database and when the service request is assessed by the Assistive Technology Partnership (ATP) Program.	■	➤

Survey results indicate that key partners mostly perceive that "slight progress" has been made on Goal 1 (Figure 24). Half of the respondents selected "slight progress" while 10% felt there was "a great deal of progress." There was not a statistically significant difference in the perception of progress based on the survey respondent's 1) amount of time involved in Olmstead Plan work or 2) level of involvement with the housing workgroup. This is the case for the level of progress among all seven goal areas, likely due to the small number of survey respondents.

Figure 24. More than half (60%) of survey respondents felt there was no or slight progress made toward the community-based services goal (n=20)



Results from the survey also indicate that about 42% of the respondents felt the outcomes were "very well aligned" with Goal 1 while another 42% felt they were "moderately aligned" (n=31). None of the respondents felt they were not at all aligned. Feedback obtained through interviews had a similar sentiment. Most appreciated that the outcomes were aspiring to the change needed, and they also appreciated that the plan was more concrete than before.

One partner did note, however, that some of the outcomes were more process-oriented rather than being outcome measures. *"You have to have those activities, but ... there should be an outcome for the consumers or for deaf and hard of hearing individuals or for providers. If I do these outreach activities, what am I expecting to change? Setting outcome measures is hard work. There's nothing wrong with the measures that they have, but it's a process measure to me not necessarily the impact or outcome measure."*

Although not necessarily captured through the outcomes, **a key success within this goal area was making the concerted effort to build connections in communities.** Stakeholders reported that working with communities created an avenue for the communities to identify their needs and become more informed about statewide services that were available, allowing them to problem-solve when they struggled to get access.

One partner noted that the COVID-19 pandemic played a role in how community engagement shifted. *"We really partnered with all of the communities to identify what the needs were. We talked with those specific clients that were out there to try and figure out how to best utilize the funding to assist them and make sure that they were making it through all the craziness that was the pandemic."* They also focused on person-centered planning to ensure that consumers were *"living the life you want to live, not just [the life] the system provides."*

The implementation of 9-8-8 was also mentioned as a success. At the time of the interview, one stakeholder reported that the crisis line had received more than 18,000 calls and was getting about 60 calls a month. This aligns with the update for Outcome 1, which is focused on increasing the call volume and number served by crisis response services.

Addressing Community-Based Services and Supports in Nebraska

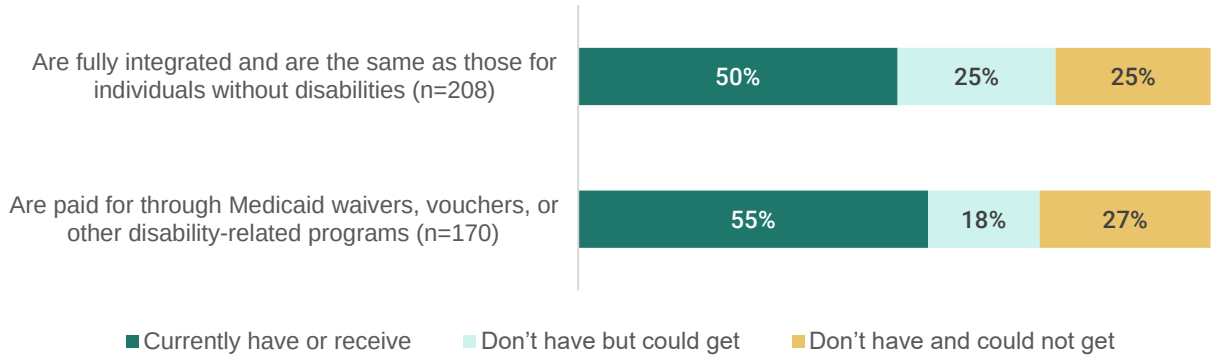
According to workgroup members (through the survey) and key partners (through the interviews), there are a variety of factors that can impact progress on ensuring individuals with disabilities can access individualized community-based services and supports that meet their needs and preferences – either positively or negatively (Figure 25).

Figure 25. A variety of factors impact Nebraska's ability to address Goal 1

Facilitators to Community-Based Services Progress	Barriers to Community-Based Services Progress
• Engaging with communities, listening to feedback, and being committed to all individuals being in the least restrictive setting. • Commitment to holding partner meetings and town halls, conducting surveys, doing media campaigns, and finding community connections. • Ensuring state agencies better understand what is needed in communities, and building a network to ensure communities can spread information when there are updates: *"I think that's why it's so important to create that communication bridge, to get the information out to as many people as we can."*	• Community supports and services often intersect with many other systems, making it difficult to coordinate. • Coordination could be enhanced between DHHS divisions. It would be ideal if there was an opportunity for people to maximize resources that can be used in conjunction with one another to serve the same populations. • Inability to use some of the funding available because workforce and services are lacking. • Lack of services, making it so that even if a person is ready and has funding for a service, it may not be available. This may be related to low provider pay rates as well as lack of workforce. • Lack of structure for individuals to know how to access services: "*… they can't just call and figure out what they need to do or get access to someone. They don't know how and that creates issues for people getting access to some of our services as well. I think we've done a lot of work to try and reduce that as much as possible and put everything that we can in place, but I think it's still an issue."*

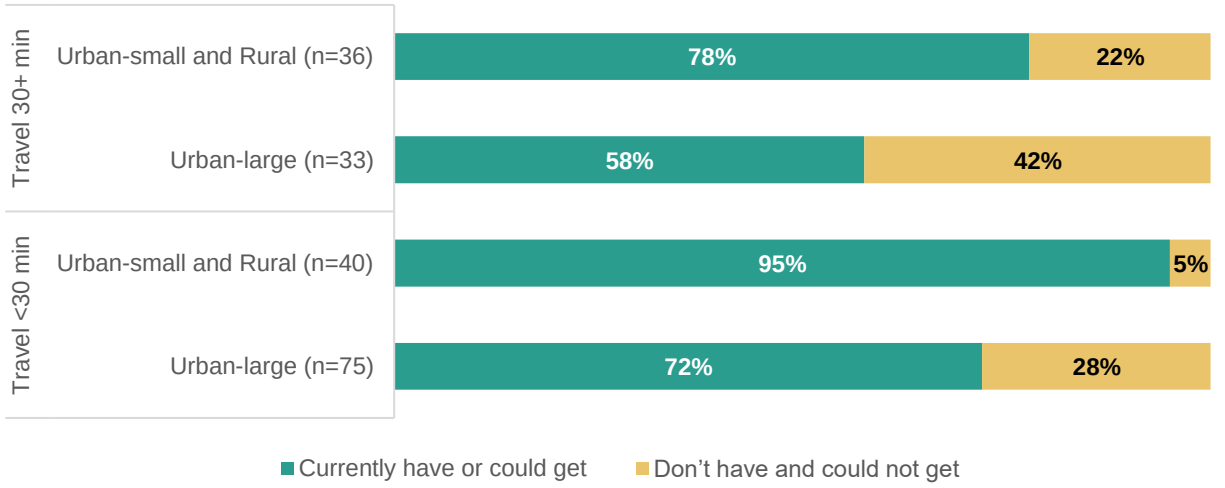
Through the survey for individuals with disabilities, about half reported they were able to access community-based services that 1) are fully integrated and 2) could be paid for through Medicaid waivers, vouchers, or other disability-related programs. However, there were also one-fourth of respondents who felt they didn't have it and would not be able to get it (Figure 26).

Figure 26. About half the survey respondents noted they currently have or receive fully integrated services and/or have services paid through Medicaid waivers, vouchers, or other disability-related programs



To some degree this varies based on where the survey respondent lived. There was a significant difference for those living in urban-large counties and traveling more than 30 minutes to access disability related services. About 42% noted they were unable to access community-based services that were fully integrated (Figure 27). For those living in urban-small and rural areas and traveling more than 30 minutes, 22% did not have and could not get fully integrated community-based services.

Figure 27. Those from urban-lage areas are more likely to report thay don't have or couldn't get access to community-based services that are fully integrated



Recommendations

To continue building on the success of the goal and given some of the barriers, the following are recommended for Goal 1. Some could be applicable to other goals as well.

1. Consider **identifying specific communities, populations, or areas that would benefit the most from engagement and intervention.** Although the Olmstead Plan is intended to be statewide and should lead to an impact for all Nebraskans, success for

this goal seems to be found when partners can work in-depth with a community or area. By identifying specific geographic areas, it may give the Community Supports workgroup an opportunity to narrow their focus and efforts to have a greater impact.

2. Modify and/or add outcomes so that **outcome-focused measures are included so the focus isn't primarily on process measures.** Although process measures are helpful for monitoring and understanding progress, one partner noted that it does not help them see if the activities are helping them achieve the goal of ensuring individuals with disabilities can access individualized community-based services and supports that meet their needs and preferences. Although outcome-focused measures may not be able to be achieved within a three-year plan, being intentional about having more long-term outcomes may help move the workgroup in a more coordinated direction.
3. Similar to other states have priorities around service coordination in their Olmstead Plans, **consider adding an outcome related to building structures or systems for people to access services more effectively**. As noted, services may be available, but often individuals with disabilities need a streamlined way to determine how to access those opportunities. This could include approaches such as advocating for liaisons that could help people with disabilities navigate services and/or having state entities create or enhance a structured coordinated entry or "no wrong door" approach.

Goal 2 – Housing

The second goal in the Olmstead Plan pertains to housing, and more specifically working to ensure that individuals with disabilities have access to safe, affordable, and accessible housing in the community where they choose to live. There are several factors that key partners felt success would look like for the housing goal:

1. Increasing the number (not just percentage) of accessible units.
2. Having inclusive development.
3. Having buy-in from the state legislature and governor to prioritize housing needs, which could include contributing state general funds specifically to housing for people who are most vulnerable.
4. Increasing the number of people with disabilities who can have their home rehabilitated so they can remain in their current housing if they choose.
5. Working to shorten the amount of time from referral to having home modifications completed.
6. Serving more people who are falling through the cracks due to income – particularly those who aren't quite Medicaid eligible but for whom having services would keep them in their homes.

Partners noted that while they do advocate for the affordability of housing, the key focus is ensuring there are accessible units available: *"I think success is any additional unit we can put on the market that is accessible and that does meet the universal design standards. No matter how many units it is, one unit is more units than we have had before."* As part of being accessible, key partners wanted to see units that were 1) inclusive so that able-bodied and persons with disabilities are in the same building and 2) visit-able, so that even if the primary resident of a unit does not have disabilities, friends or family members that may have disabilities could still visit them.

> *It's integrated so somebody can feel like they're inclusive of a bigger community rather than just moving into a place that feels more institutional.*

Progress Toward and Perceptions of Outcomes

There are six outcomes for the second goal, all of which are addressed through the housing workgroup. Based on the Olmstead outcomes monitoring system, four of the six benchmarks (67%) set for FY23 were completed (Figure 28). At the time of this report, half of the benchmarks for FY24 were completed while the other half were in progress.

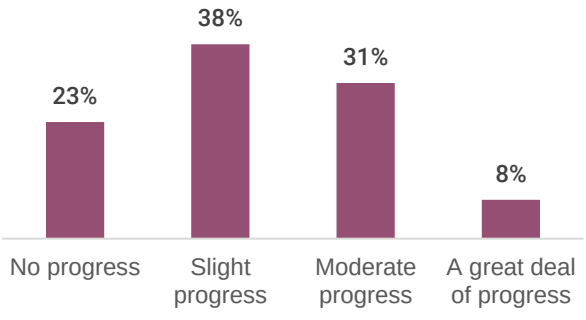
Figure 28. Nebraska achieved at least half of the FY23 and FY24 benchmarks for the housing outcomes

Outcome	Description	FY23 Status	FY24 Status
1	Increase community-integrated housing opportunities for persons with serious mental illness (SMI) by 4% from FY23.	✓	✓
2	Increase the number of projects invested in by five (5) percent through the joint Low Income Housing Tax Credit and federal housing resources available through the Nebraska Department of Economic Development (DED) which meet universal design standards.	✓	✓
3	Increase training and education on home accessibility modification programs within Nebraska for both Medicaid and non-Medicaid eligible populations.	✓	➤
4	Increase the number of home modification assessments completed by Assistive Technology Partnership (ATP) by one percent over the baseline for the Medicaid Home and Community-Based Services (HCBS) waivers.	■	➤
5	Increase the number of people with disabilities receiving state-funded rental assistance by 50.[16]	■	➤
6	Increase the number of housing projects funded through the Nebraska Affordable Housing Trust Fund (NAHTF) that prioritize accessible units for people with disabilities.	✓	✓

[16] In the published version of Nebraska's 2023-2025 Olmstead Plan, the number of people for this outcome was listed as 150; however, after publication it was changed by the Division of Behavioral Health to be 50.

Based on feedback from the key partner survey, there was varied perception on how much progress had been made within the housing goal area. Although slightly more than one-third (38%) reported there was "moderate progress" or "a great deal of progress", there were 23% who felt no progress had been made (Figure 29).

Figure 29. About 39% of survey respondents felt there was a moderate or great deal of progress made toward the housing goal (n=26)



Results from the survey also indicate that 50% of the respondents felt the outcomes were "very well aligned" with the housing goal. There were 34% who felt it was "moderately aligned," with no one reporting that there was no alignment (n=32).

Partners who were interviewed, however, were divided on how aligned the outcomes were with the goal. One challenge with the housing area – though this likely impacts other goal areas as well – is that outside barriers or factors can make some of the outcomes difficult to achieve. A lack of funding or capacity, or even losing a particular funding stream or program, can often stop progress or work toward an outcome entirely. It can also be challenging when existing programs don't align directly with the Olmstead Plan. When that occurs, it can be challenging to know if a program should be modified, or if the outcome within the Olmstead Plan should be revised.

One challenge that may be unique to the housing goal area is that sometimes the terms – such as accessible or affordable – are not defined in such a way that everyone has a consensus about what falls into that category. This can also make it challenging to assess or determine progress. This is particularly true given that many of the organizations working to advance the housing goal have a specific role or focus from housing, leaving some workgroup members feeling like each agency is doing their own thing rather than taking a coordinated approach.

Beyond the outcomes listed in the Olmstead Plan, partners noted a variety of other accomplishments that have been made related to housing:

- **Advocacy provided by the Nebraska Commission for the Deaf and Hard of Hearing**. They have been able to work with renters and landlords to find stable housing, particularly if someone is eligible for Section 8 housing.
- **Scoring for the Nebraska Affordable Housing Trust Fund through the Department of Economic Development incorporated whether an applicant took accessibility into consideration or included design features for those who may need modifications**. This has generated conversation among the scoring team regarding whether the applicant is accounting for the needs of those with disabilities: *"There's more conversation around it than there were in years past."* Even within Nebraska Investment Finance Authority (NIFA), efforts have been made to better understand integration and mindfulness of design.
- **Various nonprofits are starting to do more work in the housing arena**. There has been a greater recognition of how important housing is among the people being served by nonprofits. *"They were focused on services before and realized in order to be able to serve all the people that they're working with, how important housing is as part of that*

matrix." This has led to more robust collaborations to ensure agencies can access tools and resources for those who need housing.

- The outcomes and activities taken on by the housing workgroup are **driven by consumer voice**.
- COVID and the American Rescue Plan Act (ARPA) **funding was allocated to support housing**. This has, in turn, supported development projects, with several being completed.

> *Our communities that are active in housing, they are very vocal about the need for more resources for housing. They have been very vocal with their state senators. I think we have strong partners who are advocating for more housing resources.*

Addressing Housing in Nebraska

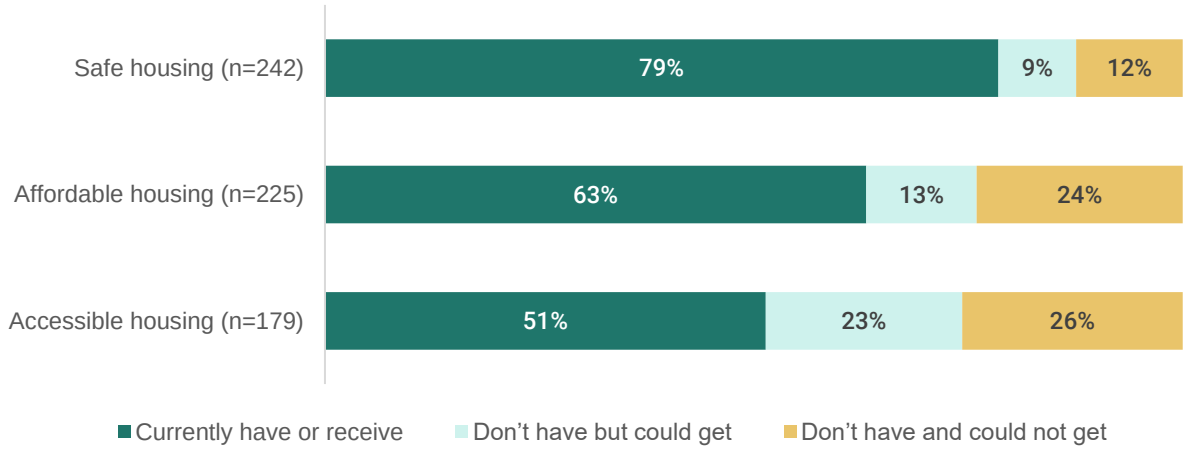
Based on input from workgroup members and key partners through the various data collected, there are a variety of factors that impact progress on housing efforts (Figure 30).

Figure 30. There were several barriers noted to addressing the housing goal for the Olmstead Plan

Facilitators to Housing Progress	Barriers to Housing Progress
• There is a large group of stakeholders involved in the housing work, providing more opportunity for collaboration and comprehensive approaches. Some partners are focused more broadly on services, some cover specific disabilities, and others have a targeted knowledge base. • State agencies and state elected officials have been vocal about their support for additional housing because they've seen how housing impacts individuals and businesses.	• Lack of housing options. There is limited availability for deeply subsidized housing, especially in rural areas. Much of the stock of affordable housing that's available is pre-1960, which is what makes it affordable but likely not accessible. • Increased expenses for housing developments. This is especially true in rural areas where there's an added transportation cost for materials. • Lack of contractors. *"In this economy, contractors have all the work they've ever wanted, so it's like pulling teeth getting them to come work for us."* • Reluctance among developers to design fully accessible units in the event they do not have someone apply that needs it.

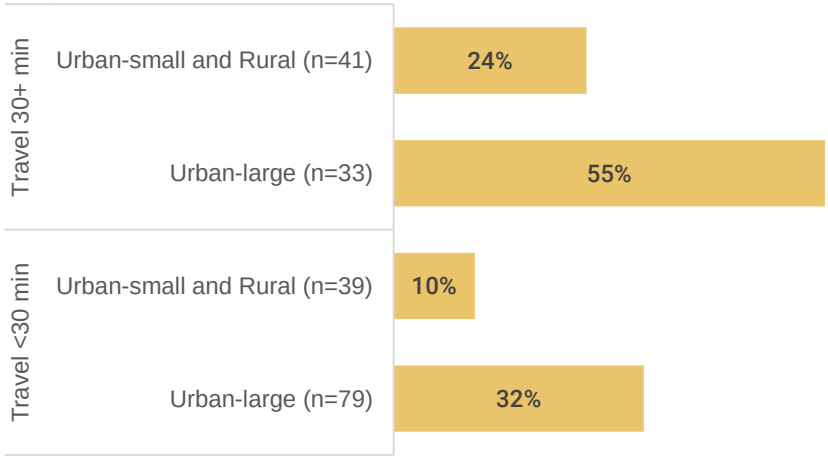
As part of the evaluation, perceptions about housing were sought among individuals with disabilities and family members/caregivers. Based on the results of the survey, safe housing was considered more available than affordable or accessible housing (Figure 31). About one-fourth of the respondents didn't have and felt they couldn't get accessible or affordable housing. Safe and affordable housing were not defined on the survey, but accessible housing was described as places that people with disabilities can enter and use, such as wider doorways, low countertops, grab bars, assistive technology, etc.

Figure 31. More than half the survey respondents reported they currently have safe, affordable or accessible housing



Not having access to safe, affordable, and/or accessible housing was most often reported by respondents living in urban-large areas who also reported having to travel 30 minutes or more to get disability-related services and supports. Over half (55%) of respondents falling in this group reported they did not have and could not get access to safe, affordable, or accessible housing (Figure 32). In comparison, only 10% of respondents living in urban-small or rural areas who reported traveling less than 30 minutes to get disability-related services and supports did not have and could not get access to safe, affordable, or accessible housing.

Figure 32. Those from urban-large areas were more likely to report they don't have or could not get safe, affordable, or accessible housing (reported lack of access to at least one)



> *"Low-income housing is not accessible here and it's not safe. It's not meant for individuals with intellectual disabilities and perhaps others as well, but certainly not that population.*

Focus group participants believed focusing on housing that is safe, affordable, and designed for people with disabilities needed to be a goal in the Olmstead Plan. They also felt a focus should be on diversifying the type of housing options. Ideally opportunities would be available to meet every person's unique and cultural values. One way to start addressing that is encouraging or advocating that management companies embrace housing for those with different abilities. Another hope was that safe housing units would have supports available. This would mean that people with disabilities could live where there are services on site, such as a tenant assistant that can answer questions or having a medication dispensary.

One thing that people mentioned they would like to see included in the Olmstead Plan was a goal related to community-based housing. One focus group participant noted that it has shown results in other states that have used it, including decreasing arrests, emergency department (ED) visits, psychiatric hospitalizations, and homelessness.

Recommendations

Based on the results, there were a handful of recommendations to consider for Goal 2. Some of these recommendations may apply to other goals as well.

1. Work to **define key terms within the housing goal, such as accessible and affordable**. This can help create common language among workgroup members and other stakeholders. Not only will this help ensure everyone is on the same page with what the terms mean, it may also help workgroup members, key partners, and stakeholders better assess the degree to which goals are being met toward those outcomes.
2. **Revisit the outcomes with the responsible agencies to ensure the programs included match the intent of the Olmstead Plan.** One stakeholder noted their existing programs don't directly align with the plan, and it may help to determine whether the program needs to be modified or if the plan does.
3. One thing that has facilitated success in this goal area is state agencies and elected officials being vocal about their support for additional housing. Some partners also mentioned that success in this goal area would mean having buy-in from the state legislature and governor to prioritize housing needs, ideally leading to the contribution of state general funds to housing for people who are most vulnerable. With that being the case, **it may be helpful for the workgroup to prioritize bringing on a member from the governor's office and/or creating an action step around working with the state legislature to gain buy-in over time.**
4. **Identify areas of crossover between agency goals and points of collaboration to avoid the perception that each agency has "their own thing."** Part of this could be accomplished by incorporating information sharing, reporting on goals, and problem solving across the agencies as part of the standing workgroup meeting agenda.

Goal 3 – Appropriate Settings

The third goal in Nebraska's Olmstead Plan goal is working to ensure that those with disabilities can receive services in the settings most appropriate to meet their needs and preferences.

During the focus group with individuals with disabilities and family members/caregivers, it was noted that it is especially important to focus on built and social environments. For those who want to and choose to stay in the community, there are things that prohibit them from being fully integrated. One example is buildings not having electric door openers as this excludes people with certain disabilities. It is worth noting that adding openers would also benefit more than just those with disabilities.

Focus group participants did note that having training opportunities for advocacy could help. This would be applicable to those with disabilities as well as their family members and caregivers: *"It comes down to training caregivers and parents to be better advocates and giving them the tools that they need and the resources they need to navigate the services, because it's not readily available."*

Progress Toward and Perceptions of Outcomes

There are six outcomes for Goal 3. These efforts are jointly addressed by the community supports group (four outcomes) and education workgroup (two outcomes - #2 and #4). Based on the Olmstead outcomes monitoring system, all but one of the benchmarks set for FY23 were completed (Figure 33). At the time of this report, four of the benchmarks for FY24 were completed. This results in a completion rate of 83% for FY23 and 67% for FY24.

Figure 33. Nearly all the FY23 benchmarks set for the Goal 3 outcomes were met

Outcome	Description	FY23 Status	FY24 Status
1	Increase awareness and education on Home and Community-Based Services (HCBS) benefits and options for members to live in the community.	✓	✓
2	Support both provider and services recipient education regarding community-based services for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID) facilities.	✓	▲
3	Increase the number of referrals for outpatient competency restoration (OCR) at Lincoln Regional Center.	✓	✓
4	Increase support and help individuals and families through the Nebraska Families Helpline.	■	■
5	Assist Native American women with substance use disorder (SUD) to seek treatment while parenting their children.	✓	✓
6	Reduce the time individuals with severe mental illness (SMI) spend waiting in jail for competency evaluation and restoration services.	✓	✓

Progress regarding Goal 3 was not included in the key partner survey, in part because there is not one primary workgroup responsible for this goal area. However, survey respondents could indicate to what degree they felt like the outcomes aligned with the goal area. Based on the results, 88% felt the outcomes were "moderately aligned" or "very well aligned." The remaining 12% felt they were "not aligned" or "slightly aligned." This is one of three goal areas where

respondents indicated the outcomes were “not aligned” with the goal. The other two included Goal 6 (data) and Goal 5 (transportation).

Addressing Appropriate Service Settings in Nebraska

Specific questions about facilitators and barriers for ensuring Nebraskans with disabilities will receive services in the settings most appropriate to meet their needs and preferences were not included in most data collection tools. This primarily because most of the questions regarding access to services related to Goal 1. However, there was one facilitator noted by a partner related to Goal 3. It helps to focus on getting people who are in services to the least restrictive setting possible and titrating services down as appropriate to support consumers as they recover: *“I think there's a commitment at all levels for individuals to be in the most independent or integrated setting.”*

Recommendations

Given much of the work for this goal is carried out by the Community Supports group, it may be helpful **to align or combine efforts under Goal 3 with Goal 1.** Part of an individual’s ability to receive services in the settings most appropriate to meet their needs and preferences may depend on their access to such services.

Goal 4 – Education/Employment

The fourth goal of the Olmstead Plan focuses on education and employment. In addition to having increased access to education for those with disabilities, the goal is also focused on ensuring people have choices in competitive, integrated employment opportunities.

> *We still have people with disabilities [experiencing a] high unemployment rate and also high underemployment rate. Those who are employed many times don't make enough and are not given the opportunity to be promoted or to have good healthcare.*

There were key themes that emerged from the feedback provided by partners regarding what success would look like for education and employment:

1. A common vision and understanding for the use of shared data:
    - Part of the shared vision is figuring out what support and services look like for individuals who are between the ages of 18 and 21 years old. According to one partner, there is not a clear line that delineates where educational services end and adult services begin. Partners should collaboratively determine how to support individuals regardless of whether they are a student or receiving services to pursue and maintain employment.
2. Having additional supports for consumers and caregivers:
    - One aspect is working to provide individuals and families with the support they need leading up to a person completing their K-12 education. *“Families need support. The education doesn’t just exist with the individual with the disability. The education has to happen with all of the caregivers and all of the [people close] to those who need those types of support.”* It may also be important to increase support for younger age children so they can become independent and advocates for their own lives.
    - Another support could come through Nebraska VR (Vocational Rehabilitation): *“Big picture, what success would look like is that more people, regardless of who it is, can access [VR] programs just like everyone else.”*

3. Better integration into the community:
    - Integration into the community is focused on pre-employment and ensuring people are fully integrated into their employment roles. Key partners reported it was essential to ensure that employment is considered while youth were still in school. *"Making sure that employment isn't the afterthought when students are still in school, the importance of beginning with the end in mind, and how we can keep that on the radar of students and families."* This would help with ensuring that all Nebraskans have an opportunity to learn about work options and having the supports they need to make an informed decision about if they work or not.

Similar to one of the over-arching goals for the Olmstead Plan, partners would also like to see a unified approach to working on the goal: *"I'd love to see more of a shared vision and more of a strategic plan come from VR, DD, Behavioral Health - those of us who are invested in employment having more of a common vision."*

Individuals with disability and family members/caregivers participating in focus groups noted success for education would also look like preschool for all. Having universal preschool would help all children but would be especially helpful for those with disabilities who are struggling with social-emotional development. It would also be helpful to help mitigate suspensions, expulsions, restraint, and/or isolation: *"Every day they're out of school they're getting farther behind, and then they start liking being separated and living in isolation and learning in isolation. No one's pressuring them, no one's bothering them. Then, before you know it, they're grade levels behind and they're not going to catch up."*

Progress Toward and Perceptions of Outcomes

There are seven outcomes for Goal 4, most of which (5 outcomes) are geared toward education. During FY23, just over half (57%) of the benchmarks were completed, though at the time of this report, an update was not available for the first benchmark (Figure 34). The two benchmarks that were not met in FY23 were the employment ones (#6 and #7). Progress in FY24 was more varied. Among the five outcomes that had a progress update, two were completed. Data was not available for one of the employment outcomes.

Figure 34. Of the seven outcomes, about half were unknown for FY23 and FY24

Outcome	Description	FY23 Status	FY24 Status
1	The Nebraska Department of Education (NDE) will support the development of improved processes to offer education, advocacy, and support to all parents of children eligible for special education services.	*No Report*	*No Report*
2	Increase the percentage of children ages 3-5 and 5-21 with Individual Education Plans (IEP)s who receive their special education and related services inside the regular class 80% of the day.	✓	*No Report*
3	Increase the number of clients served by the Nebraska Commission for the Blind and Visual Impaired (NCBVI).	✓	✓
4	Increase the number of credentials received by clients who are assisted by the Nebraska Commission for the Blind and Visual Impaired (NCBVI).	✓	▲
5	Increase the 4-year and 5-year graduation/completion rate for students identified as Special Education statewide.	✓	✓
6	Increase the number of individuals supported by the Nebraska Commission for the Blind and Visually Impaired (NCBVI) or Vocational Rehabilitation (VR) services who exit with and maintain competitive employment.	■	■
7	Increase the number of students who participate in Project SEARCH and are employed.	■	*No Report (Data Not Available)*

Perceptions regarding the progress toward Goal 4 were asked separately for education and employment in the key partner survey. Both areas had relatively similar reported levels of progress. For education, 57% felt there was “no progress” to “slight progress” (Figure 35). That was slightly higher for employment, were 60% reported “no progress” to “slight progress” (Figure 36). The degree to which people felt the outcomes aligned with Goal 4 was not broken

Figure 35. More than half (57%) felt no to slight progress was made toward the education outcomes for Goal 4 (n=21)

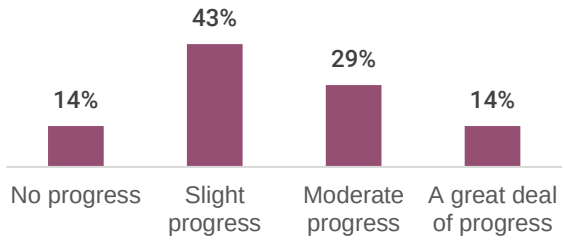
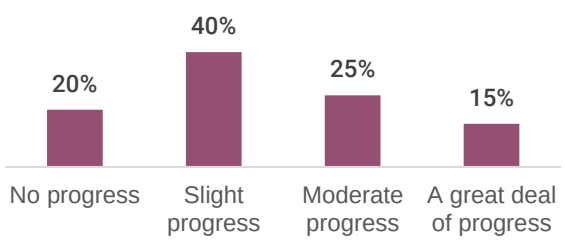


Figure 36. For the employment outcomes related to Goal 4, about 60% felt no to slight progress was made (n=20)



down between the education and employment outcomes. About 84% of respondents indicated the outcomes were “moderately” or “very well” aligned. The remaining 16% felt the outcomes were “slightly” aligned. This is based on feedback from 31 survey respondents.

Similar to other goals, key partners noted that they felt outcomes aligned, but it’s primarily due to stakeholders developing outcomes based on what they are already doing. However, those involved in the education or employment workgroup also were unclear of how the benchmarks were generated, as they felt it didn’t match with what they were able to report on within their organizations.

Someone also noted that, since this goal combines two topic areas, **it would be helpful to indicate which outcomes were affiliated with the goal of increasing access to education versus choice of competitive, integrated employment opportunities.** This was particularly the case for outcome 3 (increase the number of clients served by the Nebraska Commission for the Blind and Visually Impaired) and outcome 4 (increase the number of credentials received by clients who are assisted by the Nebraska Commission for the Blind and Visually Impaired).

This could be a goal where there is an outcome related to enhanced collaboration. One stakeholder noted that given the complexity of the goal, creating alignment between the Nebraska Department of Education (NDE), the Nebraska Commission for the Deaf and Hard of Hearing (NCDHH), and the Commission for the Blind and Visually Impaired would be incredibly beneficial.

That being said, collaboration was noted by many stakeholders as a key accomplishment. The following were noted as successes:

- Strong collaboration between the different entities within education. **Nebraska VR has an interagency agreement with NDE to ensure the same messaging is being sent to schools throughout the state.** This ensures that persons with disabilities are getting outreach and being provided information about resources. *“As part of the education program we talk about what's going on in the different agencies … so that we can make those connections with the individuals that we work with to make sure that they're able to take advantage of the different resources that are out there.”*
- **Nebraska VR is increasing collaboration between the Division of Behavioral Health (DBH) and the Division of Developmental Disabilities (DDD) around supported employment**. Through coordination with Nebraska VR, DDD and DBH are working together to make their services as seamless as possible, including looking at funding models so that their systems can coordinate more effectively.
- The **NCDHH providing educational advocacy and being involved in Individualized Education Plans (IEPs), 504 plans, and Individualized Family Service Plans (IFSPs)**. They also have a staff member who works with young people and their families one-on-one to address their needs.
- **Increasing open-mindedness around hiring people with disabilities**. More entities are willing to work with people with disabilities, but preconceptions are still a concern and are being worked on with employers.

Addressing Education & Employment in Nebraska

Based on input from workgroup members and key partners, many factors have impacted progress on employment efforts (Figure 37).

Figure 37. A variety of factors impact Nebraska's ability to address employment as part of Goal 4

Facilitators to Employment Progress	Barriers to Employment Progress
• Having a shared commitment across agencies. *"I think our dedication to working across agencies is very powerful… we're all committed to working together. We're not about finger pointing. We're not about leaving anyone out. I think we truly see that we're stronger when we work together, so that, I think, has been really important."* • The work of Dr. Lisa Mills on supported employment was incredibly beneficial for setting a larger vision for employment over the next several years. • Workforce board quarterly meetings provided another opportunity for entities to connect and share information.	• Some expressed that there are not a lot of job options for people with mental illnesses that allow them to keep their jobs if they are having difficulties on certain days. Often employment options for people with disabilities are separate from those who are not disabled. *"We need to allow people that can work to be able to work in a safe environment that is not separated."* • Not everyone knows or uses best practices when working with people with disabilities to be employed. The lack of knowledge and also system structures sometimes prevent people from being part of a seamless process to get the support they need to succeed in their employment.

Similarly, there are elements that have influenced progress on education efforts, though key partners primarily address barriers rather than facilitators (Figure 38).

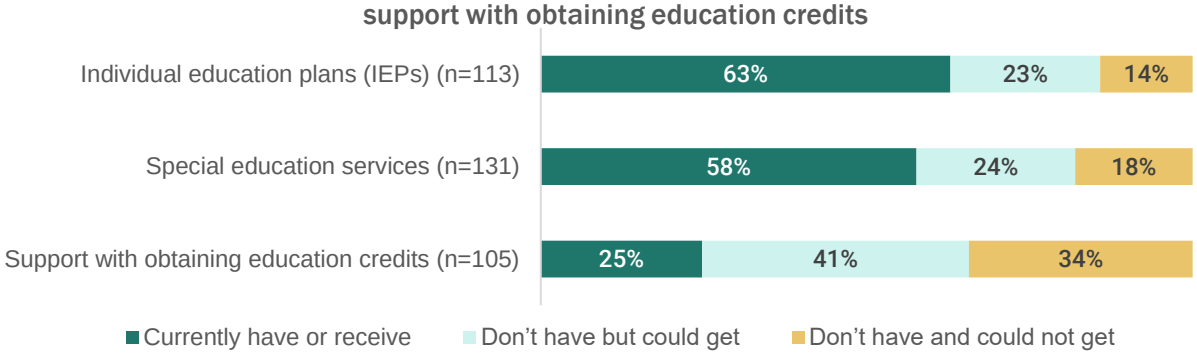
Figure 38. Many barriers were noted to addressing education as part of Goal 4

Facilitators to Education Progress	Barriers to Education Progress
None obtained through data collection	• There are limited opportunities for continuing education. One individual noted: *"I wish there were more options for continuing their education at colleges, institutes, universities where they can experience and keep learning."* • Limited funding to address new goals and to fill gaps in services – particularly for those who are 18 to 21 years of age. • Workforce shortages among special educators and DD providers. "*We have a lot of kids right now just slipping through the cracks because we don't have enough educators to provide for them."* • Misconceptions are still prevalent about people with disabilities and their ability to work and partner organizations are not leading by example. Several of the entities working on the Olmstead Plan are not hiring people with disabilities to work for them.

There was a smaller number of people responding to questions about education on the survey for individuals with disabilities. Among those who did answer, more than half noted that they currently receive or could get access to individual education plans (IEPs) and special education services. Slightly fewer felt they could get access to support with obtaining educational credits

(Figure 39). Support with obtaining education credits was not defined on the survey, which could also be a reason that a number of people reported “not applicable.”

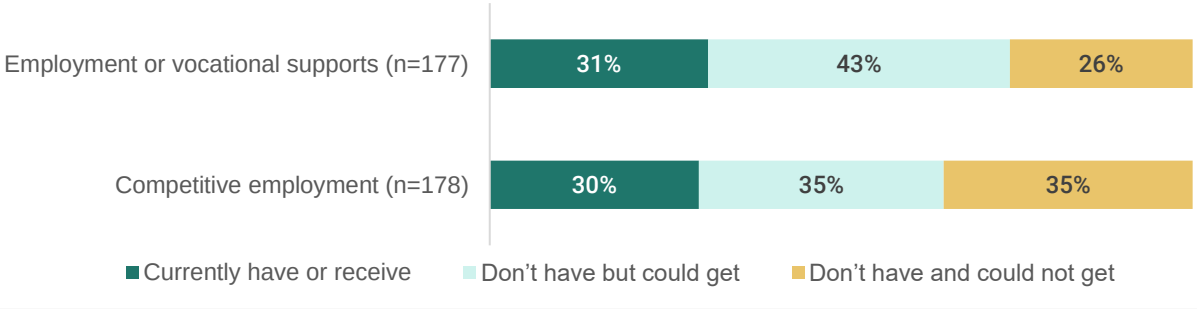
Figure 39. Survey respondents were more likely to report having or receiving individual education plans and special education services compared to support with obtaining education credits



The additional analysis (by geographic area and amount of time to get to disability-related services) did not yield any statistically significant differences in the area of education. However, that could be due to having a smaller sample size for the topic area.

Slightly more people responded to the questions regarding access to employment. About one-third of respondents noted that they currently have or receive employment or vocational supports and competitive employment (Figure 40). Both of those were defined within the survey. Competitive employment is opportunities for compensation, benefits and advancement that is comparable to employees without disabilities performing similar duties. Employment or vocational supports is help getting or keeping a job, supportive employment, job placement, etc.

Figure 40. There was a relatively even split between those who reported they currently have or receive, don't have but could get, or don't have and couldn't get for employment supports and competitive employment

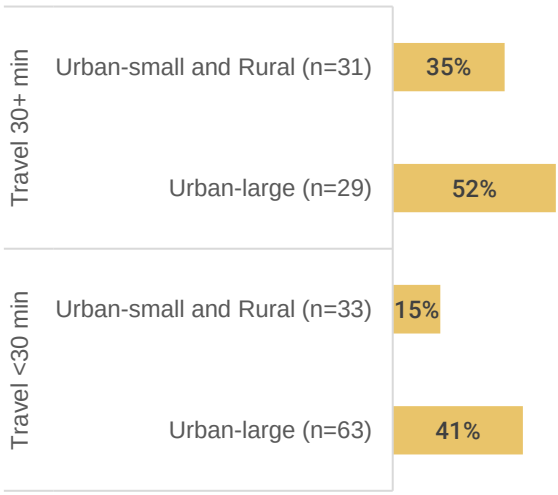


A deeper look at the data shows the same significant interaction effects where those living in urban-large counties and traveling more than 30 minutes have the biggest access problems. Among those who live in an urban-large county and who reported having to travel 30 minutes or more to get disability-related services and supports, 43% don’t have and could not get access to employment supports. This was also reported as a fairly moderate problem (~25%) by those in urban-large counties that didn’t have to travel far and those who live in more rural areas who have to travel 30 minutes or more, but again, less so for those who live in rural areas who don’t have to travel far (9%).

With competitive employment, those living in urban-large counties who are traveling more than 30 minutes or more to get disability-related services and support are the most likely to report they don't have and could not get access to it, with 52% reporting this; however, this is also reported often by those in urban-large counties who are traveling shorter distances (40%), and those in more rural areas who reported traveling 30 minute or more (39%).

When aggregating these two categories together, 52% of those who live in an urban-large county and who reported having to travel 30 minutes or more to get disability-related services and supports don't have and could not get access to competitive employment or employment or vocational supports (Figure 41). The second group reporting the biggest employment access problems is the urban-large group without notable travel time (41%), followed by the more rural group that reported traveling 30 minutes or more (35%), while those residing in rural areas who do not have to travel far for disability-related services and supports are least likely to report this problem. This is similar to what was seen for housing.

Figure 41. Respondents from urban-large counties were more likely to report they don't have and could not get access to competitive employment or employment supports (reported at least one)



Recommendations

Based on the results, there were a handful of recommendations to consider for Goal 4.

1. **Clarify each of the outcomes to be distinctly linked to the "increased access to education" portion of the goal statement or the "choice of competitive, integrated employment opportunities" portion.** That would minimize confusion about how each of the outcomes are connected to the larger goal.
2. **Make education and employment separate goals in the Olmstead Plan.** While many other states address these topic areas, they are more often treated as separate priorities or goals. Separating the goals may also help align with the new workgroup structure.
3. **Review and incorporate the recommendations from Dr. Lisa Mills**.[17] This was noted by many as an influential report that can help with setting a vision for employment in the coming years.
4. **Consider adding an objective related to collaboration**. Although there were many successes related to collaboration, a handful noted additional collaborations would create a more unified approach to the work.

[17] Mills, L. (February 2023). *Necessity or luxury? Supporting Nebraskans with intellectual and developmental disabilities to join the workforce and contribute to Nebraska's economy.* https://dhhs.ne.gov/DD%20Planning%20Council%20Documents/Necessity%20or%20Luxury%20-Nebraska%20Supported%20Employment%20Outcomes%20Study%20Final%20Report.pdf

Goal 5 – Transportation

Transportation – ensuring it is affordable and accessible for those with disabilities statewide – is the focus of Goal 5. Key partners noted that efforts are working toward all people having access to transportation that meets their needs and that they can feel good about. It would also be ideal to ensure that people can easily access education or information about the transportation options available.

> *Transportation should be accessible to individuals who can't independently transport themselves and it is done in a way that they feel meets their needs.*

Individuals with disabilities and family members/caregivers expressed a similar vision for transportation. Many would like to see options that are available every day of the week and would allow them to get to not just medical appointments, but to other services and activities as well. *"It [lack of transportation] limits you, keeps you from doing everything that the able-bodied people can do. You can't go to a late movie. You better make sure you eat quickly so you can get your return ride home. It's those kinds of things that you shouldn't have to think about."*

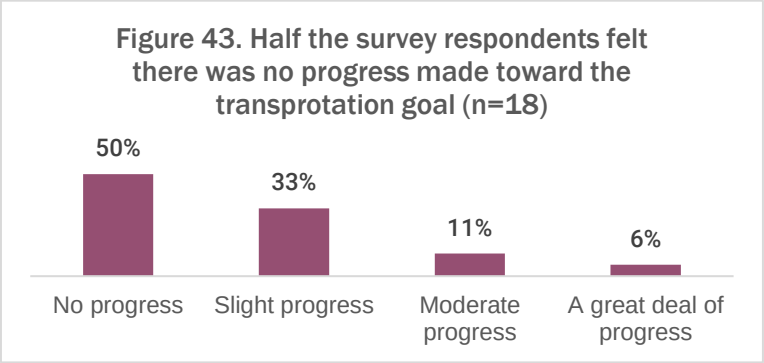
Progress Toward and Perceptions of Outcomes

There are four outcomes for transportation, all of which are carried out by the transportation workgroup. The Olmstead outcomes monitoring system shows that only one of the four benchmarks set for FY23 were accomplished (Figure 42). At the time of this report, none of the benchmarks for FY24 were completed.

Figure 42. Only one of the four FY23 benchmarks set for the housing outcomes was met, though it was stalled in FY24

Outcome	Description	FY23 Status	FY24 Status
1	Provide the state with trip planning software and make software available to Nebraskans on their website.	✓	▲
2	Increase accessible public transportation ridership in rural areas.	■	■
3	Expand transportation access to communities that have no public transportation for individuals with disabilities.	■	■
4	Increase the number of individuals with disabilities receiving Nebraska Department of Education - Assistive Technology Partnership (NDE-ATP) supported vehicle modifications.	■	■

This aligns with the feedback provided through the key partner survey. Roughly half the survey respondents felt there was "no progress" on the transportation goal (Figure 43). This is the goal area that had the highest percentage of people reporting no progress. The goal area that had the second highest "no progress" perception was housing at 23%.



There was varied perception on the degree to which survey respondents felt the outcomes were aligned for the transportation goal. Nearly one-third selected "slightly," "moderately," and "very well," while one respondent (out of 29 total) reported "not" aligned.

While there wasn't a strong perception of progress, partners did note wins that have occurred within this Olmstead Plan goal area. There was a partnering organization that, after identifying service gaps in a specific area, created a plan to address the concerns. Statewide partners met to discuss concerns and potential solutions to meeting the needs.

Another stakeholder also noted the growth in transportation access in recent years. About 10 years ago, only half the counties provided transportation to individuals with disabilities. That is now up to about 88 counties. Even if it's still limited transportation, it still indicates growth.

Addressing Transportation in Nebraska

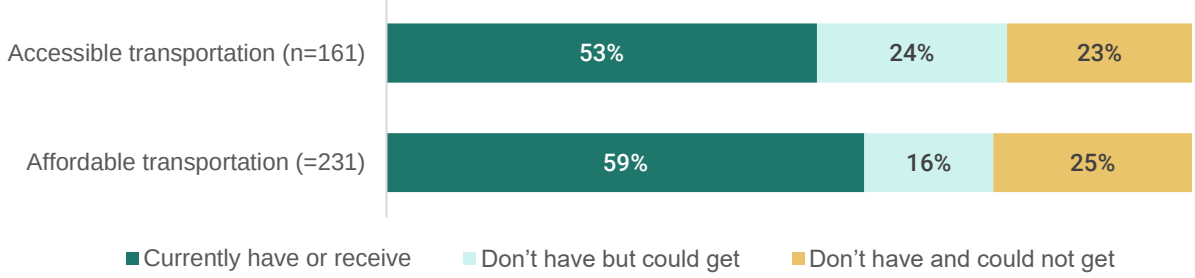
Based on input from workgroup members, key partners, individuals with disabilities, and family members/caregivers, there are a variety of factors that impact progress on transportation efforts. Most of them end up being barriers to addressing or accessing transportation (Figure 44).

Figure 44. Several barriers were mentioned for Nebraska addressing the transportation goal

Facilitators to Transportation Progress	Barriers to Transportation Progress
• Having local champions who are passionate about addressing transportation seems to help communities move forward. "*Each region or county or nonprofit really needs someone who is there and wants to support it.*" • Grants that can support systems, whether it's for local agencies to provide transportation or purchase vehicles.	• Many funding opportunities require a match at the local level, meaning that communities must provide financial support and many of them do not have that capacity. • There needs to be a local entity that is willing to do the work of implementing the project, which is not always the case. • There are not enough accessible, reliable, convenient and affordable forms of non- emergency medical transportation including taxis or Uber statewide and particularly in rural areas. • On-demand options exist, but they are not always available and typically have limited weekend ability. • Handi-buses have strict usages policies and don't always allow persons with psychiatric disabilities. People also are typically required to call a week in advance to get a ride for a specific time, and many areas of the state do not have that or similar services available. • Medicaid reimbursed transportation providers are not always reliable. Some show up late or not at all.

On the survey for individuals with disabilities, many respondents noted that accessible transportation was not applicable (again, the N/A responses were removed from the analysis). Although affordable transportation was not defined, accessible transportation was described as lifts or ramps, audio announcements, curb-cuts, and guided assistance to get on or off. About one-quarter reported they don't have and could not get access to accessible and affordable transportation, with slightly more reporting this for affordable transportation (Figure 45).

Figure 45. About one-fourth of survey respondents noted that did not have and could not get accessible or affordable transportation



Not surprisingly, those who reported traveling more than 30 minutes for disability related services and support were more likely to report they don't have and could not get accessible transportation (37% versus 16%).

Recommendations

Based on the data, these are the key recommendations for the transportation goal:

1. Given the perceived lack of progress and not meeting the FY23 benchmarks, it may be important to **revisit the outcomes that are selected for this goal area.** Workgroup members can ensure they are in alignment with the overall goal and determine if the outcomes and benchmarks set will sufficiently measure progress.
2. This is a goal that has more barriers than facilitators. It may be helpful to **brainstorm if or how some of those barriers can be overcome**. This may provide helpful context when determining the outcomes and action steps needed in the next iteration of the Olmstead Plan.
3. As with Goal 1, it may help to **identify specific communities, populations, or areas that would benefit the most from intervention.** That may give the workgroup an opportunity to narrow their focus and efforts, in part since it may be challenging to address statewide transportation in a three-year time period.

Goal 6 – Data-Driven Decision Making

Data-driven decision making is Goal 6. Through this, the hope is that individuals with disabilities will receive services and supports that reflect data-driven decision making, improvement in the quality of services, and enhanced accountability across systems. Input from key partners indicates that there are two audiences to keep in mind for this goal: partners and consumers.

To best serve partners, the aim is to ensure there is appropriate access to and utilization of data. It is essential that key partners, stakeholders, and organizations have access to relevant data that's accurate and reliable, allowing them to use it to make decisions: "*Success is the ability to automate reports that can consistently and correctly translate data entered in multiple systems into usable, visualized information that can be used to quickly make a decision ... You want good, clean data that creates easy to understand reports so that folks could make the best decision based on the numbers.*"

The second aspect is ensuring data and tools are available for consumers. One partner mentioned that in an ideal world, people could manage their own cases by having technology that allows them to track their applications, see when due dates are approaching, and know

when paperwork has been processed. The systems would allow people to have a more active role in their supports and care.

Progress Toward and Perceptions of Outcomes

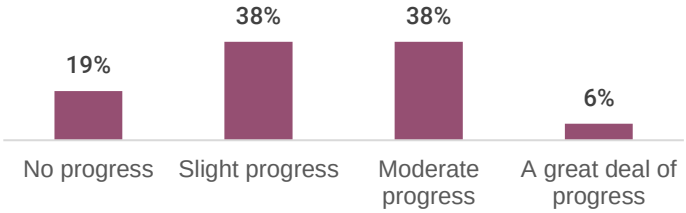
There are six outcomes for the data goal. Efforts for this area are primarily coordinated through the data workgroup, though one of the outcomes (#2) is assigned to the community supports workgroup. Based on the Olmstead outcomes monitoring system, all but one of the benchmarks set for FY23 (83%) were accomplished (Figure 46). However, the benchmark that was not accomplished was considered in progress. All (100%) of the benchmarks for FY24 were completed.

Figure 46. Nearly all the FY23 benchmarks for the Goal 6 outcomes were achieved

Outcome	Description	FY23 Status	FY24 Status
1	Improve interagency data sharing and demonstrate data outcomes.	✓	✓
2	Increase evidence-based programs through the Family First Prevention Services Act within the Department of Health and Human Services (DHHS).	✓	✓
3	DHHS divisions will generate comprehensive and longitudinal data.	➤	✓
4	The Division of Developmental Disabilities (DDD) will evaluate the Home and Community-Based Services (HCBS) waiver system and registry to identify best practices in waiver management and service provision.	✓	✓
5	Increase tracking of incidents and quality improvement actions with Home and Community-Based Services (HCBS) programs.	✓	✓
6	Increased publicly available tracking and reporting of DD system quality and performance metrics through the DHHS website.	✓	✓

This is another goal area where there was varied perception among key partners about the level of progress. Most seemed to fall right in the middle, with 75% reporting "slight" to "moderate progress" (Figure 47). This is somewhat similar to the feedback from survey respondents regarding how aligned they felt the outcomes were for Goal 6. About 59% felt that the outcomes were "slightly aligned" or "moderately aligned," though 38% did indicate they felt it was "very well aligned." There was also one respondent (out of 29 total) who reported it was "not aligned."

Figure 47. A majority (75%) of survey respondents felt there was slight to moderate progress made toward the data goal (n=20)



Those who participated in the interviews and focus groups did note that a key accomplishment within the data goal was creating the list of key performance indicators. Having a set of data to pull and review for the Olmstead Plan should prove to be a step in the right direction. In fact, one stakeholder noted that because of the Olmstead Plan goal, they were able to move some of their "wishlist" items forward more quickly.

Addressing Data in Nebraska

Workgroup members and key partners identified a handful of barriers and facilitators to progressing on the data goal (Figure 48).

Figure 48. Several barriers were mentioned for Nebraska addressing the transportation goal

Facilitators to Data Progress	Barriers to Data Progress
• The Enterprise system will enhance the way people apply for and get qualified for benefits. It creates a more streamlined approach, which will be good for consumers and stakeholders. • Project management (primarily from the Olmstead Plan staff), for the data-sharing work has been helpful for moving the work forward: *"I think that of all the facilitation and project management that I've encountered, [they are] just a natural at getting everything aligned and moving along at a pace that is productive but not daunting."*	• There are capacity and workforce challenges with getting data. Often the people who are able to pull the data are consumed with other work. • Some data systems are outdated and need to be replaced so they're more modernized. • Having data does not always ensure that is it "clean" data. *"Clean data is always an issue everywhere. When you have multiple people entering multiple versions of the same thing, where you put a comma changes your data."* • Many systems have optional data fields, and in most cases, it may not be available. *"Sometimes the data we're seeking to base our equity and access decisions on is just not available because it's optional data that's not given to us."* • Sharing data across state agencies isn't always feasible – either due to systems not linking or inability to share data.

Recommendations

A handful of recommendations are offered based on the results, including secondary data compiled as part of the evaluation:

1. **Consider removing data as a stand-alone goal for the Olmstead Plan.** As noted, many states integrate data objectives or activities into other priorities within their plans. Doing something similar in Nebraska may help focus data efforts.
    a. If data remains a stand-alone goal, it may be helpful to modify outcomes and activities to focus more on understanding, gathering, and sharing more of the basic data needs mentioned by partners and stakeholders. Many expressed a desire to have a sense for current needs and gaps within the seven goals. That could be accomplished by exploring data sources that other states used to monitor their outcomes.
2. **Utilize the data workgroup as a vehicle to showcase progress toward goals.** With the group's focus on data, members could assist with tasks such as creating a two-page summary report or complementary documents highlighting the successes of the

Olmstead Plan. That may also provide an opportunity to share the data in a meaningful way, helping to achieve the vision for the goal.

3. **Consider integration of evaluation efforts into the data work.** Beyond tracking outcomes and metrics, it may be helpful to also capture qualitative data to provide more context for progress. It would also be an opportunity to keep evaluation top of mind beyond having an external contractor conduct an evaluation every three years. As an example, an ad hoc evaluation group was formed during the implementation of this evaluation project. Ongoing discussions may help enhance data collection opportunities and identify future needs for the evaluation.

Goal 7 – High Quality Workforce

The final goal of the Olmstead Plan is related to high quality workforce. The end goal is for Nebraskans with disabilities to receive services and supports from a high-quality workforce. This goal is addressed by the employment and education workgroups, so specific feedback was not obtained about what success would look like for this specific area.

Progress Toward and Perceptions of Outcomes

The final goal of the Olmstead Plan has five outcomes. Four outcomes are carried out by the employment workgroup while the remaining one (#3) is coordinated through the education workgroup. All five benchmarks set for FY23 (100%) were accomplished (Figure 49). At the time of this report, three of the benchmarks for FY24 (60%) were completed.

Figure 49. All the benchmarks for Goal 7 were met in FY23, though two were not met in FY24

Outcome	Description	FY23 Status	FY24 Status
1	Increase in the number of certified peer support specialists statewide to support individuals with mental health and/or substance use disorders in their recovery.	✓	■
2	Increase workforce competencies to serve individuals with complex and co-occurring behavioral health needs.	✓	■
3	Increase competency in person-centered planning among participants, families, providers, and service coordinators across all Home and Community-Based Services (HCBS) waivers.	✓	✓
4	Establish rate structure for Aged and Disabled Waiver providers based on provider costs and an evaluation of peer state rate structures.	✓	✓
5	Increase provider rates to account for the minimum wage provisions in Nebraska Revised Statute 48-1203 and to ensure competitive direct support provider and other employee wages across all Home and Community-Based Services (HCBS) waivers by January 2026.	✓	✓

Progress regarding Goal 7 was not included in the key partner survey, in part because the outcomes are monitored and reported by two workgroups focused on other goals. However, the

survey did capture feedback on how aligned respondents felt like the outcomes were for Goal 7. Slightly less than half (45%) of the 31 respondents felt the objectives were “very well” aligned. The remaining felt the outcomes were “moderately” aligned (32%) or “slightly” aligned (23%).

Addressing Quality Workforce in Nebraska

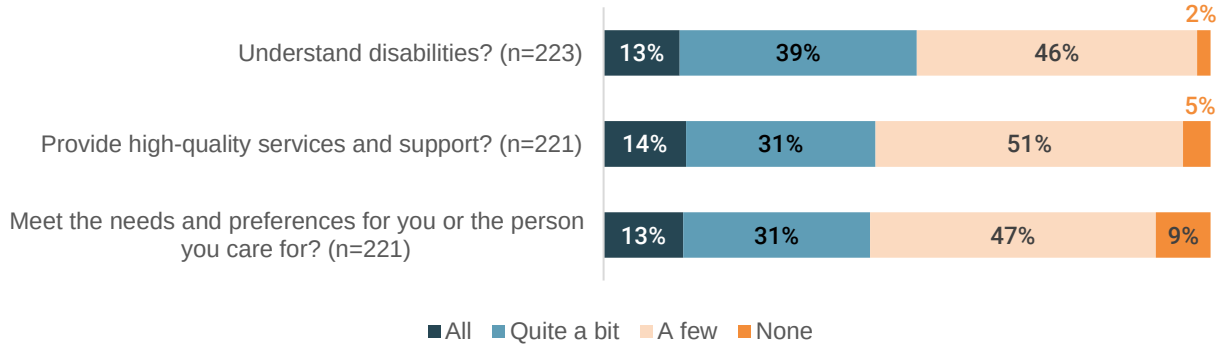
Based on input from workgroup members and key partners, there are a variety of factors that can impact the workforce for disability-related services and supports (Figure 50).

Figure 50. A handful of barriers were noted for ensuring a high-quality workforce

Facilitators to Quality Workforce Progress	Barriers to Quality Workforce Progress
• University of Nebraska Medical Center’s (UNMC’s) Behavioral Health Education Center of Nebraska has funding and programs specifically working toward expanding workforce in Nebraska.	• There’s a workforce shortage issue overall. Even people who qualify to have a caregiver with them might not be able to find or, or they mind find someone who is exploitative. • There is a need to increase pay rates for the workforce, which may or may not be feasible. • Some staff may have English as a second language, which can create some communication barriers for individuals and families.

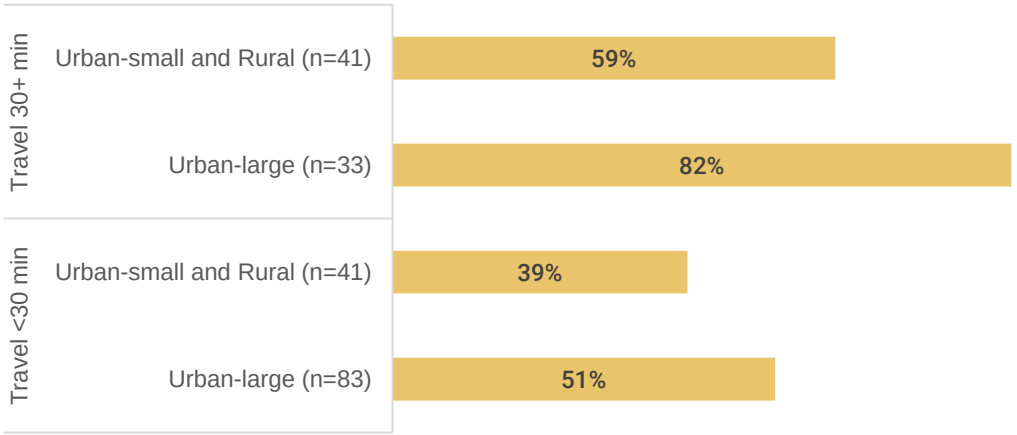
When asked about disability-related service and support providers on the survey for individuals with disabilities, about half the respondents felt that “none” or “a few” understood disabilities, provided high-quality services and supports, and met their needs and preferences (Figure 51).

Figure 51. About half the respondents felt none or a few of the people and organizations that provide disability-related services and support understood disabilities, provided high-quality services, and met the needs and preferences of the individuals



When looking specifically at those who reported that “none” or “a few” of their providers are providing high-quality services and supports, there is a similar effect to the other goal areas. Among those who live in an urban-large county and who reported having to travel 30 minutes or more to get disability-related services and supports, 82% reported “none” or “a few” of the people and organizations that provide disability-related services and supports are of high quality. However, this time, the group that was second most likely to report this were those in rural areas who traveled 30 or more minutes (59%), followed by the urban-large group that didn’t have to travel far (51%), as shown in Figure 52.

Figure 52. Those who responded "none" or "a few" of the people and organizations that provide disability-related services and support are of high quality were more likely to be in urban-large counties



Recommendations

Some of the outcomes for this goal are aligned with health efforts, such as behavioral health needs. Given Nebraska stakeholders noted there was a need to address health initiatives through the Olmstead Plan, **it may be helpful to have a health-focused workgroup to address some of those workforce outcomes**.

Conclusions

As mentioned, there were five questions that guided the evaluation conducted by PIE:

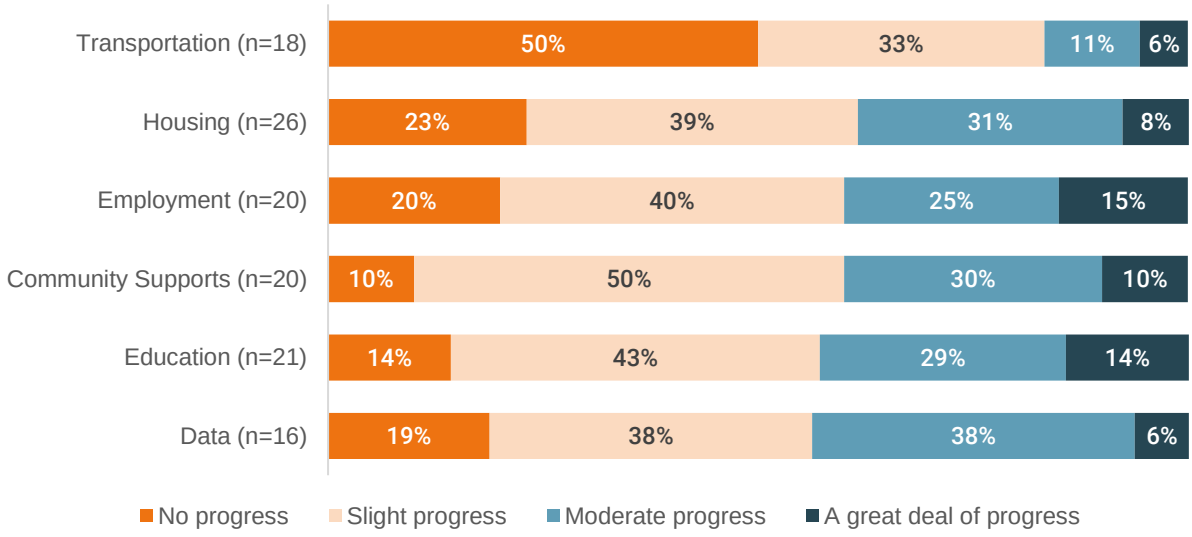
1. To what degree has progress been made among the seven goals of the Olmstead Plan?
2. What improvements and impacts have resulted from the Olmstead Plan, including collaborations between state agencies?
3. What activities and outcomes should be included in the next iteration of the Plan?
4. What are the barriers/challenges and facilitators/successes for implementing the Olmstead Plan?
5. To what degree do the metrics in the Olmstead Plan support the goals and outcomes? How could they better align?

This section summarizes information included in the results section based on the evaluation question the data addresses.

Progress Among Goals

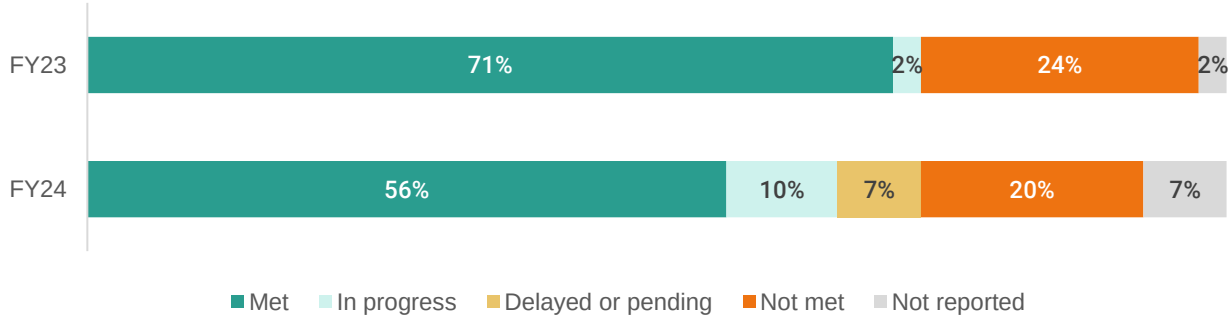
There are varied results when it comes to progress toward the goals. Across the six workgroup goal areas, on average, 10% of partner survey respondents felt there was "a great deal of progress" while 23% reported "no progress" had been made. As noted earlier in the report, the perception among key partners was that there had been more progress in the areas of data, education, and community supports (Figure 53).

Figure 53. The perceived amount of progress varied by goal, though on average, a great deal of progress was reported by 10%



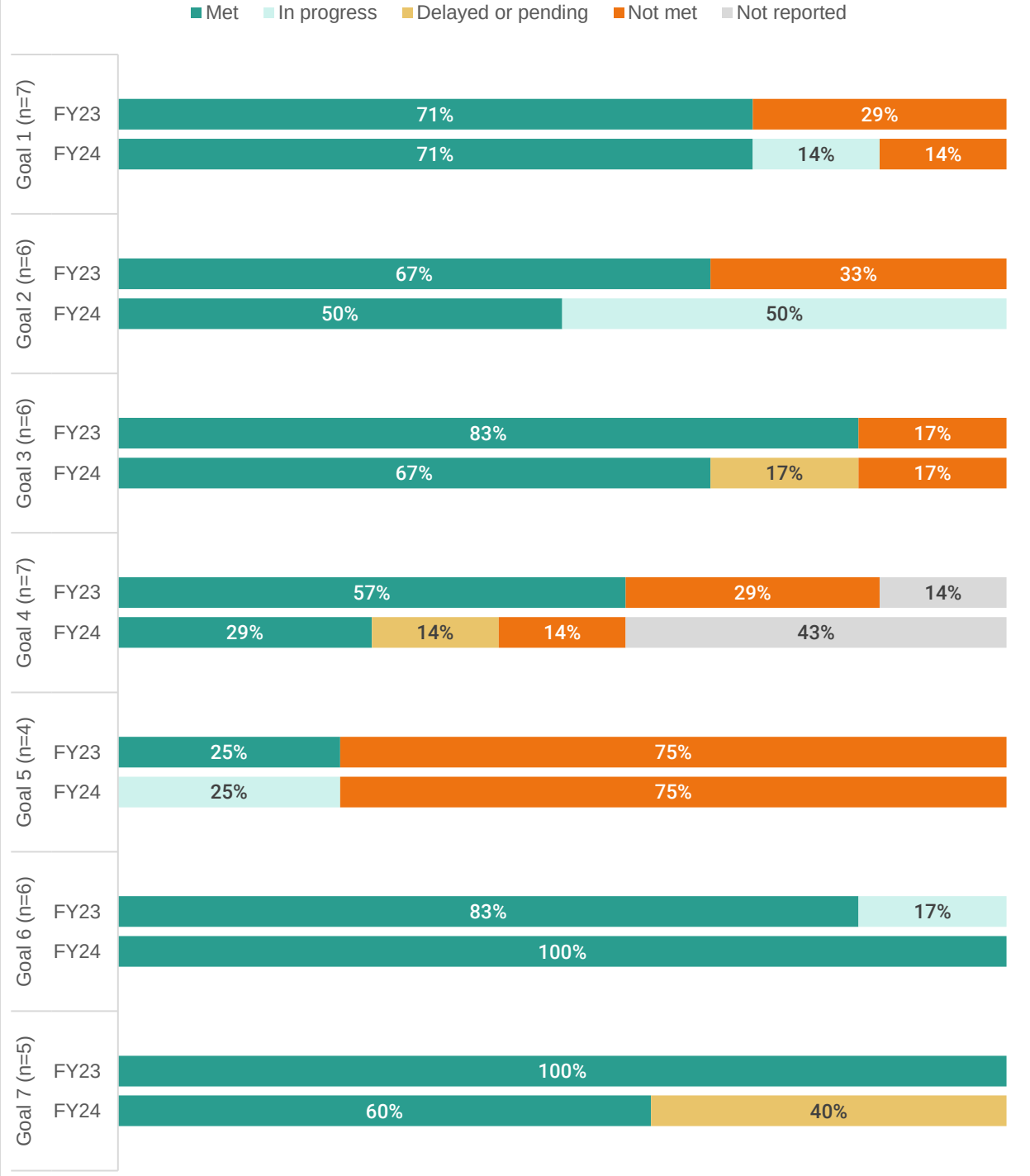
Annual benchmarks for each goal are tracked by DHHS through their Olmstead outcomes monitoring system. Among the 41 benchmarks for FY23, 29 (71%) of them were met (Figure 54). Roughly 25% of the FY23 benchmarks were not met. During FY24, there were 23 (56%) benchmarks completed.

Figure 54. Slightly more than half of the benchmarks were met in both FY23 and FY24 (n=41)



Nearly all goal areas had at least one benchmark that was met in FY23 and FY24 (Figure 55). The exception is Goal 5, where in FY24, one benchmark was in progress while the remaining three were not met. There was also one area (Goal 6) where all the benchmarks for both fiscal years were met.

Figure 55. Progress on annual benchmarks varied by goal



As noted, workgroups may be responsible for addressing outcomes within different goal areas. Looking at progress on benchmarks based on workgroup (rather than within each goal area) provides another perspective. Comparing perception and reported progress shows some alignment (Figure 56). For example, partners were least likely to report a moderate or great deal of progress in the area of transportation (only 17% reported this), which was the area showing the least amount of benchmarks met (only 25% were met in FY23 and none were met in FY24). However, it is interesting to note that perceptions of progress among the other workgroup areas was similar, with about four in ten partners feeling moderate or a great deal of progress had been made in that area, regardless of variation in actually meeting of benchmarks.

Figure 56. A handful of barriers were noted for ensuring a high-quality workforce

Workgroup	No. of Outcomes	Benchmarks Met in FY23	Benchmarks Met in FY24	% of Partners Reporting Moderate or Great Deal of Progress
Community Supports	10	100%	90%	40%
Data	5	80%	100%	44%
Education	9	67%	33%	43%
Employment	6	67%	33%	40%
Housing	7	57%	43%	38%
Transportation	4	25%	0%	17%

Key Improvements & Impacts

Beyond the benchmarks achieved, key partners noted a variety of other improvements and impacts that have been observed as a result of Nebraska's Olmstead Plan, though some may not be directly related to the plan itself.

Key accomplishments include:

1. Having a written plan publicly available and preliminary data to utilize as part of monitoring the Olmstead Plan.
2. The elimination of the Developmental Disabilities (DD) Registry, which served as a wait list of people wanting to be enrolled in the DD Waiver program.
3. Increased advocacy and individuals being more vocal. *"I think one of the biggest impacts is [that] all of us that you're talking to have gotten louder in our advocacy."*
4. Scoring for the Nebraska Affordable Housing Trust Fund through the Department of Economic Development incorporated whether an applicant took accessibility into consideration or included design features for those who may need modifications.
5. Increased access to transportation. About 10 years ago, only half the counties provided transportation to individuals with disabilities. That is now up to about 88 counties.

Activities & Outcomes for the Next Plan

Nebraska's Olmstead Plan contains most of the key areas that partners and stakeholders felt it should. Based on feedback from Nebraska partners and stakeholders, as well as information gathered from other state Olmstead Plans, there are additional activities and outcomes that could be considered for the next iteration of the plan:

1. Health could be added as an outcome for existing goals or become a goal of its own.

2. Some goal areas – Goal 1 and 4 were noted specifically – could have outcomes related to collaboration and service coordination. Collaboration and service coordination could also become a goal of its own like it is in other states.
3. Nebraska could consider reducing the total number of outcomes included in the plan. Among 19 plans from other states, there was an average of 26 objectives (which Nebraska calls outcomes) total. In comparison, Nebraska has 41 outcomes.
4. To better differentiate between the steering group, advisory committee, and workgroups, integrating an outcome related to creating or enhancing the governance structure for the Olmstead Plan may be beneficial.
5. Integrating an outcome or activity to increase awareness about the Olmstead Plan. Communication and outreach efforts are addressed in at least 13 plans from other states.

Additional recommendations to consider for the next iteration of the Olmstead Plan are outlined in the next section of the report.

Key Facilitators & Barriers

A variety of facilitators and barriers – not only for the Olmstead Plan overall but within specific goals – are noted in the findings. There are over-arching challenges and successes that seem to happen across goal areas, as noted in Figure 57.

Figure 57. Overarching facilitators and challenges exist when it comes to implementing the Olmstead Plan

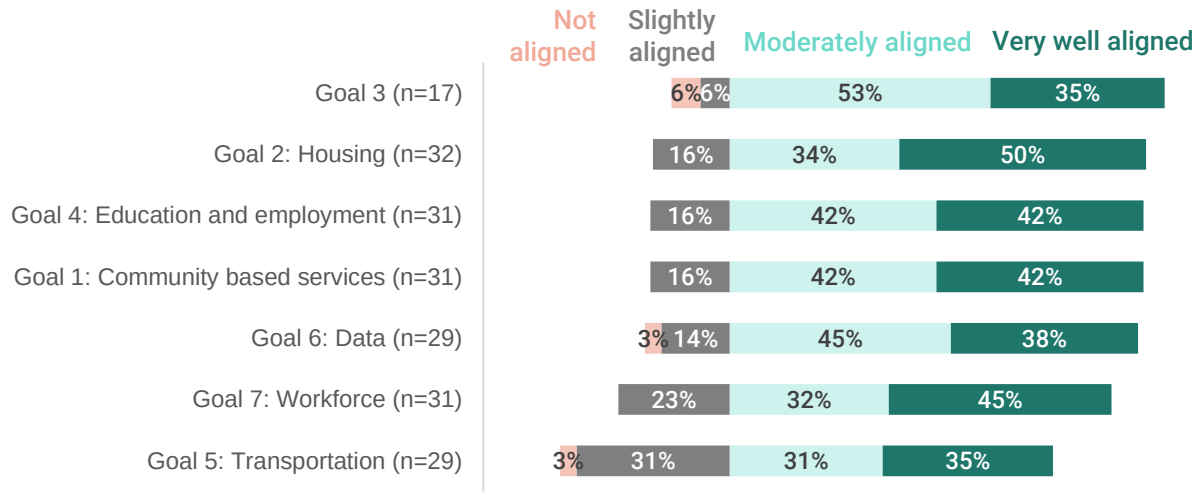
Key Facilitators	Key Barriers
• Diversity and strength in partnerships – including engagement from key state entities and new partnerships (such as nonprofits for the housing goal). • Advocacy from organizations and stakeholders. • The report developed by Dr. Lisa Mills on supported employment.	• Limited support from governor's office or legislature. • Lack of or limited funding to address each goal area sufficiently. • Limited data to know the scope of the problem in each goal area and to assess progress toward addressing those issues. • No longer having a national technical assistance provider. • Lack of public awareness about the plan and what it is set to accomplish • Workgroup leadership has been inconsistent. While the facilitators thus far have done well, *"the second we get somebody else, it's like starting all over again."* • Limited workforce in a variety of areas, including housing, education, and respite care. • Olmstead work in Nebraska tends to be slow. Although Olmstead was passed in 1999, there wasn't a push for Nebraska to have a plan. Even now that the plan exists, many advocates reported that working toward the goals continues to be slow.

Metric Alignment

On average across the seven goal areas, over eight in ten of the partner member survey respondents felt the metrics were at least moderately aligned, with 41% reporting they were "very well aligned." The perception about metric alignment varied by topic area. When

presented with the results from Figure 58, one focus group participant noted that it seemed that alignment is higher in areas where there is more data available to understand the problem. For example, the education workgroup knew how many people in the school system had 504 plans and individualized education plans (IEPs), but there was not much knowledge about how many people in Nebraska have a disability or can't access services. This prevents Nebraska from having a strong sense for what benchmarks or outcomes should be included within each goal area.

Figure 58. Survey respondents felt objectives were most aligned with Goal 3 and less aligned with Goal 5



Several key partners across the various workgroups noted that while they thought the outcomes aligned well, it is primarily because the plan includes outcomes or efforts their agency is already addressing. Many noted that they would like to see "stretch goals" integrated in order to push the outcomes further and to include more long-term outcomes rather than focusing on process measures. This may also help workgroups feel like they're working toward a common or shared vision rather than each contributing their own piece to the plan.

Recommendations

Recommendations by Goal Area

Although recommendations for each of the seven goals were provided throughout the results section, they are also included here for a comprehensive synopsis of all recommendations. As noted, some of the recommendations provided for one goal may be applicable to others.

Goal 1 – Community Services

1. Consider identifying specific communities, populations, or areas that would benefit the most from engagement and intervention. Although the Olmstead Plan is intended to be statewide and should lead to an impact for all Nebraskans, success for this goal seems to be found when partners can work in-depth with a community or area. By identifying specific geographic areas, it may give the Community Supports workgroup an opportunity to narrow their focus and efforts to have a greater impact.

2. Modify and/or add outcomes so that outcome-focused measures are included so the focus isn't primarily on process measures. Although process measures are helpful for monitoring and understanding progress, one partner noted that it does not help them see if the activities are helping them achieve the goal of ensuring individuals with disabilities can access individualized community-based services and supports that meet their needs and preferences. Although outcome-focused measures may not be able to be achieved within a three-year plan, being intentional about having more long-term outcomes may help move the workgroup in a more coordinated direction.
3. Similar to other states have priorities around service coordination in their Olmstead Plans, consider adding an outcome related to building structures or systems for people to access services more effectively. As noted, services may be available, but often individuals with disabilities need a streamlined way to determine how to access those opportunities. This could include approaches such as advocating for liaisons that could help people with disabilities navigate services and/or having state entities create or enhance a structured coordinated entry or "no wrong door" approach.

Goal 2 – Housing

1. Work to define key terms within the housing goal, such as accessible and affordable. This can help create common language among workgroup members and other stakeholders. Not only will this help ensure everyone is on the same page with what the terms mean, it may also help workgroup members, key partners, and stakeholders better assess the degree to which goals are being met toward those outcomes.
2. Revisit the outcomes with the responsible agencies to ensure the programs included match the intent of the Olmstead Plan. One stakeholder noted their existing programs don't directly align with the plan, and it may help to determine whether the program needs to be modified or if the plan does.
3. One thing that has facilitated success in this goal area is state agencies and elected officials being vocal about their support for additional housing. Some partners also mentioned that success in this goal area would mean having buy-in from the state legislature and governor to prioritize housing needs, ideally leading to the contribution of state general funds to housing for people who are most vulnerable. With that being the case, it may be helpful for the workgroup to prioritize bringing on a member from the governor's office and/or creating an action step around working with the state legislature to gain buy-in over time.
4. Identify areas of crossover between agency goals and points of collaboration to avoid the perception that each agency has "their own thing." Part of this could be accomplished by incorporating information sharing, reporting on goals, and problem solving across the agencies as part of the standing workgroup meeting agenda.

Goal 3 – Appropriate Settings

Given much of the work for this goal is carried out by the Community Supports group, it may be helpful to align or combine efforts under Goal 3 with Goal 1. Part of an individual's ability to receive services in the settings most appropriate to meet their needs and preferences may depend on their access to such services.

Goal 4 – Education/Employment

1. Clarify each of the outcomes to be distinctly linked to the "increased access to education" portion of the goal statement or the "choice of competitive, integrated employment opportunities" portion. That would minimize confusion about how each of the outcomes are connected to the larger goal.

    a. Another option would be to make education and employment separate goals in the Olmstead Plan. While many other states address these topic areas, they are more often treated as separate priorities or goals. Separating the goals may also help align with the new workgroup structure.
2. Review and incorporate the recommendations from Dr. Lisa Mills. This was noted by many as an influential report that can help with setting a vision for employment in the coming years.
3. Consider adding an objective related to collaboration. Although there were many successes related to collaboration, a handful noted additional collaborations would create a more unified approach to the work.

Goal 5 – Transportation

1. Given the perceived lack of progress and not meeting the FY23 benchmarks, it may be important to revisit the outcomes that are selected for this goal area. Workgroup members can ensure they are in alignment with the overall goal and determine if the outcomes and benchmarks set will sufficiently measure progress.
2. This is a goal that has more barriers than facilitators. It may be helpful to brainstorm if or how some of those barriers can be overcome. This may provide helpful context when determining the outcomes and action steps needed in the next iteration of the Olmstead Plan.
3. As with Goal 1, it may help to identify specific communities, populations, or areas that would benefit the most from intervention. That may give the workgroup an opportunity to narrow their focus and efforts, in part since it may be challenging to address statewide transportation in a three-year time period.

Goal 6 – Data-Driven Decision Making

1. Consider removing data as a stand-alone goal for the Olmstead Plan. As noted, many states integrate data objectives or activities into other priorities within their plans. Doing something similar in Nebraska may help focus data efforts.
    a. If data remains a stand-alone goal, it may be helpful to modify outcomes and activities to focus more on understanding, gathering, and sharing more of the basic data needs mentioned by partners and stakeholders. Many expressed a desire to have a sense of current needs and gaps within the seven goals. That could be accomplished by exploring data sources that other states used to monitor their outcomes.
2. Utilize the data workgroup as a vehicle to showcase progress toward goals. With the group's focus on data, members could assist with tasks such as creating a two-page summary report or complementary documents highlighting the successes of the Olmstead Plan. That may also provide an opportunity to share the data in a meaningful way, helping to achieve the vision for the goal.
3. Consider integration of evaluation efforts into the data work. Beyond tracking outcomes and metrics, it may be helpful to also capture qualitative data to provide more context for progress. It would also be an opportunity to keep evaluation top of mind beyond having an external contractor conduct an evaluation every three years. As an example, an ad hoc evaluation group was formed during the implementation of this evaluation project. Ongoing discussions may help enhance data collection opportunities and identify future needs for the evaluation.

Goal 7 – High Quality Workforce

Some of the outcomes for this goal are aligned with health efforts, such as behavioral health needs. Given Nebraska stakeholders noted there was a need to address health initiatives through the Olmstead Plan, it may be helpful to have a health-focused workgroup to address some of those workforce outcomes.

Recommendations for Next Olmstead Plan

Development/Revision Process

1. Before developing the plan, decide on the length of time for the plan. Although up to this point Nebraska's plan has covered three fiscal years, many noted it's hard to see the level of progress toward the outcomes. Many other states treat their plan as a living document, with only 7 of the 24 reviewed having a date range for their priorities. With the evaluation being conducted every three years, it may help to have six-year cycles to allow for a mid-point update and end-of-plan update.
2. Have workgroups identify a handful of high-level priorities for each goal. Once priorities are identified, agencies would then develop outcomes related to stakeholder priorities. As part of that process, organizations should also determine how progress and change could be measured by identifying appropriate benchmarks.

Content

1. Determine and then outline the terminology that should be utilized for priorities, goals, objectives, etc. Consider using a description similar to Iowa's Olmstead Plan.
2. Add a statement of need and information about data sources to the plan. This can be done in a variety of ways. For example, each goal could have a summary about what the priority means (see North Carolina's plan). That plan also has a section summarizing why that priority remains a focus. Another option is to have a plain language document that summarizes the core area and why it's important.
3. Share Olmstead Plans from other states with the Advisory Committee and/or other workgroups that may benefit from seeing other examples. This was a recommendation offered by a handful of partners as a way to get a sense for what other states have been successful doing.

Goals/Priorities

1. To avoid having a plan that is too overwhelming and best meets the needs of Nebraska, consider identifying specific communities, populations, or areas that would benefit the most from activities and intervention. It can be expanded over time, but that way areas of highest need can be prioritized – particularly with limited capacity.
2. Consider adding new priorities to Nebraska's existing Plan:
    a. Health or medical care. In addition to being a common priority or goal area covered by other states, focus group participants noted the importance of advocating for certain medical services (such as assisted outpatient therapy) and prioritizing education for medical providers about disabilities.
    b. Collaboration and service coordination. This is a priority or goal area for 12 states and may be beneficial for helping Nebraska achieve their vision of seeing the Olmstead Plan as a way to drive work for agencies rather than the other way around.
3. Remove data as a stand-alone goal (Goal 7). There are not many states that have data as a stand-alone goal or priority within their Olmstead Plan. Instead, data could be added as an objective within relevant goals so there is a more specific focus.

4. Articulate the successes or efforts accomplished to date related to the priority areas. Although there is a document to denote whether benchmarks have been achieved or not, it may also be important to have a document (whether it's in the Olmstead Plan or as a supplemental document) that summarizes what has been achieved thus far.
    a. A key partner stated having a one to two page "scorecard" that could summarize each goal area, what has occurred, and what is planned to meet the measures would be helpful.
    b. North Carolina includes a "priority area efforts to date" section within each of their priorities to describe successes that have occurred up to that point.

Outcomes & Benchmarks

1. Nebraska could consider reducing the total number of outcomes included in the plan. Among 19 plans from other states, there was an average of 26 objectives (which Nebraska calls outcomes). In comparison, Nebraska has 41 outcomes.
2. Have each workgroup define what success looks like for their topic area. In addition to helping each one create a common and shared vision, that information can then be used to inform what specific outcomes or objectives are included for each priority area.
3. Consider writing outcomes that go beyond what agencies are already doing so that it is not just another report out but rather pushes the system to grow and enhance efforts.
4. Clarify baseline data within the Plan so that there is clarity among all workgroups and stakeholders on whether progress has been made and/or the goals have been met.
5. Rather than having annual benchmarks, set the benchmarks for the end of the evaluation period or set a half-point benchmark. Based on feedback from key partners, there are a lot of external factors that can impact success in working on goals.
6. Consider taking a broader approach to focus on the larger picture of the plan rather than writing very specific action steps.
7. Before approving the plan, ensure the agencies required to submit data for benchmarks or outcomes have the ability to do so.

Dissemination

1. Consider a plain language version of the plan to assist with increased awareness and understanding of the plan. See Minnesota's plain language document as an example.
2. Communication and outreach efforts. This is another common priority addressed by other states to ensure the public – and particularly those with disabilities – have knowledge about the Plan and its intent. Addressing this allows Nebraska to increase awareness about the plan.

Recommendations for Implementation & Coordination

1. Consider developing an online dashboard for monitoring progress toward Olmstead Plan activities and outcomes. This would allow all committee and workgroup members to have a sense for the level of progress. An example is the "Interactive South Dakota Cancer Plan and Data Dashboard" available here: https://public.tableau.com/app/profile/patricia.da.rosa/viz/shared/MGXS85CFS
2. Explore ways to enhance partnerships and expand voices at the table. According to feedback from key partners, the following may be helpful to include: Adults experiencing multiple disabilities; Businesses; General Public; Public K-12; Colleges and universities; Someone from Housing and Urban Development (HUD); Staff from the Governor's Administration policy office; and Representative from the Nebraska Legislature.

Workgroup/Committee Efforts

1. Define the roles and responsibilities of the advisory committee, the steering committee, and the workgroups. Although the Advisory Committee has bylaws and the Steering Group has a charter to outline the expectations, there seems to be a need for a less formal description or reference for each group and instead a summary of what their core focus and expectations are. This may also provide an opportunity to look for any duplication or opportunities to streamline decision-making and information sharing. It may also help ensure those involved at each level know what they are tasked with doing.
2. To build more cohesion among workgroup members, consider 1) having some level-setting among the group – especially around terms and the data available; 2) integrating team building opportunities; 3) providing opportunities to share information, including a status update on outcomes each agency is responsible for addressing.

Recommendations for Next Evaluation

1. Align data collection with disability events to increase awareness of and participation in surveys or other collection efforts.
2. Consider geographic information systems (GIS) mapping of where services are available in the state. One data source may be the Arc's Disability Organization map, which outlines mostly developmental disability services. Other pertinent services may include assisted living facilities, skilled nursing, and Aged & Disabled Resource Centers (ADRCs).

Individuals with Disabilities Survey

Should another survey for individuals with disabilities be conducted, there are key modifications that could be made to the tool used for this evaluation to provide more meaningful data. This would, however, need to be balanced with the total number of questions being asked and the complexity of the survey.

1. Consider including questions about:
    a. What type of disability or disabilities the individual has
    b. How often people have to travel for disability-related services (to help provide context for how far they have to travel for those services)
    c. Whether people feel they have access to integrated employment (questions on the survey were only about competitive employment and employment or vocational supports)
2. When assessing access to services, it may be helpful to tease out the "not applicable" responses. If someone selects N/A for access to competitive employment, it is not known whether the individual can't work, does not want to work, or is of an age where they aren't working.
3. If the question regarding how long it takes to travel to receive disability-related services and supports remains on the survey, it may be important to also 1) define or have the respondent describe how they interpret disability services and supports and 2) indicate how they transport themselves to those services.

Appendix A: Data Sources

Primary Data

Individuals with Disabilities Survey

A survey was developed by PIE in coordination with DHHS. Although the survey was geared toward individuals with a disability, it could also be completed by family members and/or caregivers. Three individuals tested the survey before it was publicly available on February 4, 2024. The survey, which was available online and on paper, was promoted to 33 people at key organizations who could disseminate the survey widely within their agencies and community. The survey closed on March 26, 2024 with 175 people answering at least one question.

With the low response rate, an ad hoc evaluation group decided to make the survey available again on May 6 and was open through May 28. The survey was promoted among the same organizations and implemented by members of the Olmstead Plan Advisory Committee. For this survey implementation, a flyer was available to include with paper copies that may be used in waiting rooms or other public spaces. There was a caveat throughout the promotion that if people had already taken the survey, they would not need to take it again. There were 135 people who answered at least one question. For the second iteration of the survey, the survey was made available in Spanish (both online and on paper), but none were completed.

In total, 310 individuals answered at least one question on the survey. Data cleaning was done by PIE to identify any potential duplicate entries (based on IP addresses and responses). Analysis was done using SPSS.

Workgroup Member, Partner & Advocate Survey

An online survey was developed by PIE in conjunction with DHHS staff. The survey was sent to 83 individuals who were identified by the DHHS staff via SurveyMonkey and was available February 9, 2024 through March 22, 2024. Four reminder emails were sent through SurveyMonkey to those who had not completed or who had partially completed the survey. DHHS staff also sent an email out to survey recipients to encourage participation. About half (54%) of the 83 recipients participated in the survey. Analysis was done in excel and SPSS.

Interviews with Key Partners

Interviews were conducted virtually with individuals affiliated with state agencies – either state government or nonprofits that focus on statewide efforts. An interview protocol was developed by PIE in conjunction with DHHS, though each one was tailored slightly based on which goal area(s) their organization addressed and which outcome(s) they supplied data for to DHHS. The 18 individuals interviewed (2 of whom were part of one interview) represented 9 unique agencies. One of those agencies was DHHS, where all five divisions were represented.

Individuals with Disabilities Focus Group

This virtual focus group was promoted to 8 individuals who participated in the individuals with disabilities survey and indicated (through a question on the survey) they had an interest in participating in a focus group about the Olmstead Plan. The focus group was held on April 9, 2024 at 6 PM. A survey was sent to those who registered for the focus group prior to the event regarding any accommodation needs. There were four individuals who participated in the session, and two people provided feedback to the focus group questions via Qualtrics. Responses from the online form were compiled with the interview transcripts before being coded by PIE.

Family Member/Caregiver Focus Group

This virtual focus group was promoted to 20 individuals who participated in the individuals with disabilities survey and indicated (through a question on the survey) they had an interest in participating in a focus group about the Olmsted Plan. The focus group was held on April 4, 2024 at 6 PM. There were two individuals who participated in the session, and five people provided feedback to the focus group questions via Qualtrics. Responses from the online form were compiled with the interview transcripts before being coded by PIE.

Workgroup Member Focus Group

This virtual focus group was promoted to 13 individuals selected by DHHS to represent a range of the workgroups. The focus group was held on April 5, 2024 at 10 AM. There were six who participated in the session, and one individual provided feedback to the focus group questions via SurveyMonkey. Responses from the online form were compiled with the interview transcripts before being coded by PIE.

DHHS Olmstead Plan Staff Focus Group

This focus group, held virtually to more easily obtain a transcript, was conducted on May 22, 2024. There were three DHHS staff members who participated in the focus group, and one was unable to join. The focus group transcript was coded by PIE.

Secondary Data

Advisory Committee Meeting Minutes

The Olmstead Plan Advisory Committee meeting minutes were reviewed and coded by PIE. A total of 23 files were reviewed, covering meetings held since January 2019. The most recent meeting minutes reviewed were from the April 27, 2023 meeting.

Workgroup Meeting Minutes

Meeting minutes from the six workgroups were reviewed. There were 8 coded for the data workgroup (January 2022 through January 2024), 6 for the education and employment workgroups (February 2022 through January 2024), 13 for the housing workgroup (January 2022 through January 2024), 11 for the transportation workgroup (January 2022 through January 2024), and 1 for the community supports workgroup (January 2024).

Olmstead Outcomes Monitoring System

The Olmstead team at NDHHS utilized Monday.com to monitor the benchmarks and outcomes of the Olmstead Plan. The data is typically exported into an Excel or PDF file to share with the Advisory Committee.

Olmstead Plans from Other States

Olmstead Plans from 22 states (including two plans from Indiana) and the District of Columbia were obtained. The 24 documents reviewed were either publicly available or obtained by contacting the state entity leading Olmstead efforts. For some states, an Olmstead Plan could not be obtained but a progress report (either for the Olmstead Plan or a Settlement Agreement) was used. An excel spreadsheet was developed by PIE to code each plan based on what priority areas were included, the types of activities mentioned under the priority areas, terminology used in the report, and the date range covered by the plan.

Appendix B: Surveys

Survey for Individuals with Disabilities and Family Members/Caregivers

Many states – including Nebraska – have what is called an Olmstead Plan. The plans were developed after the Supreme Court's *Olmstead* decision to work toward making sure individuals with disabilities can receive support and services in their community rather than institutions, depending on that person's preferences and needs.

This survey is a way to gather feedback on the areas included in Nebraska's Olmstead Plan (more information at https://dhhs.ne.gov/Pages/Olmstead.aspx) from individuals who have a disability or are a family member/caregiver to someone with a disability. Your responses will be anonymous, meaning we will not be able to identify who you are.

All the feedback collected will be used to determine what should be prioritized or included in Nebraska's Olmstead Plan. If you have any questions, would like more information, or would prefer to complete the survey on paper or in a different language, please contact DHHS.NEOlmstead@nebraska.gov.

1. How familiar are you with Nebraska's Olmstead Plan?

☐ Not at all familiar ☐ Somewhat familiar ☐ Very familiar

2. Are you completing this survey as:

☐ As an individual who has a disability ☐ On behalf of someone with a disability ☐ As a family member or caregiver to someone with a disability

3. How much do you or the person you care for have access to the following items:

Housing	*Currently have or receive*	*Don't have but could get*	*Don't have and could not get*	*Not applicable*
Safe housing				
Affordable housing				
Accessible housing (places that people with disabilities can enter and use, such as wider doorways, low countertops, grab bars, assistive technology, etc.)				

Transportation	*Currently have or receive*	*Don't have but could get*	*Don't have and could not get*	*Not applicable*
Affordable transportation				
Accessible transportation (lifts or ramps, audio announcements, curb-cuts, guided assistance to get on or off)				

Education	*Currently have or receive*	*Don't have but could get*	*Don't have and could not get*	*Not applicable*
Special education services				
Individual education plans (IEPs)				
Support with obtaining education credits				

Employment	*Currently have or receive*	*Don't have but could get*	*Don't have and could not get*	*Not applicable*
Competitive employment (opportunities for compensation, benefits and advancement that is comparable to employees without disabilities performing similar duties)				
Employment or vocational supports (help getting or keeping a job, supportive employment, job placement, etc.)				

4. How much do you or the person you care for have access to community-based services (behavioral health supports, social services, non-profit organizations, etc.) that...

	Currently have or receive	*Don't have but could get*	*Don't have and could not get*	*Not applicable*
Are fully integrated and are the same as those for individuals without disabilities				
Require an additional fee or cost I pay				
Are paid for through Medicaid waivers, vouchers, or other disability-related programs				

5. Of the services that you receive or use, about what percentage required an eligibility determination, qualification, or special request rather than being available to the public? For example, the public bus is available to everyone at the same cost, but some may need to request specialized ADA transportation, such as Paratransit. What percentage of the services you use require the additional request, determination, or qualification?

☐ None ☐ 1 to 25% ☐ 26 to 50%

☐ 51 to 75% ☐ 76 to 100% ☐ I don't know

6. Thinking about the people and organizations that provide disability-related services and support, in general how many of them…

	None	*A few*	*Quite a bit*	*All*
Understand disabilities?				
Provide high-quality services and support?				
Meet the needs and preferences for you or the person you care for?				

7. How often have you had difficulties getting access to disability-related services and supports?

☐ Rarely ☐ Occasionally ☐ Often

8. How far do you typically have to travel to get disability-related services and supports?

☐ Less than 30 minutes ☐ 30 min to 2 hours ☐ More than 2 hours

9. In what county do you live? _____

10. Which age group do you fall into?

☐ 18 and under
☐ 19 to 34
☐ 35 to 54
☐ 55 to 74
☐ 75 and older

11. Are you:

☐ Male
☐ Female
☐ Prefer not to say
☐ :_____

12. What is your race? Select all that apply.

☐ American Indian or Alaska Native
☐ Asian or Pacific Islander
☐ Black or African American
☐ Native Hawaiian or other Pacific Islander
☐ White
☐ Prefer not to say
☐ Other (please specify): _____

13. Are you Hispanic or Latino?

☐ Yes ☐ No

14. What is the primary language that you speak?

☐ English ☐ Spanish
☐ Other (please list): _____

15. Would you be interested in participating in a discussion with a small group of similar individuals (called a focus group) about areas included in the Olmstead Plan?

☐ No

☐ Yes, please contact me using the information below. *Please note: this information will only be used to contact you about participation in the focus group. Your survey responses will still remain confidential.*

Name:	
Email Address:	
Phone Number:	

16. If you responded yes to the question above, which topic area(s) are you most interested in discussing? Select all that apply.

- ☐ Community-based services
- ☐ Employment
- ☐ Housing
- ☐ Transportation
- ☐ Education
- ☐ Service or Provider Workforce Quality

17. Please describe any accommodations you may need for participating in a virtual focus group.

Workgroup Member, Partner & Advocate Survey

This survey is a way to gather input from key partners and advocates regarding Nebraska's Olmstead Plan. Your responses will be kept confidential, meaning any identifying information about you will be removed from any reporting.

All the information collected through the survey will be used to determine what type of progress has been made on the Olmstead Plan and how it can be enhanced. If you have any questions or would like more information, please contact DHHS.NEOlmstead@nebraska.gov.

1. How long have you been involved with the Olmstead Plan?
   - ☐ I haven't been directly involved
   - ☐ Less than 1 year
   - ☐ 1 to 3 years
   - ☐ More than 3 years

2. Select which category best describes your level of involvement with each of the Olmstead Workgroups.

	Regularly attend meetings	*Occasionally attend meetings*	*Do not attend meetings, but stay informed about efforts*	*No involvement or awareness*
Community Supports				
Data				
Education				
Employment				
Housing				
Transportation				

3. Since Nebraska published its first Olmstead Plan in December 2019, how much progress has been made within each of the goal areas? If you are unsure or not involved in those efforts, select N/A.

	No progress	*Slight progress*	*Moderate progress*	*A great deal of progress*	*I don't know or N/A*
Community Supports					
Data					
Education					
Employment					
Housing					
Transportation					

4. Have the following factors helped or hindered Nebraska's progress with implementing or carrying out the Olmstead Plan?

	Hindered Significantly	*Hindered Somewhat*	*No effect*	*Helped Somewhat*	*Helped Significantly*	*I don't know, N/A*
Communication efforts regarding the Olmstead Plan						
Funding						
Leadership within workgroups						
Partnerships and collaborations						
Support from legislators or other decision makers						

5. What other factors hindered progress?

6. What other factors helped?

7. What successes or key impacts have occurred as a result of Nebraska's Olmstead Plan?

8. What works well with the current structure and approach for implementing the Olmstead Plan (workgroups, meetings, templates, communication, etc.)?

9. What would help workgroups and key partners feel more equipped to implement the Olmstead Plan?

10. How satisfied are you with the current objectives that are included in the Olmstead Plan?
    - ☐ 1 – Very dissatisfied
    - ☐ 2 – Somewhat dissatisfied
    - ☐ 3 – Neither satisfied nor dissatisfied
    - ☐ 4 – Somewhat satisfied

☐ 5 – Very satisfied
☐ I don't know

11. If you selected 1 (very dissatisfied) or 2 (somewhat dissatisfied) in the previous question, please describe why.

12. How aligned do you feel the objectives are with the goal area?

	Not aligned	*Slightly aligned*	*Moderately aligned*	*Very well aligned*	*Unsure*
Goal 1 (community-based services and supports)					
Goal 2 (housing)					
Goal 3					
Goal 4 (education and employment)					
Goal 5 (transportation)					
Goal 6 (data-driven decision-making)					
Goal 7 (high-quality workforce)					

13. What additional objectives or activities should be considered for the next iteration of the Olmstead Plan?

14. What other agencies or individuals should be involved in implementing the Olmstead Plan?

15. Please include any additional comments or feedback on Nebraska's Olmstead Plan.

Thank you for participating in this survey! Your feedback is very important.

Appendix C: Focus Group Protocols

Caregiver Focus Group

Introductions

To start, I'd love to know who's in the group. Please share your name and where you are from.

Olmstead Plan Goals/Priorities

1. The Olmstead Plan is Nebraska's strategic plan to ensure that individuals with disabilities are fully integrated into their community – meaning they have housing, transportation, education, etc. like others in the community do. Given this goal, what would success look like for you and for the person(s) you care for with a disability?

2. To be successful and make an impact, what would be the ONE thing you would want to see included in the plan? Why?

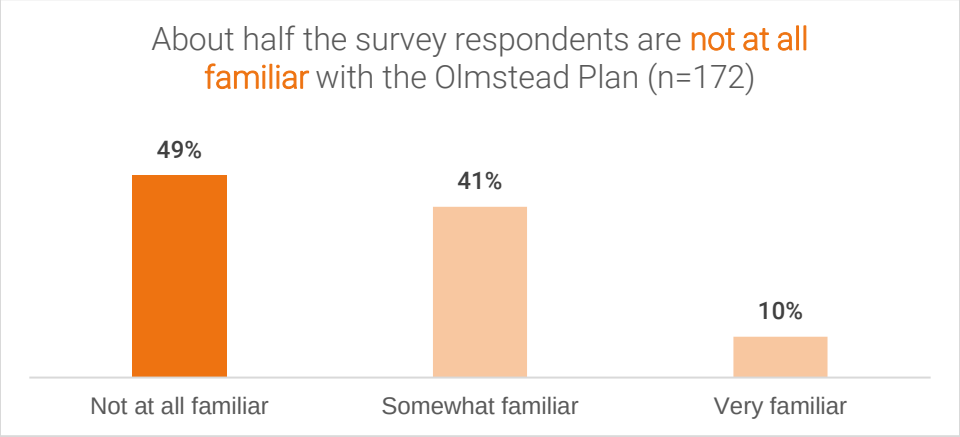
3. What are some of the key challenges that either you as the family member/caregiver or the individual with disabilities experience the most when it comes to being fully integrated in the community? (Probes: Are certain things unavailable or inaccessible? What services or aspects of living, such as transportation, are hardest to obtain? How much of those require specialty qualifications or eligibility determination rather than being available to the public?)

4. What are the things that are currently working well in Nebraska in terms of services for those with disabilities or working toward community integration for those with disabilities? Are there things you feel Nebraska has made progress on in recent years or could use as a "gold star" for seeing what success looks like?

Olmstead Plan Awareness

5. What word comes to mind when you think of the Olmstead Plan?

As you may know, we did a survey last month for individuals with disabilities, though families/caregivers could also complete the survey as well. We asked people how familiar they were with the Olmstead Plan. Preliminary results show that about half are "not at all familiar" with the plan. Only 10% were very familiar with it.



6. What jumps out to you about these results? (Probes: are you surprised by them? Is this what you would expect to see?)

7. What would you suggest to increase awareness and/or understanding of the Olmstead Plan? What should people know about the Olmstead Plan? (Probes: Are there specific resources or materials that would be helpful? Is it something people need to know about?)

Closing

8. What other final comments, thoughts, or feedback would you like to share about the Olmstead Plan or navigating services for individuals with disabilities in Nebraska?

Thank you for participating in this focus group! As I mentioned, your feedback will be combined with others to share in an aggregate report for the Division of Developmental Disabilities.

Individuals with Disabilities Focus Group

Introductions

To start, I'd love to know who's in the group. Please share your name and where you are from:

Olmstead Plan Goals/Priorities

1. The Olmstead Plan is Nebraska's plan to make sure individuals with disabilities are fully integrated into their community – meaning they have housing, transportation, education, etc. like others in the community do. What would that look like for you?

2. What's ONE thing that would be helpful to set as a goal or have included in the Plan? Why is that?

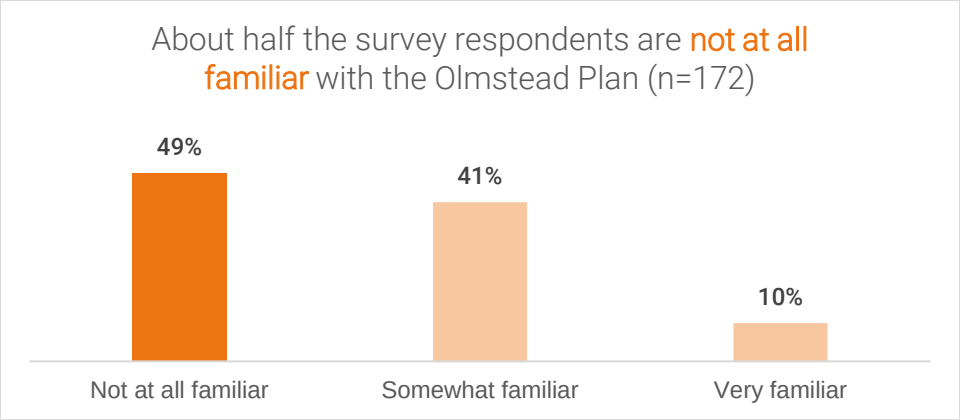
3. What are some of the major challenges you experience most when it comes to being fully integrated into your community? (Probes: Are certain things unavailable or inaccessible? What services or aspects of living, such as transportation, are hardest to obtain? Are there other barriers, such as cost or a waiting list, that prevent you from getting the services you need?)

4. What do you think is working well in Nebraska in terms of services for those with disabilities or working toward community integration for those with disabilities?

Olmstead Plan Awareness

5. What word comes to mind when you think of the Olmstead Plan?

As you may know, we did a survey last month for individuals with disabilities, though their families/caregivers could also complete it. We asked people how familiar they were with the Olmstead Plan. Preliminary results show that about half of those individuals were "not at all familiar" with the plan.



6. What stands out to you about these results? (Probes: are you surprised by them? Are they what you would expect?)

7. What would help increase people's awareness or understanding of the Olmstead Plan? What do people need to know about it? (Probes: Are there specific resources or materials that would be helpful? Is the Plan something people need to know about?)

Closing

8. What other final comments, thoughts, or feedback would you like to share about the Olmstead Plan or getting services in Nebraska?

Thank you for participating in this focus group! As I mentioned, your feedback will be combined with others to share in an aggregate report for the Division of Developmental Disabilities.

Olmstead Plan Staff Focus Group

Introductions

1. Please share your name, how long you've been involved with Olmstead Plan efforts, and one word that comes to mind when you think of the Olmstead Plan.

Overall Olmstead Plan

The first few questions are about the Olmstead Plan in general.

2. Can you tell me how the Olmstead Plan came to be in Nebraska, or at least what you know about how it originated? (Probes: Who or what entity pushed it forward and made it happen? Who came up with the original goal areas?)

3. What are some of the facilitators to advancing the Olmstead Plan in Nebraska? In other words, what's helping your team, workgroups, steering committees, and partnering agencies find successes and wins?

4. Conversely, what are some of the barriers or challenges with the Olmstead Plan? (Probes: are objectives too lofty? Lack of funding or alignment or leadership?)

5. What's your overall sense about the sustainability of what's being done or implemented through the Olmstead Plan? Are current activities ones that can be sustained or lead to more permanent change over time?

Goal Area(s)

The next set of questions are about the seven goal areas so we can get your take on how things are progressing.

6. Within each of the goal areas, what would success look like? If you had a magic wand, what would you like to see change or happen in the next 5-10 years?

7. Within the goals areas, what stands out as being the key wins, successes, or accomplishments?

8. Within the goal areas, what stands out as being the key challenges or barriers? Where has there been less movement?

Collaboration & Coordination

9. How would you describe the partnerships, engagement, and collaboration for the Olmstead Plan? What's been working well and where could improvements be made?

10. What new partners would be beneficial for the Olmstead Plan? Or is it moreso about enhancing the relationships with the programs/agencies already involved?

11. Moving forward, what would you like to see or what would you recommend for breaking down siloes or working collaboratively to achieve some of the big picture goals of an Olmstead Plan?

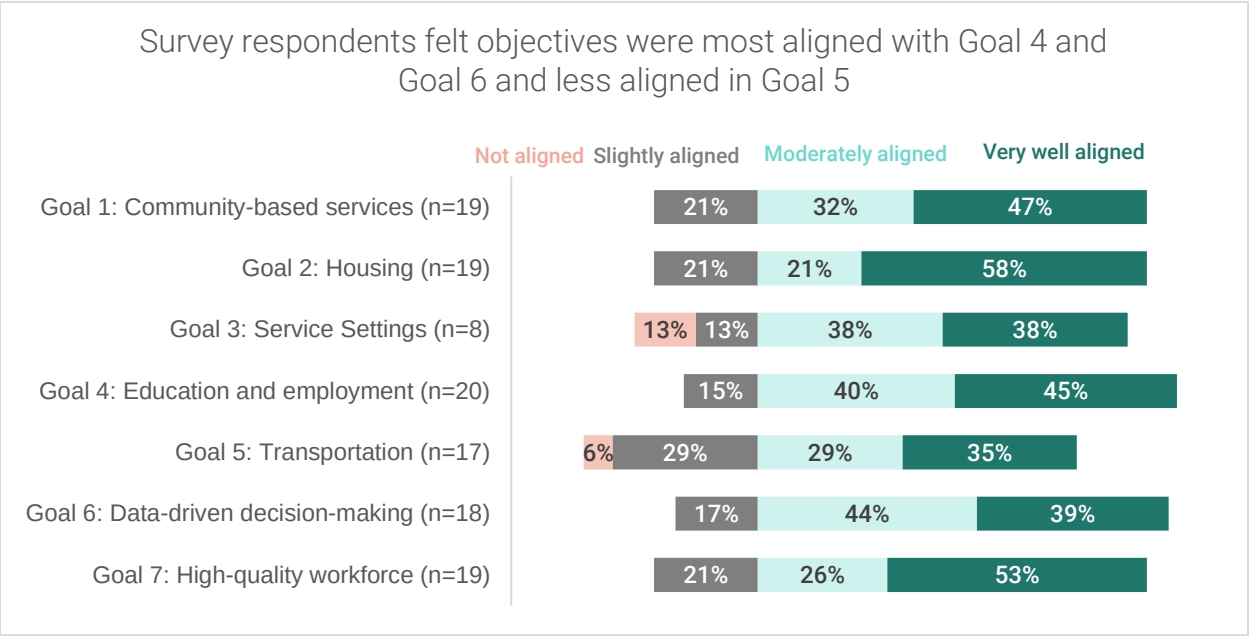
12. How well does the current workgroup meeting coordination and structure work? What would you say is working well and where could improvements be made? (Probes: is the quarterly frequency appropriate, is communication between meetings sufficient, are the number/diversity of workgroup members sufficient, etc.)

Olmstead Plan Content

One way the Olmstead Plan was enhanced was creating metrics and activities within each of the goal areas. The next few questions are geared at getting feedback on those changes, in part to see what should remain or be modified for the next Olmstead Plan.

13. Describe how the metrics and activities were developed for each of the seven goal areas. What worked well, and what would you change? (Probes: Who drafted them? Who did the final revision/approval for what's now included in the Plan?)

14. On the workgroup member, partner, and advocate survey, we asked people how aligned the outcomes/objectives with each goal area are. Based on the preliminary results, people felt the objectives were most aligned with Goal 4 (education and employment) and Goal 6 (data-driven decision making). People were less likely to see alignment with Goal 5 (transportation). How much do you agree with the results, and why? What do you feel could be done to improve alignment where it's needed?



15. What types of modifications or changes would you like to see for the next iteration of the Olmstead Plan, either in terms of how it's structured, updated, or implemented?

Closing

16. What other final comments, thoughts, or feedback would you like to share about the Olmstead Plan and efforts connected to the Plan?

Workgroup Member Focus Group

Introductions

To get started, I'd love to know who's in the focus groups. Please share your name, your organization, and which Olmstead Plan workgroup(s) you are involved with currently.

Overall Olmstead Plan

The first few questions are about the Olmstead Plan in general.

1. What word comes to mind when you think of the Olmstead Plan?

2. What successes, improvements, or impacts have you noticed as a result of or through Nebraska's Olmstead Plan? (Probes: better collaboration, changes to programs or state efforts, increased awareness, etc.)

3. What are some of the facilitators to advancing the Olmstead Plan in Nebraska? In other words, what's helping workgroups and agencies find successes and wins?

4. Conversely, what are some of the barriers or challenges with the Olmstead Plan? (Probes: are objectives too lofty? Lack of funding or alignment or leadership?)

Collaboration & Coordination

5. Thinking about collaboration within the Olmstead Plan workgroups that you're a part of and also the partnerships with other workgroups, how would you describe the collaboration for implementing the Olmstead Plan? What would you say is working well and where could improvements be made?

6. How would you define success or what does success look like with the Olmstead Plan? Consider the specific goal areas that you work in and also the plan overall.

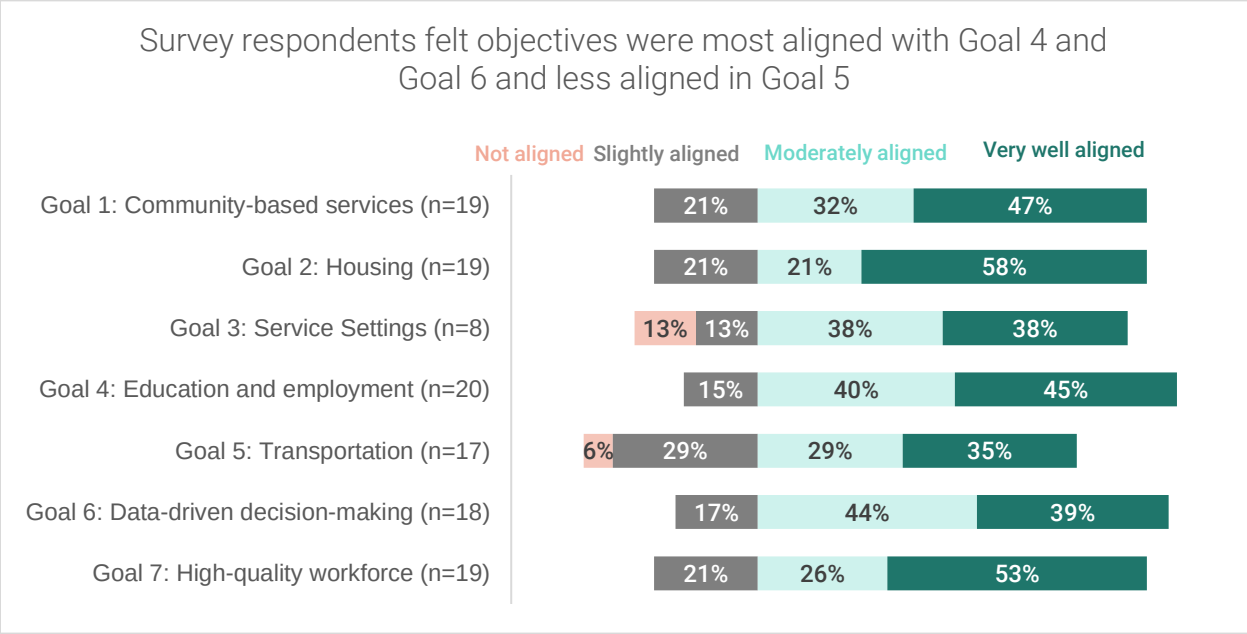
7. How well does the current workgroup meeting coordination and structure work? What would you say is working well and where could improvements be made? (Probes: is the quarterly frequency appropriate, is communication between meetings sufficient, are the number/diversity of workgroup members sufficient, etc.)

Olmstead Plan Structure

One way the Olmstead Plan was enhanced was creating metrics and activities within each of the goal areas. The next few questions are geared at getting feedback on those changes, in part to see what should remain or be modified for the next Olmstead Plan.

8. What's helpful about having the outcomes, benchmarks, and action items within each goal area?

9. On the partner survey, we asked people how aligned the outcomes/objectives with each goal area are. Based on the preliminary results, people felt the objectives were most aligned with Goal 4 (education and employment) and Goal 6 (data-driven decision making). People were less likely to see alignment with Goal 5 (transportation). What's your initial reaction to the preliminary results from the survey? Are you surprised by anything?



10. What would help improve the alignment of the outcomes/objectives, benchmarks, and action items for the goals?

11. What changes – to the formatting, language, content, etc. – would you change about the Olmstead Plan?

Closing

12. What other final comments, thoughts, or feedback would you like to share about the Olmstead Plan and efforts within the workgroup(s) that you are involved with currently?

Thank you for participating in this focus group! As I mentioned, your feedback will be combined with others to share in an aggregate report for the Division of Developmental Disabilities. We won't specifically list your name or organization with your response.

Appendix D: Key Informant Interview Protocol

Olmstead Alignment
The first few questions are about the Olmstead Plan in general.

1. How familiar are you with the Olmstead Plan? Is it something you work with or reference quite a bit, or moreso something you deal with occasionally?

2. How does the Olmstead Plan align or fit into work that your program or organization is already doing?

3. What would make the Olmstead Plan and related efforts more beneficial or meaningful for your organization? (*Probes*: incorporating certain goals into the Plan, ensuring workgroups are addressing certain goals within your organization, etc.).

Overall Olmstead Plan

4. What successes, improvements, or impacts have you noticed as a result of or through Nebraska's Olmstead Plan? (Probes: better collaboration among state agencies, policy changes, increased awareness, etc.)

5. How has the collaboration been in implementing the Olmstead Plan? In particular, what would you say is working well and where could improvements be made? (Probes: Consider communication or coordination with state partners, members in the workgroup you may participate in, etc.)

Goal Area(s)
The next set of questions are about the specific goal area(s) that you are involved with, either as a workgroup member or based on similar work your organization does. Based on our records, we'll be covering [insert goal areas] during the interview.

6. How would you define success within [insert goal area]?

7. What successes or key accomplishments have you seen related to [insert goal area] the last few years?

8. What are some of the facilitators to advancing in [insert goal area] within Nebraska? In other words, what's helping Nebraska or the workgroup find successes and wins in that area?

9. Conversely, what are some of the barriers or challenges to addressing [insert goal area]?

Goal Content
[PIE shares screen] One way the Olmstead Plan was enhanced was creating metrics and activities within each of the goal areas. The next few questions are geared at getting feedback on those changes, in part to see what should remain or be modified for the next Olmstead Plan.

10. How aligned or appropriate do the outcomes seem for [insert goal area]? What changes, if any, would you suggest?

11. Your organization is asked to supply data for ## outcomes in the current Olmstead Plan. What's that process like for your organization? (*Probes*: is it time consuming, is it data your agency already has readily available or uses anyway, are there outcomes that might be more appropriate from your organization?)

12. We won't go through all the benchmarks and action items, but on the whole, how do those seem to align with [insert goal area]? What changes, if any, would you suggest?

13. What other changes – to the formatting, language, content, etc. – would you change about the Olmstead Plan?

14. Do you have any other final comments, thoughts, or feedback about the Olmstead Plan?

Thank you for participating in this interview! As I mentioned, your feedback will be combined with others to share in an aggregate report for the Division of Developmental Disabilities. We won't specifically list your name or organization with your response.

Appendix E: Other State Olmstead Plans

Below is a list of the documents that were reviewed related to Olmstead Plans from other states.

State	Document Reviewed	Plan Duration	Include in Analysis?
Arizona	Plan	Not specified - living document	**Yes**
Colorado	Plan	Not specified (2014 update)	**Yes**
Delaware	Settlement Agreement Progress Report	N/A	**Yes**
District of Columbia	Plan	2021 - 2024 (4 years)	**Yes**
Georgia	Plan	Not specified	**Yes**
Illinois	Implementation Plans for Consent Decrees	Annual Plans ▪ Colbert - FY23 ▪ Ligas - FY24	**Yes**
Iowa	Plan	2016 - 2020 (5 years)	**Yes**
Kentucky	Olmstead Compliance Plan	Not specified (2019 update)	**Yes**
Maine	Plan	Not specified (2016 update)	**Yes**
Massachusetts	Plan	Not specified (2018 update)	**Yes**
Minnesota	Plan	Seems to be annual (2022)	**Yes**
Missouri	Strategic Plan	2023 - 2027 (5 years)	**Yes**
Nevada	Plan Presentation	2023 - 2028 (6 years)	**Yes**
New Jersey	Plan	Not specified (2007 update)	**No** - outlines transition plan, not goals
New York	Report and Recommendations of Olmstead Cabinet	Not specified (2013 update)	**Yes**
North Carolina	Plan	2024 - 2025	**Yes**
North Dakota	Plan	Not specified (2021 update)	**Yes**
Ohio	PIE Interview Notes		**Yes**
Oklahoma	Olmstead Strategic Plan	Not specified (2006 update)	**Yes**
Pennsylvania	Plan	Not specified (2016 update)	**Yes**
Texas	Plan	Not specified (2022 update)	**Yes**
Vermont	Plan	Not specified (2006 update)	**Yes**
Virginia	Plan	Not specified (2014 update)	**Yes**
Washington	Plan	Not specified (2019 update)	**No -** overview of services and activities by agency
West Virginia	Plan Update	Not specified (2020 update)	**Yes**

Brain Injury Assistance Act

ANNUAL REPORT

Key Highlights from the Brain Injury Association of Nebraska for Fiscal Year 2024-2025

BRAIN INJURY ASSOCIATION OF NEBRASKA

Partners for Insightful Evaluation

Brain Injury Assistance Act

The Brain Injury Assistance Act – known as the Brain Injury Trust Fund Act until 2022[1] – allocates $500,000 each year from the Nebraska Health Care Cash Fund. Although a portion of that funding is provided to the University of Nebraska Medical Center to coordinate efforts with a Brain Injury Oversight Committee, the remaining funds are awarded to an entity that to address seven expenditure priorities[2]:

The Brain Injury Association of Nebraska (BIA-NE) has received the Brain Injury Assistance Act funding each year.

- Year 1: July 2021 – June 2022
- Year 2: July 2022 – June 2023
- Year 3: July 2023 – June 2024
- Year 4: July 2024 – June 2025

This report summarizes BIA-NE efforts in each of the seven priority expenditures, primarily focusing on work carried out during Year 4. As applicable or pertinent, data from previous years is included in the report to show trends.

The evaluation is conducted by Partners for Insightful Evaluation (PIE), with bi-annual reports developed for the Brain Injury Oversight Committee and public.

[1] Legislative Bill 914 https://nebraskalegislature.gov/FloorDocs/107/PDF/Slip/LB971.pdf
[2] Legislative Bill 418 https://nebraskalegislature.gov/FloorDocs/106/PDF/Slip/LB481.pdf

PRIORITY 1
Resource Facilitation

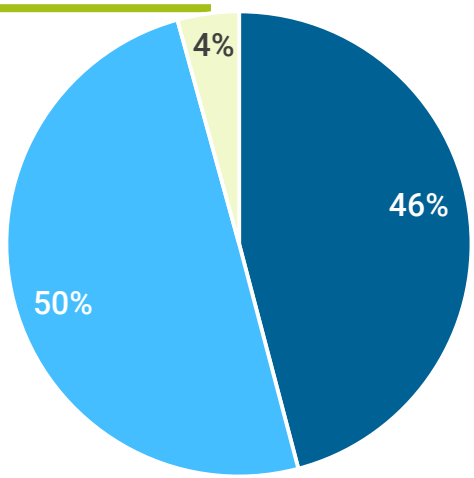
Resource Facilitation is a free service through the Brain Injury Association of Nebraska (BIA-NE). Resource Facilitators provide support, resources, and referrals to 1) individuals with brain injury; 2) family members and caregivers; and/or 3) health care or other social service professionals related to brain injury.

Services Provided

Among the three types of Resource Facilitation service levels, half of those served between July 1, 2024 and June 30, 2025 were Information & Referral (n=584)[3]

Professional Consult
This reflects support that Resource Facilitators provide to professionals to assist their clients or patients.

- **25 professionals received resources, support or referrals during the FY**
- **Professionals were from 8 different counties in Nebraska while 3 were out of state**



Case Management (CM)
An intensive level of support where the Resource Facilitator helps develop a personalized plan for the client. These are generally individuals that need ongoing support rather than just resources or referrals.

Information & Referral (I&R)
Engagement focused on providing resources and referrals without doing a full client intake; may be one call or up to six interactions.

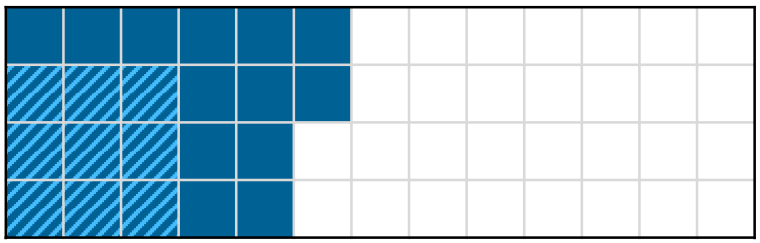
492

unique individuals were served through I&R and Case Management[4]

About 5% (n=22) were non-professional support individuals to the person with a brain injury

On average, among the cases that were completed during the year...

CM cases (n=208) were 22.4 weeks | **I&R cases (n=270) were 9.5 weeks**

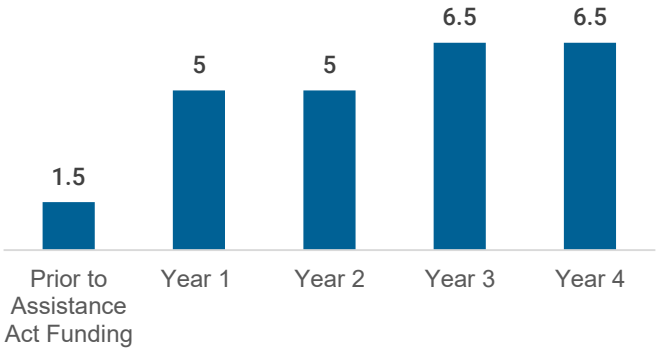


Each square represents one week in a year

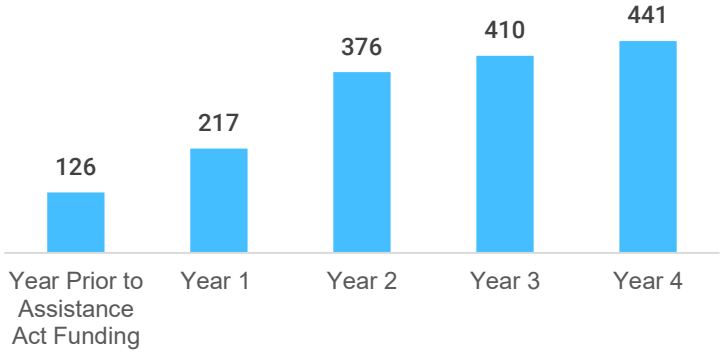
[3] This includes any clients who were actively served July 1, 2024 and June 30, 2025. It includes those who started a case during the year as well as those who started a case prior to July 2024 and were still receiving services during the funding period. Case open and closure is up to the Resource Facilitator based on guidance provided to staff.
[4] This is the total of unique individuals served. Some graphs included in the report will have less than 315, likely indicating information is missing for some clients. Other graphs may have more than 315. That indicates the graph is related to cases rather than clients, as an individual may have been served more than once during the time period.

Resource Facilitation Capacity

The number of full-time equivalents (FTEs) had quadrupled through the Assistance Act dollars[5]



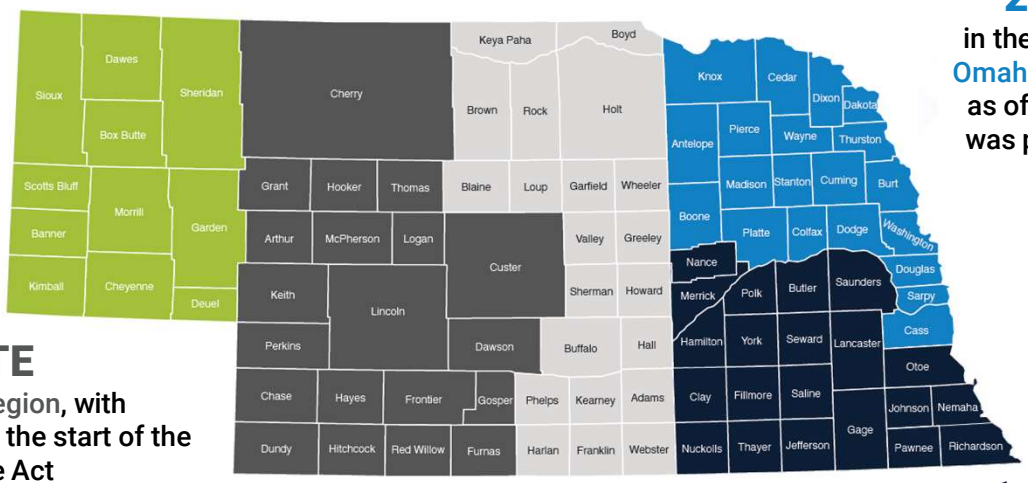
The number of CM and I&R cases started each year has grown in relation to the BIA-NE's capacity[6]



The geographic locations of clients served during the year varied, in part based on the capacity of Resource Facilitation in that region (n=502)[7,8]

.5 FTE
in the Panhandle though was 1 FTE for part of Year 2

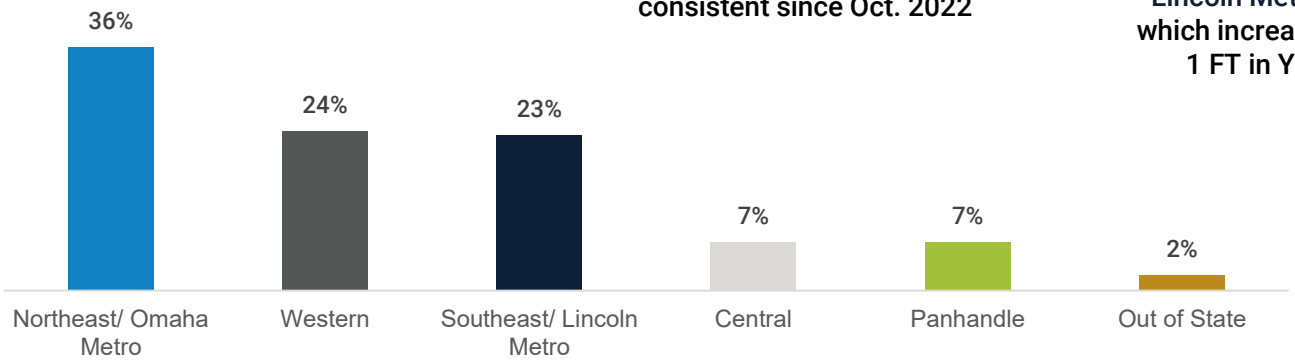
2 FTEs
in the Northeast/ Omaha Metro area as of Aug. 2023; was previously 1 FTE[9]



1.5 FTE
in the Western region, with consistent staff since the start of the Assistance Act

1 FTE
in the Central region, with staff consistent since Oct. 2022

1.5 FTE
in the Southeast/ Lincoln Metro area, which increased from 1 FT in Year 4

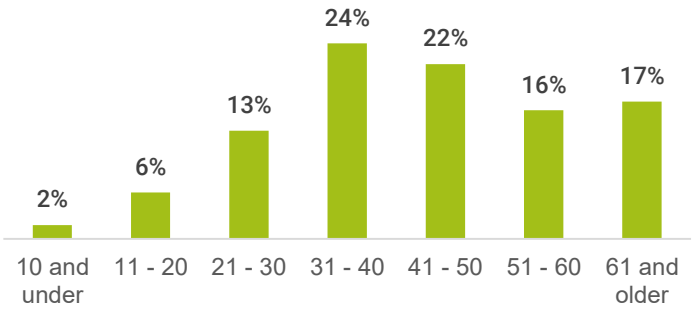


[5] This is the number of designated of FTEs each year. Throughout the year there may have been staff vacancies.
[6] BIA-NE started using a new database in January 2023, which made the tracking of services more accurate. This graph reflects cases that started during that fiscal year, so the actual caseload may be higher in a given year.
[7] Two Resource Facilitators in the western region work directly with the Lincoln County Jail, which results in several clients being served specifically in Lincoln county.
[8] Of the out of state clients, two were from Iowa, and one each from South Dakota, Kansas, and Missouri.
[9] One staff member in the Northeast/Omaha region is primarily dedicated to special projects. Although they will have a small RF caseload, most of their work is more targeted, such as working with juvenile justice centers.

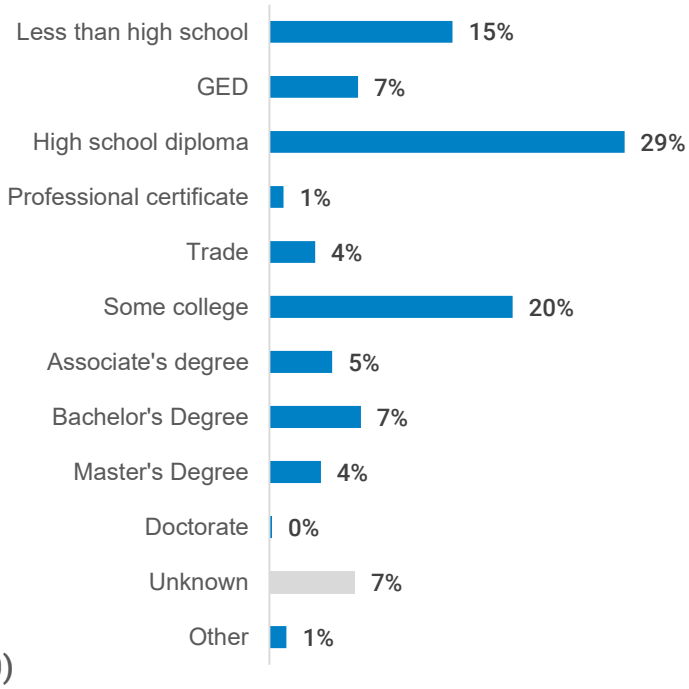
Demographics of Clients Served[10]

48.5% male  50.5% female [11]

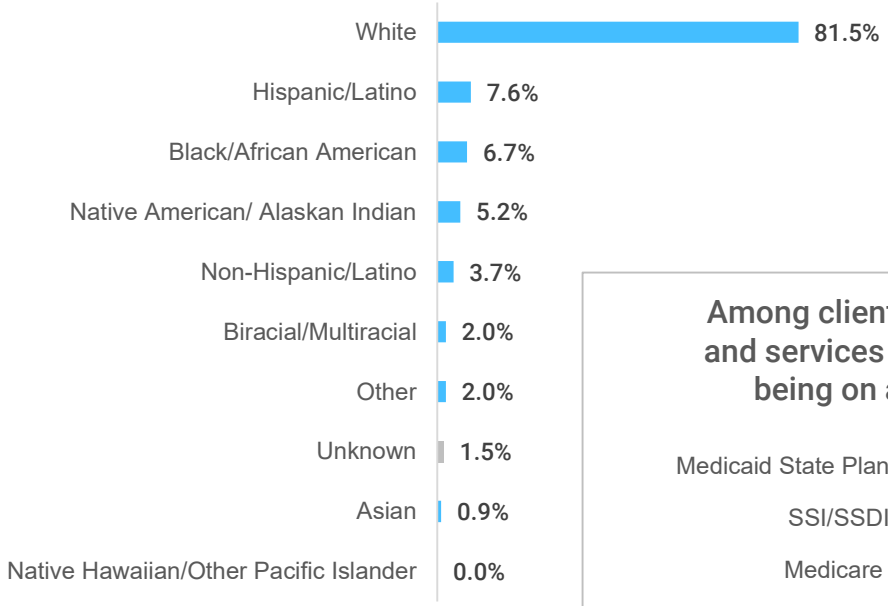
Individuals with brain injury were between the ages of 4 and 85, with the average age being 43 (n=469)



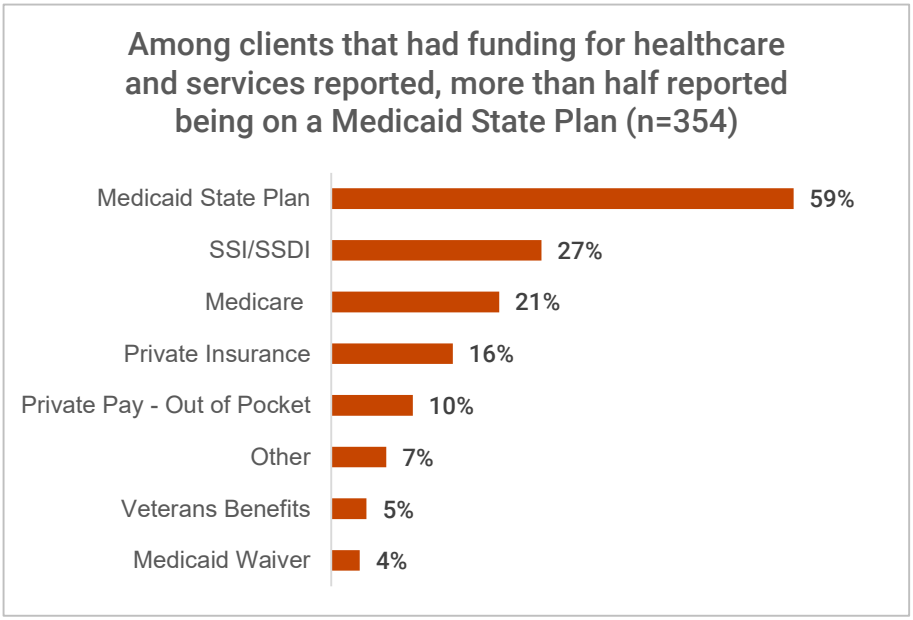
Half the clients served have a high school diploma or less (n=434)



A majority of the clients served were white (n=460)



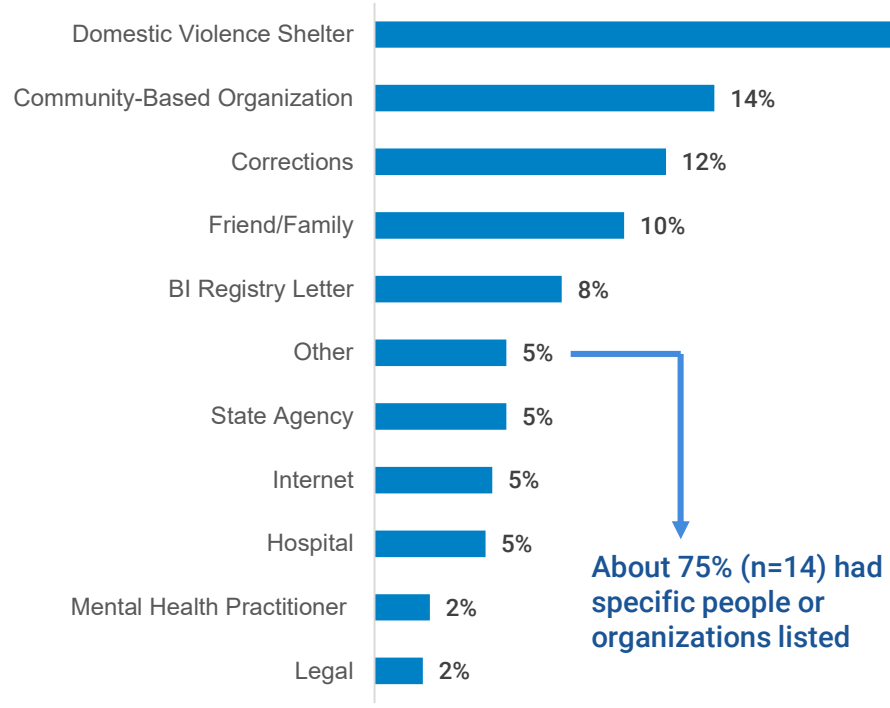
Among clients that had funding for healthcare and services reported, more than half reported being on a Medicaid State Plan (n=354)



[10] An "unknown" response among any of the demographic data elements indicates the Resource Facilitator did not ask the client. A client may also refuse to disclose, which is a separate response option.
[11] The remaining 0.8% were for "unknown" and "other" responses.

Hearing About BIA-NE[12]

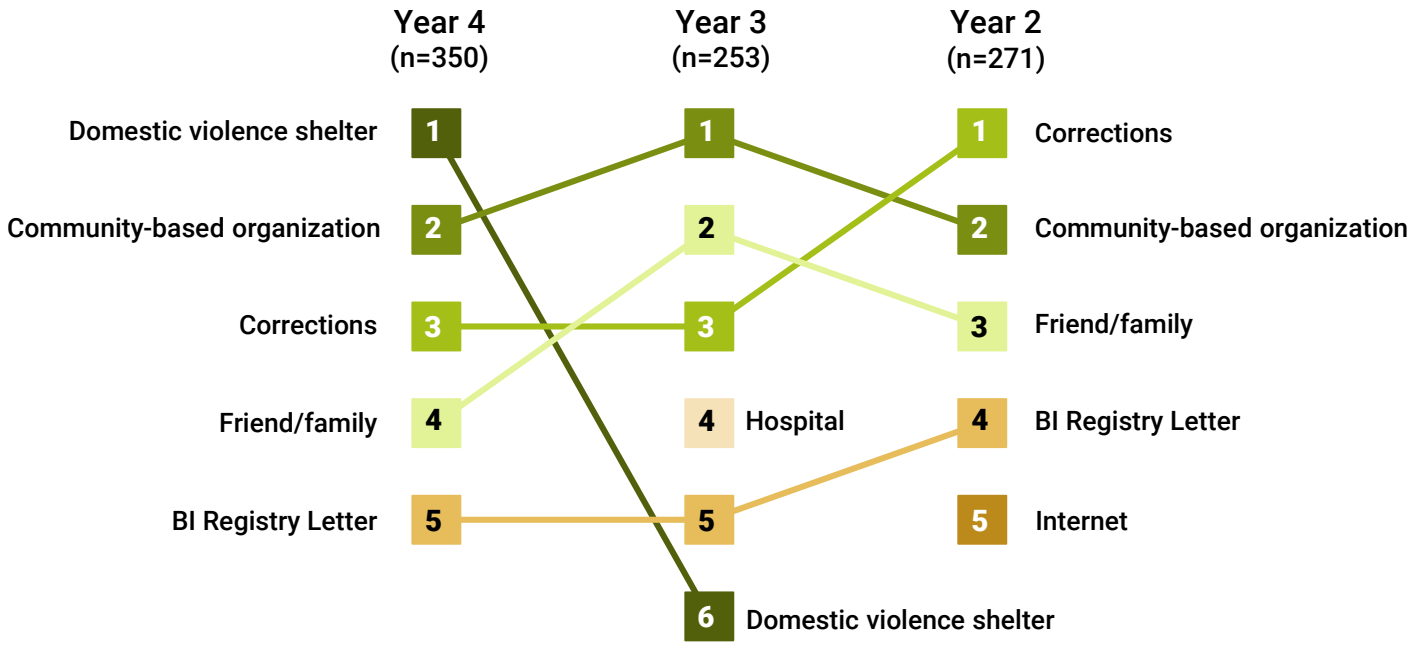
Domestic violence shelters were the most common source people found out about the BIA-NE during the year (n=350)[13]



BIA-NE saw an increase in referrals from DV programs because they are participating in a National Institutes of Health (NIH) grant with the University of Nebraska Medical Center, which has DV programs screening clients and referring them to BIA if the client is interested in receiving services

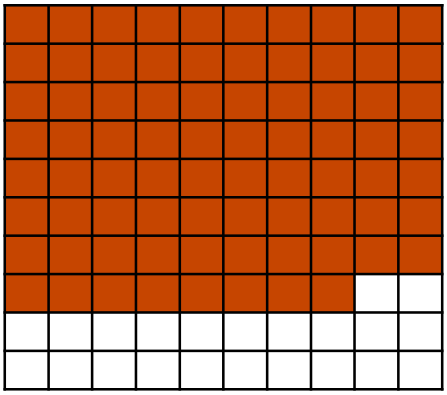
About 75% (n=14) had specific people or organizations listed

How people most commonly hear about the BIA-NE has been consistent the last three years, with the top five generally including community-based organizations, corrections, and the BI Registry letter



[12] Data is based on the date of the inbound referral. This will include any individual (regardless of whether they received Information & Referral or Case Management services) that was referred to BIA-NE between July 1, 2024 and June 30, 2025. It would not reflect clients served during this fiscal year that were referred to BIA prior to July 1, 2024.

[13] The following accounted for 1% of the inbound referrals: Aging & Disability Resource Center, Agency on Aging, Media - Social Media, Personal Professional Contact, Support Group, and Veteran's Affairs.



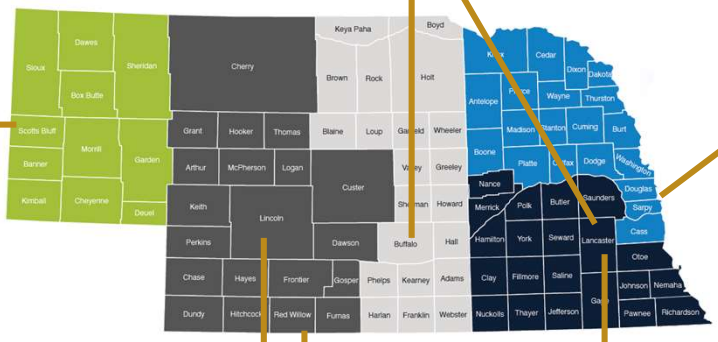
78%

of all inbound referrals during the year had a specific organization listed for how the individual heard about BIA-NE

Clients were referred to BIA-NE by at least

81

different organizations



3 Nebraska Vocational Rehabilitation (9%, n=24)

5 The Doves Program (4%, n=10)

1 Women's Center for Advancement (12% n=34)

3 Heartland Housing Sanctuary (9%, n=24)

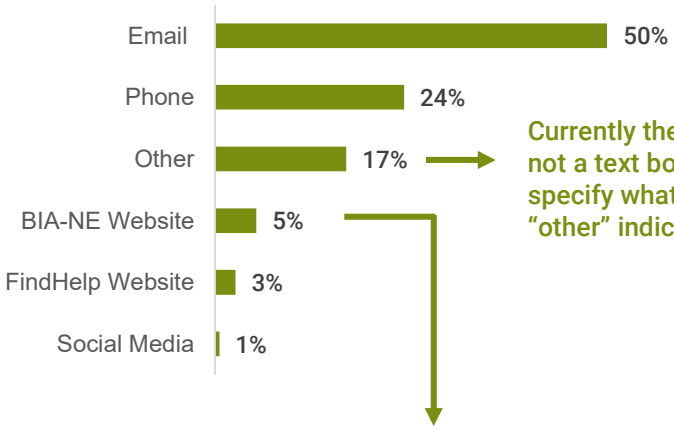
4 Heartland Family Service (7%, n=19)

2 Lincoln County Sheriff's Office and Detention Center (10%, n=28)

6 The Bridge Behavioral Health (3%, n=9)

6 Red Willow County Sheriff Department (3%, n=8)

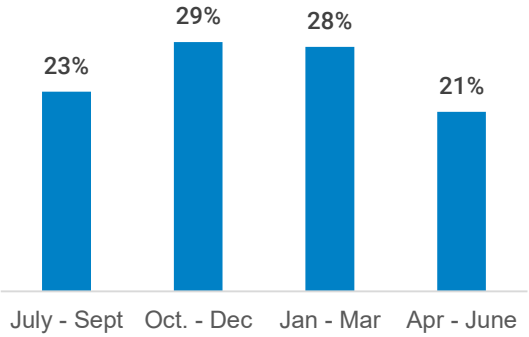
Half of the inbound referrals to the BIA-NE were via email (n=338)



Currently there is not a text box to specify what "other" indicates

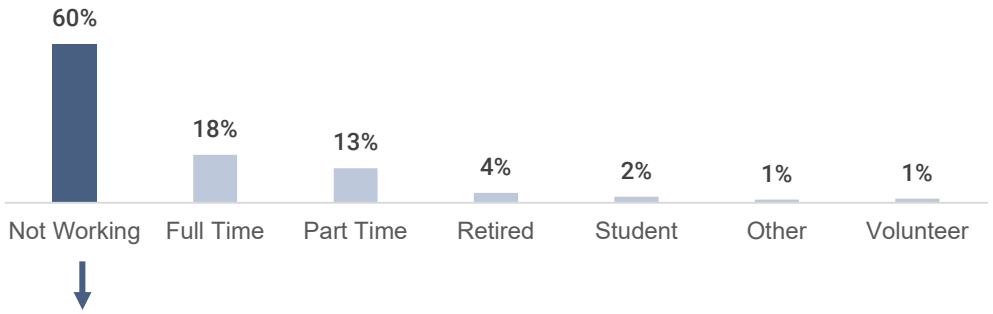
It is anticipated this will increase over time. In April 2025, BIA-NE transitioned to using a form on their website as a key entry point. This allows the staff to capture preliminary information about the client to more effectively and efficiently meet their needs. It also allows professionals and family members/caregivers to connect the BIA-NE to the individual with a brain injury.

Inbound referrals were slightly more likely to occur during the winter months (n=350)



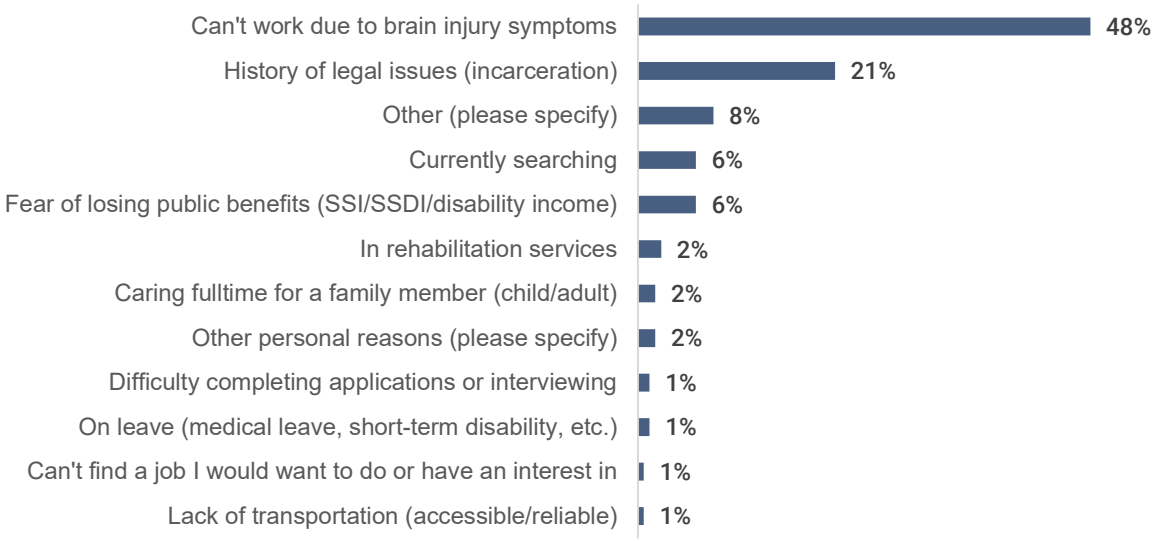
Employment

More than half the clients who began a Resource Facilitation case in the past year had an employment record of "not working" (n=269)[14]



of the individuals served through I&R or CM this fiscal year had a record of not working in the database

Nearly half have that they are unable to work due to brain injury symptoms reported as the reason for not working (n=161)[15]



Among the needs documented during the fiscal year among clients who have a record of not working in the database (487 needs among 178 unique individuals) Brain Injury 101 and Financial were the top areas needing to be addressed for clients

High Needs

- Brain Injury 101 (40%)
- Financial (25%)

Moderate Needs (10-15%)

- Legal (Other)
- Personal Support System (Support Groups)
- Housing (Search)
- Mental Health
- Health Insurance/Long Term Care
- Executive Functioning/Organization Skills
- Employment (Job Search / Modification / Maintenance)

Slight Needs (6-9%)

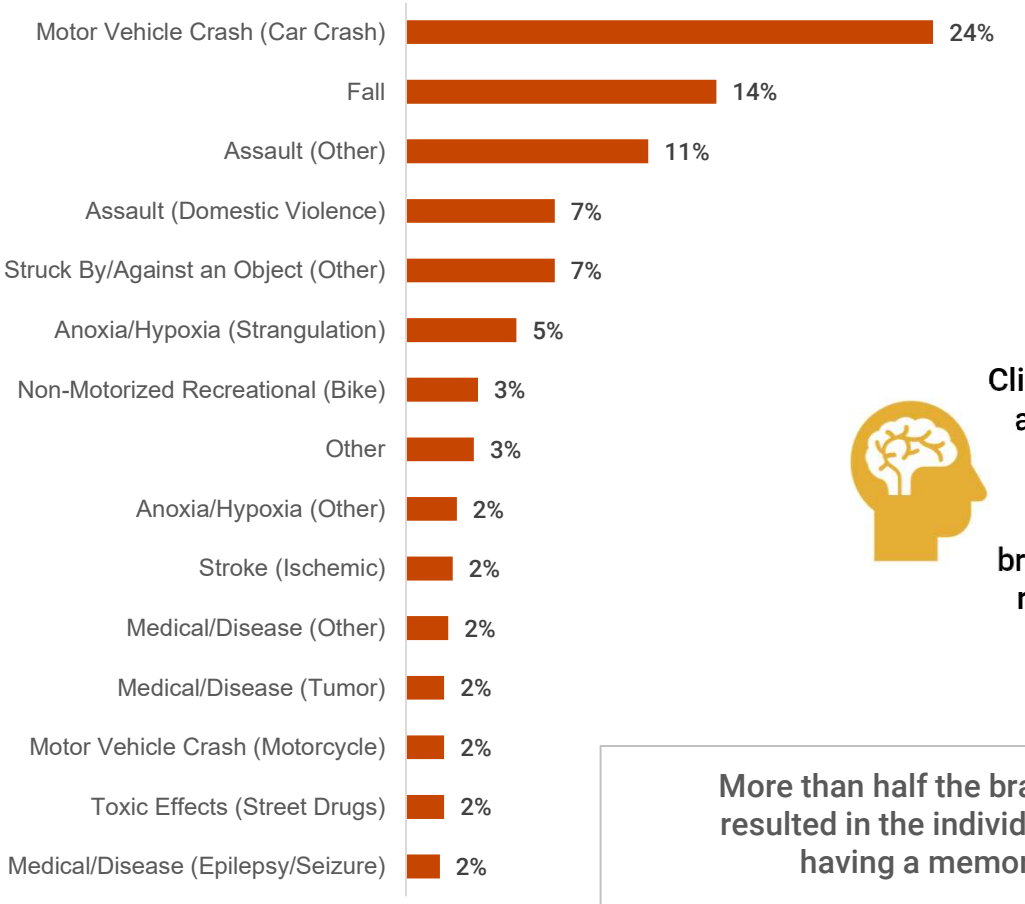
- Personal Support System (Professionals)
- Food Security / Nutrition Support
- Housing (Financial Assistance)
- Transportation
- Physical Health (Vision)
- Substance Use Treatment/Support
- Housing (Stability)

[14] Due to how data elements are tracked (on a contact page versus a case page), there are two key caveats with the employment data. One, it only reflects clients who started receiving services between July 1, 2024 and June 30, 2025.That reflets about Second, the employment record may not reflect their employment during that time period, if the data is even available. That information is updated as able by staff primarily for case management clients. This employment data reflects information from about 300 of the 492 (~61%) served during the fiscal year.

[15] Can't work due to brain injury symptoms may include noise sensitivity, light sensitivity, not getting or having accommodations, etc. This is based on discussion between the client and Resource Facilitator.

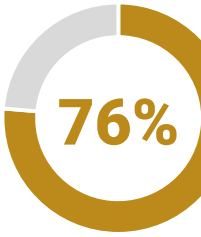
Injury Details[16]

Among 527 injuries documented for 283 clients, car crash, fall, and assault (other) accounted for slightly less than half of the injuries[17]



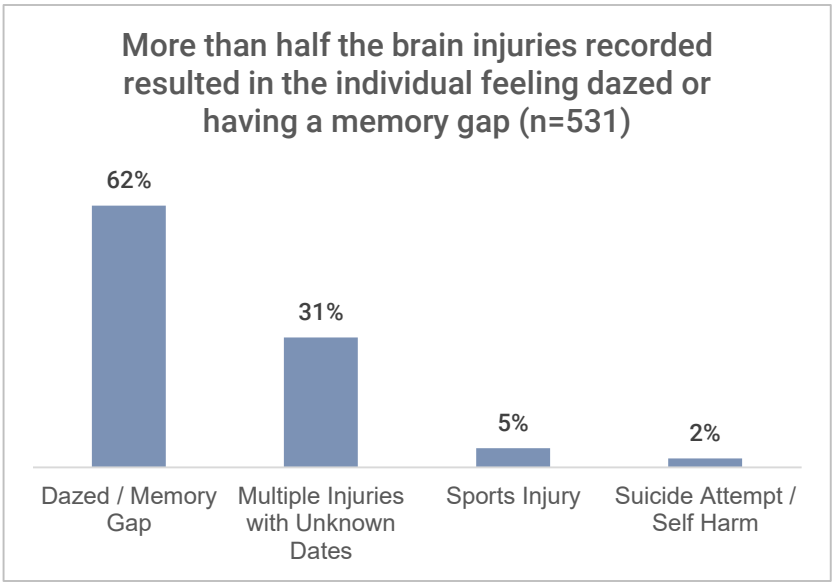
The average age at time of injury for those reporting car crash was 29

Clients had an average of **1.8** brain injuries reported[18]



of the injuries with a classification were considered TBI; the remaining were non-TBIs (n=503)

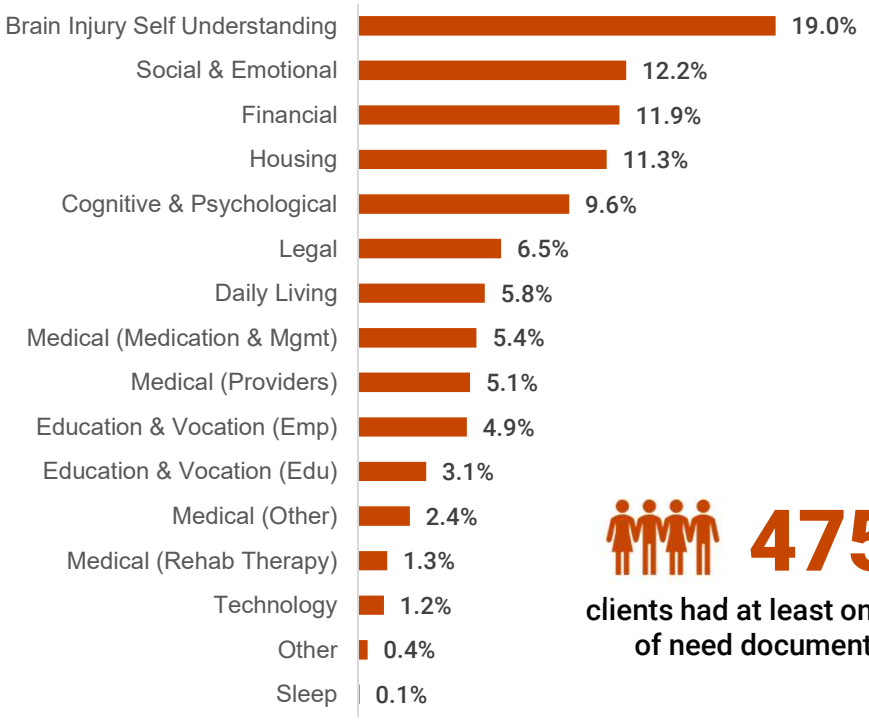
More than half the brain injuries recorded resulted in the individual feeling dazed or having a memory gap (n=531)



[16] Injury information is reported for the clients that were actively served from July 1, 2024 through June 30, 2025. The types of injury include up to 48 causes, which aligns with other states that utilize SalesForce to track services.
[17] The following causes were reported less than 2%: Assault (Abusive Head Trauma/Shaken Baby Syndrome); Stroke (CVA) Stroke (Hemorrhagic); Blast Injuries/Explosion; Gunshot; Motor Vehicle Crash (Other); Struck By/Against an Object (Pedestrian); Anoxia/Hypoxia (Near Drowning); Toxic Effects (Chemical Exposure); Anoxia/Hypoxia (Opioid Overdose); Motorized Recreational (ATV); Toxic Effects (Other); Mechanism Unknown; Medical/Disease (Meningitis); Medical/Disease (MS); Non-Motorized Recreational (Horseback); Medical Interventions (ECT Treatment); Medical Interventions (Other); Motorized Recreational (Other); Non-Motorized Recreational (Other); Non-Motorized Recreational (Skateboard); Stroke (TIA); and Toxic Effects (Alcohol).
[18] BIA-NE staff vary in the extent to which injury information is obtained from clients. While some may complete a brain injury screening tool to capture all potential injuries, others may document what the clients shares – particularly if a full intake is not being done, which is often the case for those who have Information & Referral cases.

Areas of Need Among Clients[19]

Among all the needs documented during the fiscal year that were assigned to one of 12 need categories, the most common was Brain Injury Self-Understanding (n=1356)



A Note About Needs

Areas of need are meant to describe what anyone – regardless of whether they've had a brain injury – need support with working through, understanding, or navigating. The goal for Resource Facilitators is not to identify every single need. The RF works with the client to prioritize what core needs may need to be addressed in the coming weeks, and that is what the staff will provide referrals, resources, and support around.

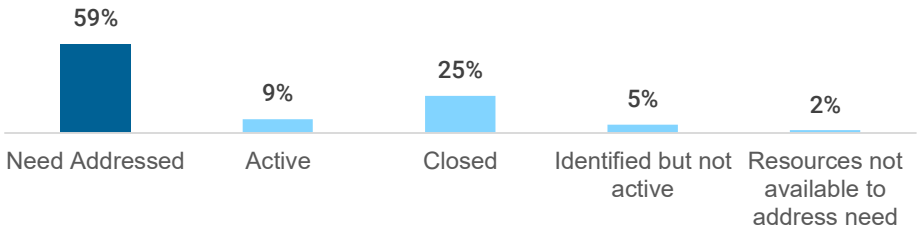
475

clients had at least one area of need documented

29%

of those clients (n=137) had 4 or more areas of need documented

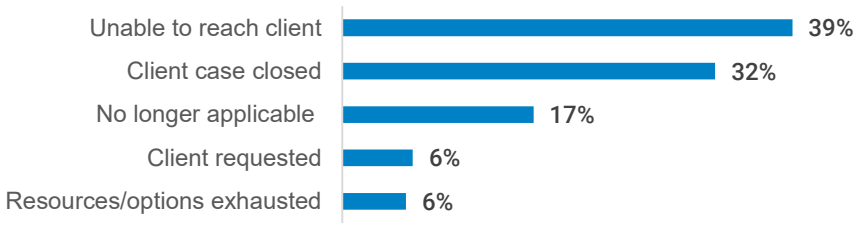
Nearly 60% of the needs identified were addressed by the Resource Facilitator, though some needs were still active (n=1361)



Of the 25 needs that could not be met…

- About one-fourth pertained to **housing** (cleanup, facility care, rent)
- Five categories reflected 12% each: education & vocational, financial, legal, medical, and social & emotional needs

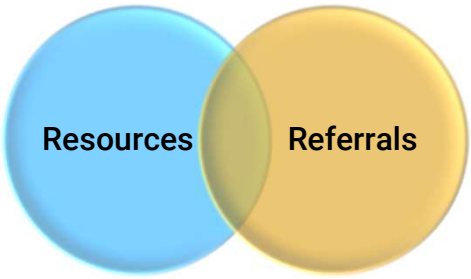
Among needs that weren't addressed, more than two-thirds were because staff could not reach the client or the case closed (n=343)



[19] For areas of need, Resource Facilitators write in a description of the need and categorize it from a list of 59 types of need. This list was revised in the spring of 2025 to be more descriptive of the types of needs experienced. Each category is defined in a reference document for staff and fall under 12 different categories of need.

Referrals & Resources[20]

These are informative or self-directed activities that clients can choose to use, such as websites, trainings, or handouts

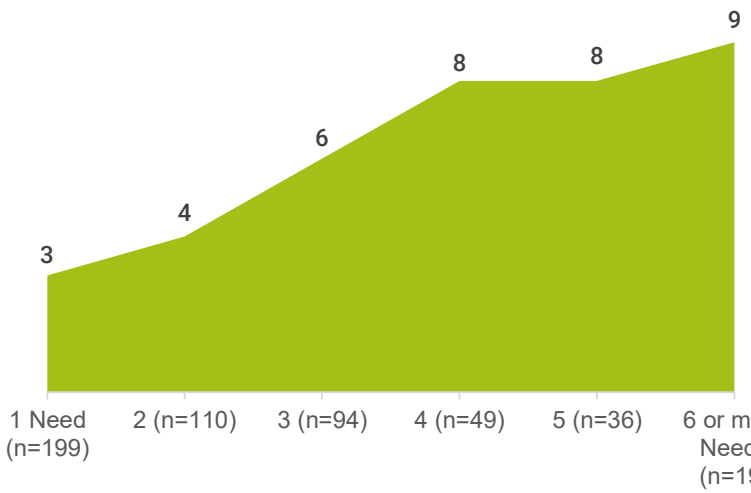


Referrals connect a client to a specific person or organization in which they can receive services or additional support.

1,715
resource shares were documented during the year

The most common resources were:
- BIA-NE Staff Verbal Support (226 shares)[21]
- Resource Facilitation Brochure (136 shares)
- A Guide to Working with Individuals with Brain Injury (114 shares)
- OBISSS Flyer (85 shares)
- Feeling Different After a BI / BI Symptoms Rack Card (79 shares)

The average number of referrals and resources provided during a case is relative to the number of needs identified for the client (n=507 cases)



A Note About Resources

BIA-NE staff use the SalesForce database to resources to provide clients. During this fiscal year, each resource was 1) categorized based on the need categories to allow for more effective searching and 2) given an active link to ensure clients can always access the most recent version of any resource. By the end of the fiscal year, there were 355 active resources in the Resource Library. Staff receive an email each week summarizing new resources that have been added.

Clients were referred to
268
different organizations

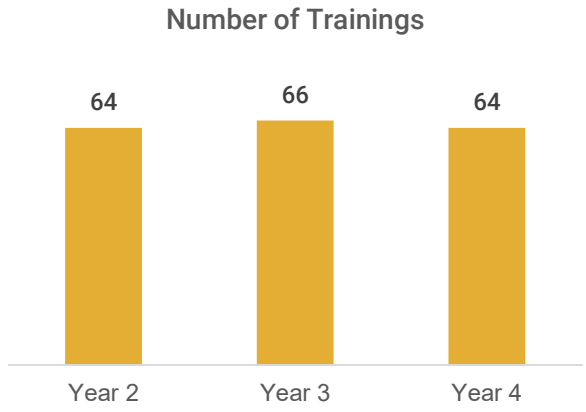
The most common organizations that clients were referred to included:
- Madonna Rehabilitation – Lincoln (23 referrals)
- Families 1st Partnership (19 referrals)
- Easterseals Nebraska (15 referrals)
- Nebraska Legal Aid (13 referrals)
- Nebraska Vocational Rehabilitation (13 referrals)
- Madonna Rehabilitation – Omaha (11 referrals)
- League of Human Dignity (10 referrals)
- Lutheran Family Services Headquarters (10 referrals)

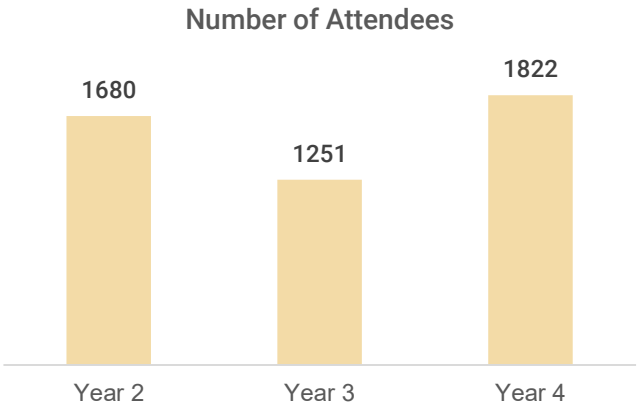
[20] Data on this page includes referrals and resources that were provided between July 1, 2024 and June 30, 2025 for greater accuracy. If a client started receiving services prior to July 1, 2024 (~40% of those served during the fiscal year), resources that were shared or any referrals provided before that date would not be included in this data.
[21] BIA-NE Staff Verbal Support describes assistance provided by staff members based on their expertise and/or experiences, such as social work, behavioral health, etc. This is not meant to capture general engagement with clients.

PRIORITY 2
Training for Service Providers

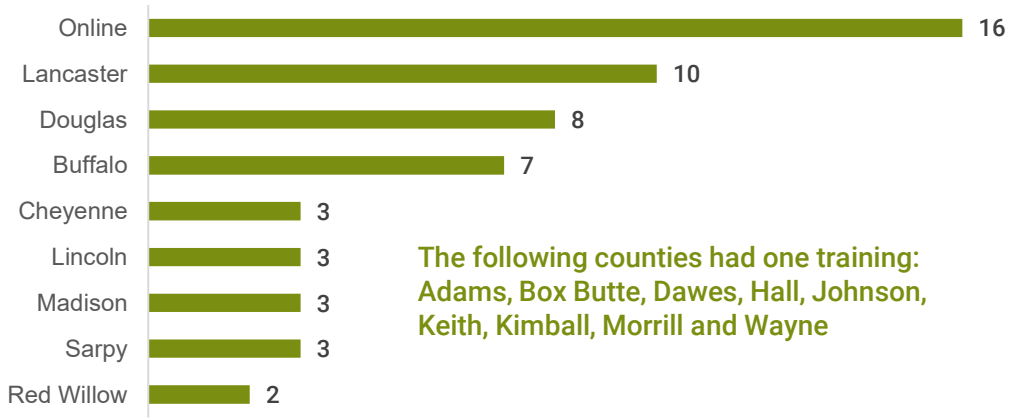
I enjoyed it all, but I do appreciate the parts that pertain to my role as a teacher.

BIA-NE has consistently offered BI 101 trainings, with more than 1,000 attendees each year





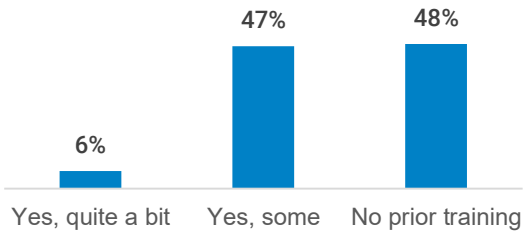
BI 101 Trainings were held in 17 counties (n=64)



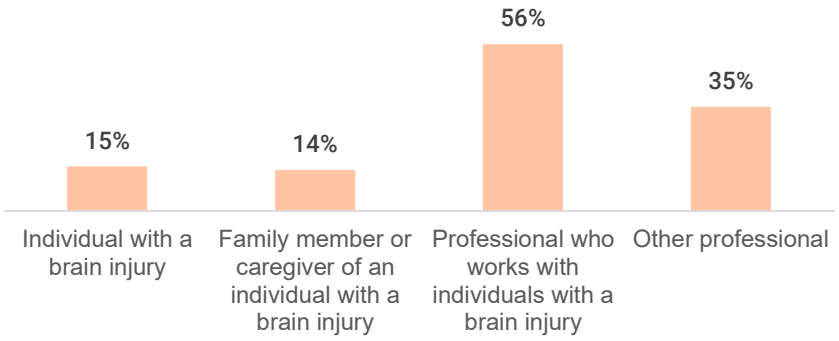
The following counties had one training: Adams, Box Butte, Dawes, Hall, Johnson, Keith, Kimball, Morrill and Wayne

268
evaluations were completed[22]

Nearly half indicated they had not previously attended a training or educational opportunity about brain injury (n=263)



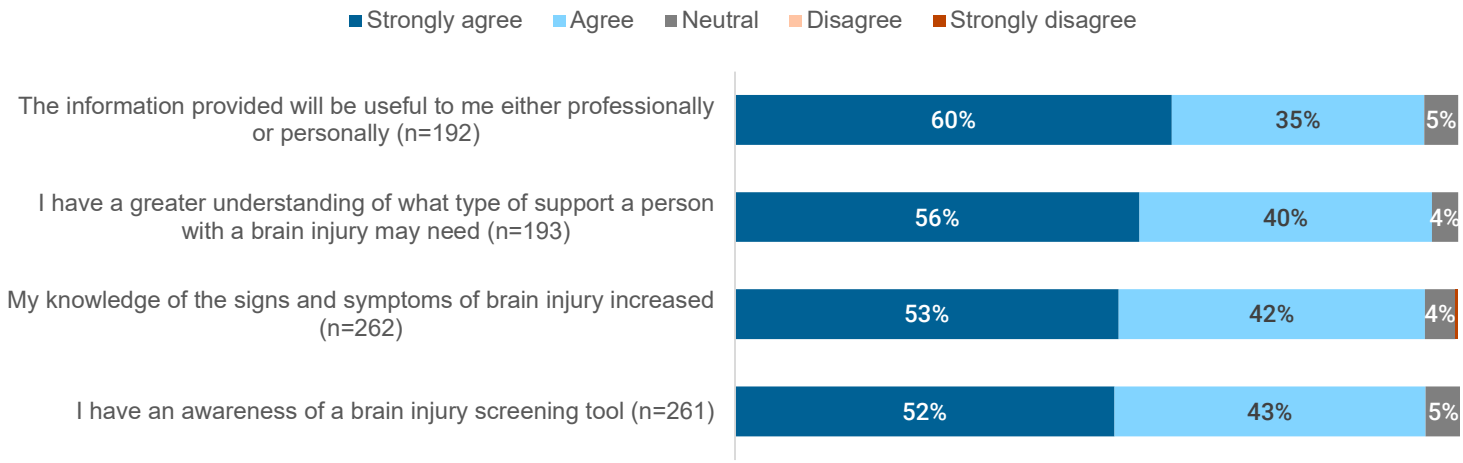
Although most were professionals, there were a portion that had experienced a brain injury or were a family member/caregiver to someone with a brain injury (n=260)[23]



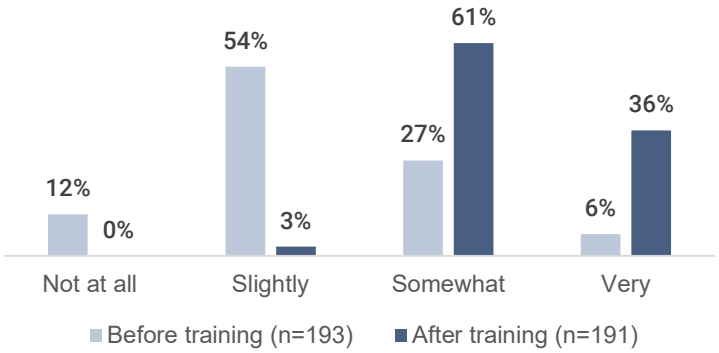
[22] The results include 73 evaluations that were done as part of a project with the DHHS Division of Behavioral Health (DBH). That survey was a pre/post survey with slightly different questions, so the number of responses on each graph may vary. Although various approaches are used to increase response rates – including QR codes within presentation slides and sending emails after the training – not all attendees complete the survey.

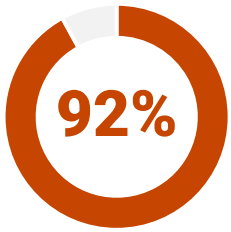
[23] A respondent could select more than one response option. That was the case for 42 of the respondents.

More than half strongly agreed with all the statements regarding the training[24]



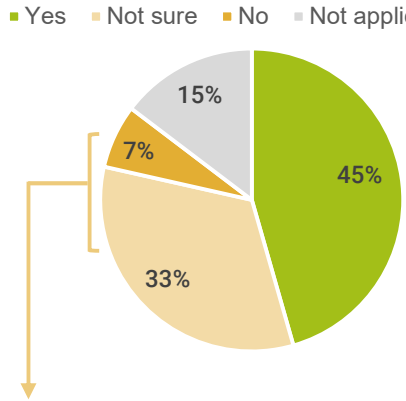
Nearly 80% of attendees reported an increase in knowledge about brain injury[25]





of those who had not previously attended a training on brain injury reported an increase in knowledge (n=97)

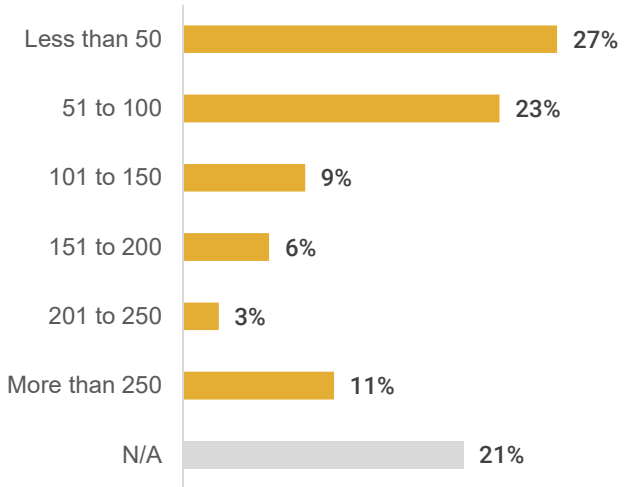
Nearly half indicated they will get a chance to use the brain injury screening tool (n=191)



Among 72 respondents who noted why they would not or weren't sure if they could use the screening tool:

- **43% reported they would need agency approval**
- **42% reported it is not their role in the agency**
- **24% reported they weren't sure when to use it**

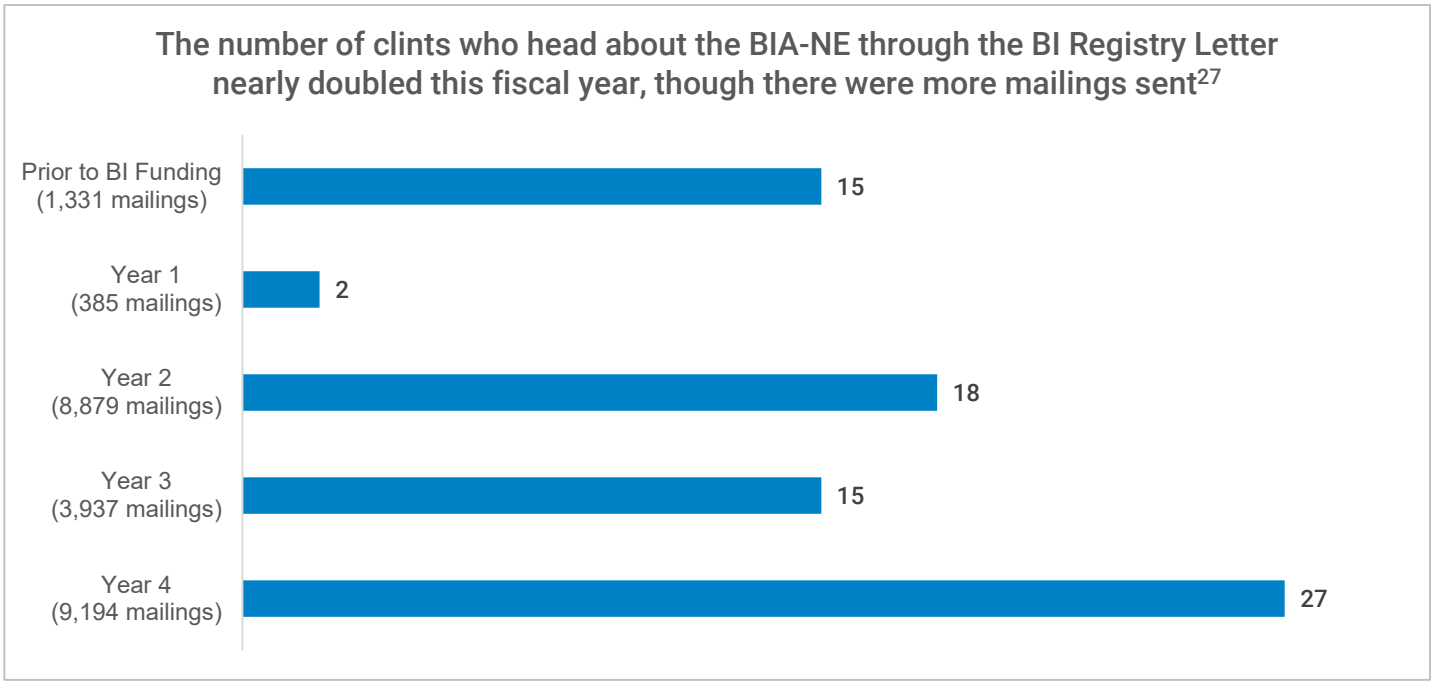
Half indicated they work with up to 100 clients or patients each year (n=190)

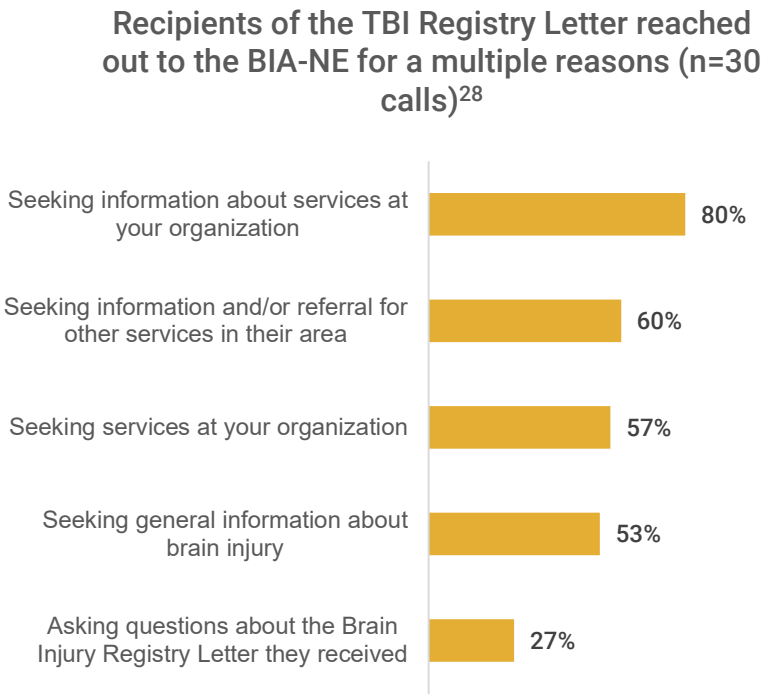


[24] The evaluation form was updated in December 2023 to include visual prompts in the likert scale to minimize the likelihood of people accidentally selecting "strongly disagree." Since then, only one participant has selected that response.
[25] These results do not include the 73 participants from the DBH project, as the evaluation form asked about knowledge after the training but not before. They were instead asked a series of 15 true or false statements.

PRIORITY 3

Brain Injury Registry Letter Follow-up[26]





[26] Information about the TBI Registry mailing can be found here: https://braininjury.nebraska.gov/resources/brain-injury-data-and-statistics.

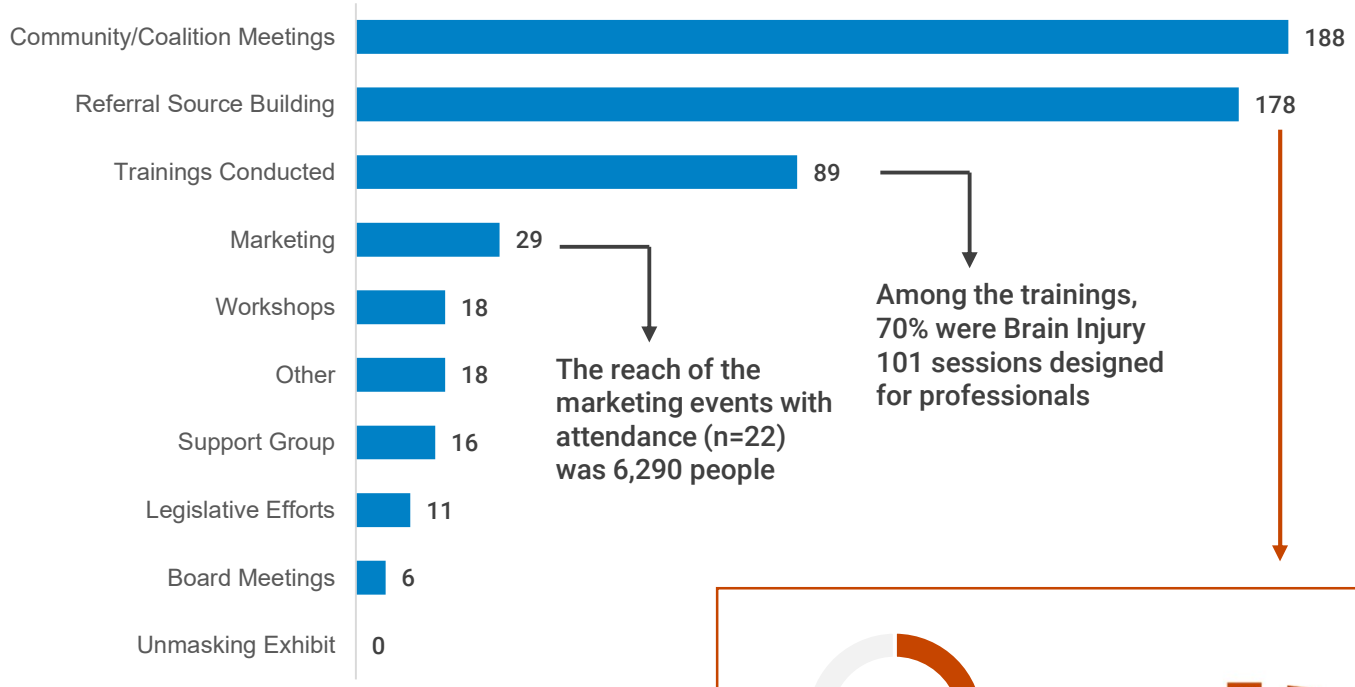
[27] Prior to January 2023, there were 30 response options for Resource Facilitators to select for how the client heard about BIA-NE, though only one option could be selected. That was modified in the new database so staff can select all that apply. As a result, it is possible that more people prior to January 2023 heard about the BIA-NE through the Registry letter.

[28] BIA-NE staff record information about calls they receive because of the BI Registry Letter through a survey for Nebraska VR. Staff have a prompt within their database to complete the form if they select that a client heard about the BIA-NE through the BI Registry Letter.

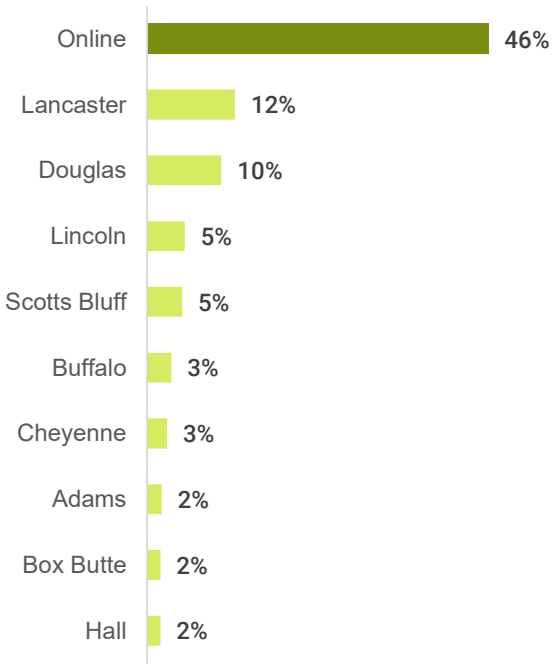
PRIORITY 4
Public Awareness

The intent of community outreach is to ensure people in need of services within various communities are aware of and can connect to BIA-NE.

More than 550 outreach events took place during the year (n=553)



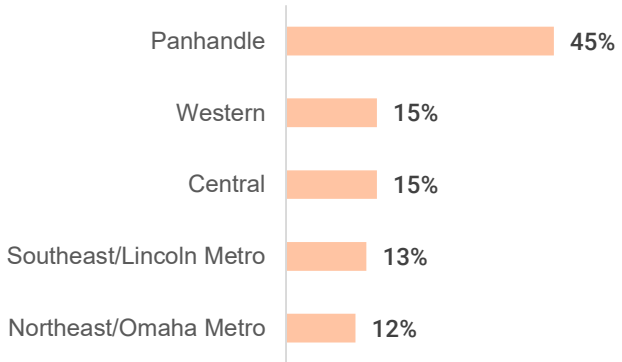
In-person events during this fiscal year took place in 31 counties in Nebraska (n=550)[29]



of the referral source building outreach were initial meetings for staff (n=172)

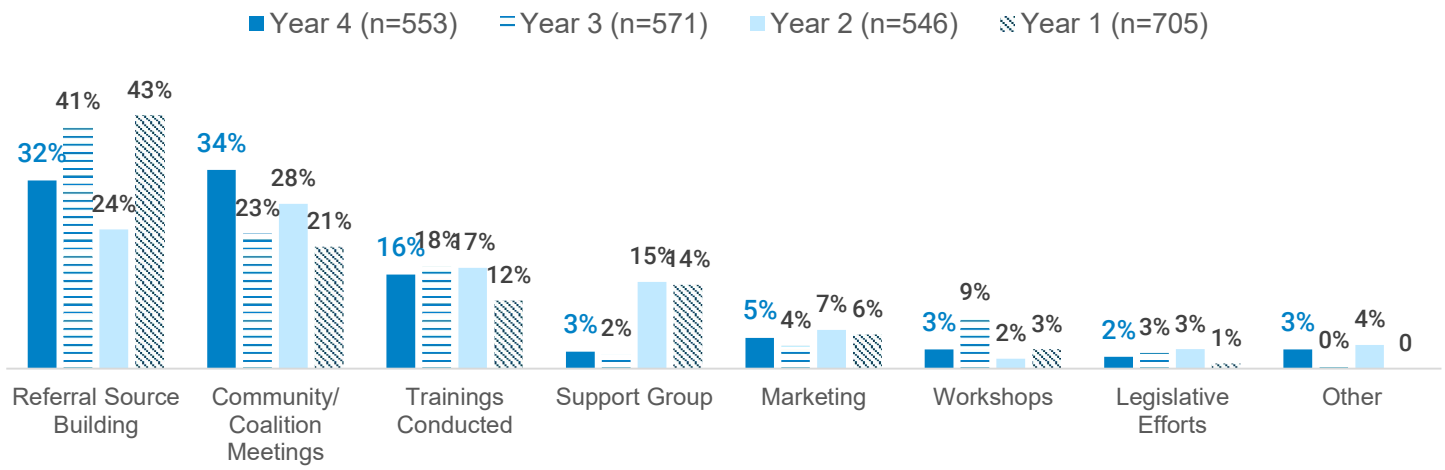
Staff met with **145** unique organizations

A majority of the referral source building event took place in the Panhandle region (n=112)

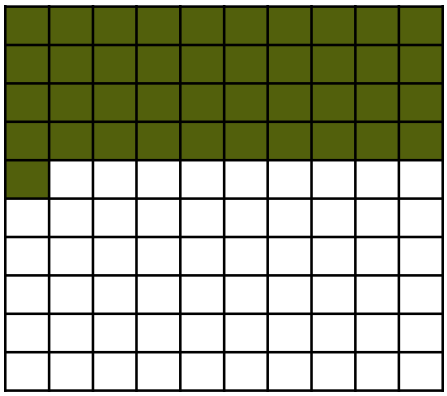


[29] Events were also held out of state (n=7) and in the following counites: Butler, Cherry, Dawes, Dawson, Dundy, Gage, Garden, Jefferson, Johnson, Keith, Kimball, Madison, Merrick, Morrill, Phelps, Platte, Red Willow, Sarpy, Saunders, Seward, Wayne, and York.

Referral source building and community/coalition meetings remain the most common types of community outreach for the BIA-NE



10,415
people receive BIA-NE emails

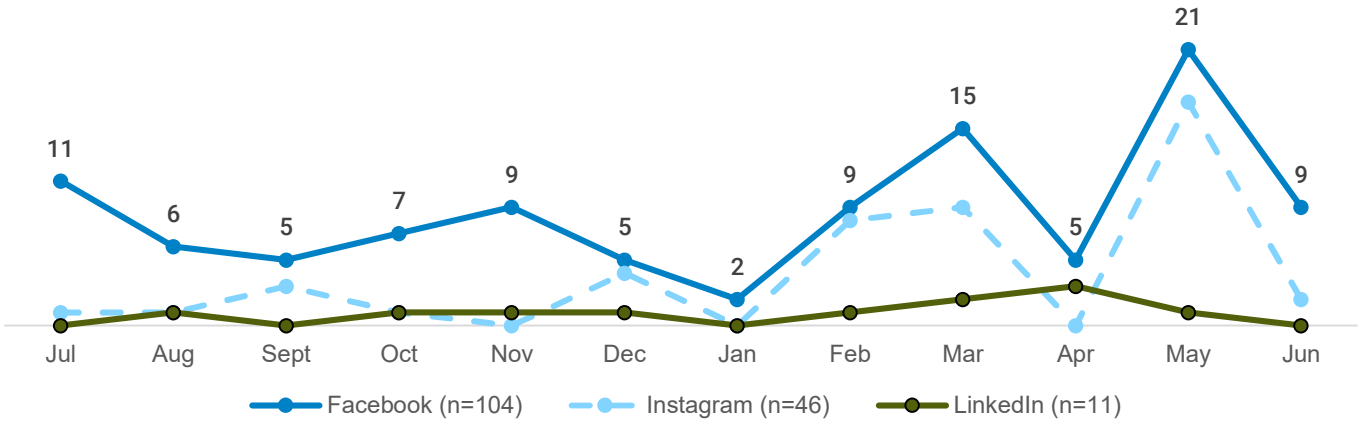


41% of people, on average, who received BIA-NE emails opened it

118
files were downloaded from the BIA-NE website

Top 5 Downloads:
- Annual Reports (33%)
- REAP: Concussion Management (27%)
- Behavioral Health (14%)
- Blazing Trails (12%)
- Courses & Trainings (8%)

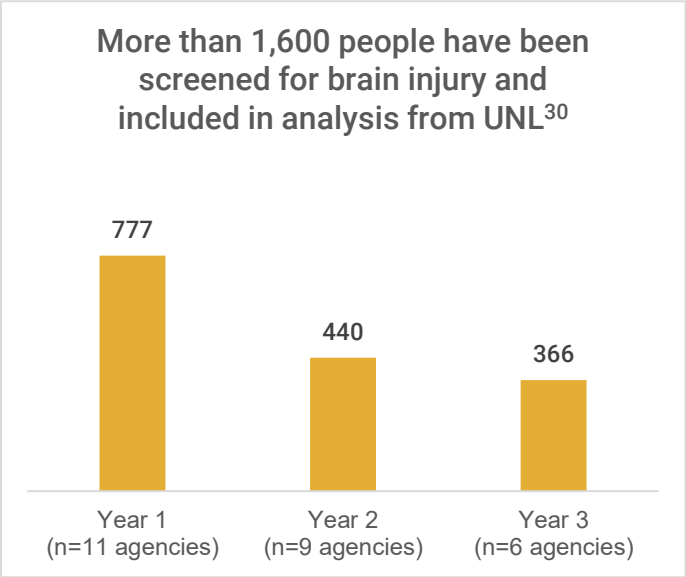
Most social media postings occur on Facebook, with the most popular months being May and March

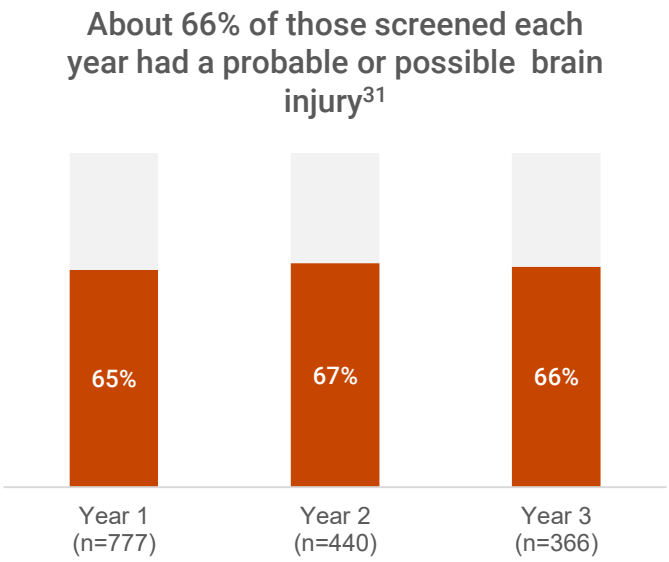


PRIORITY 5
Supporting Research

BIA-NA is collaborating with Dr. Kathy Chiou at the University of Nebraska – Lincoln. Dr. Chiou received IRB-approval to collect brain injury screening data. The goal is to explore the outcomes and prevalence rates to publish findings. A variety of screening tools have been used throughout the course of the research.

- **Up to 2023: HELPS screening tool**
- **Early-2023 through fall 2024: Modified Ohio State University (OSU) screening tool**
- **Fall 2024: Online Brain Injury Screening and Support System (OBISSS)**






Brain Injury Alliance Nebraska

Online Brain Injury Screening and Support System for Nebraska

What is the Online Brain Injury Screening and Support System (OBISSS)?
The OBISSS is an online screening system to determine lifetime exposure to brain injury and to identify associated challenges that may be present for youth and adults. This system utilizes the validated and reliable Ohio State University TBI-Identification Method (OSU TBI-ID).

OBISSS is self-administered and appropriate for ages 10 and up. With the link provided below, any individual can complete the OBISSS screen on their own, or with help. OBISSS collects additional demographic information from each individual, and the individual will be prompted to complete the Symptoms Questionnaire for Brain Injury (SQBI).

Tip sheets are delivered, responding to identified challenges, to the individual and a copy can be sent to case managers or providers. OBISSS will provide customized referral information and where to access additional resources and supports. OBISSS helps in the following ways:

Client Support:
- Identify a likely history of brain injuries.
- Identifies individual challenges and offers personalized strategies.
- Provides practical advice on supporting individuals with brain injury.

Data:
- Shares data on brain injury trends in screening settings.
- Adds to the national understanding of brain injury history.
- Improves brain injury programs and policies.

Is the OBISSS a public platform?
Only in the sense that you can share the link with anyone you are serving. NASHIA manages the OBISSS through a secure, HIPAA-compliant data platform.

Directing clients to OBISSS:
Share the link, log in information, and your email address with the individual who is completing the screener.

Direct the individual to add your email address to the first page when prompted.

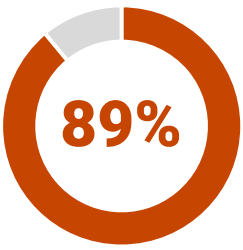
Review the emailed results.

Access OBISSS Now:
OBISSS Link: nashia.org/obisss
State: Nebraska
Password: 402

OBISSS is provided in partnership with:
NASHIA OBISSS — National Association of State Head Injury Administrators (NASHIA).

Questions?
Contact the Nebraska OBISSS Administrator:
Peggy Reisher, Executive Director, BIA-NE | peggy@biane.org | 402-890-0606

248
screenings have been completed through the OBISSS[32]



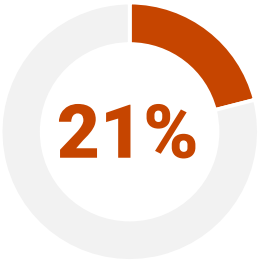
of the individuals had a probable or possible brain injury

[30] The counts in the figure are likely under-reported, as additional screenings may have been sent to UNL for that time period after reporting to the Brain Injury Oversight Committee.
[31] Although Resource Facilitators routinely use a brain injury screening tool, these results reflect those from organizations who were formally conducting screening with their clients – as noted in the figure to the left – to better understand the prevalence of brain injury among their populations.
[32] The OBISSS can be accessed at www.nashia.org/OBISSS with Nebraska as the state and 402 as the password. The use of OBISSS should increase opportunities for agencies to refer people to a brain injury screening tool, though it can also be completed independent of an organization.

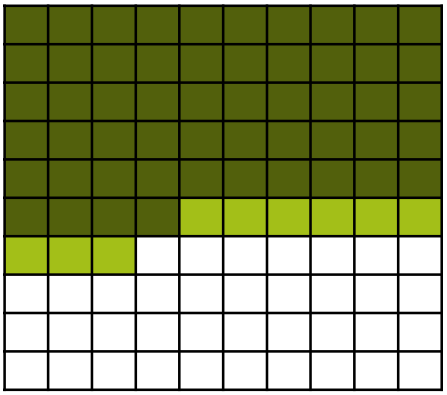
PRIORITY 6

Quality Improvement & Standards of Care

Screening BIA-NE Clients for Adverse Childhood Experiences (ACEs)[33]

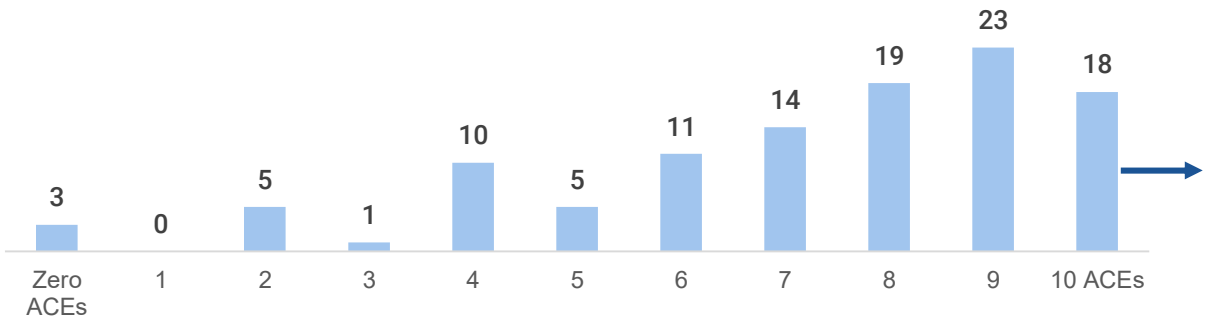


of case management clients since 1/1/23 were screened for ACEs (n=469)



54% wanted to be connect to resources related to their ACEs, though 9% wanted to wait

More than half (55%) reported 8 or more ACEs (n=109)

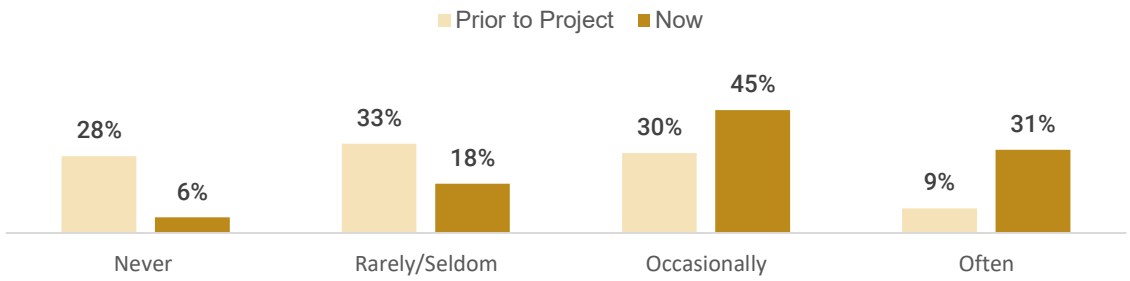


17% of clients screened reported all 10 ACEs

36% of the US population and 44% of Nebraskans reported experiencing zero ACEs[34,35]

Brain Injury Screening within Juvenile Justice System

After 16 months of implementing the project, staff were more likely to consider brain injury among youth at their center (n=88)



[33] Centers for Disease Control and Prevention (June 2023). Adverse Childhood experiences. https://www.cdc.gov/violenceprevention/aces/index.html

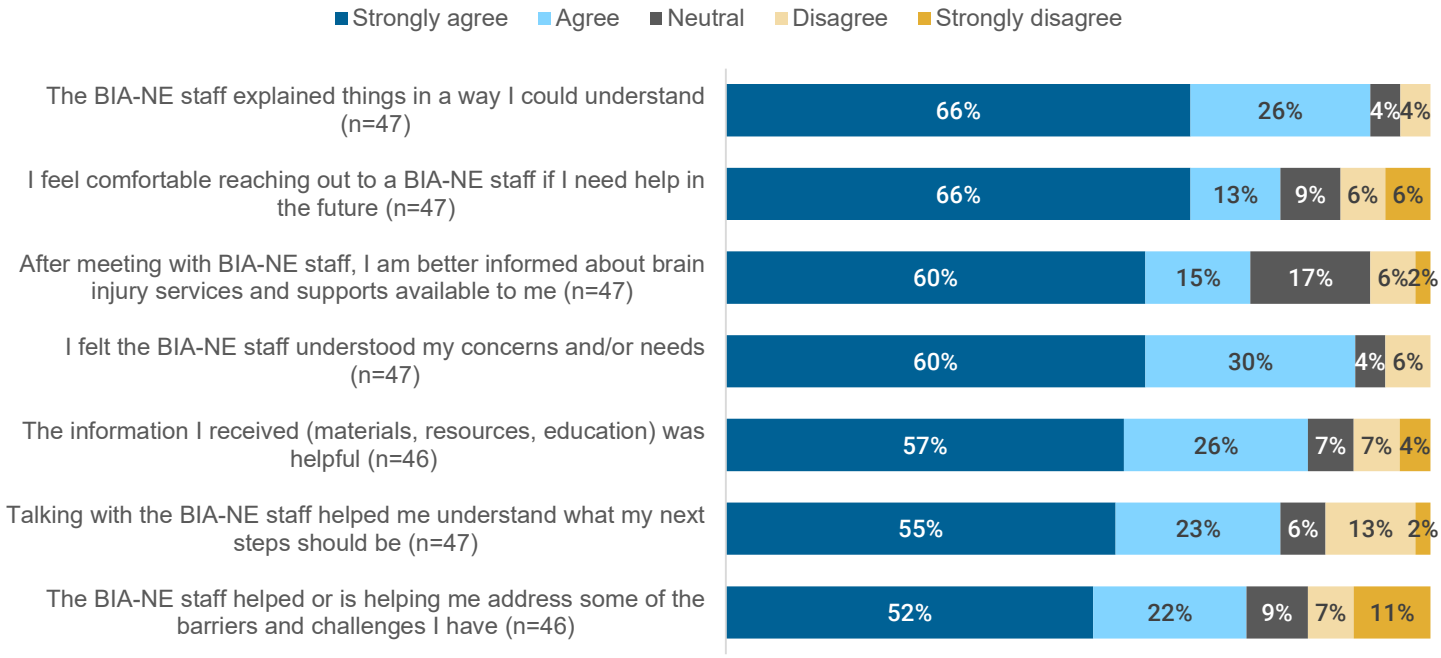
[34] Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/aces/ace-brfss.html

[35] Swedo EA, Aslam MV, Dahlberg LL, et al. Prevalence of Adverse Childhood Experiences Among U.S. Adults — Behavioral Risk Factor Surveillance System, 2011–2020. MMWR Morb Mortal Wkly Rep 2023;72:707–715. DOI: http://dx.doi.org/10.15585/mmwr.mm7226a2.

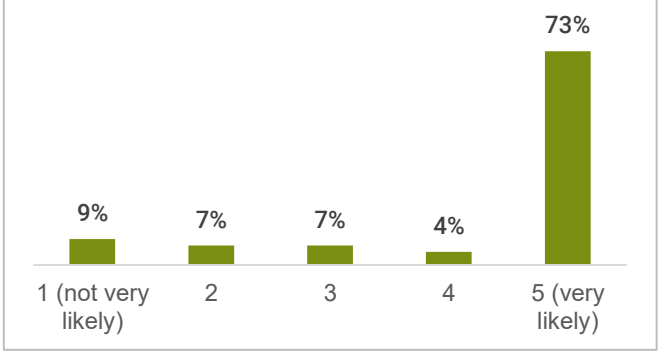
PRIORITY 7
Evaluating Needs

I truly appreciated the information and the offer for future assistance if needed.

More than half the respondents agreed to all the statements included on the satisfaction survey, though there were some areas of disagreement

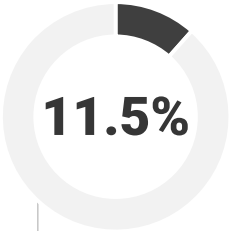


On a scale of 1 to 5 for whether clients would recommend BIA to others, the average rating was 4.3 (n=45)



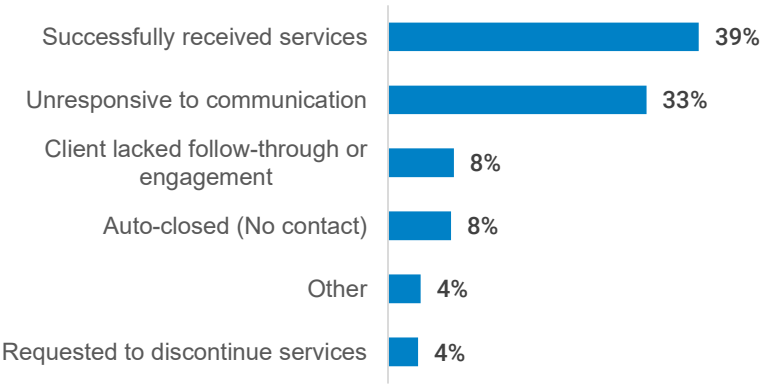
85%

reported the amount of communication they had with the BIA-NE staff was "about right"



of those who received the client satisfaction survey during the year participated in it (n=286)[36]

Nearly 40% who did not participate in the survey successfully received services from the BIA-NE (n=289)[37]



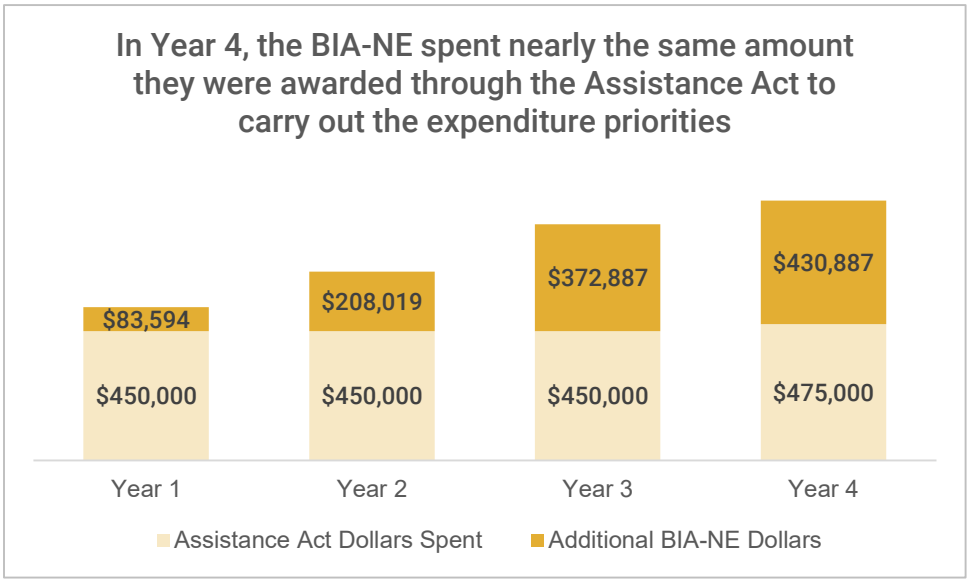
[36] Client satisfaction surveys were sent twice during the fiscal year. Clients with a case ending between July and December 2024 received a survey in January 2025 while clients with a case ending between January and June 2025 received a survey in July 2025. There were 20 clients who received it during both administrations. Surveys were sent via SurveyMonkey. To help increase the response rate, BIA staff sent a generic link of the survey to their clients who had not responded to the survey following two reminder emails via SurveyMonkey.

[37] There were 6 additional reasons for closures that accounted for 1% or less. This only accounts for those who participated in the survey via the email sent through SurveyMonkey. This does not include the 12 that completed the generic link.

BRAIN INJURY ASSISTANCE ACT SPENDING

	YEAR ONE July '21 - June '22	YEAR TWO July '22 - June '23	YEAR THREE July '23 - June '24	YEAR FOUR July '24 - June '25
Total Funding:	**$ 450,000.00**	**$ 450,000.00**	**$ 450,000.00**	**$ 475,000.00**
Use of Funding:				
Payroll and Related Expenses	$ 373,079	$ 484,488	$ 622,091	$ 698,359
Accounting and Auditing Fees	$ 4,451	$ 5,645	-	$ 16,144
Consultants	$ 47,107	$ 61,762	$ 47,904	$ 64,735
Advertising & Promotion	$ 23,069	$ 23,447	$ 11,471	$ 6,263
Bank, Credit Card, and Investment Fees	$ 989	$ 640	$ 811	$ 903
Software and Website Expenses	$ 24,155	$ 7,757	$ 39,404	$ 27,904
Conferences and Meetings	$ 731	$ 1,976	$ 3,830	$ 6,399
Dues & Subscriptions	$ 7,407	$ 6,687	$ 12,748	$ 4,696
Program Events and Efforts	$ 200	$ 7,045	$ 12,588	$ 4,524
Insurance	$ 5,346	$ 9,592	$ 5,931	$ 6,060
Office Supplies and Expenses	$ 11,494	$ 4,593	$ 7,068	$ 8,493
Postage, Mailing Service	$ 126	$ 205	$ 214	$ 611
Printing & Copying	$ 10,429	$ 2,889	$ 15,690	$ 7,319
Rent and Utilities (Telephone, Internet)	$ 3,163	$ 4,982	$ 6,561	$ 4,148
Travel and Meals	$ 9,009	$ 21,970	$ 31,831	$ 41,876
Professional Development/Training	$ 12,772	$ 13,460	$ 4,324	$ 6,148
Miscellaneous	$ 67	$ 882	$ 421	$ 1,303
Total Use of Funding:	**$ 533,594**	**$ 658,019**	**$ 822,887**	**$ 905,887**
Underspent (Overspent)	$ (83,594)	$ (208,019)	$ (372,887)	$ (430,887)

Throughout the last four years, BIA-NE spent more than $1,095,387 of its own operating funds to supplement the work funded by the Brain Injury Assistance Act. Although the Assistance Act funds most costs incurred, demand for resources and assistance and the resulting costs exceed what the Act funds. To cover the additional costs, BIA-NE utilizes contributions from its donors and Medicaid Administrative Claiming (MAC) funding received through the Aging and Disability Resource Center (ADRC).



BRAIN INJURY ASSOCIATION OF NEBRASKA

Partners for Insightful Evaluation

BRAIN INJURY ASSOCIATION OF AMERICA - MAINE

Integrating Brain Injury Awareness, Screening, and Systems Change in Substance Use & Behavioral Health Settings

PILOT PROJECT

In 2024, the Brain Injury Association of America – Maine Chapter began implementing a pilot project with **three behavioral health centers** in three different areas of Maine. The intent was to identify and better support clients within those agencies that may have experienced a brain injury. This was done primarily through education, tailored guidance, and tools to screen clients for potential brain injury and subsequent symptoms.

- AMHC — Aroostook Mental Health Center
- Kennebec Behavioral Health — Kennebec Behavioral Health
- SPURWINK — Spurwink

The results form the pilot primarily draw on feedback from the three sites. Interviews with each site were conducted by Partners for Insightful Evaluation (PIE) in November 2025. Overall, the pilot seemed to achieve its intended goals, with sites reporting meaningful changes. The pilot demonstrated that integrating brain injury-informed approaches into behavioral health and substance use treatment facilities or centers is both feasible and valuable, though not without challenges. Key barriers included staff turnover, screening logistics, trauma-related concerns during screening, and the challenge of adding new processes to already burdened systems.

KEY ELEMENTS OF THE PILOT

There were three core elements of the pilot project:

- Training and professional development on brain injury, including how it intersects with substance, behavioral health, and trauma
- Implementing brain injury screening with the Online Brain Injury Screening and Support System (OBISSS) and using results to link people to additional support
- Adjusting policies, procedures, and environmental factors within the agency to more systematically identify, understand, and respond to individuals with potential brain injury

TRAININGS, SUPPORT & RESOURCES

During the project **at least 9 trainings** were offered to staff among the three organizations and other agencies.

Perhaps the most impactful was the **training and consultation with Dr. Lemsky**. Staff valued the opportunity to dive into agency-specific challenges or scenarios to discuss the most effective approaches given their environment.

- Sites emphasized the value of working with an expert who **traveled on-site** and **tailored the instruction** to their specific environment. *"It was really phenomenal, because it was personal to us. She came to us and met with the staff."*
- Staff felt the trainer deeply **understood the intersection of overdose, substance use, and brain injury**, making it highly relevant and useful.
- One site noted that it impacted staff beyond those participating in the training with Dr. Lemsky, creating an agency-wide impact: *"I think a lot of people found that very eye-opening and helpful in terms of just informing their practice with clients. It's been very useful throughout the agency, in addition to in the pilot programs."*

All pilot sites reported that the **Brain Injury 101 training was important**. Staff appreciated that the content explicitly addressed substance use disorders, which reflected the realities of their client populations. One site described a shift within their organization from being trauma-informed to *neuro-informed*, recognizing the interconnected roles of substance use, trauma, and brain injury.

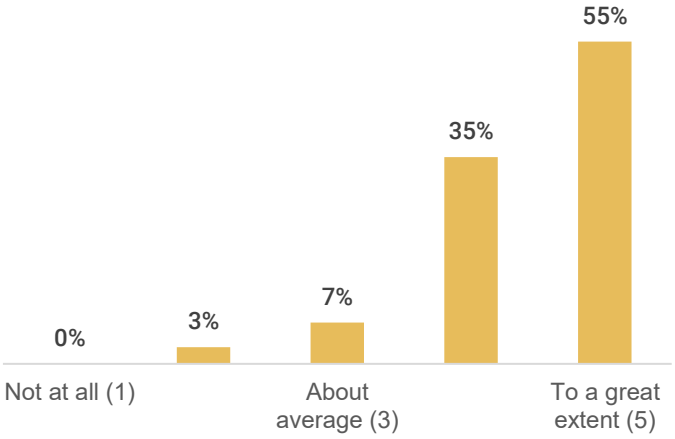
Training on OBISSS was also effective, especially when staff were able to practice the tool before administering it with clients. Having a trainer walk through the process demystified the screening and increased staff confidence. However, while the OBISSS is relatively straightforward to learn, ***"nothing prepares you for how each individual client is going to react during the screening."***

Other challenges common to offering professional development were experienced through this project too, with **staff not being able to attend trainings** due to scheduling and/or struggling to ensure staff completed the self-paced virtual trainings. It was also challenging to find a balance in training content, as **people who were already working in the field felt some trainings were a bit redundant** or more of a refresher. Overall, however, **the trainings were well received** by those who participated.

TRAININGS OFFERED

- ✓ Know What You May Be Missing: Recognizing and Managing the Impact of Acquired Brain Injury in Your Clients Webinar and Site Visit(s)
- ✓ Accommodations for Treatment of Co-Occurring TBI and Substance Use in Group Settings
- ✓ Overview of the Substance Use and Brain Injury (SUBI) Model of Care
- ✓ Session 1: Introduction to Opioid Misuse and Treatment
- ✓ Session 2: Neurobiology/Complex Opioid Overdose and the Brain
- ✓ Session 3: Community Resources for Brain Injuries and OUD
- ✓ Session 4: Clinical Challenges of Co-morbid TBI and OUD Treatment
- ✓ Governors Opioid Summit Session: Enhancing Treatment Approaches – The Impact of Brain Injury on Opioid Use Disorder Recovery

Results from four training evaluations indicate a majority were satisfied with the training (n=71)



> ***"The resources provided along with monthly working groups helped to answer any questions providers may have as it [related to] administering the OBISSS and supporting our clients."***

OBISSS & CLIENT SUPPORT

All three sites developed their own approach for doing the screenings, though each was still modifying or considering slight changes to their process at the time of the interview. The sites typically did not screen all clients or individuals in their program – in part because consenting to the screening is part of the OBISSS, though none of the sites indicated a challenge with that.

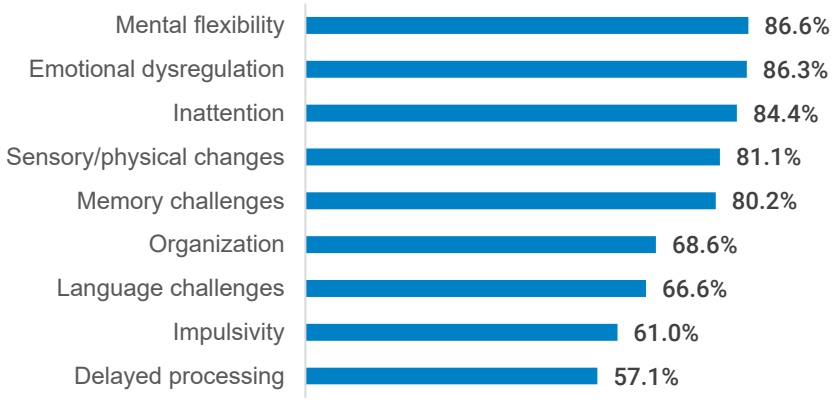
Determining when to screen clients was something each agency had to work through – and to some degree are still considering – given differences in program structure, client stability, and staffing. More specifically, sites noted that:

- ➡ While it would be ideal to conduct the OBSSS when an individual first comes to or is admitted to a program, those individuals are often trying to get their bearings and already have a lot of information to process. It may be overwhelming to do the brain injury screening too early.
- ➡ Although it seemed effective to have one or two people conduct all the screenings, that does create limitations on when it can be done and the stress that person may experience. One site initially relied on one person to do the screenings but plans to shift to having one person who oversees the screening efforts but has support from other staff to conduct the OBISSS with clients.

Based on OBISSS data from 2024 and the first three quarters of 2025, about 54 screenings were done in Maine, with a majority (94%) being possible brain injury. Staff noted that, at least in some cases, the client suspected or even had a diagnosed brain injury while others had not even considered brain injury.

Sites reported that **having the screening results often provided relief and validation for clients**. Learning about potential brain injury helped some reframe lifelong struggles and reduced self-blame. Staff shared stories of clients expressing hope after having an explanation for challenges they had previously internalized as personal failings.

The first three quarters of OBISSS data from 2025 indicated that the most common symptoms experienced among individuals was mental flexibility and emotional dysregulation



Following the screening, all sites **offered some type of resources or support to those who screened as having a possible brain injur**y. Trust played a central role when determining whether referrals would be appropriate for the individual. Clients were more willing to pursue referrals when they felt confident that recommended providers would treat them with dignity. One site noted that even giving a copy of the OBISSS-generated information was helpful with getting people connected to services and support: *"We actually did have a client who tested positive for the screening and was able to take the information their primary care, and they got a referral for neurology."*

> ***The clients tend to trust us a little bit in the sense [that] if we're recommending someone, then they get the strong impression that we know that this person's going to treat them respectfully.***

POST-SCREENING RESOURCES

- ✓ OBISSS-generated resources
- ✓ Information about BIAA-Maine
- ✓ Other programs/staff within their organization
- ✓ Warm hand-offs to trusted partners
- ✓ Referrals to providers with established relationships

SYSTEMS CHANGE

Changes made within each organization varied based on staff capacity, turnover, buy-in, and other factors. In general, **management and leadership teams were supportive of the project**. There were more mixed reactions when it came to staff, however. Some were interested in learning more about clients through the OBISSS while others were a bit more hesitant.

> ***It was quite an awakening that there could have been something else going on that isn't talked about, that isn't asked about, and how important it would be not only for us to know, but more importantly, for the consumer themselves to know.***

The **biggest source of hesitation seemed to be knowing how to support clients and provide resources after the screening**. Another concern was **the OBISSS becoming mandatory tool for all clients**. One site noted there are staff that *"are all for every client being screened, and there is staff that feel it is only appropriate for some clients."* There was also still uncertainty about how the information from OBISSS should be incorporated into their practice, though the tailored support from Dr. Lemsky helped identify some initial steps.

Other factors influenced how sites began integrating brain injury into their standard practice.

- Staff **turnover meant agencies lost champions** for the project and capacity. It was difficult to lose the momentum and try to get new staff up to speed on the project's purpose.
- The **in-person time with Dr. Lemsky was a "powerful" way for staff to come together to have discussions** about the project and agency-specific implications.
- Funding allowed staff to participate in the **Certified Brain Injury Specialist (CBIS) training, which was viewed as a significant capacity-building investment.** This strengthened internal expertise, likely in a more sustainable way. All sites found value in having that internal knowledge. In fact, some wanted to have more staff members trained and able to offer educational sessions to other staff and partners.
- Support and **collaboration from the state team** was essential: *"Everyone that has been a part of the pilot project has been great at taking feedback and finding helpful ways to overcome some of the barriers we faced during the onset of starting the OBISSS screening."*

INTERNAL CHANGES MADE

- ✓ Reduced total hours of group carried out each day
- ✓ Created individualized plans for clients, particularly when setting deadlines or requesting homework/assignments
- ✓ Established personal recovery goals that align with areas of concern identified in the OBISSS
- ✓ Changed language and conversations in clinical reviews and coordination with the organization
- ✓ Added lamps to rooms that only had fluorescent lights
- ✓ Implemented therapeutic naps

GENERAL FINDINGS

Integrating brain injury screening and BI-informed practices **appeared to improve staff understanding, reduce stigma, and help clients better engage in care and access additional resources**. The pilot demonstrated value among staff and clients while creating a strong foundation for sustainability and expansion. Some trainings were more integral than others and staff turnover did impact progress at different points of the pilot. A key result, however, is that people had the chance to come together to talk about brain injury in different facets and not feel like *"brain injury is an island to itself."*

> ***The project has contributed positively by shifting staff and client perspectives. It helps clients understand that their challenges may extend beyond substance use, highlighting the need for different interventions to support regulation and functionality. This broader understanding promotes better long-term outcomes and more individualized care.***

Lessons Learned

- ✓ Start small and intentionally integrate the project into organizations. It's important to identify key champions and a lead person for the project with the organization first and ensure they have time to implement the work. Two sites noted it was important to build the foundation internally before widely training staff on brain injury and engagement strategies.
- ✓ It's helpful to have a point-person overseeing the screening process within a program or agency but multiple people available to do the OBISSS with clients. All sites felt the OBISSS screenings should be paired with provider support, rather than being used as a self-administered tool for clients.
- ✓ A big contributor of success was having targeted, expert-led training that connects brain injury, substance use, and trauma – especially the interactive, in-person sessions. Having someone on-site with the agency helped them more effectively identify how to integrate screenings and support into their program(s).
- ✓ Having webinar and asynchronous training options provided flexibly for those who couldn't attend trainings, but may have been less impactful and more limited accountability.

There has been a shift in how staff are thinking about clients that may show certain symptoms, such as slow processing speed or behavioral challenges. Instead of thinking people may just be resistant to treatment or difficult, they now consider whether this behavior might to due to a brain injury. *"I think that in the past, we've kind of looked at things black and white, and this allows for more gray."*

> ***"At the bare minimum, continue to educate people. Offer Brain Injury 101. Offer that training absolutely everywhere to absolutely everyone. If somebody said, you can only pick one, I would say do that. Educate people."***

RECOMMENDATIONS

Initial recommendations were identified as part of the evaluation. These are broken down by the three key aspects of the pilot project.

Training

To build upon the training component of the project, the following suggestions were offered by sites:

- ➡ Develop **an introductory webinar or training about the project** for sites to have a clear understanding of the project upfront and also have a way to onboard new staff to the project.
- ➡ Provide **opportunities for more staff to participate in trainings**, with slightly larger budgets to accommodate the training needs and flexible options to participate. At least one site noted it would be helpful to be able to increase the number of internal trainers within their organization.
- ➡ Offer **additional periodic opportunities to meet with Dr. Lemsky** the further along with implementation the sites get.
- ➡ To have further reach, it may also be important to **make trainings more widely available** across the state.

Screening

Sites offered recommendations on how to enhance or improve the use of OBISSS within organizations:

- ➡ **Create a short pre-screening process** that would indicate if a person should complete the full OBISSS screening.
- ➡ Offer **supports or training to staff to better manage trauma that may emerge from clients** when completing the OBISSS with them.
- ➡ Identify ways to integrate **OBISSS or alerts pertaining to the screening into the electronic medical record** and care planning workflows.

System Change

To promote system change within the current sites and also other organizations in Maine, it may be important to:

- ➡ **Identify a handful of new sites** to implement the project. *"This project could be expanded statewide by integrating it into key organizations that work with individuals at risk for brain injury, such as substance use treatment centers, mental health programs, and correctional facilities."*
- ➡ **Build in time for consultation**, reflection and practice change, not just the implementation of the project, given the level of coordination needed.

Nebraska Brain Injury Needs Assessment – 2024 Report Executive Summary

The Nebraska 2024 Brain Injury Needs Assessment was conducted to understand the landscape of services, supports, and unmet needs for individuals affected by brain injuries across the state. Led by Partners for Insightful Evaluation (PIE) in collaboration with Nebraska Vocational Rehabilitation (VR) and the Brain Injury Advisory Council (BIAC), the needs assessment drew from multiple data sources. This included three statewide surveys, programmatic data from Nebraska VR and the Brain Injury Association of Nebraska (BIA-NE), secondary data such as the Traumatic Brain Injury (TBI) Registry, and administrative records. The findings are meant to inform Nebraska's Brain Injury State Plan and help identify opportunities to enhance the coordination and delivery of services for those who have experienced and/or care for those with a brain injury.

Findings about Brain Injury

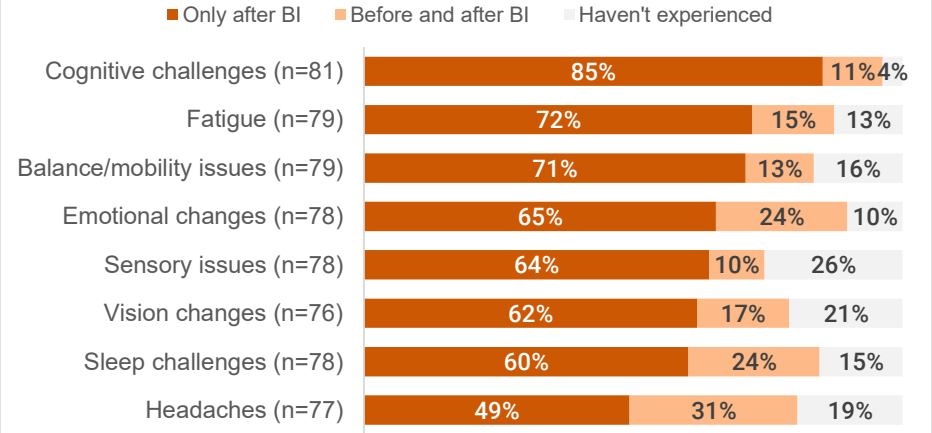
Brain Injury in Nebraska

- Between 2017 and 2022, over 75,000 traumatic brain injuries (TBIs) were reported in Nebraska, with **a 29% increase** over that period.
- **Falls** remain the leading cause, followed by being struck by/against and **motor vehicle accidents**. Other data sources also indicate that motor vehicle accidents are a common cause.
- Individuals with brain injuries span all age groups, but **older adults** (particularly women 85+) **and teenagers** (especially males 15–19) had the highest rates of TBI-related hospitalizations and emergency department visits.
- Across the data, **employment and independent living vary significantly**, with many individuals struggling with long-term impacts.

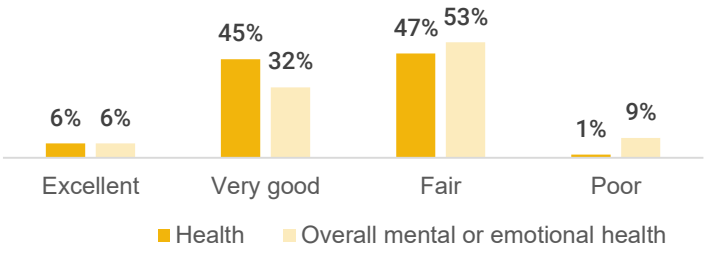
Symptoms & Impacts

Cognitive, emotional, and sensory symptoms are common. Many report multiple daily living challenges, including difficulty maintaining employment and emotional well-being.

A majority of people reported symptoms only after experiencing their brain injury



About half the respondents to the individual with brain injury survey noted their health and mental/emotional health were "fair" or "poor" (n=78)



Data from the 2022 Behavioral Risk Factor Surveillance System shows 15% of Nebraskans reported their overall health being "fair" or "poor"

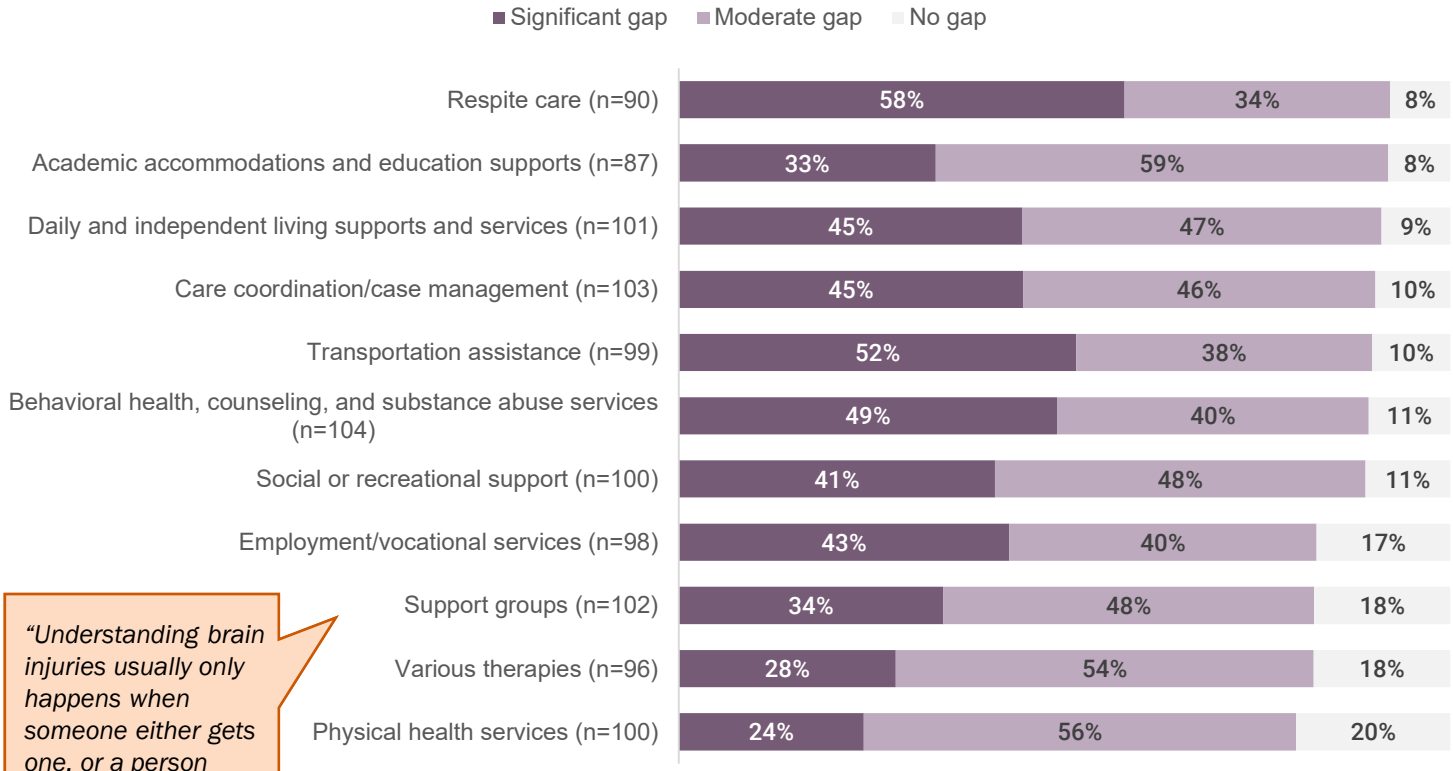
This publication was supported by the Administration for Community Living (ACL), U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $1,000,890.00 with 100 percent funding by ACL/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by ACL/HHS, or the U.S. Government. The full needs assessment report is available on the Brain Injury Advisory Council website at: https://braininjury.nebraska.gov/resources/brain-injury-data-and-statistics

Findings about Services & Barriers

Service Needs & Gaps

In general, there were three key themes people felt needed to be addressed: gaps in services (particularly in rural areas), challenges with service coordination, and need for increased education and awareness:

There were three types of services where more than 90% of service providers and family members/caregivers felt there was a gap



"Understanding brain injuries usually only happens when someone either gets one, or a person close to them sustains one."

"We need this information in different languages and targeting diverse communities so they also get the information in a culturally-relevant way."

Recommendations

Prioritize & Coordinate Trainings

Results from previous and the current needs assessments point to the need to educate a variety of service providers on brain injury. This includes information about brain injury identification as well as how to navigate life after brain injury, such as behavioral health challenges and appropriate services.

Improve Service Navigation

Increase outreach and centralize information regarding services available, eligibly requirements, and common resources for brain injury recovery – particularly for individuals in rural or underserved areas.

Invest in Public Awareness

Awareness continues to be a key need among individuals with brain injury to help reduce stigma and promote early intervention. There has also been a push to support prevention efforts around the common mechanisms that lead to TBI, including falls and motor vehicle accident prevention.

Strengthen Support Networks

This is not only for those with brain injury, but also family members/caregivers. This may include tailored resources, support groups, culturally responsive materials, and specialized services for high-need groups or those with co-occurring conditions.

A comprehensive list of recommendations are outlined in the full evaluation report.

Nebraska Adolescent Health Report 2025

Partners for Insightful Evaluation

Table of Contents

Office of Coordinated Student Support Services

The Nebraska Department of Education's (NDE) Office of Coordinated Student Support Services (CSSS) ***provides coordinated support related to the social, emotional, behavioral, mental and physical health and safety of students to enhance learning and achievement.*** To best serve and support all students and school staff throughout Nebraska, the CSSS Team:

- **Ensures equity** by advancing demonstrable access and opportunity for an equitable, high-quality education and associated student support services.
- **Provides collaborative leadership, content expertise and technical assistance** related to student support services and corresponding resources.
- **Fosters alignment by promoting the shared goals** of improving the social, emotional, behavioral, mental and physical health and safety of all students and helping them establish lifelong healthy behaviors.
- **Cultivates coordination** in development, implementation and evaluation of **a comprehensive array of student support services and corresponding professional development** for school staff.
- **Encourages adoption of evidence-based and best practices** in student services and supports, as well as exploration of **innovation and promising practices**.
- **Establishes and sustains collaborative strategic partnerships** among State and local agencies, non-profit organizations, post-secondary education institutions, community groups, businesses and industry partners.
- **Promotes timely, effective response** by bringing together multidisciplinary expertise and resources to produce the needed array of cross-systems services and supports for students and school staff.
- **Advises and encourages collaboration** with other NDE Teams, the Nebraska State Board of Education and external partners **to produce greater impact** in matters related to student support services **for true systems change.**

The remainder of this report is organized around the **Whole School, Whole Community, Whole Child (WSCC)** model, shown to the right. This framework integrates health and learning by emphasizing the importance of aligning education, health, and community efforts to support student well-being and academic success. Each section of the report corresponds to one of the WSCC components, highlighting how Nebraska schools address these interconnected areas to create safe, supportive, and engaging learning environments.

Adolescent Health

The Institute of Medicine (IOM) describes health as "optimal physical, mental, social, and emotional functioning and well-being"[1]. Schools and families play an important and unique role in providing environments where youth can learn and practice positive health behaviors. The Nebraska Department of Education (NDE) and the Nebraska Department of Health and Human Services (NDHHS) work together to support and enhance the efforts of schools and parents to facilitate optimal healthy outcomes for our youth.

Together, NDE and NDHHS monitor how common and widespread various health risk behaviors are among Nebraska youth. Vital statistics records and surveys provide data for this monitoring and the measurement of change and progress towards health goals. This report primarily focuses on the results of two sets of data collection: 1) the Youth Risk Behavior Survey (YRBS) and 2) the School Health Profiles (SHP). The findings in this report are intended to be a resource for future discussion and action around health education, risk reduction, and prevention activities targeted towards youth in Nebraska. Please note that only statistically significant differences between groups or over time are reported.

Primary Data Sources

2023 Youth Risk Behavior Survey (YRBS)

The Centers for Disease Control and Prevention (CDC) started the YRBS in 1990 to monitor youth health behaviors and provide comparable data across different populations. The survey covers six categories of behavior linked to the leading causes of death, disability, and social problems for youth and adults in the United States:

- Unintentional injuries and violence
- Alcohol and other drug use
- Tobacco use
- Unhealthy dietary behaviors
- Inadequate physical activity
- Risk behaviors

Administered every other year, the YRBS is collected from a random sample of 9th-12th grade students within a random sample of public schools. The Nebraska survey results are weighted to generalize to the entire 9th-12th grade public school population of Nebraska.

Learn more and view Nebraska YRBS data

2024 School Health Profiles (SHP)

The IOM recommends that all secondary schools require for graduation, at minimum, a one semester health education course. Starting in 1995, the CDC established SHPs to monitor school health practices. The data is intended to be used by decisionmakers to understand gaps in policies and practices that impact student academics and health. Topics include:

- Health education requirements
- Physical education and activity
- Safe and supportive environments
- Health services
- School health coordination
- Family involvement in schools

Conducted every other year, separate surveys are conducted with school principals and lead health educators in school enrolling students in 6th – 12th grades. In 2024, the principal data was not weighted due to non-response bias.

Learn more and view Nebraska SHP data

[1] National Academies of Sciences, Engineering, and Medicine. 1997. Schools and Health: Our Nation's Investment. Washington, DC: The National Academies Press. https://doi.org/10.17226/5153.

Health Education + Adolescent Health

Health education provides opportunities for students to learn and develop skills to make quality health decisions. To best address students' needs and work collaboratively with the community, schools are encouraged to follow National Health Education Standards and promote personal, family, and community health.

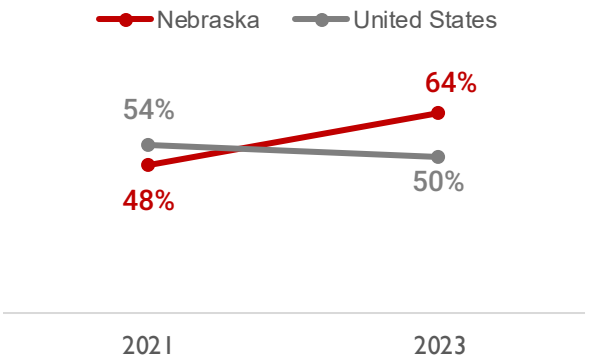
What lead health education teachers reported in 2024…

Four out of five (80%) lead health educators were certified, licensed, or endorsed by the state to teach health education

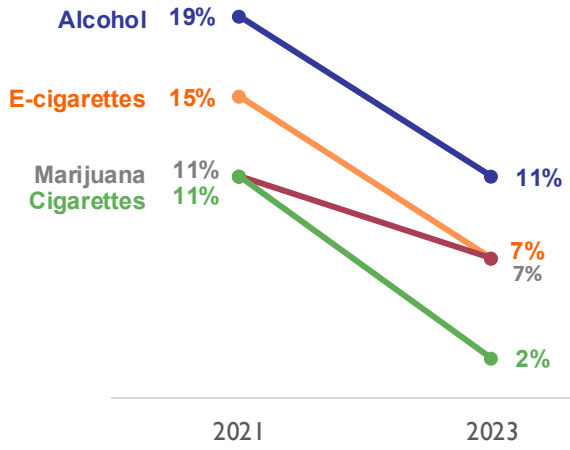
*This is an increase from **66%** in 2006*

What students reported in 2023…

Nebraska students showed an increasing (though not significant) trend in quitting all tobacco products, opposite the national decline



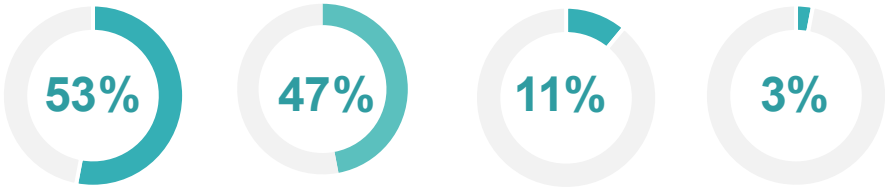
Teens' substance use in the past 30 days declined significantly over the past 2 years



Lifetime marijuana use decreased from previous years and is lower than the national average

(14% in NE vs. 30% nationally)

Past month teen behaviors associated with accidents



- 53% texted or emailed while driving
- 47% did not always wear a seatbelt
- 11% rode with a driver who was drinking
- 3% drove while under the influence of alcohol

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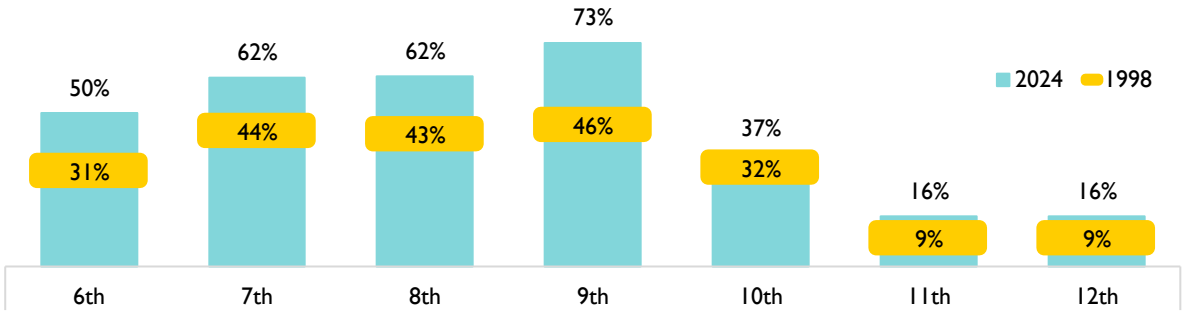
Health Education

Health education provides opportunities for students to learn and develop skills to make quality health decisions. Following National Health Education Standards, and promoting personal, family, and community health, education should address students' needs and work in collaboration with the community.

School Practices

Four out of five (80%) lead health educators were certified, licensed, or endorsed by the state to teach health education in 2024, which is a significant increase from 66% in 2006. The number of required health education courses and what grade they are taught varies. The majority of schools require instruction in health education in any grade between sixth and twelfth – which was higher in 2024 than in 1998 for all grades, most notably for 6th-9th grades (Figure 1). Overall, required health education courses were less common after grade nine – and a required course in grade nine was more common in junior/senior high schools (80%) than high schools (64%).

Figure 1: Which grades included a required health education course



Four out of five instructors (81%) were provided with goals, objectives, and expected outcomes for health education. At least seven out of ten had written health education curriculum (73%), plans for how to assess students' performance in health education (72%), and written instructional competencies (70%). Charts describing the annual scope and sequence of instruction for health education were the least common (63%) – but more common in high schools (72%) than junior senior high schools (50%).

Written health education curriculum was also more common in high schools (83%) than junior/senior high schools (65%).

As shown in Table 1, most schools reported health education curriculum intended to help adolescents make informed decisions about their health. Skills coverage in 2024 was generally the same as in 2022, varying by no more than 2%, with the least common (accessing valid information and products and services to enhance health) still reported by 86% of responding schools. Assessing validity was more common in high schools (96%) than in middle schools (78%). Analyzing the influence of their community and media, using interpersonal skills, and practicing health enhancing behaviors were taught in all responding high schools.

Table 1: Percentage of schools whose health education curriculum addresses each skill.

	2022	2024
Practicing health-enhancing behaviors to avoid or reduce risks	91%	93%
Comprehending concepts related to health promotion and disease prevention to enhance health	91%	92%
Analyzing the influence of family, peers, culture, media, technology, etc. on health behaviors	91%	92%
Using decision-making skills to enhance health	91%	91%
Using goal-setting skills to enhance health	90%	91%
Using interpersonal communication skills to enhance health and avoid/reduce health risks	91%	90%
Advocating for personal, family, and community health	89%	88%
Accessing valid information and products and services to enhance health	85%	86%

The majority of high schools, middle schools, and junior/senior high schools cover health topics in a required course with the intent to increase student knowledge. Alcohol and other drug prevention, tobacco-use prevention or cessation, sleep health, and injury prevention and safety were covered in 95%, 95%, 88%, and 84% of schools, respectively.

Four out of five (79%) teachers said they tried to increase student knowledge of combating stressors that negatively impact health. Almost as many covered social factors (access to education, housing stability, etc.) that influence health (76%), more than covered individual factors (such as demographic differences) that influence health (66%). Social factors were more common topics in high schools (87%) than in middle schools (65%). Slightly more than half of teachers (52%) tried to increase students' knowledge of identifying systems of oppression.

Teachers were asked about the coverage of nine alcohol and other drug-use prevention topics. The least common was alcohol and other drugs as an unhealthy way to manage weight (78%), while the harmful short- and long-term physical, psychological, and social effects was the most common (92%). Only one topic differed by school type: 80% of middle schools covered using interpersonal communication skills to avoid alcohol and other drug use, which was significantly less than both high schools (95%) and junior/senior high schools (93%).

When asked whether their school taught 19 different tobacco use or cessation topics in a required course, teachers reported coverage ranging from 71% to 92% depending on the topic, with 61%

reporting they taught all 19 topics in the current school year. This was most common for high school teachers (73%), and least common for junior/senior high school teachers (48%). Teachers were most likely to discuss vaping (91%), cigarettes (88%), and smokeless tobacco (87%), and least likely to discuss cigars (72%) and pipes (60%).

Student Health

Motor Vehicle Accidents: The Centers for Disease Control (CDC) collect data on fatalities suffered by different age groups. According to their WISQARS data portal, the age-adjusted rate of motor vehicle deaths per 100,000 people for adolescents ages 15-19 was 15.90 between 2018-2023[2]. This was higher for males (18.61) than for females (13.05) in this age range. There was also a difference based on location: adolescents in non-metropolitan areas were more than twice as likely to die in a motor vehicle accident than adolescents in metropolitan areas (22.86 vs. 12.44).

Self-reported behaviors in the YRBS indicate behaviors that can lead to these accidents are common among adolescents. Slightly more than half of Nebraska teens (53%) said they had texted or emailed while driving in the month prior to the survey. This behavior has increased between 2012 and 2023 among White teens in Nebraska. Fewer than half of Nebraska teens (47%) said they did not always wear a seat belt when riding in a vehicle in 2023, which is roughly 50% lower than 20 years ago (70%).

Alcohol-related driving behaviors were less common in Nebraska, where 3% drove under the influence of alcohol in the past 30 days, and 11% rode in a car with a driver who had recently consumed alcohol. Both of these behaviors have decreased between 2012-2023 (Figure 2).

Figure 2: The percentage of students driving after drinking alcohol and riding with an alcohol impaired driver continues to decline

	2012	2014	2016	2018	2021	2023
Riding	20%	22%	22%	15%	15%	11%
Driving	7%	10%	6%	6%	5%	3%

Alcohol Use: Nine percent of Nebraska high school students had their first drink of alcohol before the age of 13 – a significant decline from 13% in 2012. One in nine students (11%) reported currently drinking alcohol (had at least one drink in the past 30 days) – this is half of the national average (22%) and reflects a decrease from 19% in 2021 and from 24% in 2016. Hispanic and White students were not significantly different in 2023, but there were different historical trends, with a stronger downward trend in current alcohol use among Hispanic students (Figure 3). Eleven percent of boys and girls in

[2] Data from the CDC's Web-based Injury Statistics Query and Reporting System, pulled March 23, 2025.

Nebraska drank alcohol in the past month, compared to 24% of girls surveyed nationally, and 20% of boys nationally.

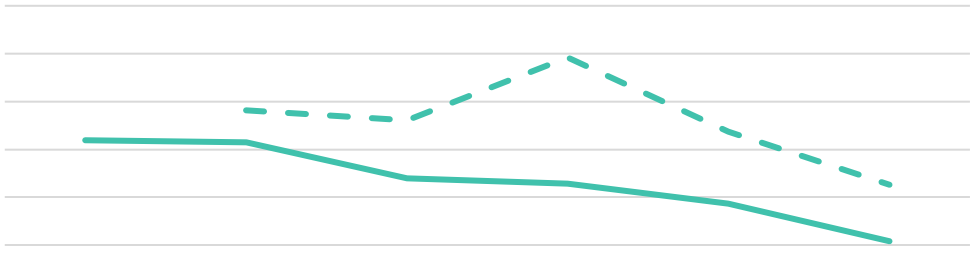
Figure 3: Hispanic adolescents were less likely than White students to say they had a drink in the past 30 days

	2012	2014	2016	2018	2021	2023
Hispanic	22%	30%	27%	21%	16%	7%
White	22%	21%	25%	22%	22%	13%

Four percent binge drank in the past 30 days (defined as having four or more drinks in one sitting if female, and five or more drinks if male), which is less than half of what was reported in 2021 (9%) and the national average (9%). There was also a decline between 2021 and 2023 among students who said they had ten or more drinks in a row in one setting, decreasing from 4% to 1%. Half of students (51%) were given the alcohol they drank, an increase from 32% in 2016.

Tobacco Use: Four percent of students had tried smoking tobacco prior to the age of 13, which is half of what was reported in 2016 (8%). One in nine Nebraska youth reported ever trying smoking cigarettes (11%), a drop from 32% in 2012 and 19% in 2021 (Figure 4). Less than a quarter (23%) had ever vaped (aka used an e-cigarette, vape, vape pen, e-cigar, e-hookah, hookah pen, mod), a decrease from 2014 (38%) and 2021 (34%, which was also the national average in 2023). Girls in Nebraska were less likely than girls nationally to have ever vaped (25% vs. 39%). Overall, a linear decline was observed for lifetime cigarette use between 2012 and 2023, while vaping peaked in 2018 and then declined. It is possible that the recent declines could be due to the 2019 law prohibiting the purchase of tobacco for those under the age of 21.

Figure 4: The percentage of Nebraska students who ever used cigarettes or vapes continues to decline



	2012	2014	2016	2018	2021	2023
Cigarettes	32%	31%	24%	23%	19%	11%
Vapes		38%	36%	49%	34%	23%

Table 2 shows the frequency of use of common types of tobacco, which shows that vaping was the most common behavior overall, with much greater frequency than cigarettes, or smokeless tobacco (aka chewing tobacco, snuff, dip, snus).

Table 2: Use of tobacco products in past 30 days			
	Current (1+ day)	Frequently (20+ days)	Daily (30 days)
Cigarettes	1.8%	0.2%	0.2%
Vape/e-cigarette	6.9%	3.2%	2.2%
Smokeless tobacco	1.9%	0.5%	0.5%

Current cigarette use was 2%, a decline from 11% in 2012, and frequent cigarette use was a tenth of that (0.2%) – a decline from 2016 (2%). Daily cigarette use was also down from 2012, decreasing from 2.4% to 0.2%. Current vaping was more than twice as common nationally (17%) than in Nebraska (7%), with differences between Nebraska teens and teens nationally by sex: 8% of Nebraska girls vs. 20% of US girls, and 6% of Nebraska boys vs. 14% of US boys. Frequent use of vaping increased from 2.3% in 2014 to 3.2% in 2023, and daily use increased over the same time period, from 1.5% to 2.2%; however, both of these follow declining trends in vaping since 2018. Current use of smokeless tobacco is significantly lower than it was in 2016, decreasing from 5.3% to 1.9%.

Of the students that used tobacco, nearly two-thirds (64%) had tried to quit in the past year. While not statistically significant, the percentage of Nebraska students who reported trying to quit increased from 48% in 2021, in contrast to the declining trend seen nationally (from 54% to 50%). Three out of four girls in Nebraska (76%) who used tobacco products tried to quit, versus approximately half of tobacco using girls nationwide (54%)

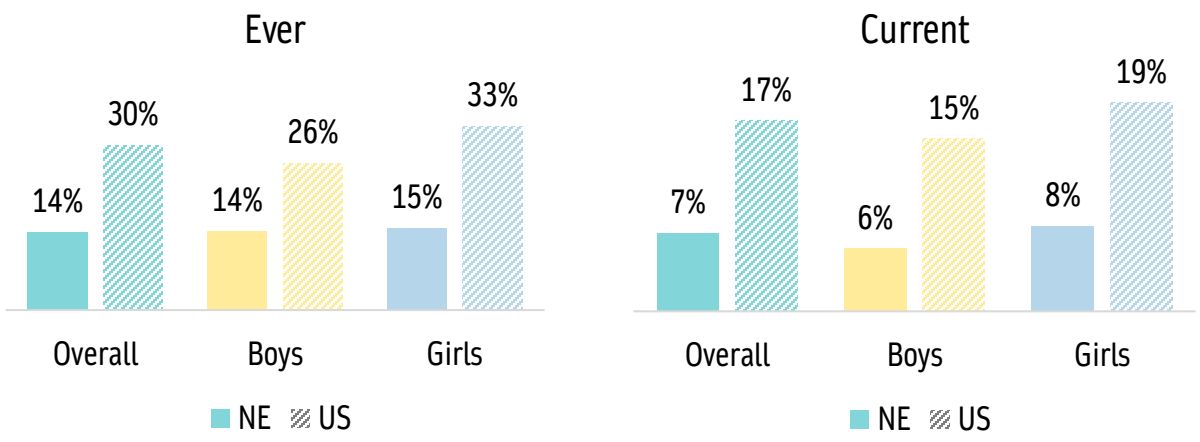
Marijuana Use: Three percent of students had tried marijuana before the age of 13 (down from 6% in 2012). Approximately one in seven (14%) had ever used marijuana (down from 24% in 2012), less than half of than the national average of 30% and is a long-standing difference (Figure 5).

Figure 5: Lifetime use of marijuana was consistently lower for Nebraska students than national averages

	2012	2014	2016	2018	2021	2023
NE	24%	27%	25%	26%	19%	14%
US	41%	39%	36%	37%	28%	30%

Seven percent had used marijuana in the last 30 days, which was lower than the 11% reported in 2021, and also lower than the 17% of teens nationwide. For both ever and current use, girls and boys in Nebraska were similar to each other, but different from girls and boys nationwide (and they were different from each other for ever using) (Figure 6).

Figure 6: Ever and current marijuana use was half as common in Nebraska than the US as a whole, with differences between by sex by location



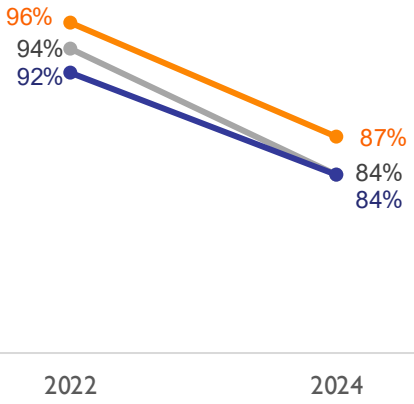
Other Drug Use: One in ten Nebraska teens had ever used prescription pain relief drugs without a doctor's prescription or other than prescribed, a decline from 14% in 2016. Three percent of students reported ever using inhalants (such as sniffing glue, or inhaling contents of aerosol spray cans or paints), down from 7% in 2021. Injecting illegal drugs was uncommon, with less than 1% of students reporting ever injecting, a decline from 4% in 2014. The lifetime use of other illegal drugs, including cocaine, heroin, methamphetamines, and ecstasy was reported by no more than 1% of teens.

Other Student Outcomes: Four out of five Nebraska teens (79%) earned mostly As and Bs, according to self-report. Girls in Nebraska were more likely than girls nationally to report this (87% vs. 76%). More than a quarter (28%) got at least eight hours of sleep a night.

Physical Education and Physical Activity + Adolescent Health

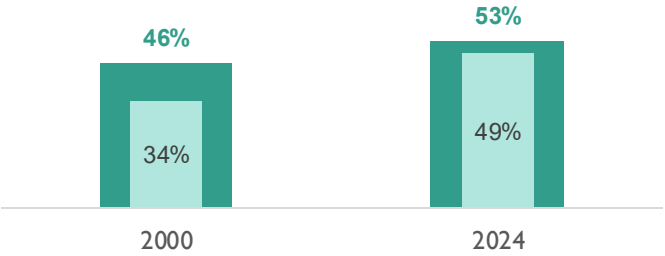
The national framework for physical education (PE) and physical activity (PA) includes five components: physical education, physical activity during school, physical activity before & after school, staff involvement, and family & community engagement.

Physical activity topics were less commonly covered in 2024 than in 2022

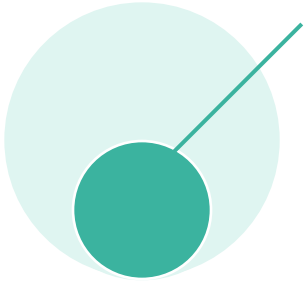


What lead health education teachers reported in 2024...

There was an increase in teachers that wanted and received professional development in physical activity and fitness from 2000 to 2024



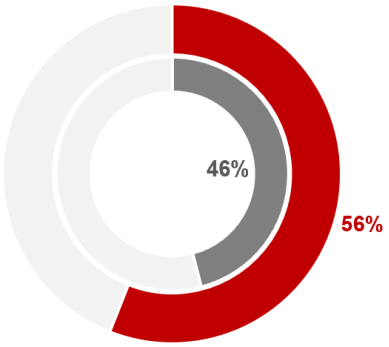
What students reported in 2023...



29%
Nebraska students were active for at least an hour every day

Boys (37%) more than girls (21%)

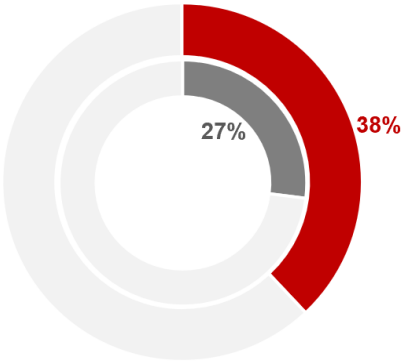
Nebraska teens were more likely than US teens to be...



Active for 1+ hour on 5+ days (56% vs. 46% US)

One out of ten students (10%) had a concussion from playing sports or being physically active in the year prior to the survey

Down from 17% in 2021



Attend PE five days a week (38% vs. 27% US)

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Physical Education and Physical Activity

The national framework for physical education (PE) and youth physical activity (PA) includes 5 components:

1. Physical education
2. Physical activity during school
3. Physical activity before & after school
4. Staff involvement
5. Family & community engagement

School Practices

Nearly half of high school students (46%) reported attending PE at least once a week. More than a third of Nebraska students (38%) reported attending PE daily, which was an increase from 2016 (28%), and higher than the national average (27%).

Many PA topics were commonly covered in these classes in 2024 – all of which trended in the direction of being less common than in 2022:

- 96% - Increasing daily physical activity
- 96% - Benefits of drinking water before, during, and after physical activity
- 95% - Mental and social benefits of physical activity
- 94% - Health-related fitness.
- 94% - Short-term and long-term benefits of physical activity, including reducing the risks for chronic disease
- 93% - Incorporating physical activity into daily life (without relying on a structured exercise plan or special equipment)
- 91% - Preventing injury during physical activity.
- 91% - Decreasing sedentary activities (e.g., television viewing, using video games)
- 88% - Recommended amounts and types of moderate, vigorous, muscle-strengthening, and bone-strengthening physical activity
- 87% - Phases of a workout (i.e., warm-up, workout, and cool down) – was 96% in 2021
- 84% - Using safety equipment for specific physical activities – was 94% in 2021
- 84% - Dangers of using performance-enhancing drugs (e.g., steroids) – was 92% in 2021
- 83% - Weather-related safety (e.g., avoiding heat stroke and hypothermia while physically active)

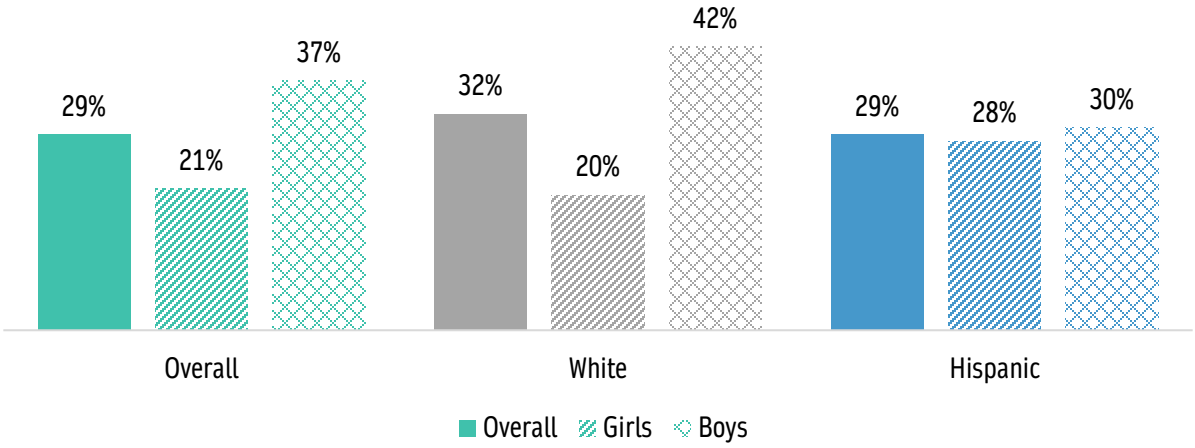
Seven out of ten teachers (71%) taught all 13 topics. Half of schools (49%) provided students' families with information to increase their knowledge about physical activity.

Half of lead health instructors (49%) said they received professional development in physical activity and fitness in the prior two years, an increase from 34% from 2000. More than half (53%) wanted future professional development, an increase from 46% in 2000, although it was a decrease from a high of 67% in 2008.

Student Health

Student Physical Activity: Thirteen percent of students were not active for at least an hour in the week prior to the survey. Nearly three out of ten students (29%) were active for at least 60 minutes seven days in the week prior to the survey, and boys (37%) were more likely to report this behavior than girls (21%) (Figure 7). The difference by sex is greater among White students, where boys were more than twice as likely as girls to be active daily, 42% vs. 20%. Over half of Nebraska teens (56%) were active for at least an hour five or more days a week, which was higher than the national average of 46%. Forty-six percent of students attended PE on one or more days, on average, and 38% attended every day of the school week, which is more than the national average (27%).

Figure 7: Boys were more likely than girls to be active daily, with the largest differences between White boys and girls



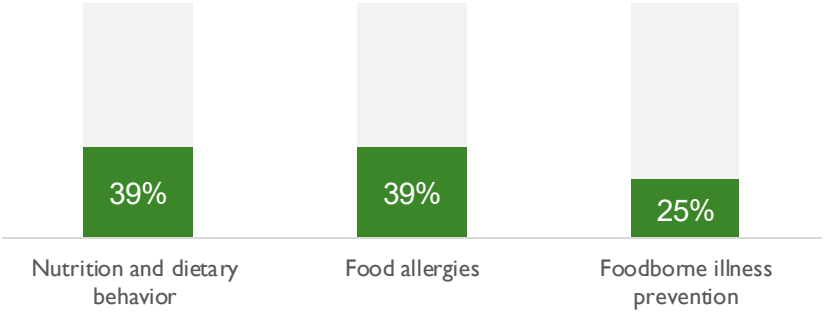
Fifty-six percent of Nebraska students played on at least one sports team, which was more common among White students (62%) than Hispanic students (42%). One in ten (10%) experienced a concussion from playing sports or being physically active in the year prior to the survey, which is a substantial decline from 17% in 2021.

Nutrition Environment and Services + Adolescent Health

The nutrition environment is about students' learning and healthy eating, including messaging and access to healthy food and drink. Nutrition services cover the school meal programs, making sure all food options meet standards, and education for those who provide these services.

What lead health education teachers reported in 2024...

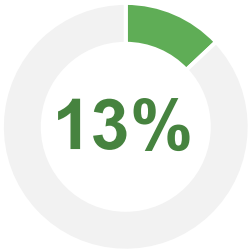
Less than half of health health instructors had nutrition related professional development on the following topics in the past two years



The largest increase in school coverage of topics related to nutrition and dietary behaviors was in finding valid information about nutrition (e.g., differentiating between advertising and factual information)

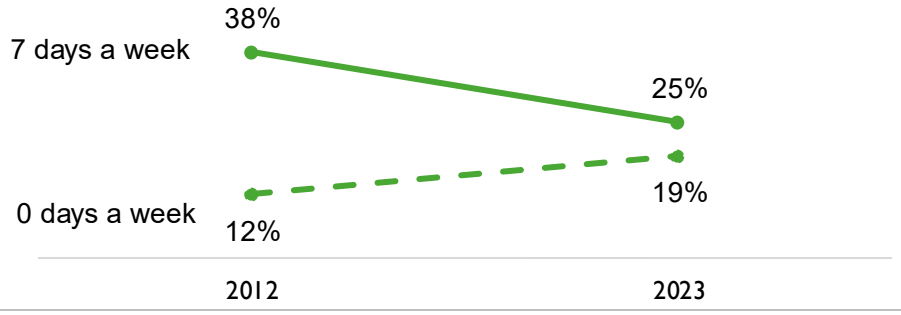
94% in 2024 vs. **88%** in 2022

What students reported in 2023...



Drank an energy drink in the past week

Despite 96% of schools teaching about the benefits of eating breakfast every day - eating breakfast is less common for teens than a decade ago



56% drank a glass or bottle of water at least 3x a day

75% drank a glass or bottle of water at least 2x a day

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Nutrition Environment & Services

The nutrition environment is about students' learning and healthy eating, including messaging and access to healthy food and drink. Nutrition services cover the school meal programs, making sure all food options meet standards, and education for those who provide these services.

School Practices

Table 3 shows the percentage of schools in which teachers taught nutrition and dietary behavior topics in a required course for students in grades sixth through twelfth. Individual topics were taught by at least three-quarters of schools, and 68% taught all the topics in their school. The most common topics taught were the benefits of healthy eating and drinking plenty of water, and eating more fruits, vegetables, and whole grain products, covered in 98% of schools. While not a significant increase, the greatest increase in coverage between 2022 and 2024 was in finding valid information about nutrition, which increased from 88% to 94%.

Table 3: Percentage of schools in which teachers taught each of the following nutrition and dietary behavior topics in a required course for students in any of grades 6 through 12 during the current school year.

Topics	%
Benefits of healthy eating	98%
Benefits of drinking plenty of water	98%
Eating more fruits, vegetables, and whole grain products	98%
Benefits of eating breakfast every day	96%
Choosing a variety of options within each food group	96%
Balancing food intake and physical activity	95%
Differentiating between nutritious and non-nutritious beverages	94%
Finding valid information about nutrition (e.g., differentiating between advertising and factual information)	94%
Choosing foods, snacks, and beverages that are low in added sugars	94%
Using food labels	94%
Choosing foods and snacks that are low in solid fat (i.e., saturated and trans-fat)	94%
Food guidance using the current Dietary Guidelines for Americans (e.g., MyPlate)	93%

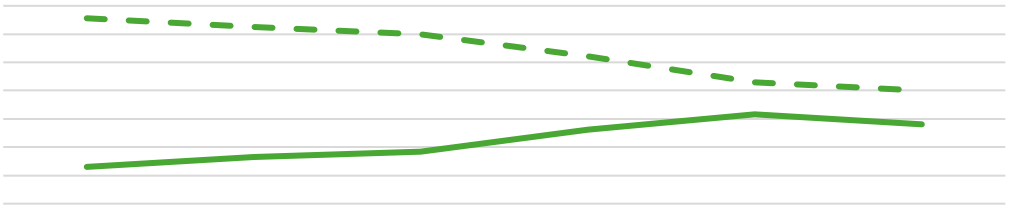
Topics	%
Choosing nutrient-dense foods and beverages that reflect personal preferences, culture, and budget	92%
Choosing foods and snacks that are low in sodium	92%
Risks of unhealthy weight control practices	91%
Relationship between diet and chronic diseases	90%
Eating a variety of foods that are high in calcium	90%
Accepting body size differences	88%
Preparing healthy meals and snacks	88%
Eating a variety of foods that are high in iron	87%
Food safety	87%
Signs, symptoms, and treatment for eating disorders	85%
Food production, including how food is grown, harvested, processed, packaged, and transported*	78%
Taught all 23 topics	*68%*

Less than half of lead health instructors said they received nutrition related professional development on the following topics in the prior two years: nutrition and dietary behavior (39%), food allergies (39%), and foodborne illness prevention (25%).

Student Health

Student Eating and Drinking: While the benefits of eating breakfast daily was one of most common nutrition and dietary behavior topics taught, only one in four Nebraska students (25%) reported doing so, the lowest level since YRBS data on the topic is available. One in five (19%) did not eat breakfast at all in the seven days prior to the survey, an increase from 12% in 2012. Figure 8 shows these trends over the last decade.

Figure 8: One in four Nebraska students ate breakfast every day and one in five not at all, with daily breakfast becoming less common over the last decade



	2012	2014	2016	2018	2021	2023
0 days	12%	13%	14%	18%	21%	19%
7 days	38%	36%	35%	31%	27%	25%

Thirteen percent of Nebraska teens said they drank a can, bottle, or glass of energy drink in the past week. Three out of four Nebraska teens (75%) drank a glass or bottle of water at least twice a day, and 56% drank water at least three times a day. Nearly one in four students had eaten fast food three or more days in the past week.

Health Services + Adolescent Health

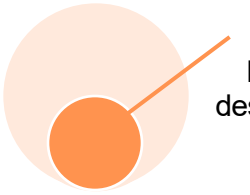
School health services address actual and potential health issues. Beyond first aid, emergency care, and chronic conditions, services include wellness promotion, student and parent education, and referrals to care. Health services also work with community services to help students and their families deal with stressors.

Nine out of ten lead health instructors (91%) covered chronic disease prevention (e.g. diabetes, obesity prevention) in a required course in the current school year

What lead health education teachers reported in 2024...

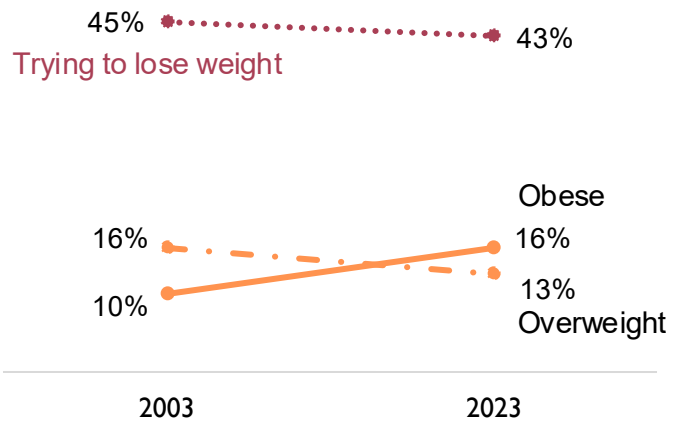
Had professional development on this topic in the past 2 years, while **41% want it in the future**

What students reported in 2023...



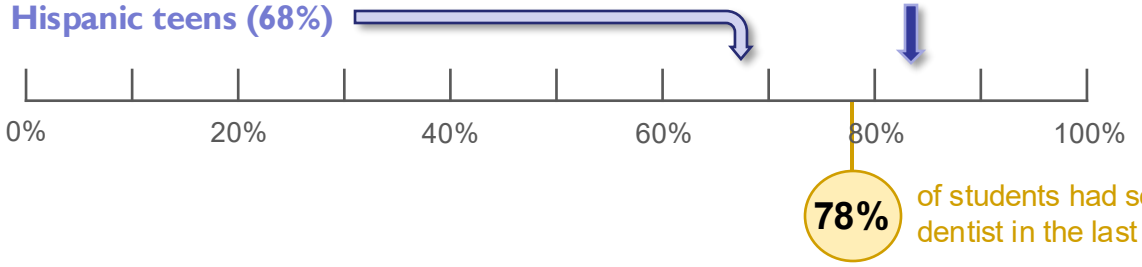
3 out of 10 Nebraska teens describe themselves as overweight

Obesity increased in the last 20 years, while there are fewer overweight students, and no significant change in those trying to lose weight



- Trying to lose weight was more common for girls than boys (57% vs. 31%)
- Fewer boys were overweight in 2023 than in 2012 (13% vs. 16%)
- More girls were obese in 2023 than in 2012 – an increase from 8% to 13%

Seeing a dentist in the last year was more common for White teens (83%) than Hispanic teens (68%)



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Data from the Nebraska 2022 and 2024 School Health Profiles Lead Health Education Teacher data *(2022 n=168, 2024 n=156).* *Funded by the CDC cooperative agreement, "Promote Adolescent Health through the School-Based HIV/STD Prevention and School-Based Surveillance"*; 2021 YRBS data. Use the QR code to view more information.

Health Services

School health services address actual and potential health issues. Beyond first aid, emergency care, and chronic conditions, services include wellness promotion, student and parent education, and referrals to care. Health services also work with community services to help students and their families deal with stressors.

School Practices

The most common professional development received over the past two years addressed epilepsy and seizure disorders, but it was the topic least covered in required courses aiming to increase student knowledge. In contrast, chronic disease prevention was commonly covered in courses, but less often received through professional development (Table 4).

Table 4: Topics of student knowledge coverage and instructor professional development history and goals

		Professional Development	
	Covered	*Had*	*Wanted*
Chronic disease prevention	91%	30%	41%
Infection disease prevention	81%	42%	27%
HIV prevention	80%	24%	37%
Asthma	60%	39%	31%
Epilepsy and seizure disorders	52%	49%	35%

Student Health

Oral Health: Over three out of four students (78%) had seen a dentist in the year prior to the survey, which was an increase from 2021 (71%). Only 1% of Nebraska students had never seen a dentist.

Obesity: Three out of ten students described themselves as overweight. Based on calculations from height and weight, 13% were categorized as overweight and 16% as obese (up from 13% in 2012 and 10% in 2003). Compared to 2012, boys in 2023 were less likely to be overweight (13% vs. 16%), and girls in 2023 were more likely to be obese (13% vs. 8%). Hispanic teen obesity increased from 21% in 2012 to 24% in 2023. Nearly three in ten students (29%) experienced teasing or name calling because of their weight, size, or physical appearance in the past year. Forty-three percent of students said they were trying to lose weight – this was more common for girls (57%) than for boys (31%; down from 41% in 2021). White boys (23%) were less likely to be trying to lose weight than both Hispanic boys (49%) and White girls (58%). For weight management, 3% of students used diet pills or similar substances for weight management without doctor's supervision, and one in five students (19%) went without eating for 24 hours or more. Not eating was more common for girls than boys (27% vs. 12%).

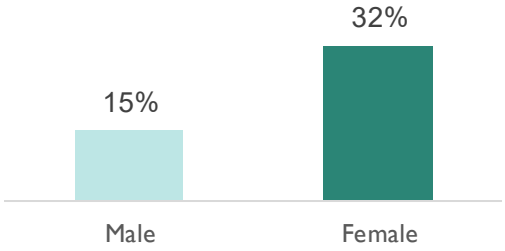
Counseling, Psychological, and Social Services + Adolescent Health

These services support behavioral, emotional, and mental health for students through on-site services, referrals to services, and school-community-family collaborations. Assessments and interventions help address psychological, academic, and social barriers to learning.

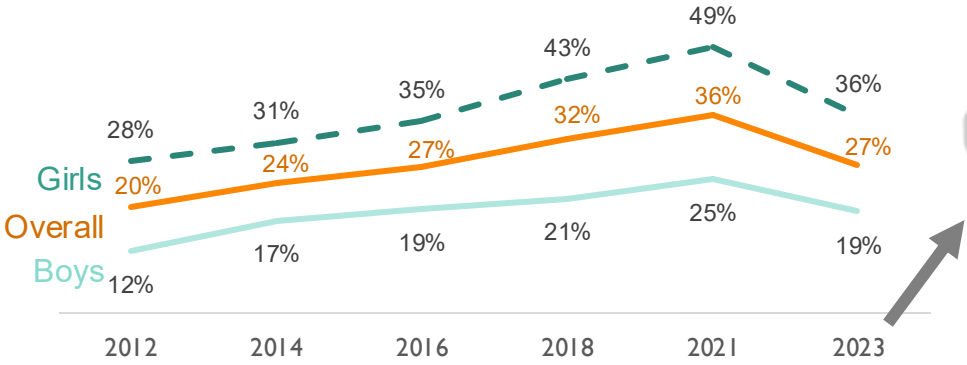
What students reported in 2023…

Nearly one in four (23%) students reported that their mental health was not good most of the time or always

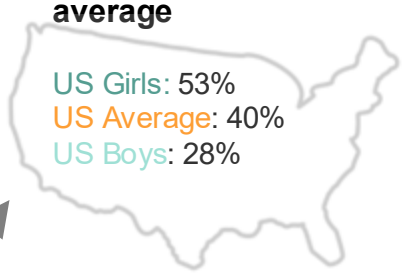
Females were significantly more likely to report that their mental health was not good most of the time or always



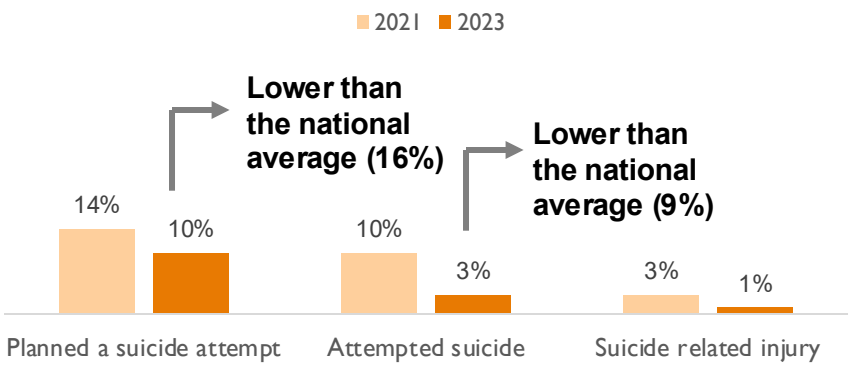
Girls in Nebraska were twice as likely as boys to say they felt sad/hopeless, but there was a significant decrease in the past two years



Nebraska's rates in 2023 were all lower than the national average



Suicide related outcomes declined from 2021 to 2023



14X

Students who were often sad were much more likely than less sad peers to say they had seriously considered suicide (43% vs. 3%)

Emergency department hospitalizations show that girls are about two to three times as likely as boys to be treated for deliberate self-harm and suicide ideation among teens between 10-19.[1]

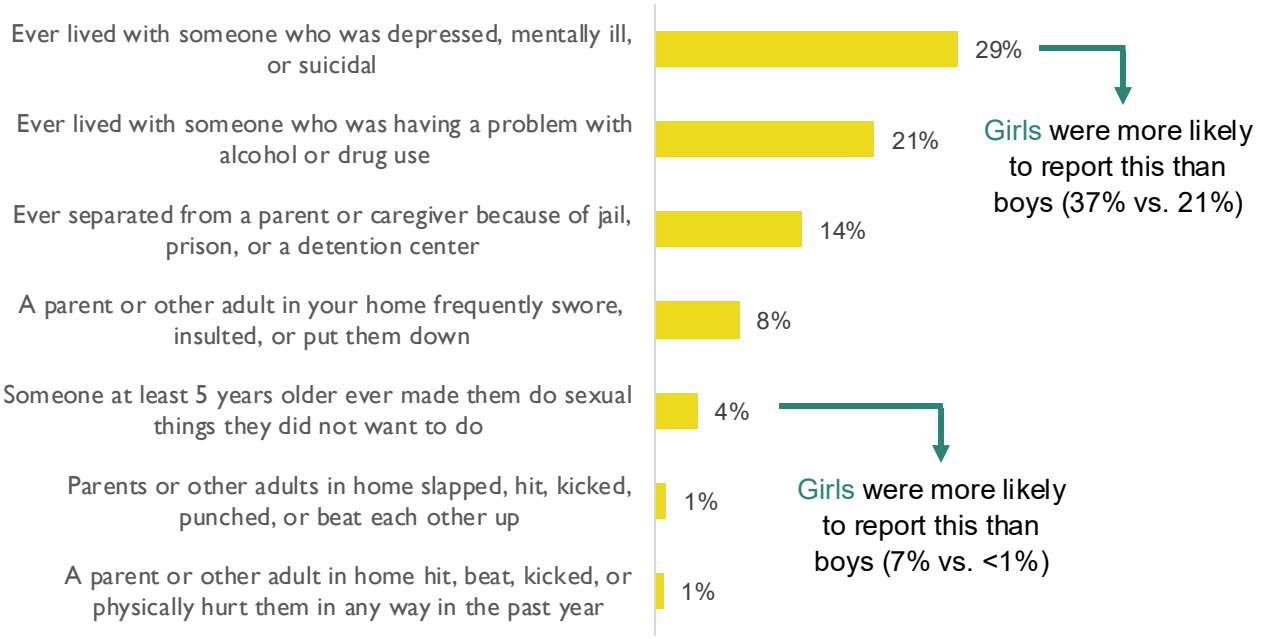
Between 2018-2023, the age adjusted suicide rate for Nebraska adolescents ages 15-19 was 13.94 per 100,000 persons.[2]

This was **much higher for males (20.52)** than females (7.03).

Adverse Childhood Experiences (ACEs)

ACEs are events experienced in childhood that are potentially traumatic and can be associated with various negative outcomes, such as increased risk for substance use and poor mental health.

ACEs were reported by up to 73% of teens in Nebraska, with slightly less than one-third living with someone who was depressed, mentally ill, or suicidal



of students said an adult in their household tried hard to make sure basic needs were met

[1] Data from the Nebraska Hospital Discharge Data, May 4, 2023
[2] Data from the CDC's Web-based Injury Statistics Query and Reporting System, June 6, 2025

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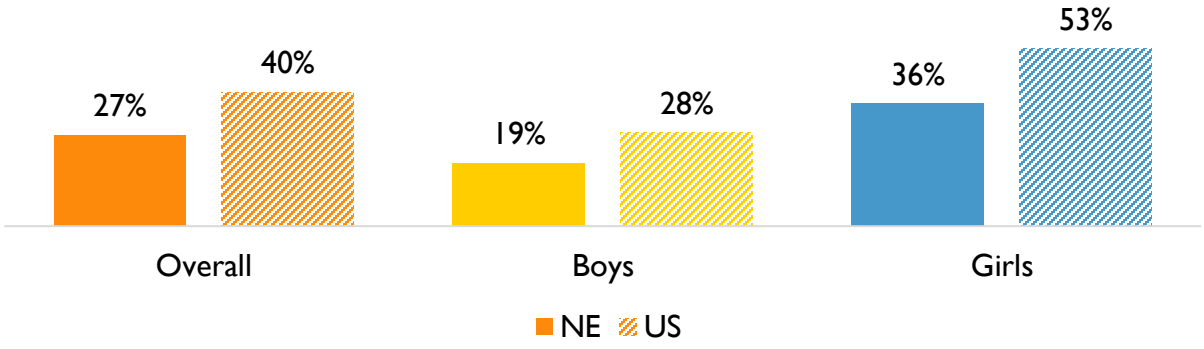
Counseling, Psychological, and Social Services

These services support behavioral, emotional, and mental health for students through on-site services, referrals to services, and school-community-family collaborations. Assessments and interventions help address psychological, academic, and social barriers to learning.

Student Health

Mental Health: More than a quarter of Nebraska students (27%) felt sad or hopeless almost every day for two weeks or more in the past year, which was an increase from 2012 (20%), but a decline from 2021 (36%). There were substantial differences between girls and boys in Nebraska, as well as compared to national numbers, overall and by sex (Figure 9). Fewer students reported that their mental health was not good most of the time or always (23%), but the sex differences remained (32% of girls and 15% of boys).

Figure 9: Teens in Nebraska were less likely than teens nationwide to feel sad and hopeless

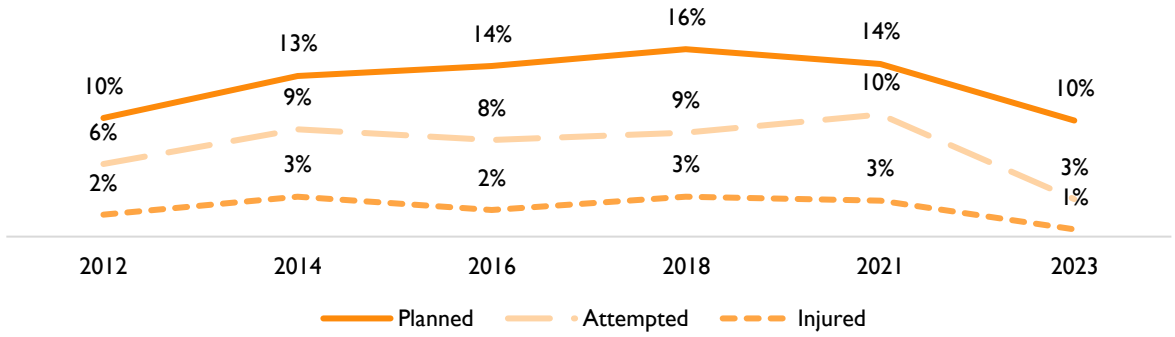


The CDC collects data on injuries and deaths for different age groups at the state level. Between 2018-2023, the age-adjusted suicide rate for Nebraska adolescents ages 15-19 was 13.94 per 100,000 persons[3]. This was much higher for males (20.52) than for females (7.03). The YRBS data showed one in seven Nebraska students (14%) seriously considered attempting suicide in the past year, which was lower than the national average of 20%. One in ten planned how they would attempt suicide in the last year, 3% attempted suicide, and 1% had a resulting injury – all of which were lower than in 2021 (Figure 10). Nationally, teens were more likely to make a suicide plan (16%) and girls in Nebraska were half as

[3] Data from the CDC's Web-based Injury Statistics Query and Reporting System, pulled June 6, 2025.

likely than girls nationally to make a suicide plan (10% vs. 21%). Suicide attempts were three times as common, nationally (9% vs. 3% in NE). Students who were often sad were more likely than less sad peers to say they had seriously considered suicide (43% vs. 3%). Emergency department hospitalizations show that girls are about two to three times as likely as boys to be treated for deliberate self-harm and suicide ideation among teens between 10-19[4].

Figure 10: Suicide related outcomes decreased between 2021 and 2023



Adverse Childhood Experiences: Adverse Childhood Experiences (ACEs) are events experienced in childhood that are potentially traumatic and can be associated with various negative outcomes, such as increased risk for substance use and poor mental health. These can create an environment that undermines a child's sense of stability and safety. Eighty-five percent of students said an adult in their household tried hard to make sure basic needs were met, such as looking after their safety and making sure they had clean clothes and enough to eat, which is considered a protective factor against ACEs. Table 5 shows the percentage of Nebraska students reporting different ACEs risk factors in the YRBS. The most common, living with someone with poor mental health, was reported more frequently by girls (37%) than boys (21%). Girls were also more likely to experience being made to do sexual things they did not want to do by an adult or someone at least five years older than them (7% vs. <1% of boys). Adult forced sexual activity also dropped by at least half from 2021 to 2023 for boys (from 3% to <1%), and White teens (from 6% to 3%). There was a decline in the percentage of teens who were often physically hurt by their parents, from 2% in 2021 to <1% in 2023, which declined from 3% to <1% for boys, and from 2% to <1% for White teens. The percentage of girls who were separated from parent(s) due to incarceration also changed, from 17% in 2021 to 11% in 2023.

Table 5: Adverse Childhood Experiences (ACEs)	
	%
Ever lived with someone who was depressed, mentally ill, or suicidal	29%
Ever lived with someone who was having a problem with alcohol or drug use	21%
Ever separated from a parent or guardian because of jail, prison, or a detention center	14%
A parent or other adult in your home often swore, insulted, or put them down	8%
Someone at least 5 years older ever made them do sexual things they did not want to do	4%
Parents or other adults in home slapped, hit, kicked, punched, or beat each other up	1%
A parent or other adult in home often hit, beat, kicked, or physically hurt them in any way	<1%

[4] Data from the Nebraska Hospital Discharge Data, pulled by NE-DHHS analyst on May 4, 2023

Related indicators show that 2% of Nebraska teens reported having unstable housing in the month before the survey, and 1% said they were frequently hungry because there was not enough food at home.

Child Abuse and Neglect: In 2023, there were 36,366 reports of child abuse or neglect made to the Nebraska Department of Health and Human Services[5]. Sixty percent of these reports were screened out for not meeting the severity or definition required. Of the substantiated cases, 13% were aged 15 and older. In slightly more than half of the cases, the victim was female (53%). One in five victims in this age group was Hispanic. Of racial categories, 56% were White, 10% were Black or African American, 9% were of multiple races, 6% were American Indian or Alaska Native, and 2% were Asian.

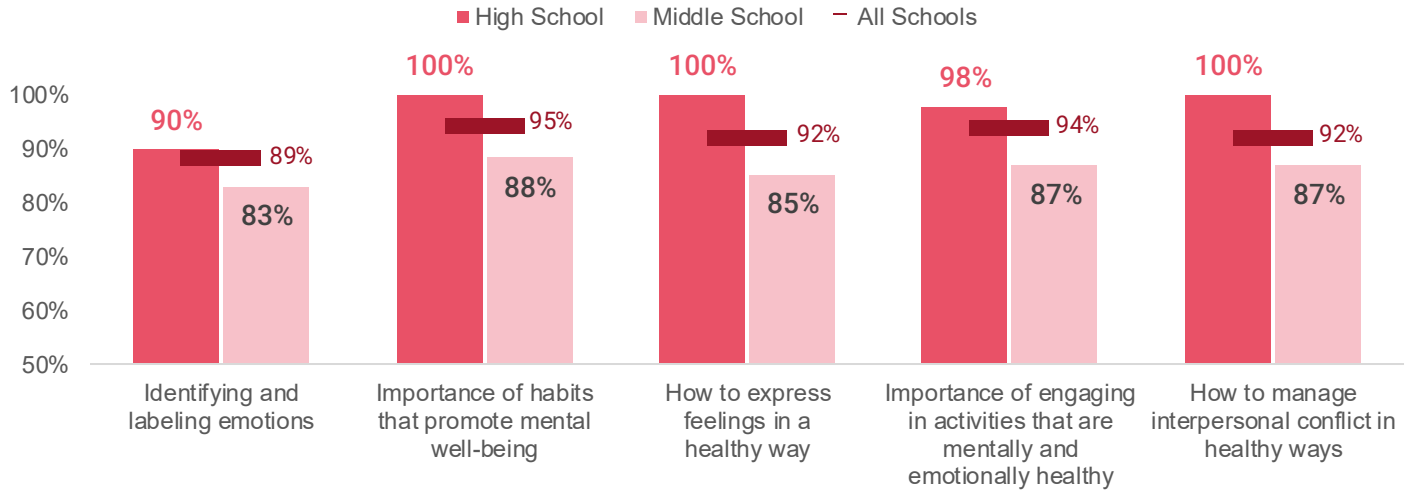
[5] 2023 Child Abuse and Neglect Report

Social and Emotional Climate + Adolescent Health

The interaction between society and students' thoughts and behaviors impact development and the learning experience. A positive social and emotional climate promotes student academic performance, engagement, relationships, and feeling safe and supported.

What lead health education teachers reported in 2024…

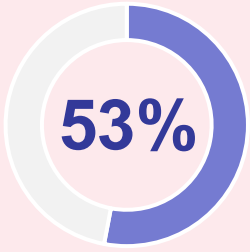
In 2024, about nine in ten schools in Nebraska taught each of the mental and emotional health topics in a required course for students grades 6 through 12, with coverage generally higher in high schools than middle schools



About nine in ten schools (92%) included analyzing the influence of family, peers, culture, media, technology, and other factors on health behaviors in their health curriculum

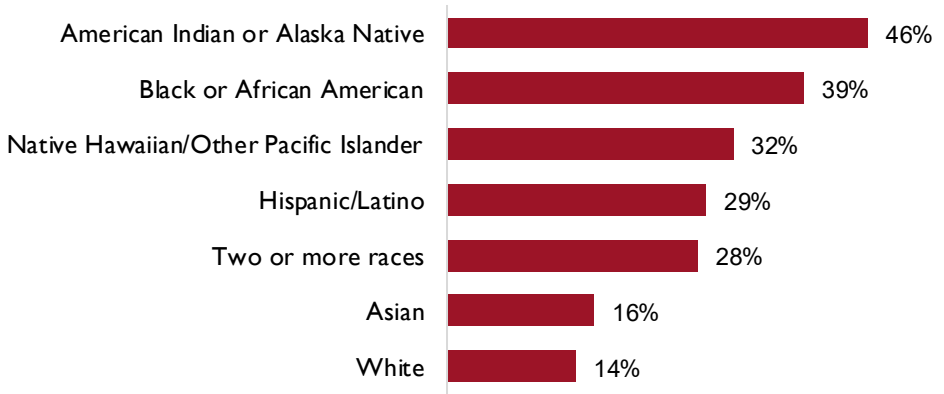
What we know about students who were chronically absent

(meaning students miss about 10% of school days)

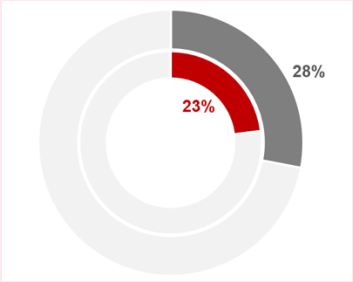


of children with disabilities were chronically absent[1]

Nearly half of Native American students in Nebraska were chronically absent in the 2023-24 school year



In the 2022-23 academic year, about one in four Nebraska students were chronically absent. The average in the US was slightly higher.[1]



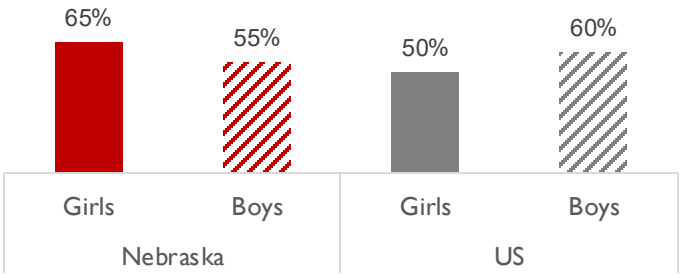
High school students more likely to be chronically absent:[2]

- Those with poor relationships with teachers were **1.8X** more likely
- Those with low self-efficacy were **1.7X** more likely
- Those with low school climate were **1.6X** more likely

What students reported in 2023…

3 out of 5 students agreed or strongly agreed that they felt close to people at their school

It was more common for girls in Nebraska - compared to boys in NE and females in the US - to strongly agree or agree they feel close to people at their school

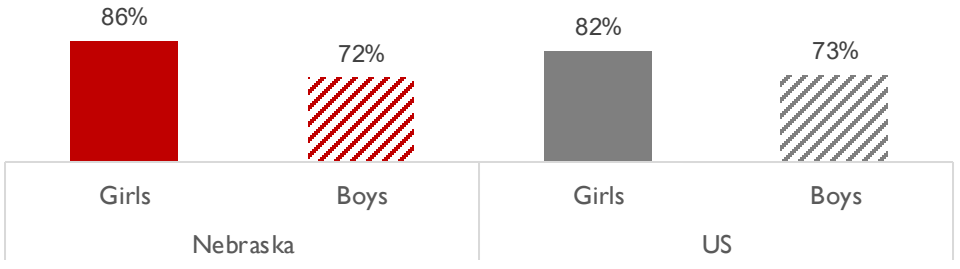


of teens felt they could often talk to a friend about their feelings

Boys were significantly less likely compared to girls to feel they could talk to a friend about their feelings most of the time or always

Four out of five (79%) students used social media several times a day

In Nebraska and across the US, females are signficantly more likely to use social media at least several times a day compares to males



[1] Chronic Absenteeism, US Department of Education, Accessed February 23, 2025
[2] The State of Chronic Absenteeism, Panorama Education, Accessed February 23, 2025

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Social and Emotional Climate

The interaction between society and students' thoughts and behaviors impacts development and the learning experience. A positive social and emotional climate promotes student academic performance, engagement, relationships, and feelings of safety and support.

School Practices

Assessing the ability of students to set personal goals that enhance health, take steps to achieve these goals, and monitor progress in achieving them occurred in a required course in two-thirds of schools (67%) for grades 9-12 and in 56% of schools for grades 6-8. This was more common in middle schools (66%) than in combined junior/senior high schools (44%) for grades 6-8. The surveyed teachers reported that most mental and emotional health topics listed in Table 6 were taught in a required course for students in grades 6-12. Eighty-four percent of responding schools taught all ten topics. The importance of habits was most commonly covered. In 2022, Nebraska teachers reported coverage at higher rates than the national average for the following topic areas: the importance of habits (NE 94% vs. US 89%), the value of individual differences (NE 91% vs. US 85%), and establishing and maintaining healthy relationships (NE 93% vs. US 88%).

Table 6: Mental and emotional health topics in a required course for students in any grade	
	%
Importance of habits (e.g., exercise, healthy eating, meditation, mindfulness) that promote well-being	95%
The importance of engaging in activities that are mentally and emotionally healthy	94%
How to establish and maintain healthy relationships	93%
How to prevent and manage emotional stress and anxiety in healthy ways	93%
How to use self-control and impulse control strategies to promote health (e.g., goal setting and tracking, breathing techniques)	93%
How to express feelings in a healthy way	92%
How to manage interpersonal conflict in healthy ways	92%
How to get help for troublesome thoughts, feelings, or actions for oneself and others	92%
Identifying and labeling emotions	89%
Value of individual differences (e.g., culture, ethnicity, ability)	89%

Several topics were covered by all reporting high schools: expressing feelings in a healthy way, managing interpersonal conflicts in healthy ways, preventing and managing emotional stress, using self-control and impulse control strategies to promote health, getting help for troublesome thoughts, and the importance of habits. Nearly all students in junior/senior high schools (98%) learned about engaging in mentally and emotionally healthy activities, compared to 87% of middle school students.

All high schools included the influence of media (as well as family, peers, culture, technology, etc.) on health behaviors in their health education curriculum – the average across school types was 92%. More than half of schools (53%) with grades 6-8 covered the impact of these factors on sexual risk behaviors, and nearly the same percentage assessed the ability of students to analyze such factors. Schools with grades 9-12 were much more likely to both cover the materials (79%) and assess students' analysis ability (73%). Two out of three schools (65%) with grades 6-12 provided students an opportunity to practice their analysis skills. Media was also covered in required courses in middle and high school related to tobacco use (86%) and alcohol and other drug use (89%).

The 2024 State of the American Teacher Survey by the RAND Corporation[6] included questions about coverage of social and political topics in K-12 public schools, nationally. Nine out of ten teachers taught social and emotional learning (SEL), with more than half (54%) reporting addressing the topic regularly. As a topic, SEL was less common in high schools (84%) than in elementary and middle schools (both 93%). Social and political topics were most commonly covered in ELA and social studies courses.

Chronic Absenteeism

Chronic absenteeism is a barrier to learning that refers to students who have missed days of instruction in school, including excused and unexcused absences, as well as disciplinary removals. Many sources use 10% of missed school days as a metric for chronic absenteeism. In the 2022-23 academic year, the US Department of Education[7] reported that 28% of US students were chronically absent from school, while 23% of Nebraska students were chronically absent.

In the 2023-24 academic year, out of a student population of 328,649, there were 6,692,219 total absences recorded[8]. Three out of 10 Nebraska high school students (31%) were classified as chronically absent, with grade and absenteeism increasing together: 9th – 25%, 10th – 30%, 11th – 34%, and 12th – 36%. The percentage of students within each racial/ethnic group who were chronically absent in this academic year varied widely, with nearly half of Native American students in this category, which is more than three times higher than White students (Figure 11).

Figure 11: Nearly half of Native American students in Nebraska were chronically absent in AY 2023-24

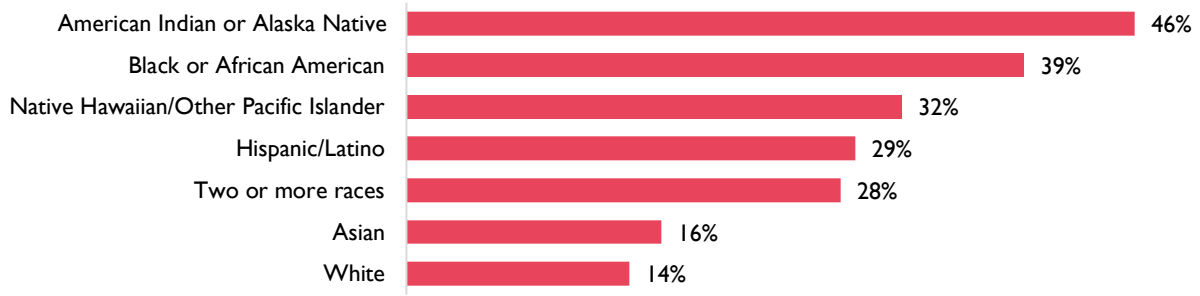
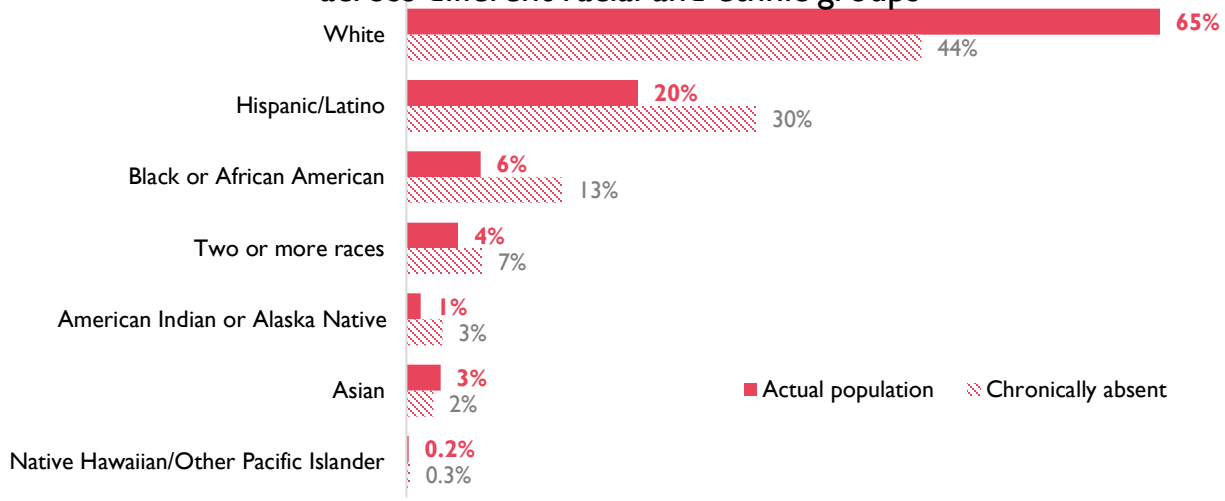


Figure 12 shows the absenteeism data from the US Department of Education (ED)[9] and population values from the Nebraska Department of Education (NDE) for Academic Year 2022-23. Chronically absent students are not proportional to their numbers in school. Native American students are three

[6] Report: State of the American Teacher Survey, 2024
[7] Chronic Absenteeism, US Department of Education, Accessed February 23, 2025
[8] NE Attendance Data Statistics, SY 2023-2024, Nebraska Department of Education
[9] Nebraska Department of Education 2022/23 Membership by Grade, Race, and Gender Data Report

times as likely to be in the chronically absent group than the overall population, and Black students are twice as likely. White and Asian students are the only groups underrepresented.

Figure 12: Chronic absenteeism is not experienced the same across different racial and ethnic groups



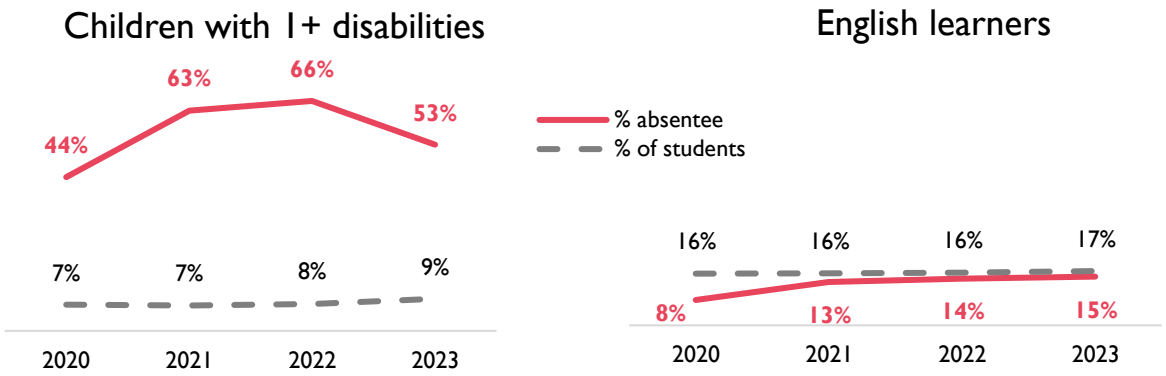
While not specific to grade level, the most common reasons recorded for absences from school in the 2023-2024 school year were unexcused (39%), excused for illness/medical reasons (29%), and 21% were other types of excused absences outside of disciplinary actions, noninstructional activity, or transportation issues (which represented less that 3% of absences). There are many reasons for chronic absenteeism, which may be organized into three primary categories[10]: barriers, aversion, and disengagement. Barriers include adult responsibilities, disciplinary issues, health, housing instability, involvement in child welfare, and transportation issues (including neighborhood safety). Aversion includes low academic performance, mental health reasons, receiving special education, and school climate. Disengagement includes low connectedness, negative peer influence, and substance use. The Panorama Education study[11] found that after controlling for learning needs, school poverty level, and student demographics, school safety and engagement were related to as much as 22% of the likelihood of a student being chronically absent. Among high school students, Panorama found that social awareness, self-management, and supportive relationships were most strongly linked to chronic absenteeism. Specifically, those with poor relationships with teachers are 1.8 times more likely, those with low self-efficacy are 1.7 times more likely, and those with low school climate are 1.6 times more likely to be chronically absent.

This report includes data on several relevant topics, such as the topics described earlier in this section, and the later section on Physical Environment, although they are not connected directly to absenteeism data. Some characteristics that also may help explain chronic absenteeism are in the ED datasets. For Figure 13, the raw numbers of chronically absent from the ED data were applied to overall population numbers from NDE for the two groups shown (pink line). For both children with disabilities and English learners, you can see an increase after 2020, when remote learning was more common, but no similarities otherwise. Although children with one or more disabilities make up less than 10% of the student population, they accounted for over half of chronically absent students after 2020. In contrast,

[10] Center for Applied Research and Educational Improvement, Attendance and Chronic Absenteeism
[11] State of Chronic Absenteeism: New Research from Panorama Education

English learners saw an increase in chronic absenteeism but remain slightly underrepresented among chronically absent students relative to their overall enrollment.

Figure 13: The percentage of students who are chronically absent is much higher for some groups than others



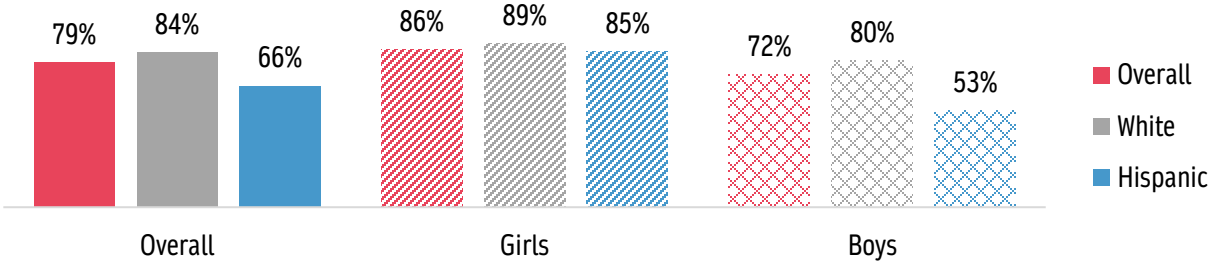
The ED data also includes raw values for homeless students and those with Section 504 disability status (both ~3% of all chronically absent on average). In 2023, they added economic disadvantaged as a characteristic, who were 78% of the chronically absent in that year.

Student Health

Student connections: Among students, 55% said they were able to talk to an adult in their family or another caring adult about their feelings. Three out of five agreed or strongly agreed that they felt close to people at their school. This was more common for girls in Nebraska compared to girls across the US (65% vs. 50%). Fifty-five percent said they felt they could often talk to a friend about their feelings, but this was more common for girls (64%) than boys (46%), with a larger difference among White teens (71% of girls vs. 47% of boys). In less positive forms of communication, 22% received a text or e-mail or saw a social media post with a revealing or provocative photo of someone in the last month. This was more common for White teens (25%) than for Hispanic teens (13%).

Social media: Four out of five students (79%) used social media several times a day – girls more than boys, and White students more than Hispanic students (Figure 14). That difference is driven mostly by differences among boys.

Figure 14: Girls and White teens were more likely to use social media several times a day than their counterparts, with the biggest differences between White and Hispanic boys



Physical Environment + Adolescent Health

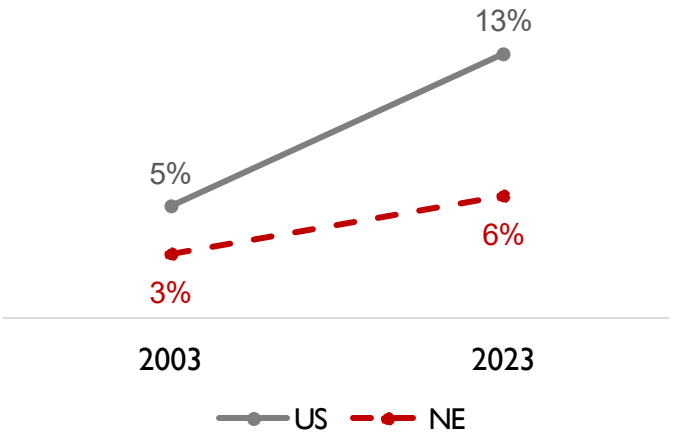
A healthy school environment includes the school building and its physical conditions, plus the surrounding area. The school should protect students and staff from physical threats to promote learning.

What lead health education teachers reported in 2024…

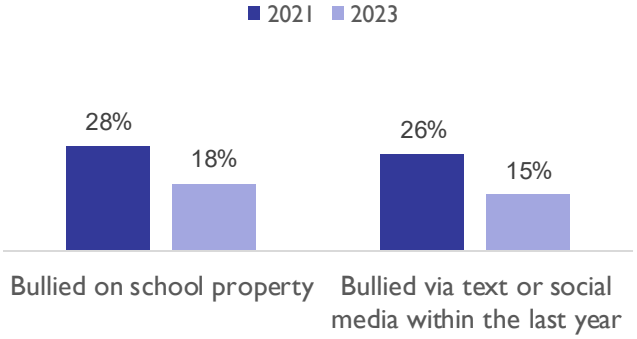
Overall trends show slightly fewer schools taught most of the following violence prevention topics in a required course for students in grades 6 through 12 in 2024 than in 2022

What students reported in 2023…

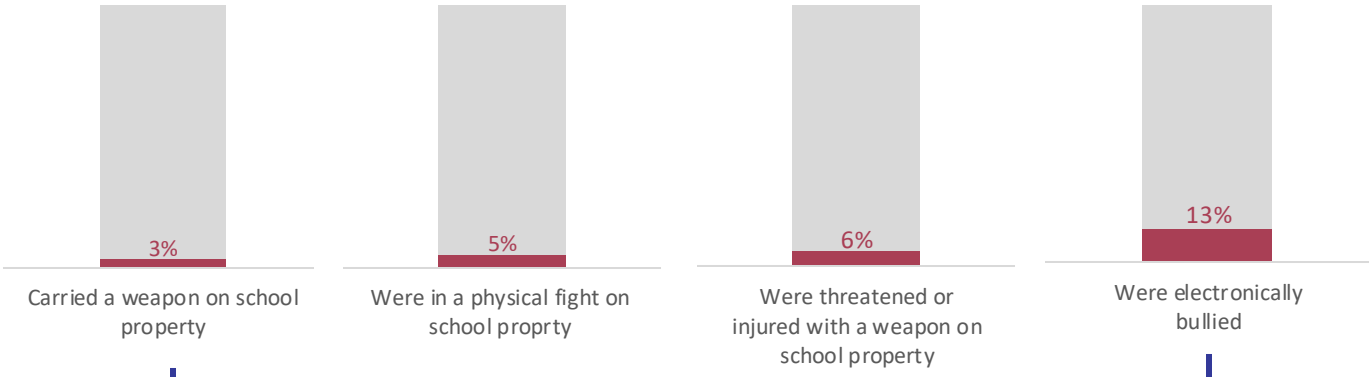
Nebraska students were less likely than teens nationally to have skipped school in the past month because they felt unsafe at or on the way to school



In 2023, girls in Nebraska were less likely to say they had been bullied on school property or via text or social media compared to 2021



Among Nebraska students in 2023…



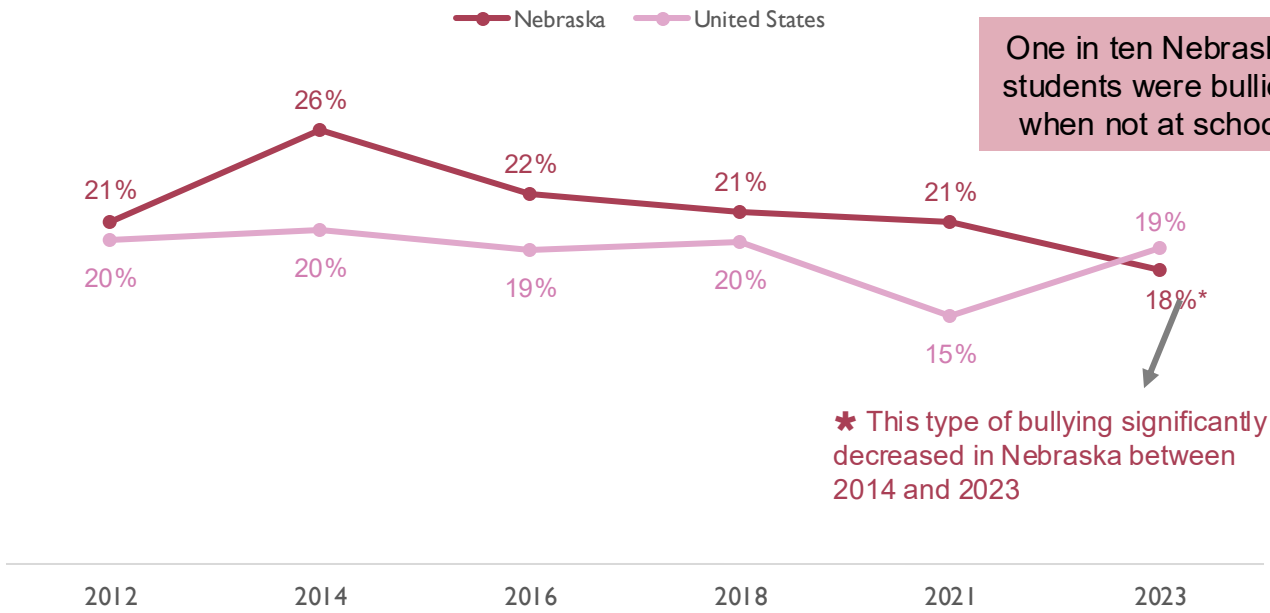
Less common than in 2014 (8%), most notable declines among boys (declined from 10% to 4%) and Hispanic youth (from 8% to 1%)

Boys more likely to be in a physical fight on school property than girls (8% v. 1%)

Between 2021 and 2023, fewer girls were bullied on school property (28% to 18%) and fewer faced electronic bullying (26% to 15%)

Less common than in 2014 (26%), declining among Hispanic teens from 23% to 7% in this time

Until 2023, Nebraska had consistently higher rates of students reporting being bullied on school property compared to the US



NEBRASKA DEPARTMENT OF EDUCATION

Partners for Insightful Evaluation

Data from the Nebraska 2022 and 2024 School Health Profiles Lead Health Education Teacher data *(2022 n=168, 2024 n=156). Funded by the CDC cooperative agreement, "Promote Adolescent Health through the School-Based HIV/STD Prevention and School-Based Surveillance"*; 2021 YRBS data. Use the QR code to view more information.

Physical Environment

A healthy school environment includes the school building and its physical conditions, plus the surrounding area. The school should protect students and staff from physical threats to promote learning.

School Practices

Ninety-three percent of schools tried to increase student knowledge of violence prevention. Half of health instructors had professional development on violence prevention in the last two years (50%), with about the same proportion wanting it (51%).

Seventy-three percent of schools taught all seven of the violence prevention topics listed in Table 7 in a required course for students in any grade between 6th and 12th grades. Getting help for those who are in danger of hurting themselves was the most common topic. In 2022, Nebraska schools were more likely to teach building empathy than the national average (89% vs. 85%).

Table 7: Violence prevention topics taught in a required course

	%
Getting help for self or others who are in danger of hurting themselves	88%
Getting help to prevent or stop violence (including inappropriate touching, harassment, abuse, bullying, hazing, fighting, and hate crimes)	87%
Building empathy (e.g., identification with and understanding of another person's feelings)	85%
Identifying the signs and symptoms of when someone may be thinking of hurting themselves	83%
Perspective taking (e.g., taking another person's point of view)	83%
Strategies for being a positive bystander (e.g., safely de-escalating, preventing, or stopping bullying and harassment)	81%
Describing how stigma, bias, and prejudice can lead to stereotypes, discrimination, and violence	78%

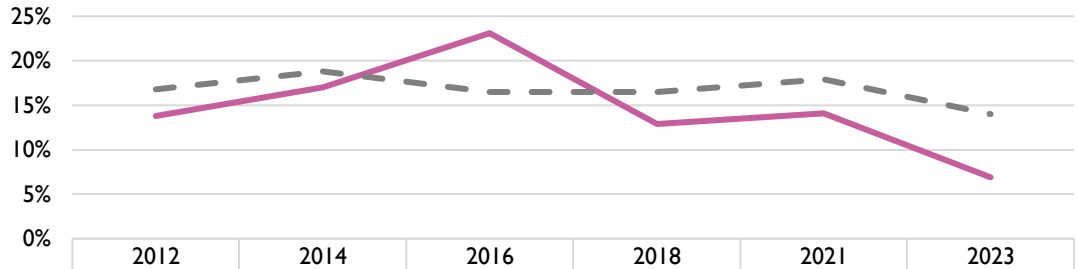
Student Health

School Safety: Six percent of students did not go to school at least one day in the past month because they felt unsafe at school or on the way, which was less than the national average (13%). This was more common for White students in 2023 (5%) than in 2012 (3%). Teens carrying weapons like guns or knives in the last month was less common in 2023 (3%) than in 2014 (8%). Among boys, there was a decline from 10% to 4%, girls' carrying dropped from 5% to 2%, and Hispanic youth declined the most from 8% to 1%. Overall, 6% of teens reported being threatened or injured with a weapon on school property. This was less common for Hispanic students in 2023 than in 2012 (5% vs. 9%). Fewer students (5%) reported being in a physical fight on school property, but there were large differences by sex: 8% of

boys fought at school, compared to 1% of girls. These differences were even larger among White teens, with 11% of boys fighting vs. <1% of girls.

Eighteen percent of Nebraska teens were bullied on school property, which is a drop from 26% in 2014. Electronic bullying was reported by 13% of surveyed students. Between 2021 and 2023, fewer girls were bullied on school property (28% to 18%), and fewer faced electronic bullying as well (26% to 15%). There was a decline in electronic bullying among Hispanic teens as well, at only 7% in 2023, which was significantly lower than 2012 and 2016 (Figure 15; White students shown for comparison – not significantly different).

Figure 15: Hispanic teens' experience of electronic bullying is at its lowest in over a decade



	2012	2014	2016	2018	2021	2023
Hispanic	14%	17%	23%	13%	14%	7%
White	17%	19%	17%	17%	18%	14%

Violence: Twelve percent of Nebraska teens saw someone get physically attacked, beaten, stabbed, or shot in their neighborhood (the US average was almost double at 23%), and 16% were in a physical fight in the year before the survey. This was more common for boys than girls (23% vs. 9%), with larger differences between White boys and girls (27% vs. 8%). One in ten students were bullied when not at school, and 9% said they bullied someone when not at school. Four percent had carried a gun that wasn't for sport or hunting on at least one day in the past year – this was more common for White boys (9%) compared to White girls (1%).

Nine percent of students experienced sexual violence (being forced by anyone to do sexual things) in the prior year, which was more common for girls (13%) than boys (5%). Experiences of sexual dating violence (being forced by someone they were dating or going out with to do sexual things) was reported by 8% of students. This was reported by 4% of boys and 13% of girls, which was a sharp decline from 2021, when 26% of girls reported sexual dating violence. There was also a decline among White students (16% to 9%) and Hispanic students (16% to 3%). Among the 8% of Nebraska students reporting this in 2023, it was reported more often by those who reported being suicidal (30% vs. 5% who were not suicidal), students who felt unsafe going to school (27% vs. 7% of those who felt safe), and those who reported being sad/hopeless (16% vs. 5% for those who did not report being sad/hopeless). Physical dating violence (being physically hurt on purpose by someone they were dating or going out with) also dropped for girls, from 11% in 2021 to 5% in 2023. Among the 6% of Nebraska students reporting this, it was more often reported by students who felt unsafe going to school (23% vs. 5%), said they were suicidal in the past year (22% vs. 3%), and reported being sad/hopeless (12% vs. 3%). There was a decline in physical dating violence for Hispanic students between 2012 (8%) to 2023 (1%). Six percent of students were physically forced to have sex when they did not want to; this declined for girls from 2021 (17%) to 2023 (8%).

Employee Wellness + Adolescent Health

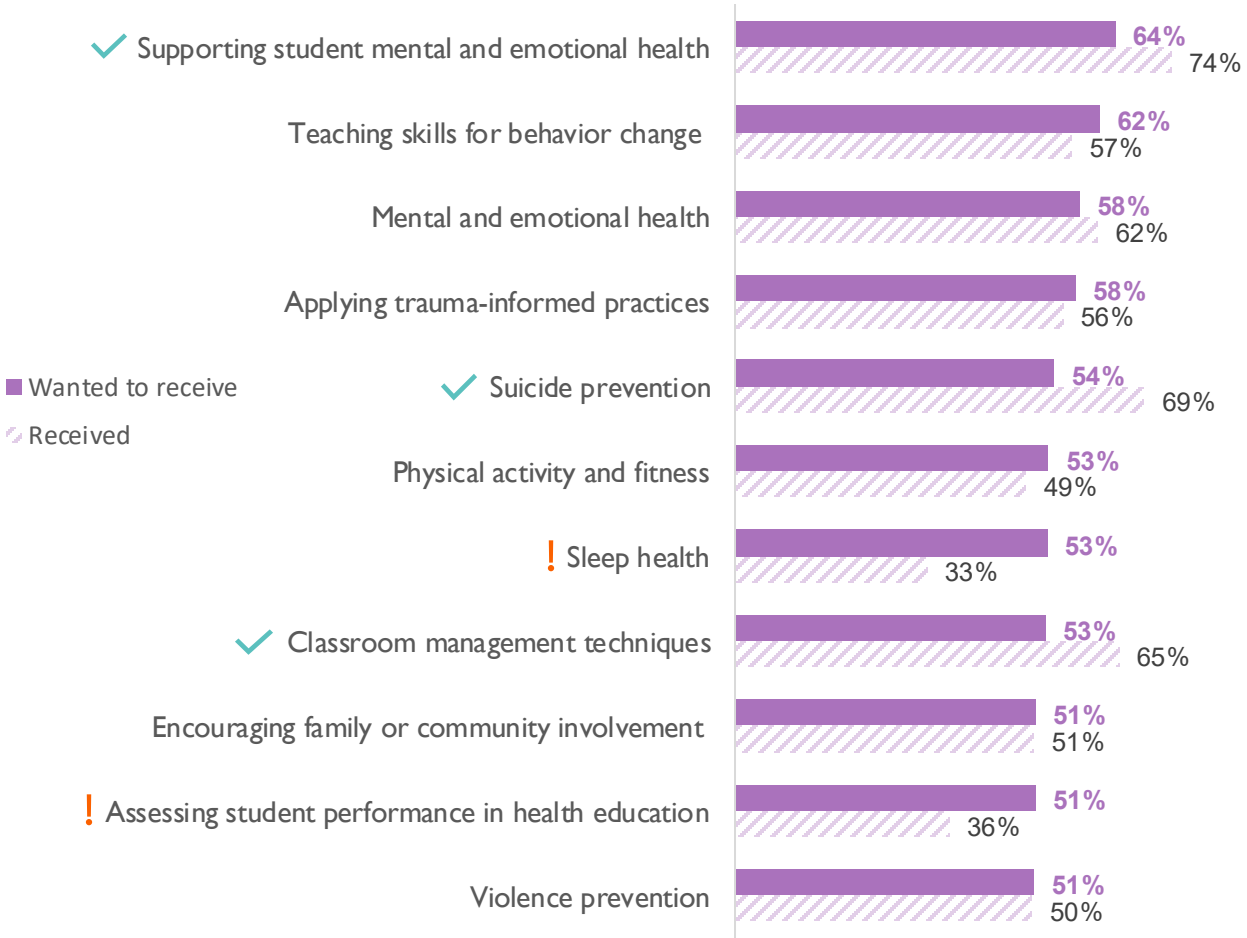
Healthy school staff support students' wellbeing and academic success. As a worksite, schools foster employees' physical and mental health. Staff who have appropriate training and resources are a benefit to their students and community.

What lead health education teachers reported in 2024...

✓ more people received PD in that topic than reported wanting PD

! more people reported wanting PD in that topic than receiving it

In 2024, there were 11 topics that more than half the lead health education teachers wanted to receive professional development around



Nationally[1]

72% of teachers were glad they selected teaching as a career

76% of teachers didn't seem to have as much enthusiasm now as they did when they began teaching

[1] Report: State of the American Teacher Survey, 2024.

NEBRASKA DEPARTMENT OF EDUCATION

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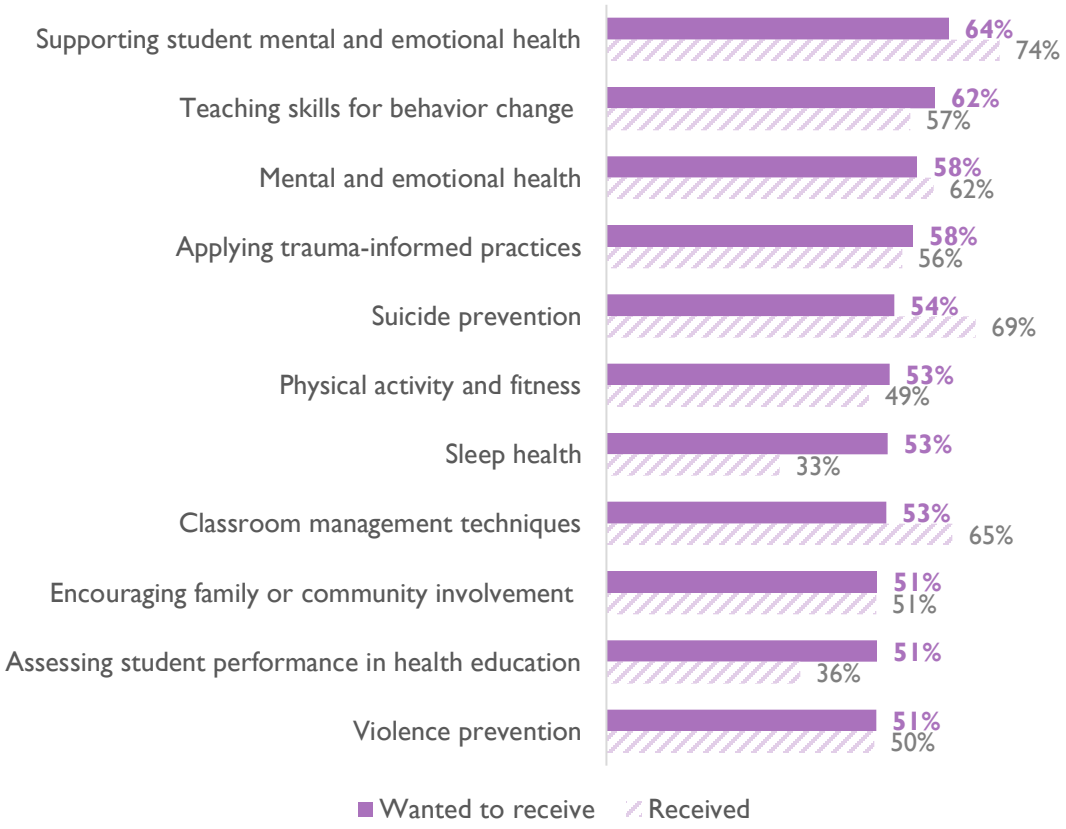
Employee Wellness

Healthy school staff support students' wellbeing and academic success. As a worksite, schools foster employees' physical and mental health. Staff who have appropriate training and resources are a benefit to their students and community.

School Practices

The majority of Nebraska lead health educators surveyed received a variety of professional development in the two years before the survey. Figure 16 shows the most frequently cited topics desired by teachers, organized from most wanted to least. Mental and emotional health was the most received and desired professional development. The largest differences between those who wanted and had training were for assessing student performance in health education, which was one of the topics least likely to be received.

Figure 16: Professional development wanted and received

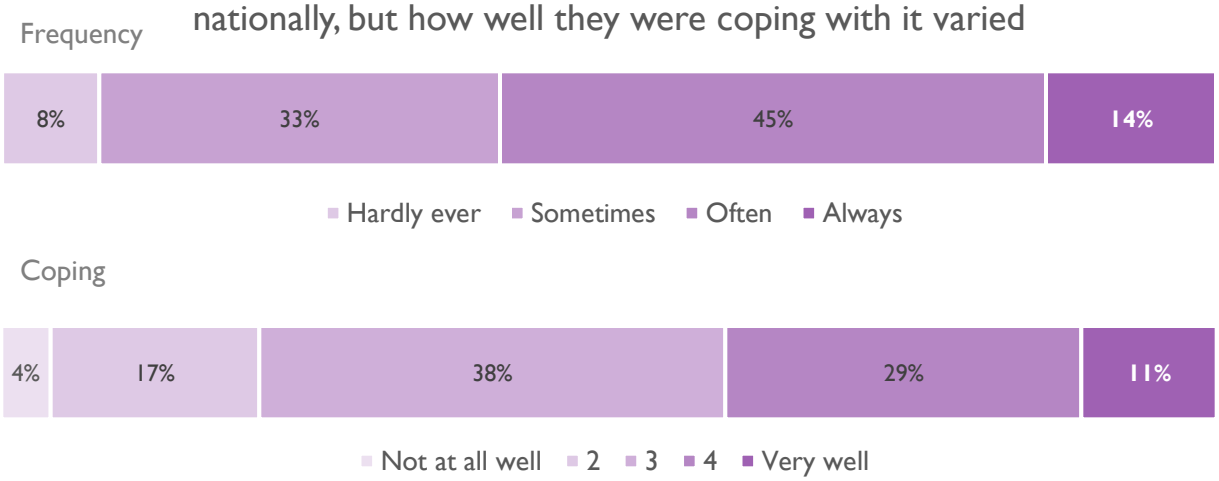


While limited data is specifically available for Nebraska, the findings from the State of the American Teacher by the RAND Corporation[12] include data on teachers at the national level. Nearly three-quarters of teachers (72%) agreed that they were glad they selected teaching as a career, but fewer looked forward to teaching in the future (57%). Seventy-six percent said they didn't have as much enthusiasm for teaching as they did when they began teaching, and 58% agreed that the stress and disappointments involved in teaching aren't really worth it.

When asked how often their work has been stressful, nearly three out of five said often or always (none said never), and the ability to cope varied (Figure 17). Among the general population, 28% reported feeling often and always stressed, none said they were coping not well at all, and 34% said very well. Top sources of stress included managing student behavior (in the top three for 45% of respondents), salary (37%), administrative work outside of teaching (33%), and spending too many hours working (26%). Fewer than 5% rated feeling physically unsafe or lacking adequate mentoring. Ninety-two percent of teachers were contracted to work 21-40 hours a week, but only 10% reported doing so.

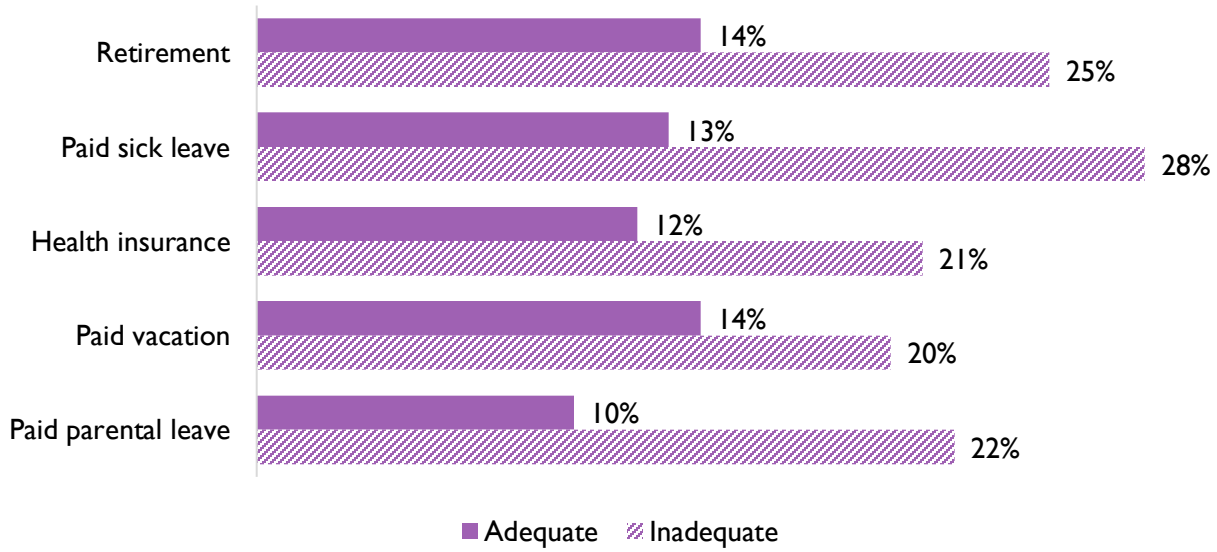
[12] Report: State of the American Teacher Survey, 2024.

Figure 17: Frequent stress was common among teachers, nationally, but how well they were coping with it varied



Nationally, 17% of teachers report an intention to leave the profession at the end of the academic school year. One in five teachers who received no salary increase said they intended to leave the profession, and 24% who received an increase of less than 3% said the same. When asked about the relationship between their change in base salary and intention to leave, 74% said it had no impact, 8% said it made it more likely, and 18% said it made them less likely to leave their job. Teachers who felt their benefits were adequate were less likely to leave – Figure 18 shows the differences in intention to leave based on perceived adequacy of different benefits.

Figure 18: Teachers who think their benefits are inadequate are more likely to say they intend to leave teaching*



*Graph based on a figure from the 2024 RAND report Larger Pay Increases and Adequate Benefits Could Improve Teacher Retention.

The National Educator Association (NEA) collects information on teacher pay and other financial characteristics by state in their Ranking of the States report[13]. In Nebraska, the salaries of public school teachers and instructional staff increased by 2.5% between 2022-23 to 2023-24, which was the 44th largest increase, nationally. (Unfortunately, in constant dollars, the salaries of Nebraska teachers are estimated to decline 7.8% between 2016-2025.) Student fall enrollment in Nebraska schools during that time dropped -.02%, which was less than the national average of -.21% (only 12 states had an increase). Average daily attendance dropped by 4.1% (rank of 49th). The number of teachers increased by 0.3%, and the number of instructional staff increased by 0.5%. In Nebraska, the public schools' current expenditures per student in average daily attendance increased by 8.2%, the 6th highest in the US. These statistics suggest an increase in resources that would benefit teachers.

Resource availability is another way to support employee wellness. Four out of five (81%) Nebraska schools provided health educators with goals, objectives, and expected outcomes for health education, and/or a written curriculum. Nearly three-quarters received a written health education curriculum – this was more common for high school instructors (83%) than junior/senior high school instructors (65%). Almost the same number (72%) provided plans for assessing health education performance. Written instructional competencies were provided to 70% of instructors. Sixty-three percent of schools provided a chart describing the scope and sequence of instruction for health education over the year, which was more common in high schools (72%) than junior/senior high schools (50%).

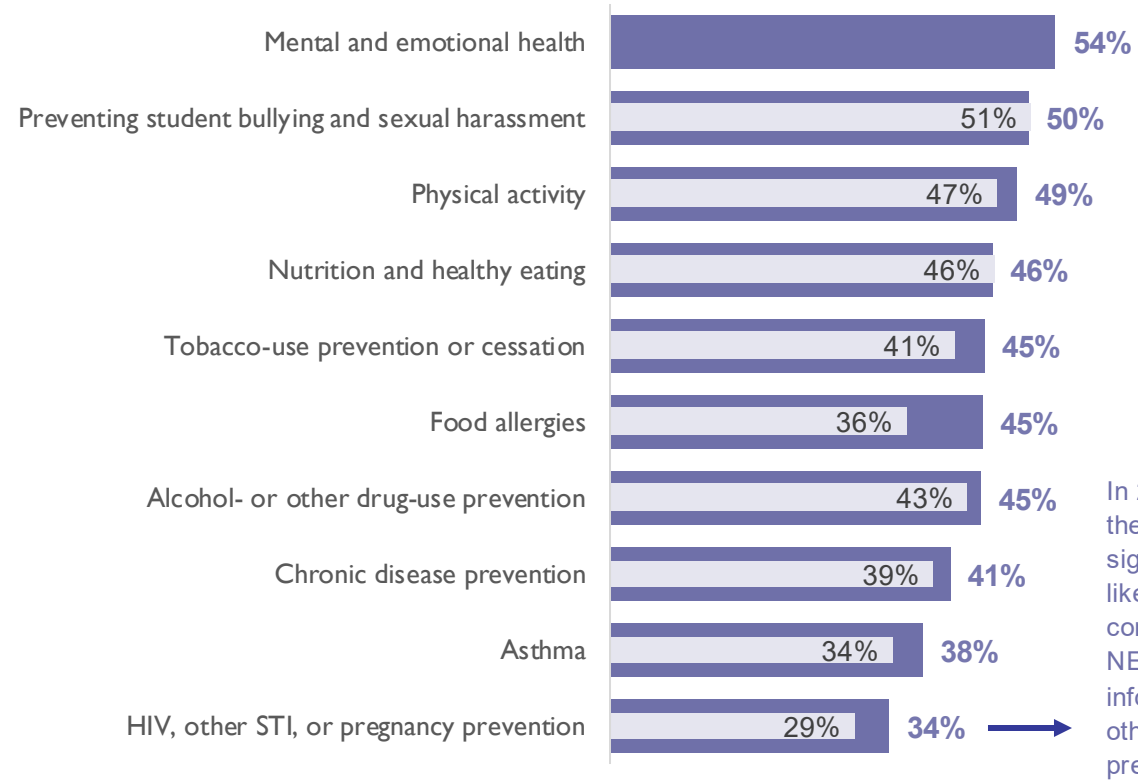
[13] NEA Ranking of the States 2024 and Estimates of School Statistics 2025 report

Family Engagement & Community Involvement + Adolescent Health

Student learning and development is supported when family and school staff work together. When families feel welcomed and engaged, with the support of school staff, student health and wellbeing is reinforced.

What lead health education teachers reported in 2024…

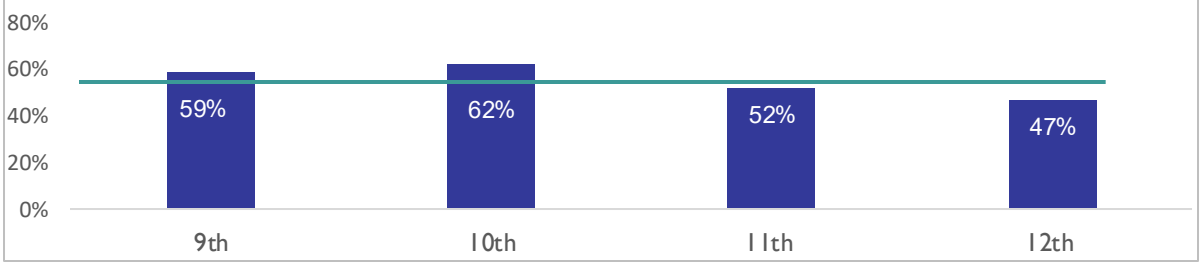
Overall trends show slightly more schools in Nebraska provided parents and families with health information designed to increase parent and family knowledge in 2024 than 2022



In 2022, schools in the US were significantly more likely (37% compared to 29% in NE) to provide information on HIV, other STI, or pregnancy prevention

What students report in 2023…

More than half (55%) reported they felt they were able to talk to an adult in their family or another caring adult about their feelings most of the time or always during their life



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Family Engagement & Community Involvement

Student learning and development are supported when family and school staff work together. When families feel welcomed and engaged, with the support of school staff, student health and wellbeing are reinforced.

Partnerships with community groups, local businesses, and other organizations can support student learning by coordinating information, resources, and services. Staff, students, and families contribute to the community through the sharing of school resources and service-learning opportunities.

School Practices

Table 8 shows health information that was shared with parents and families during the school year. At least half of schools provided information on mental and emotional health (54%) and bullying prevention (50%). HIV, other STI, or pregnancy prevention was the least common topic in 2024, and was similarly low in 2022, when it was significantly lower than the national average (29% vs. 37%).

Table 8: Percentage of schools that provided parents and families with health information designed to increase parent and family knowledge of the following topics during the current school year.

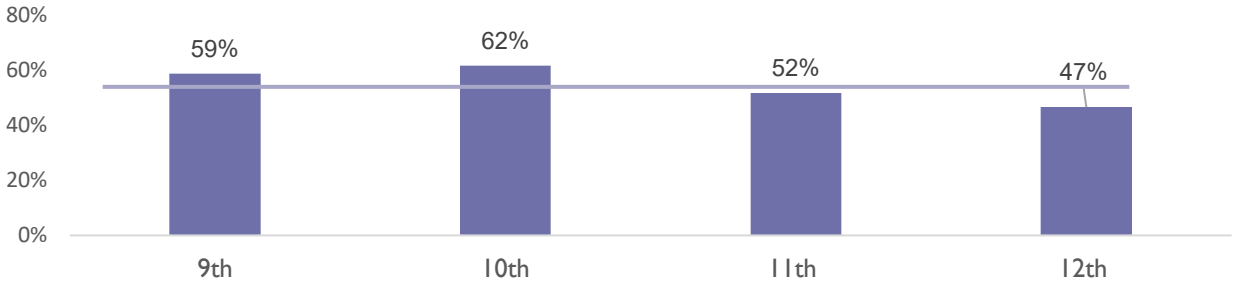
	%
Mental and emotional health	54%
Preventing student bullying and sexual harassment, including electronic aggression	50%
Physical activity	49%
Nutrition and healthy eating	46%
Alcohol- or other drug-use prevention	45%
Food allergies	45%
Tobacco-use prevention	45%
Chronic disease prevention (e.g. diabetes, obesity prevention)	41%
Asthma	38%
HIV, other STI, or pregnancy prevention	34%

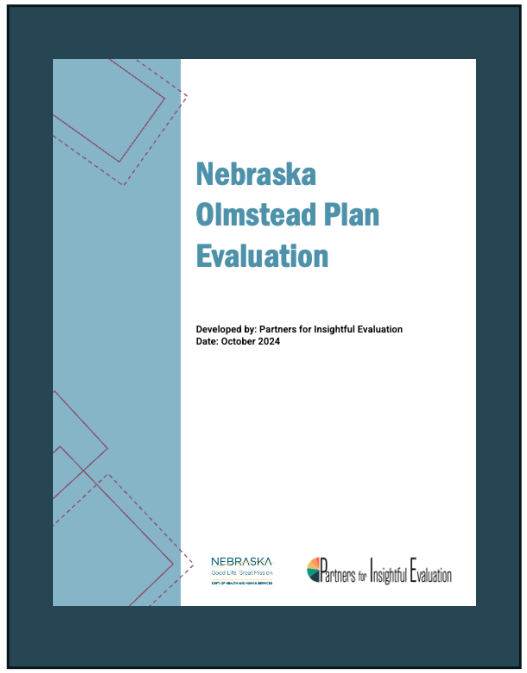
Eighty-eight percent of schools included advocating for personal, family, and community health in health education curriculum, a decline from 95% in 2020. This was more common in high schools (98%) than in middle schools (79%). Half of the instructors both received (in the past two years) and wanted professional development on encouraging family or community involvement.

Student Health

Among students, 55% said they were able to talk to an adult in their family or another caring adult most of the time or always about their feelings. This varied across grades (Figure 19).

Figure 19: Many teens felt they could talk to an adult in their family about their feelings, but this varied across grades





Nebraska Olmstead Plan Revision Process:

Transportation Workgroup Vision Setting

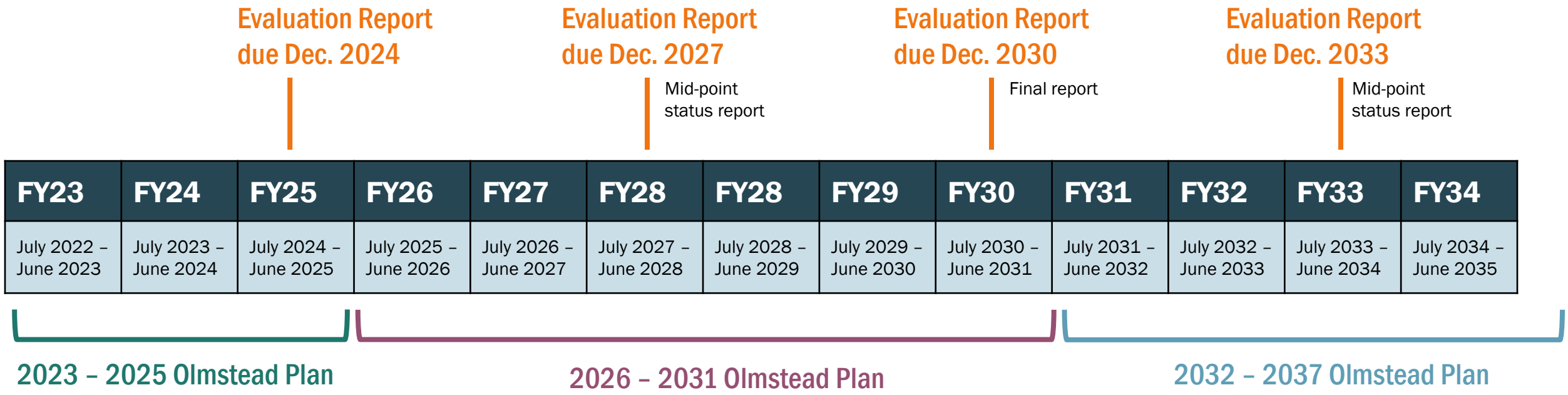
Partners for Insightful Evaluation (PIE)

February 26, 2025

Partners for Insightful Evaluation

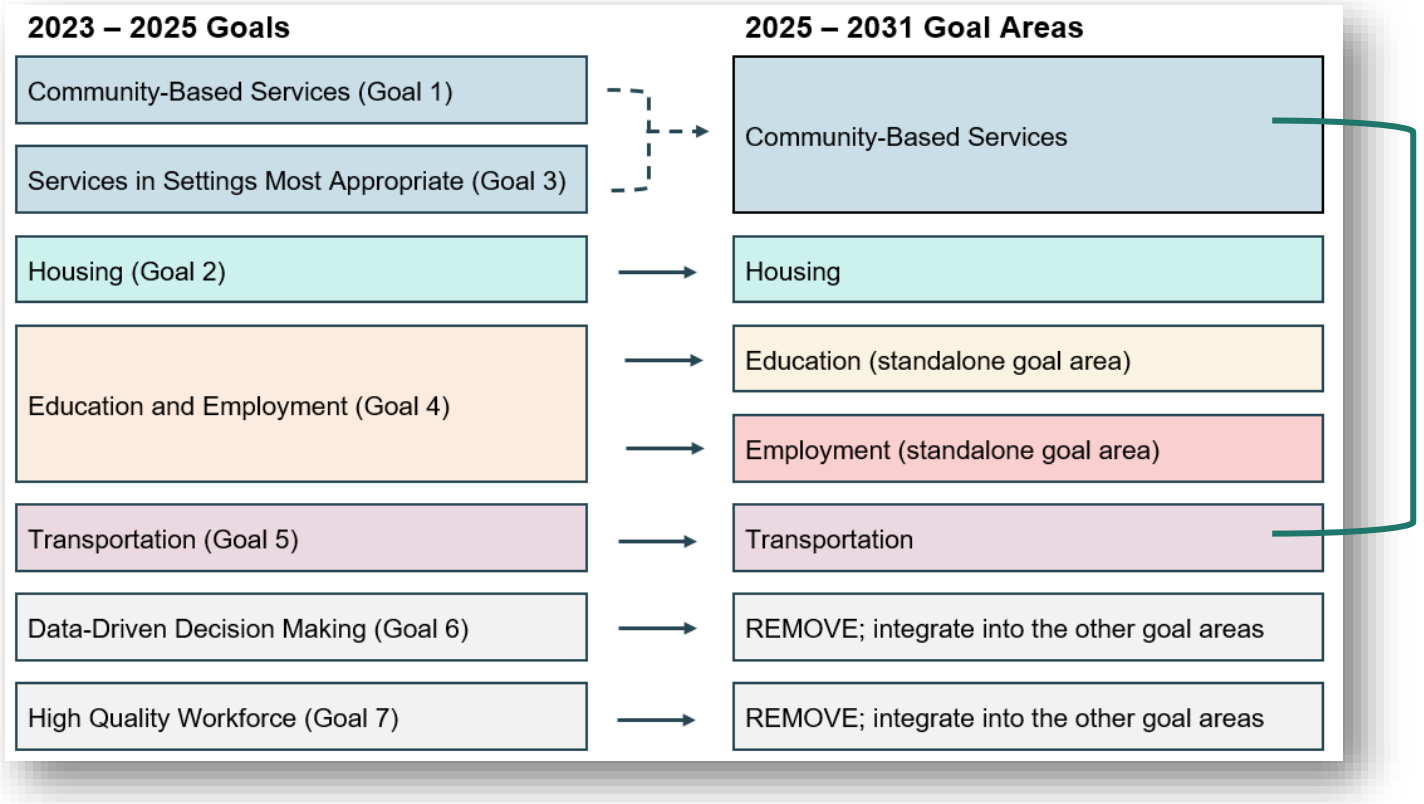
Key Update: Transition to 6 year plan

- Current Plan is from July 2022 through June 2025
- Next plan will be July 2025 – June 2031



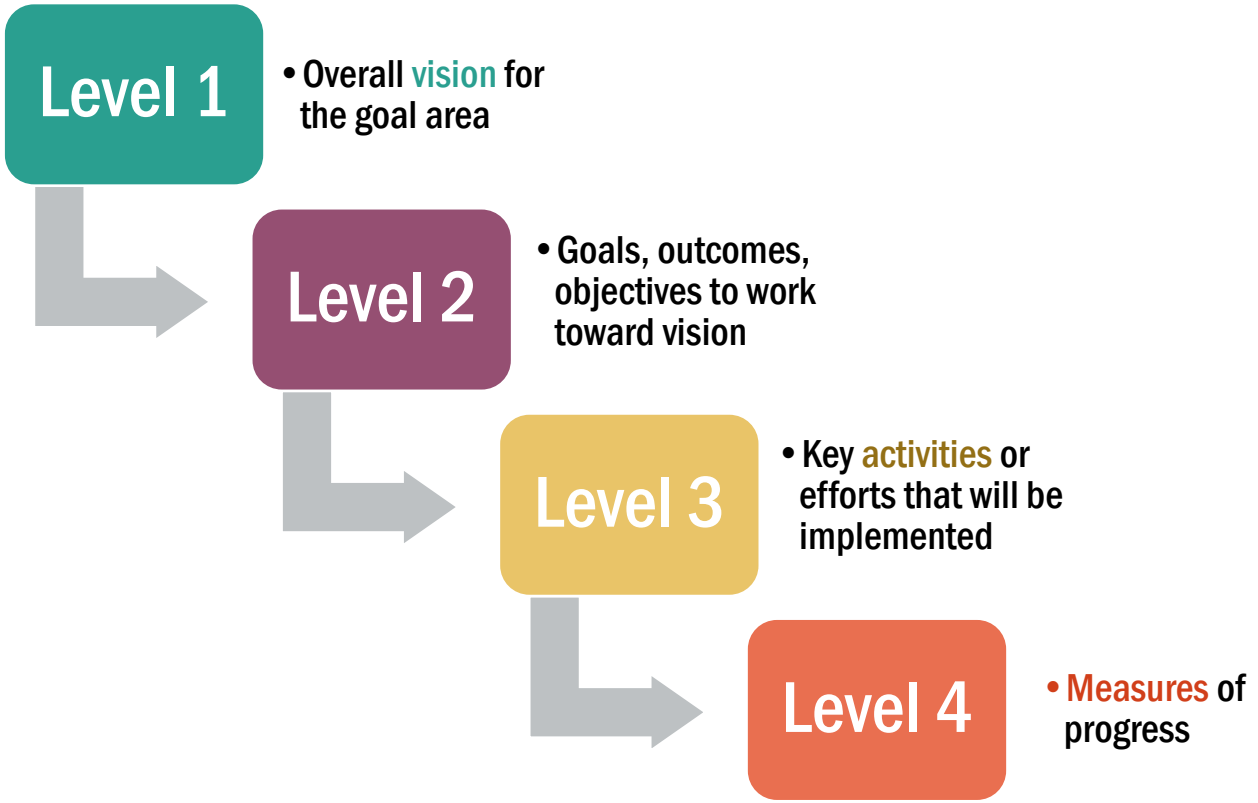
Key Update: Condense to 5 goal topics

- Current plan has 7; next iteration will have five key areas
  - Intent of aligning with existing workgroups



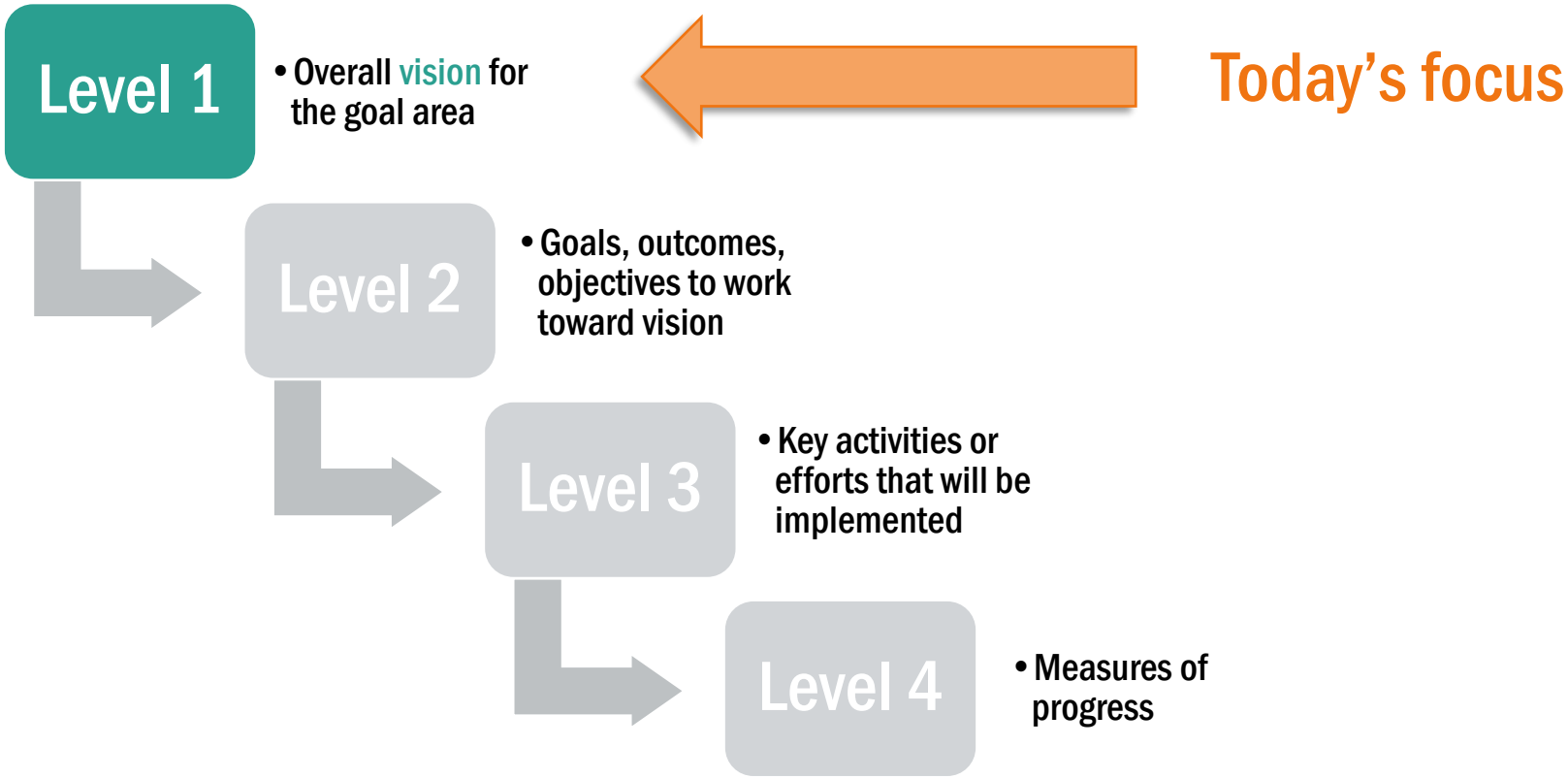
Olmstead Plan Structure

- Each goal topic area has four ‘levels’



Olmstead Plan Structure

- Each goal area has four ‘levels’



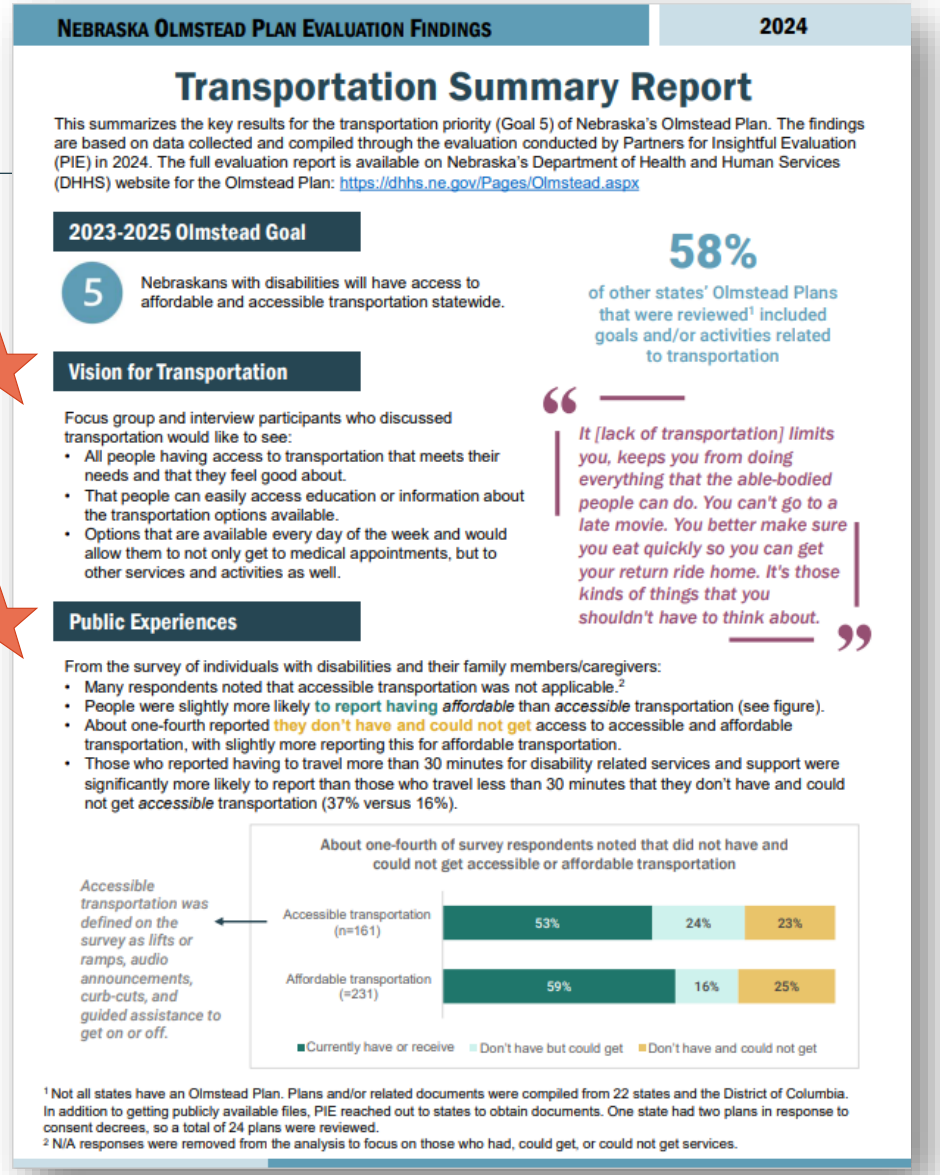
Purpose for Level 1 Discussion

- Meant to help workgroups find consensus and rally around the big picture for that topic
  - Not focused on wordsmithing
  - Not limited to just the period of the Olmstead Plan → what's driving the work? What's our why?

- Information will be used to:
  - Populate a "why this matters" section in the revised plan
  - Provide direction for the remaining levels

Helpful Materials

- May help to reference key sections on the infographic summary
  - Vision is based on feedback from key partners, individuals with disabilities, and family members/caregivers
  - Public experiences summarize results from survey for individuals with disabilities



NEBRASKA OLMSTEAD PLAN EVALUATION FINDINGS 2024

Transportation Summary Report

This summarizes the key results for the transportation priority (Goal 5) of Nebraska's Olmstead Plan. The findings are based on data collected and compiled through the evaluation conducted by Partners for Insightful Evaluation (PIE) in 2024. The full evaluation report is available on Nebraska's Department of Health and Human Services (DHHS) website for the Olmstead Plan: https://dhhs.ne.gov/Pages/Olmstead.aspx

2023-2025 Olmstead Goal

5 Nebraskans with disabilities will have access to affordable and accessible transportation statewide.

58% of other states' Olmstead Plans that were reviewed[1] included goals and/or activities related to transportation

Vision for Transportation

Focus group and interview participants who discussed transportation would like to see:
- All people having access to transportation that meets their needs and that they feel good about.
- That people can easily access education or information about the transportation options available.
- Options that are available every day of the week and would allow them to not only get to medical appointments, but to other services and activities as well.

"It [lack of transportation] limits you, keeps you from doing everything that the able-bodied people can do. You can't go to a late movie. You better make sure you eat quickly so you can get your return ride home. It's those kinds of things that you shouldn't have to think about."

Public Experiences

From the survey of individuals with disabilities and their family members/caregivers:
- Many respondents noted that accessible transportation was not applicable.[2]
- People were slightly more likely to report having *affordable* than *accessible* transportation (see figure).
- About one-fourth reported they don't have and could not get access to accessible and affordable transportation, with slightly more reporting this for affordable transportation.
- Those who reported having to travel more than 30 minutes for disability related services and support were significantly more likely to report than those who travel less than 30 minutes that they don't have and could not get *accessible* transportation (37% versus 16%).

About one-fourth of survey respondents noted that did not have and could not get accessible or affordable transportation

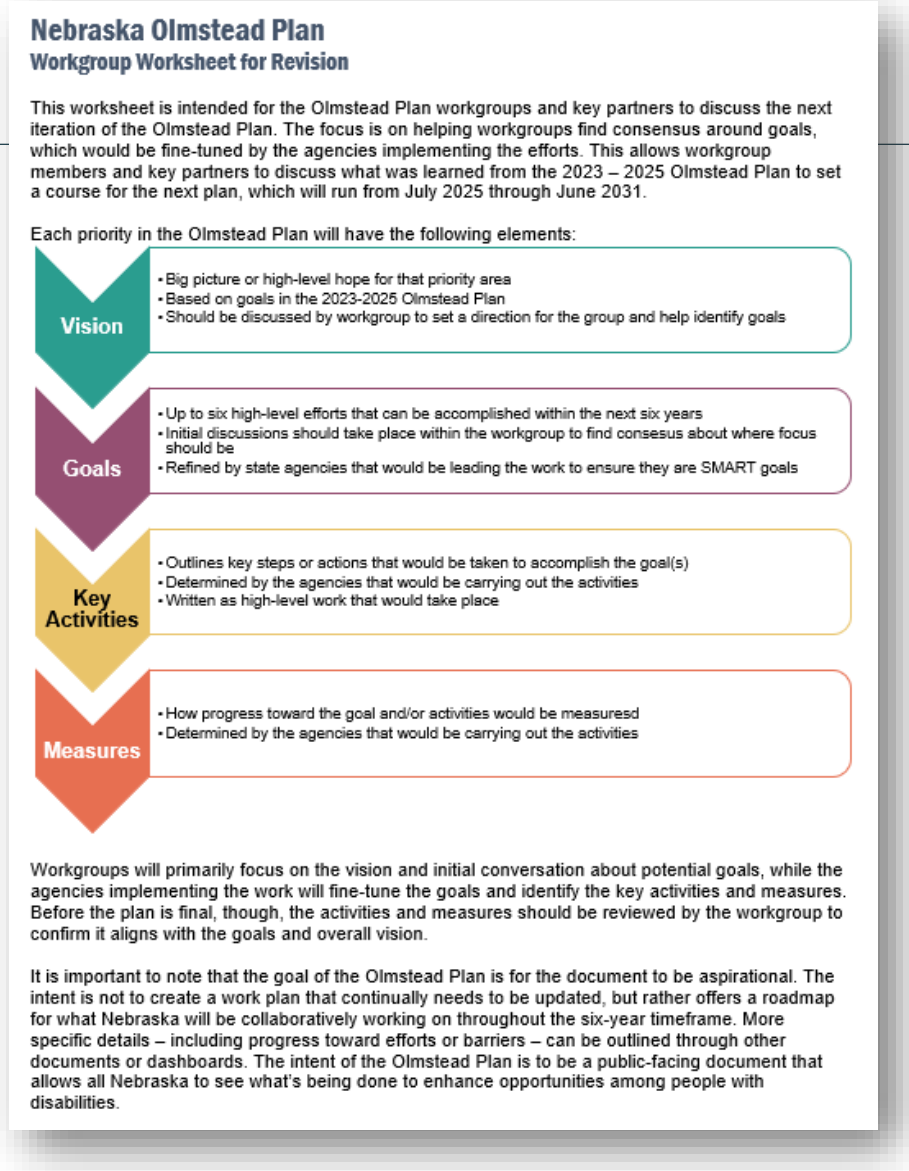
Accessible transportation was defined on the survey as lifts or ramps, audio announcements, curb-cuts, and guided assistance to get on or off.

	Currently have or receive	Don't have but could get	Don't have and could not get
Accessible transportation (n=161)	53%	24%	23%
Affordable transportation (=231)	59%	16%	25%

[1] Not all states have an Olmstead Plan. Plans and/or related documents were compiled from 22 states and the District of Columbia. In addition to getting publicly available files, PIE reached out to states to obtain documents. One state had two plans in response to consent decrees, so a total of 24 plans were reviewed.
[2] N/A responses were removed from the analysis to focus on those who had, could get, or could not get services.

Level 1 Discussion

- Four questions
  - PIE will document on screen and more thoroughly as part of a worksheet
- Share any and all ideas
- Use chat and/or follow-up with PIE as needed
  - hello@pievaluation.com



Nebraska Olmstead Plan

Workgroup Worksheet for Revision

This worksheet is intended for the Olmstead Plan workgroups and key partners to discuss the next iteration of the Olmstead Plan. The focus is on helping workgroups find consensus around goals, which would be fine-tuned by the agencies implementing the efforts. This allows workgroup members and key partners to discuss what was learned from the 2023 – 2025 Olmstead Plan to set a course for the next plan, which will run from July 2025 through June 2031.

Each priority in the Olmstead Plan will have the following elements:

Vision
- Big picture or high-level hope for that priority area
- Based on goals in the 2023-2025 Olmstead Plan
- Should be discussed by workgroup to set a direction for the group and help identify goals

Goals
- Up to six high-level efforts that can be accomplished within the next six years
- Initial discussions should take place within the workgroup to find consesus about where focus should be
- Refined by state agencies that would be leading the work to ensure they are SMART goals

Key Activities
- Outlines key steps or actions that would be taken to accomplish the goal(s)
- Determined by the agencies that would be carrying out the activities
- Written as high-level work that would take place

Measures
- How progress toward the goal and/or activities would be measuresd
- Determined by the agencies that would be carrying out the activities

Workgroups will primarily focus on the vision and initial conversation about potential goals, while the agencies implementing the work will fine-tune the goals and identify the key activities and measures. Before the plan is final, though, the activities and measures should be reviewed by the workgroup to confirm it aligns with the goals and overall vision.

It is important to note that the goal of the Olmstead Plan is for the document to be aspirational. The intent is not to create a work plan that continually needs to be updated, but rather offers a roadmap for what Nebraska will be collaboratively working on throughout the six-year timeframe. More specific details – including progress toward efforts or barriers – can be outlined through other documents or dashboards. The intent of the Olmstead Plan is to be a public-facing document that allows all Nebraska to see what's being done to enhance opportunities among people with disabilities.

Why is transportation important to include in Nebraska's Olmstead Plan?

- Transportation is critical to ensuring individuals with disabilities are connected to and included in their community. All too often, physical and operational barriers to transportation impair employment opportunities, healthcare outcomes for people with disabilities. Such transportation system is critical for persons living in the community rather than in institutional settings. Accessible transportation is essential to participate in all areas of life.
- Even living in Papillion, only the paratransit can be used a couple days a week so it's not available whenever it's needed or wanted. In Omaha, you can't necessarily get to western Omaha – so if you work there, you can't get there. The idea of actually traveling across the state would take 2 days if you're a person with a disability because you can only take transportation in certain places and you have to switch to another transportation provider. Need to find a way to better connect this all. To get from Omaha to Scottsbluff, you should be able to do that in a reasonable amount of time at a reasonable expense – most live at the poverty levels.
- All school districts supported were rural – most of those districts don't have any form of transportation and those individuals are captured there. School buses stop once a diploma is received so transportation becomes a real barrier to obtaining employment or live independently. Or you have to go through a process to obtain, maybe from a neighboring town, some type of transportation service. As a statewide entity, we need to think outside the box on how to help those rural folks with disabilities obtain transportation. Accessibility and affordability is key. May have family members they're trying to raise or integrate.

Why is transportation important to include in Nebraska's Olmstead Plan?

- Accessing Handivan is cumbersome – you have to plan your life a week out and have to hope there's availability. Only the first few may get it, so it's limited. It's non user-friendly. Continuously call on Monday morning to get on the list for the next week. How do we help people to get Uber more available or some type of ride share and affordable. Not just fix what's here, but how can we add to our transportation menu?
- Some of the transportation that people experience concerns and problems with not getting to places that they need to because of demand. Holding Medicaid transportation companies hold up their end of the deal. They're signing up for Handivan because they're not getting their Medicaid company to provide reliable transportation.
  - They recognize there are issues with people not showing up on time. Medicaid needs to hear about it so they can work with their vendors
  - Even if Handivan is cumbersome, it's more reliable than Medicaid's transportation system.
  - Out of 300,000 Medicaid members, a little over 30,000 take advantage of non-EMT. The amount of complains they get in a given year is probably under 300. That's from each of the managed care organizations (MCOs). Some of it is a lack of transportation companies that they can work with throughout the state. Contract with any appropriate, willing provide but there's a lack.

When it comes to transportation for individuals with disabilities, what problem are we aiming to solve or need are we fulfilling in Nebraska?

- Paratransit anywhere in the state is the same as Handivan. Need to find a way to make paratransit use-friendly. It'd be great if it could be on demand – that'd be the ideal.
- Non-EMT (emergency medical transportation) – Medicaid looking to do pilot project with Uber or Lyft to test it out. If they could get them in the Medicaid game, it could open up opportunities for people to get rides on their terms when they need it. Project hasn't started yet.
  - Would the vehicles be accessible? That's the unknown. Wheelchair accessible, as an example. That might be available in larger cities like Chicago.
  - MCOs do utilize Uber and Lyft in other states, so we'll learn what types of vehicles can be included.

When it comes to transportation for individuals with disabilities, what problem are we aiming to solve or need are we fulfilling in Nebraska?

- Accessible sidewalks are critical for people with disabilities to be able to live and work in the community because they enable the safe passage between their home, transportation, and/or their destinations in the community.
  - Periphery issues with transportation that are important to think about – how accessible is the bus stop for someone using a wheelchair or walker?
  - Accessible parking spots can sometimes be filled with equipment, trash cans, etc. Venues aren't accessible because of that. Need to make public more aware.
- Scooters that are available for people often get dumped in the curb cuts, so those using a wheelchair would have a hard time accessing that specific area of the sidewalk.
- In the winter, we don't shovel the curb cuts – ends up being piles of snow where people who are plowing dump it, which limits access.

When it comes to transportation for individuals with disabilities, what problem are we aiming to solve or need are we fulfilling in Nebraska?

- Public Service Commission is the regulatory agency in NE for for-hire transportation – Uber doesn't have the ability to provide the service in NE – they'd need to come to the commission first and meet a specific legal burden to promote that Medicaid service. Not as simple as a license – there's a specific legal burden they have to show. Some can protest their applications as part of a new market entrance.
  - Happy Cab (now Z-trip) in Omaha has been able to keep out a lot of independent providers
  - There may be some hesitancy to contact PSC
  - PSC's role is to be a gatekeeper for those who want to come into the market; hands are tied by statutory standard (75-311) for what's needed to enter the market. Their role isn't to assess the accessibility or availability of current transportation. The need to meet the legal burden. https://nebraskalegislature.gov/laws/statutes.php?statute=75-311
    - Trying to do outreach and education around this topic.
    - To what degree are Nebraska's statutes and requirements comparable to other states?
    - In the last four years, only about a dozen have been denied
  - Is there a way to integrate a requirement around accessibility? This could potentially be some type of activity or goal to include in the Olmstead Plan.
    - The challenge with that is an ADA question and the Commission couldn't enforce ADA on state level
    - There may be a practical need for transportation, but carriers need to show legalness of the need. They may also only be applying for one type of service (limo, for example) and there couldn't be a requirement to make them do things like taxi service.
    - Would need to go to legislature. LB 227 – seeking to shift the burden. The applicant has to prove everything; under 227, it would shift that burden.

What impact do we want to make on transportation for individuals with disabilities? Consider what success would look like six years from now and beyond.

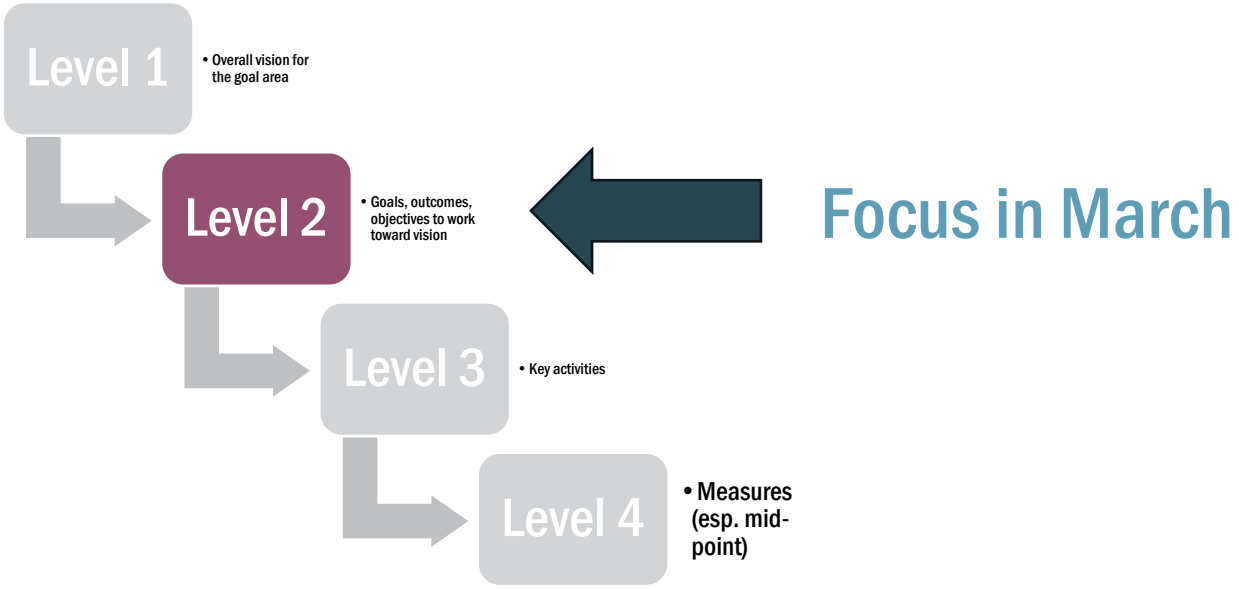
- I could walk out my house and be able to go wherever I wanted, whenever I wanted without having to make a call to schedule a week in advance.
  - And if you have to schedule ahead of time, you should be able to schedule it in bulk or all at one time.
  - Also ability to schedule for evening hours. Things should be available when you need transportation.
  - Not having to worry about no-show transportation. Getting stranded somewhere is a huge safety issue.
- Intentional planning on the front-end so that when you're designing communities, you're thinking about how to design that on the front-end.

What terms, if any, need to be defined or clarified for a better understanding of this goal area?

- Accessible – what does it mean for that community? It has different meanings for different communities
- Public Right of Way
- Clarification of the standards from 75-311

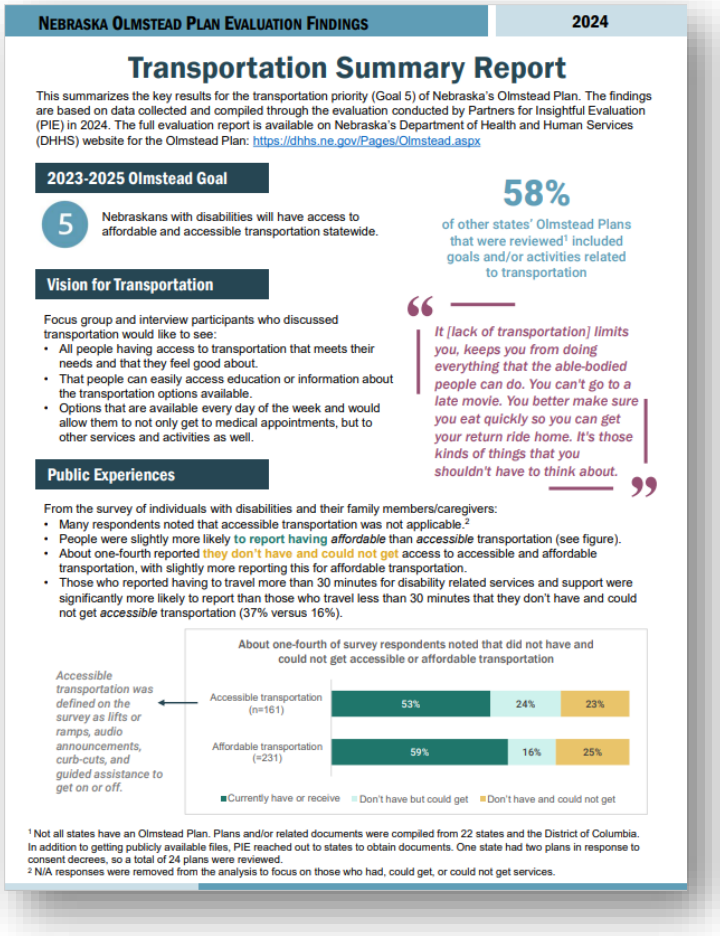
Next Steps

- PIE will summarize today's discussion and share back with DHHS and the group
- Meet in March to identify suggestions for Level 2 content
  - Those will address what efforts should be the priority during the 6-year plan



Things to Consider/Review

- Review infographic summary to see progress thus far and facilitators/barriers to work
- Consider…
  - Data – what's available and/or needed?
  - Workforce needs or challenges
  - What other agencies are already doing in this area?



NEBRASKA OLMSTEAD PLAN EVALUATION FINDINGS 2024

Transportation Summary Report

This summarizes the key results for the transportation priority (Goal 5) of Nebraska's Olmstead Plan. The findings are based on data collected and compiled through the evaluation conducted by Partners for Insightful Evaluation (PIE) in 2024. The full evaluation report is available on Nebraska's Department of Health and Human Services (DHHS) website for the Olmstead Plan: https://dhhs.ne.gov/Pages/Olmstead.aspx

2023-2025 Olmstead Goal

5 Nebraskans with disabilities will have access to affordable and accessible transportation statewide.

58% of other states' Olmstead Plans that were reviewed[1] included goals and/or activities related to transportation

Vision for Transportation

Focus group and interview participants who discussed transportation would like to see:
- All people having access to transportation that meets their needs and that they feel good about.
- That people can easily access education or information about the transportation options available.
- Options that are available every day of the week and would allow them to not only get to medical appointments, but to other services and activities as well.

> *"It [lack of transportation] limits you, keeps you from doing everything that the able-bodied people can do. You can't go to a late movie. You better make sure you eat quickly so you can get your return ride home. It's those kinds of things that you shouldn't have to think about."*

Public Experiences

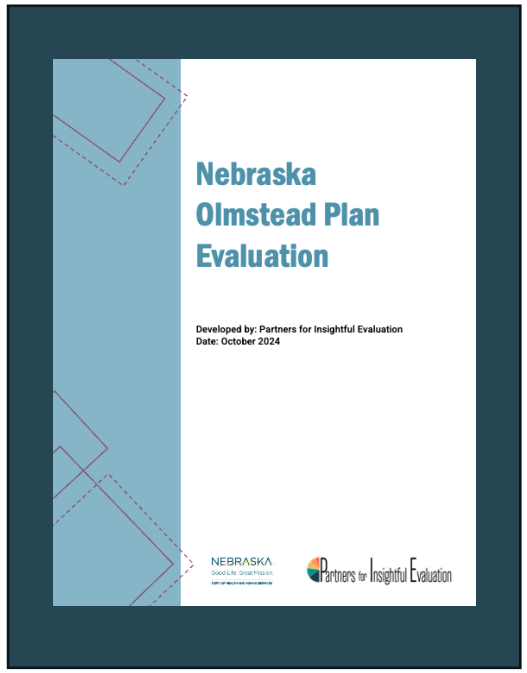
From the survey of individuals with disabilities and their family members/caregivers:
- Many respondents noted that accessible transportation was not applicable.[2]
- People were slightly more likely to report having *affordable* than *accessible* transportation (see figure).
- About one-fourth reported they don't have and could not get access to accessible and affordable transportation, with slightly more reporting this for affordable transportation.
- Those who reported having to travel more than 30 minutes for disability related services and support were significantly more likely to report than those who travel less than 30 minutes that they don't have and could not get *accessible* transportation (37% versus 16%).

About one-fourth of survey respondents noted that did not have and could not get accessible or affordable transportation

Accessible transportation was defined on the survey as lifts or ramps, audio announcements, curb-cuts, and guided assistance to get on or off.

	Currently have or receive	Don't have but could get	Don't have and could not get
Accessible transportation (n=161)	53%	24%	23%
Affordable transportation (=231)	59%	16%	25%

[1] Not all states have an Olmstead Plan. Plans and/or related documents were compiled from 22 states and the District of Columbia. In addition to getting publicly available files, PIE reached out to states to obtain documents. One state had two plans in response to consent decrees, so a total of 24 plans were reviewed.
[2] N/A responses were removed from the analysis to focus on those who had, could get, or could not get services.



Nebraska Olmstead Plan Revision Process:

Transportation Workgroup: Six Year Focus

Partners for Insightful Evaluation (PIE)

March 27, 2025

Partners for Insightful Evaluation

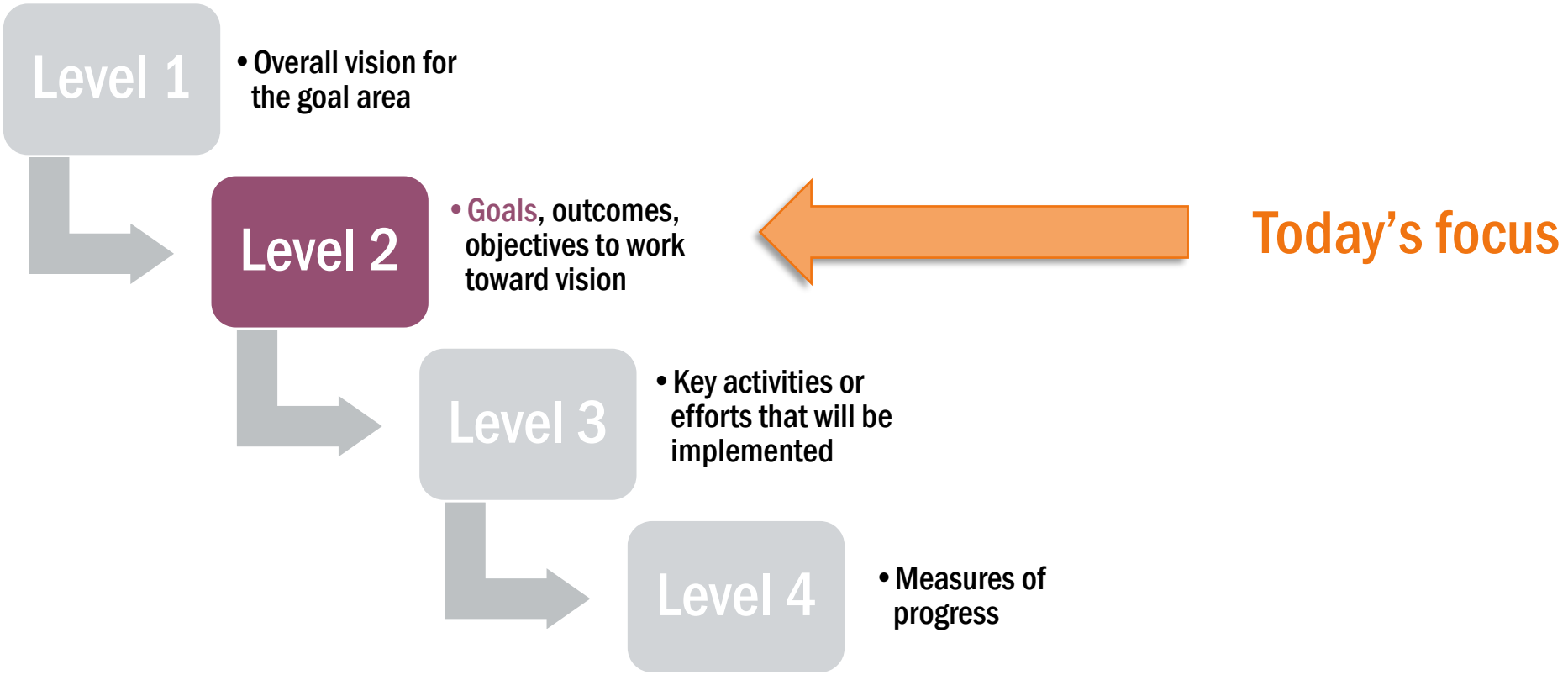
Olmstead Plan Structure

- Each priority area has four ‘levels’

Last month’s discussion

Olmstead Plan Structure

- Each goal topic area has four ‘levels’



Scope for Goals/Objectives

- Should encompass work that will occur during the six-year period
  - These may not need to be a full six years – okay to include things that can be accomplished in 3 or 5 years
  - Could be things that will be continued beyond the six years

FY23	FY24	FY25	FY26	FY27	FY28	FY28	FY29	FY30	FY31	FY32	FY33	FY34
July 2022 – June 2023	July 2023 – June 2024	July 2024 – June 2025	July 2025 – June 2026	July 2026 – June 2027	July 2027 – June 2028	July 2028 – June 2029	July 2029 – June 2030	July 2030 – June 2031	July 2031 – June 2032	July 2032 – June 2033	July 2033 – June 2034	July 2034 – June 2035

2023 – 2025 Olmstead Plan

2026 – 2031 Olmstead Plan

2032 – 2037 Olmstead Plan

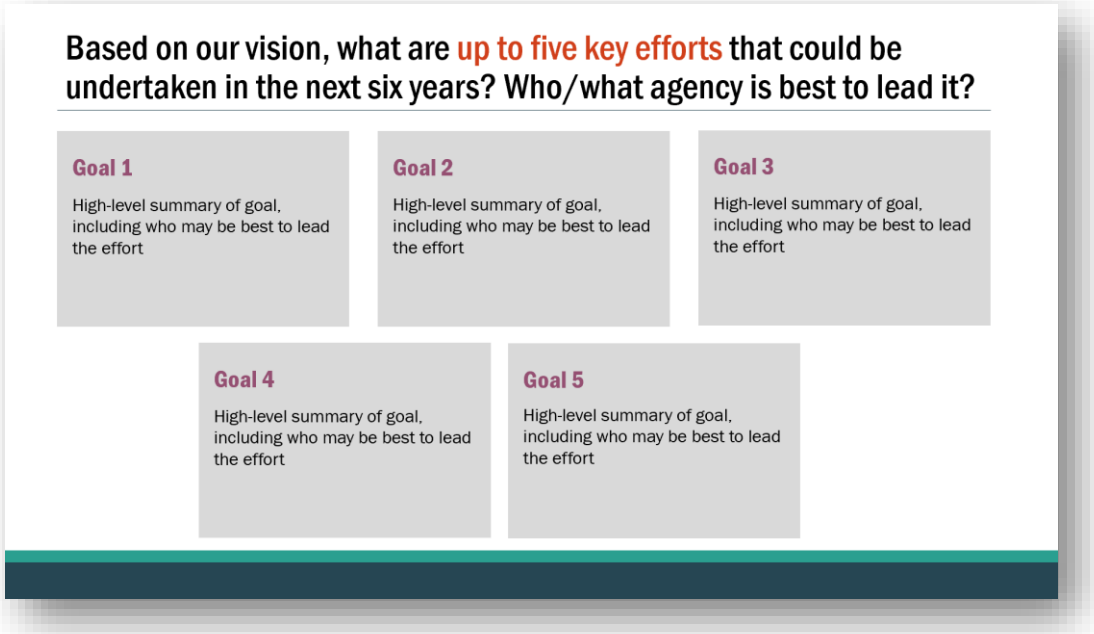
Purpose of Goals/Objectives

- Geared toward creating a strategic, visionary plan for Nebraska rather than a work plan
  - Annual efforts or tactical plans can be discussed by workgroups, advisory committee, etc.

https://ideascale.com/blog/tactical-planning-definition/

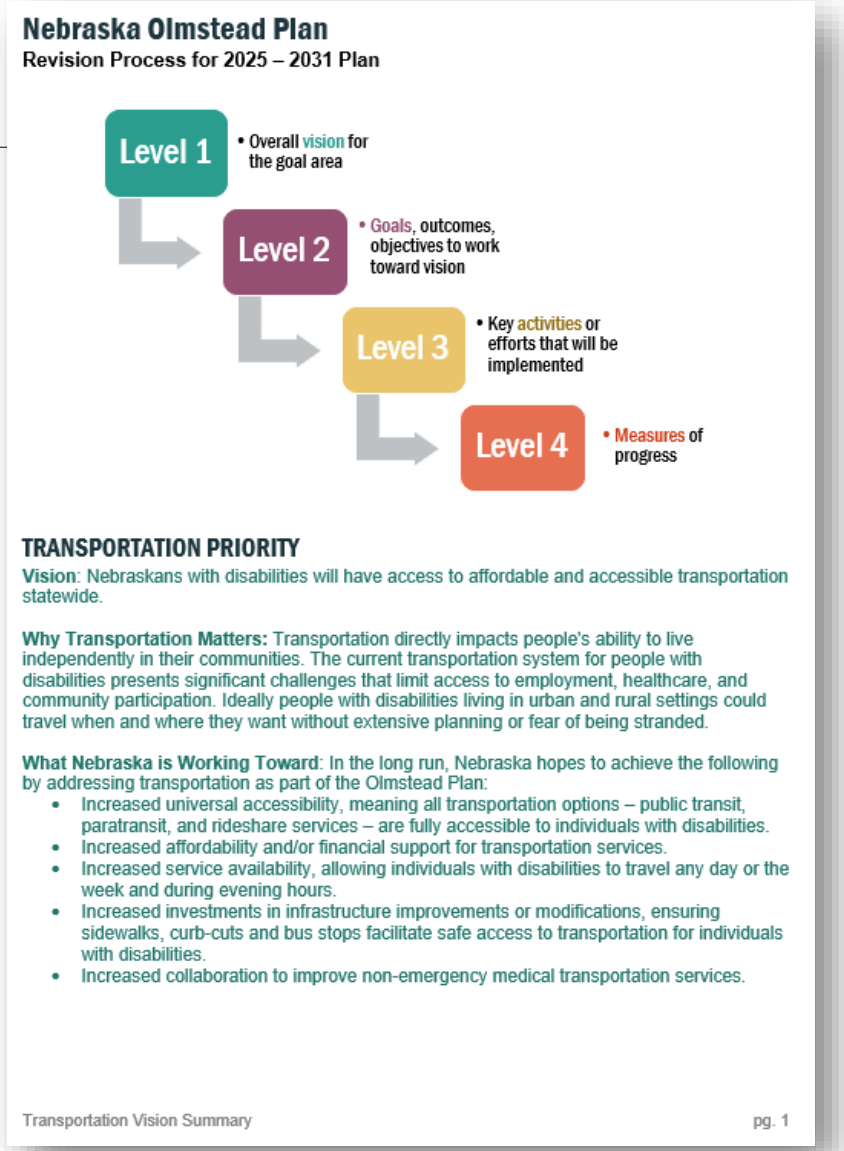
For Today's Discussion

- Identify up to 5 key goals/objectives for the transportation priority
  - High-level ideas for what will help advance the vision (on next slides)
  - Not focused on wordsmithing or identifying specific action steps
  - Consider who might be lead each goal
- Questions geared toward gauging need or interest in specific areas
  - PIE will document on screen
  - Use chat and/or follow-up with PIE as needed (hello@pievaluation.com)



Preview of Next Steps

- Will send out notes from the goal discussion
  - DHHS will use info to coordinate with agencies leading the effort to finalize wording of goals, develop measures
- Workgroup can fine-tune the vision portion as needed to include in the Olmstead Plan



Nebraska Olmstead Plan

Revision Process for 2025 – 2031 Plan

Level 1 • Overall vision for the goal area

Level 2 • Goals, outcomes, objectives to work toward vision

Level 3 • Key activities or efforts that will be implemented

Level 4 • Measures of progress

TRANSPORTATION PRIORITY

Vision: Nebraskans with disabilities will have access to affordable and accessible transportation statewide.

Why Transportation Matters: Transportation directly impacts people's ability to live independently in their communities. The current transportation system for people with disabilities presents significant challenges that limit access to employment, healthcare, and community participation. Ideally people with disabilities living in urban and rural settings could travel when and where they want without extensive planning or fear of being stranded.

What Nebraska is Working Toward: In the long run, Nebraska hopes to achieve the following by addressing transportation as part of the Olmstead Plan:

- Increased universal accessibility, meaning all transportation options – public transit, paratransit, and rideshare services – are fully accessible to individuals with disabilities.
- Increased affordability and/or financial support for transportation services.
- Increased service availability, allowing individuals with disabilities to travel any day or the week and during evening hours.
- Increased investments in infrastructure improvements or modifications, ensuring sidewalks, curb-cuts and bus stops facilitate safe access to transportation for individuals with disabilities.
- Increased collaboration to improve non-emergency medical transportation services.

Transportation Vision Summary pg. 1

Vision for Transportation

DRAFT

- Vision: Nebraskans with disabilities will have access to affordable and accessible transportation statewide.
- Why Transportation Matters: Transportation directly impacts people's ability to live independently in their communities. The current transportation system for people with disabilities presents significant challenges that limit access to employment, healthcare, and community participation. Ideally people with disabilities living in urban and rural settings could travel when and where they want without extensive planning or fear of being stranded. Transportation is more than just having a car or access to a vehicle – it's also considering aspects such as sidewalks, curb-cuts, and more.

Added from discussion at March meeting

In the Long Run…

- Increased universal accessibility, meaning all transportation options – public transit, paratransit, and rideshare services – are fully accessible to individuals with disabilities.
- Increased affordability and/or financial support for transportation services.
- Increased service availability, allowing individuals with disabilities to travel any day or the week and during evening hours.
- Increased investments in infrastructure improvements or modifications, ensuring sidewalks, curb-cuts and bus stops facilitate safe access to transportation for individuals with disabilities.
- Increased collaboration to improve non-emergency medical transportation services.

What training or workforce development are important or needed for transportation?

- What currently exists statewide – identify areas that are doing it well, whether it's a small or large community
- Conducting survey that's specific to transportation needs

What does the data currently tell us about transportation? What additional data or information would be helpful to collect and/or monitor?

- Unsure how much data is available for transportation – typically have to contact each individual community and not always sure where to get the information
  - MCOs (managed care organizations) track the non-emergency medical transportation
- Would be helpful to do survey among individuals (family members, caregivers, the whole gamete)
  - What their experiences are, what their needs are
  - Carrying out in a statistically valid way
  - Broad reach – using Facebook, Instagram, etc. It's also provides an opportunity to do awareness building and provide education → making it specific to transportation so that it's not lumped with all the other categories
- For communities that have things like ride share programs or Handivan, what's working well, how is it going? Explore more about what's happening in these individual communities.

What other efforts are happening related to transportation? What other committees or groups are addressing this? Who else needs to be part of the discussion?

- Department of Transportation did an accessibility survey – Dianne sent it out to workgroup members
  - Focuses on physical access
  - Statewide but got specific about communities throughout the state – ones that passed an accessibility review, ones that needed work; issues about right of way, sidewalks, curb-cuts, etc.

Other Considerations

- Important to remember that transportation includes things like sidewalks, curb-cuts – not just having a car
- Funding sources at the federal or regional level that provide opportunities to improve transportation?
- Efforts also benefit the entire community, not just those with disabilities
- Discussion with Public Service Commission – in some ways it feels like they're the enemy with state government; works against our efforts to expand transportation and include those with disabilities
  - Education/awareness around PSC role – what they have a say in and what they don't

Other Considerations

- Similar to exploring funding, it may help to look at some of the policies that may prevent the improved/enhanced transportation; identifying the impediments
- Adding in non-MCO / private companies / providers / carriers to engage in the workgroup and conversations regarding transportation
  - People apply to provide services to PSC, they don't seek companies out
- For the goals, it's also important to keep in mind the implementation component of it – you don't just want to identify things, we also want to be acting of what we've learned and discovered

Based on our vision, what are up to five key efforts that could be undertaken in the next six years? Who/what agency is best to lead it?

Conduct Survey

Conduct survey specific to transportation; tie it to an educational or awareness opportunity

Identify Best Practices

Explore challenges and what's working well in specific NE communities (Kearney, North Platte, Omaha) that are implementing transportation efforts; case studies → also include an implementation component so we act on what we've learned or discovered

Identifying Funding

See what other states have used or currently have; getting creative with how we fund transportation; could include legislature

Cultivating Partnerships

Do you bring in large private employers to help? Business groups. Public Service Commission. Chambers of Commerce. Carriers, bringing on providers to the discussion; bringing in the appropriate legislative bodies or committees

Increase Awareness/Education

Making people aware of the need; informing about workgroup efforts

PIE Post-Meeting Summary

Statewide Transportation Survey

- Implement survey for people across NE to see what their experiences and needs are; conduct it in a statistically valid way
- Incorporate awareness/education about transportation when disseminating the survey

Identify Funding Opportunities

- Explore what funding other states have for transportation
- Identify funding that might be available at the federal or regional level for transportation improvement
- As applicable, apply for funding; find ways to be creative with funding/supporting transportation

Increase Awareness/Education

- Make people aware of the need
- Inform people and organizations about the workgroup/Olmstead Plan efforts for transportation

Identify Best Practices / Conduct Case Studies

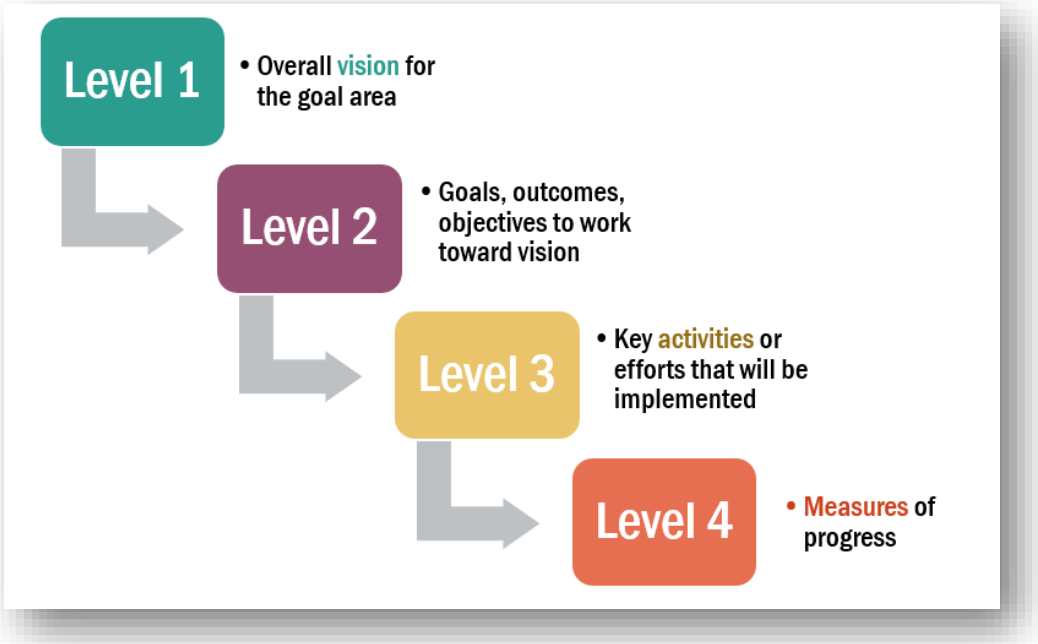
- Get a sense for what's happening in the state – identify areas/communities where they are doing it well
- Review information from Dept. of Transportation's accessibility survey – helps identify who passed an accessibility review, areas that still need work
- Explore the policies or efforts that prevent the improvement or enhancement of transportation

Cultivate Partnerships

- Expand involved in workgroup and enhance collaboration or engagement with large private employers, non-MCO transportation services, carriers, etc.
- Generate awareness/offer education about Public Service Commission's role
- Bring in or at least engage appropriate legislative bodies or committees

Next Steps

- Will send out notes from the goal discussion
  - DHHS will use info to coordinate with agencies to finalize wording of goals, develop measures
- Workgroup can fine-tune the vision portion
- Draft of vision, goals and measures will be presented to Advisory Committee on 4/30/25
- Workgroups can begin identifying key activities to focus their efforts for the year



Nebraska Community Health Workers

Since the 1990s, Nebraska has been developing its Community Health Worker (CHW) workforce. A 2025 assessment, conducted by Partners for Insightful Evaluation in collaboration with the Nebraska Dept. of Health and Human Services, provides an updated snapshot of the CHW workforce following significant investment through three Health Resources and Services Administration (HRSA) training grants. It also provides an update to previous assessments done in 2019 and 2022, with additional considerations based on the CHW Common Indicators outlined by the CHW Center for Research and Evaluation.

Two surveys – available August through October 2025 – were used for the assessment. One was for CHWs while the other was for employers of CHWs. The CHW survey was made available in both English and Spanish. Below are key aspects of the methodology, with further details and data analysis approaches noted in the full report.

Focus group with CHWs to review tool
PIE held virtual focus group with 5 CHWs to capture feedback on the CHW survey and promotional materials and made modifications based on feedback received

Surveys disseminated
Email lists and flyers used to broadly promote surveys

Surveys closed
After validating data, 229 CHWs and 78 employers participated in the surveys

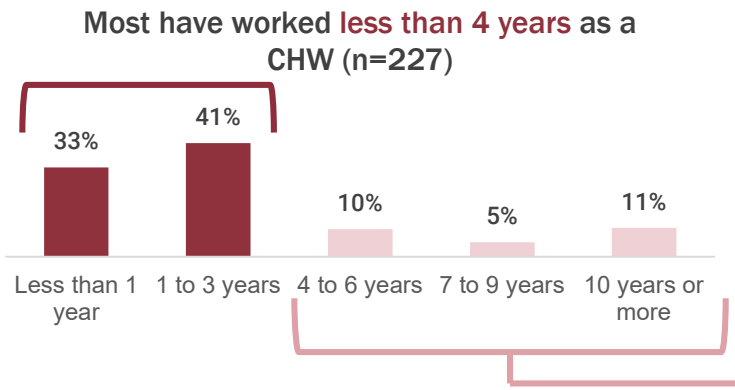
JULY | AUG | SEPT | OCT

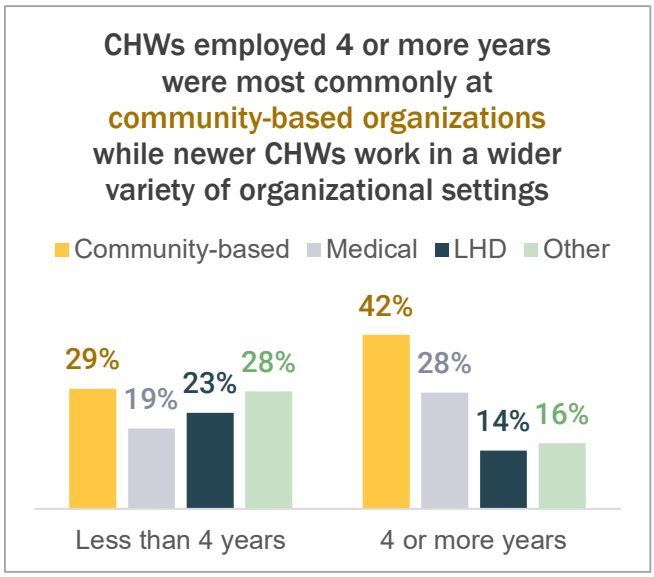
Dissemination approach modified
Due to automated bot responses and fraudulent submissions, open survey links were suspended to a more secure approach utilizing individual email invitations with personalized, unique URLs sent directly to verified CHWs and employers*

Seven categories emerged through the results, which are described in more detail in the full report.

Workforce Composition and Growth

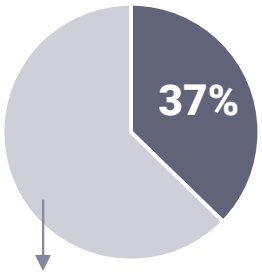
The CHW workforce has experienced substantial growth, with one-third (33%) of respondents reporting less than one year of CHW experience and 74% working in the field for fewer than four years. This represents a significant influx of newer CHWs compared to previous assessments.





*A limited exception was made for the Nebraska Chronic Disease Prevention and Control Program and Creighton University. They were provided open survey links to share with their verified CHW contact lists. This led to the distribution of the survey to approximately 200 CHWs through their existing communication channels while maintaining a higher level of verification than the broad public distribution.

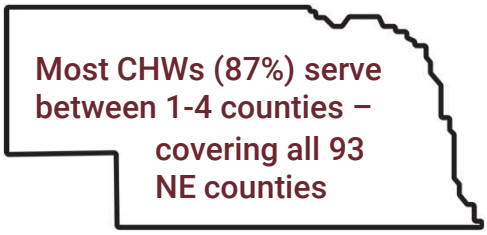
Roles and Service Delivery



have a job title of "Community Health Worker"

At least 26 other job titles were noted among CHWs

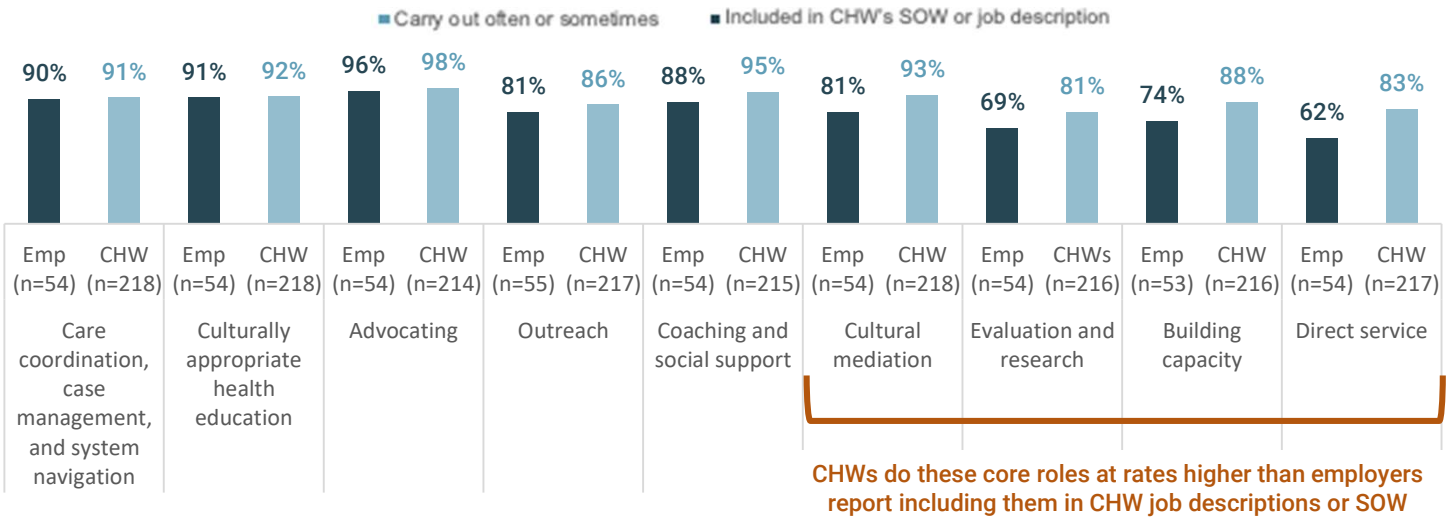
CHWs primarily focus on behavioral and mental health (82%), and chronic disease prevention (67%) and management (64%)



Most CHWs (87%) serve between 1-4 counties – covering all 93 NE counties

CHWs predominantly serve African American/Black (52%) and Hispanic/Latino (58%) populations

CHWs report doing most common roles often or sometimes, which are generally included in CHW job descriptions or scope of work as reported by employers



CHWs do these core roles at rates higher than employers report including them in CHW job descriptions or SOW

CHWs reported serving between 0 and 200 clients in the past month, with the average being **31.5**

Those who have worked as a CHW for four years or more were significantly more likely to serve a higher number of individuals than those who have worked less than four years

27

avg. for CHWs working less than 4 years (n=139)

44

average clients/month for CHWs working 4 or more years (n=51)

Skills and Competencies

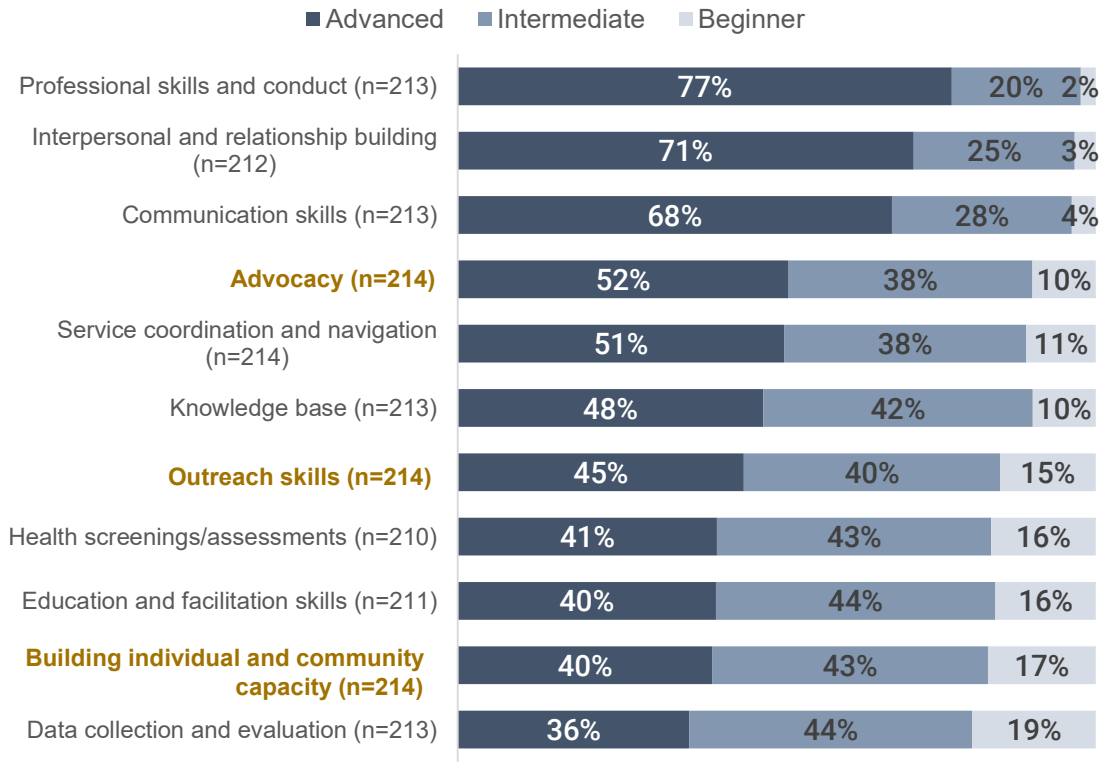
Among the 11 CHW skills and/or competencies assessed on the survey using three categories (beginner, intermediate, advanced), on average CHWs reported being beginners in 1.2 skills/competencies and advanced in 5.7 skills/competencies

CHWs who participated in trainings and certifications were significantly more likely to report being advanced in a higher number of skills/competencies

The largest average gains after training were in:

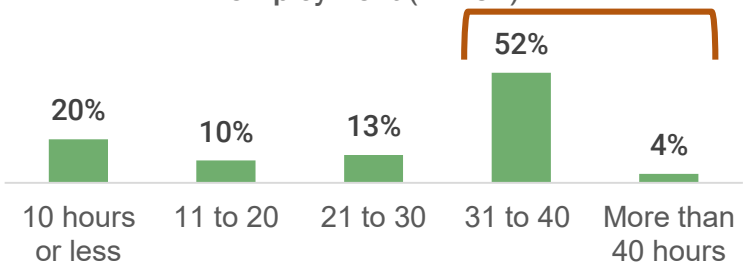
- Advocacy
- Building individual and community capacity
- Outreach skills

CHWs rate their knowledge, skills, and abilities most advanced in the areas of professional skills and conduct, interpersonal and relationship building, and communication

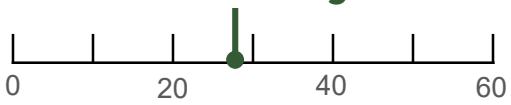


Employment Conditions

About half the CHWs reported working hours that would be considered full-time employment (n=191)



CHWs reported working anywhere between 0 and 54 hours a week as a CHW, with 28.7 hours being the average

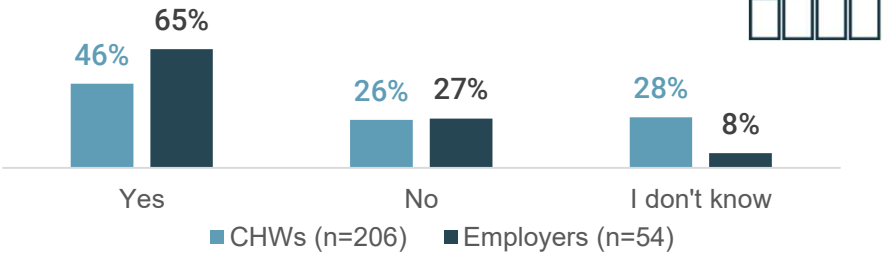


CHWs working for Local Health Departments (LHDs) reported working more hours per week compared to those who work at other organizations*

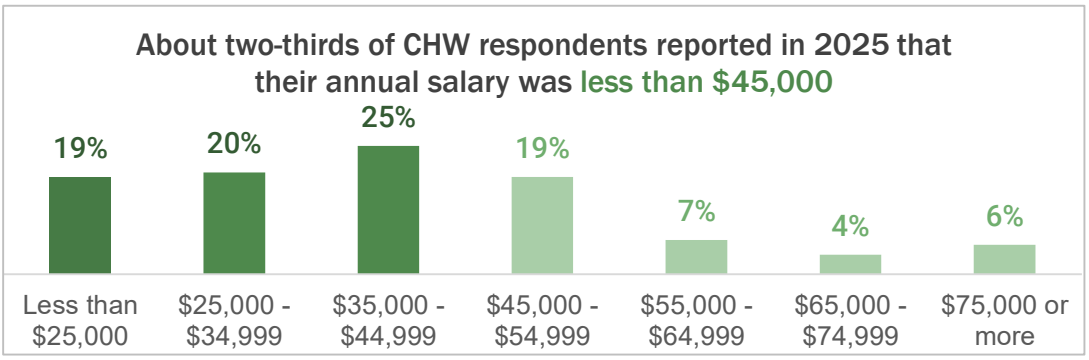
LHDs	v.	Other
32.2		24.0
Hours/week (n=43)		Hours/week (n=41)

"As I take on more responsibilities and supervision of other employees, I would like a pay increase to reflect that. Right now, I do more and more with no additional compensation."

Less than half of CHWs report being eligible for promotions/step-ups with pay increases, which is notably less than employers report



*Other organizations include school/university, insurance companies, tribal-based organizations, faith-based organizations, and "other."



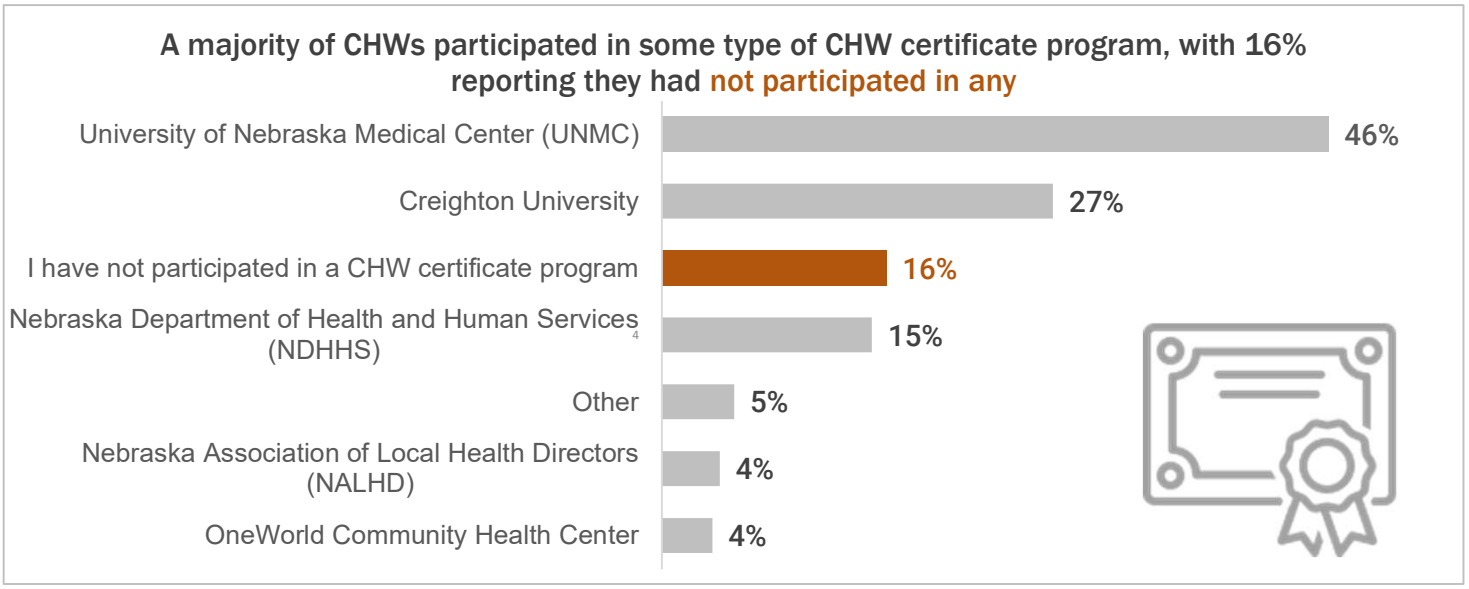
About two-thirds of CHW employers offer health, dental, and vision insurance, and paid time off

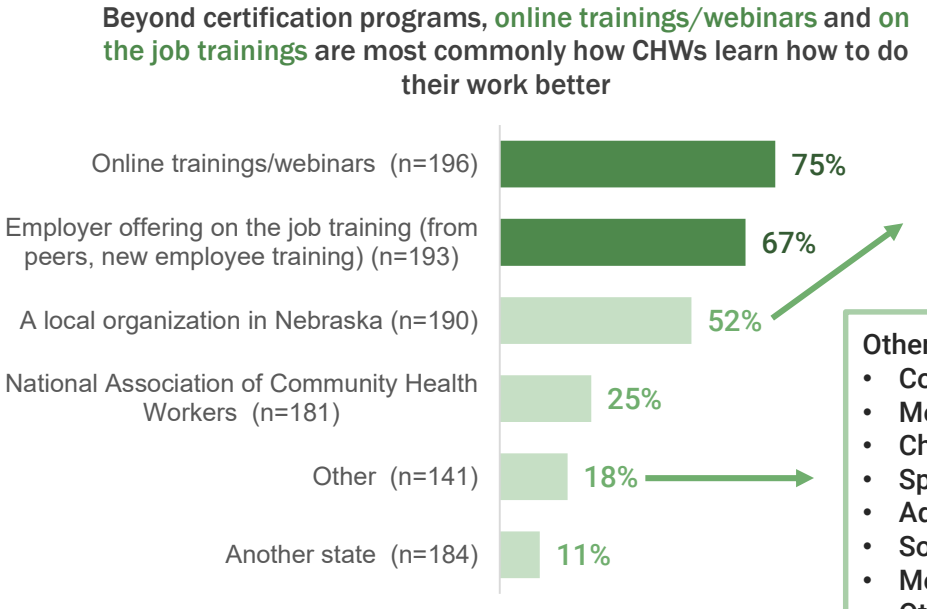
Based on employers, hourly wages for part-time CHWs were $2.62 lower, on average, compared to full-time CHWs

	Full-Time CHWs	Part-Time CHWs
Minimum	$15.00/hr	$15.00/hr
Maximum	$38.46/hr	$28.85/hr
Average	$22.41/hr	$19.79/hr
Median	$22.00/hr	$19.27/hr

CHWs are less aware of:
- Disability insurance
- Mental health coverage
- Family leave

CHW Certification Programs and Other Trainings





Common local organization types included:
- Coalitions/collaborations
- LHDs
- Medical organizations
- Behavioral health regions

Other Trainings included:
- Community Health Worker Training
- Mental Health & Trauma
- Chronic Disease Management
- Specialized Populations
- Advanced Degrees
- Social Services & Equity
- Medical/Emergency
- Other Professional Development

Challenges and Support

Top challenges among CHWs were language barriers, financial, and stress/burnout

5.5

the average number of challenges (major or moderate) reported by CHWs (out of 10)

CHWs who feel more support (at work, at home, and/or by the community) report fewer challenges

More than half the CHWs reported they enjoyed being a CHW very much (n=197)

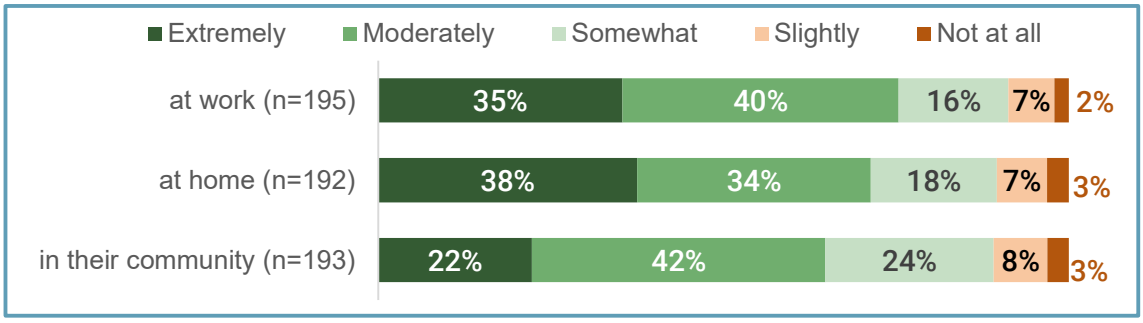
Those who were more likely to report enjoying being a CHW very much also reported:

- ✓ Better physical and mental health
- ✓ Feeling more supported

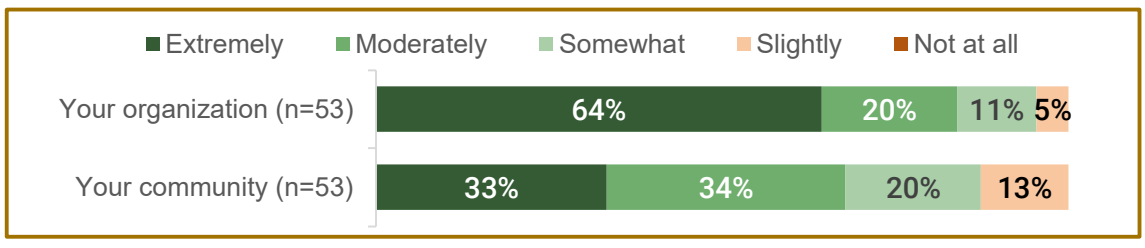
5

CHWs feelings of support

Most CHWs feel at least somewhat supported at work, at home, and in their community, though employers report more organization support for CHWs than CHWs report

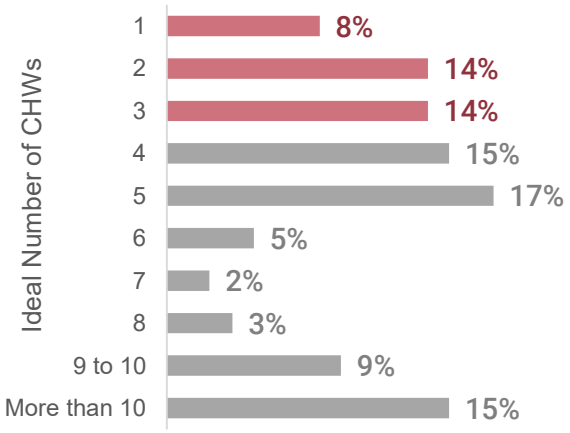


Employers' perspective of support for CHWs

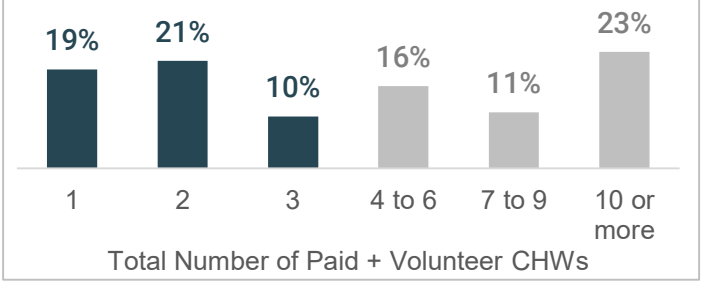


Employer Perspectives

About one-third of employer respondents noted it would be ideal for their agency to have 3 or fewer CHWs (n=54)

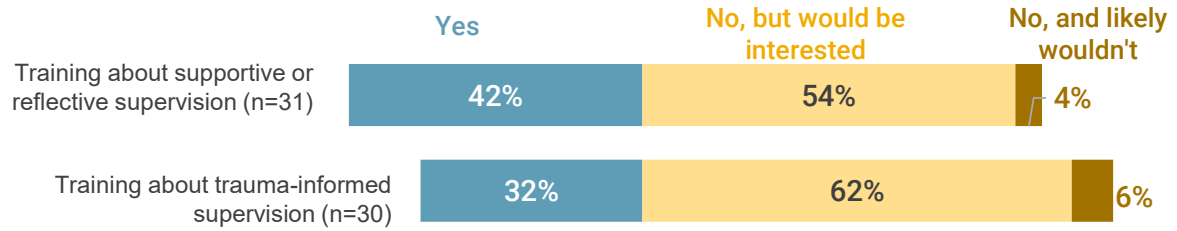


Half the employers reported having 3 or less paid and/or volunteer CHWs at their organization (n=70)



The number of paid CHWs ranged from 1 to 50, though on average, organizations employed 6.1 paid CHWs; agencies would ideally staff an average of 7.8 CHWs

Employers were more likely to have participated in training about supportive or reflective supervision than trauma-informed supervision, but over half are interested in both trainings



The results demonstrate both the growth and continued needs of Nebraska's CHW workforce. Based on the findings and building upon suggestions from the previous assessments, a variety of recommendations are outlined in the full report.

- ✓ **Creating a formal statewide CHW network or collaborative**. Ideally this would be a formal entity that works to connect CHWs statewide, facilitating peer learning, professional development, and collective advocacy. This would address the need for CHWs to feel part of a professional community and create a mechanism for ongoing communication and support.
- ✓ **Improve compensation and benefits to support workforce recruitment and retention**. With financial challenges identified as a major barrier by one-third of CHWs, organizations should work to provide living wages and comprehensive benefits (employers report average CHW wages of $22.41/hour FT, $19.79/hour PT). Organizations should also ensure CHWs are fully informed about available benefits, as gaps exist between employer reporting and CHW awareness of disability insurance, mental health coverage, family leave policies, and opportunities for promotions.
- ✓ **Enhance supervision capacity through training in trauma-informed and supportive/reflective supervision**. More than half of CHW supervisors have not participated in trauma-informed or supportive/reflective supervision training but expressed interest.
- ✓ **Focus training on identified competency gaps**. Training opportunities and programs should place particular emphasis on areas where CHWs report beginner-level competencies, including data collection and evaluation, and building individual and community capacity.

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PROFESSIONAL EXPERIENCE

President 2022 – present
Partners for Insightful Evaluation, Lincoln, NE

- Lead evaluation projects and provide strategic guidance to ensure impactful research outcomes

Expedited Protocol Reviewer 2010 – present
University of Nebraska-Lincoln, Lincoln, NE

- Provide reviews of expedited research protocols for the Office of Research Compliance to ensure adherence to regulatory standards
- Serve on the Institutional Review Board

Vice President of Research and Evaluation 2018 – 2022
Schmeeckle Research, Lincoln, NE

- Lead evaluation projects and directed organizational evaluation strategies and expanded research capacity.

Director of Evaluation and Development 2006 – 2018
University of Nebraska-Lincoln, Lincoln, NE

- Directed the Social and Behavioral Sciences Research Consortium
- Co-established and directed the Methodology and Evaluation Research Core Facility
- Managed and directed the Survey, Statistics and Psychometrics Core Facility
- Managed the Minority Health Disparities Initiative

Assistant Director 2001 – 2006
The Pennsylvania State University, University Park, PA

- Co-established and directed the Survey Research Center

Project Manager 1999 – 2001
University of Nebraska-Lincoln, Lincoln, NE

- Managed multiple survey research projects for the Bureau of Sociological Research

Research Assistant 1998 – 1999
University of Nebraska-Lincoln, Lincoln, NE

- Assisted in the administration and analysis of survey research projects for the Bureau of Sociological Research

EDUCATION & PROFESSIONAL DEVELOPMENT

Certificate in Evaluation Practice 2010
The Evaluator's Institute, George Washington University, Washington, DC

Master of Arts in Sociology 2000
University of Nebraska-Lincoln, Lincoln, NE

Bachelor of Arts in Sociology 1998
Doane University, Crete, NE

SKILLS

Program Evaluation and Impact Assessment, Quantitative and Qualitative Research, Stakeholder Engagement and Facilitation, Strategic Planning and Implementation, Data Visualization and Reporting, Microsoft Office Suite (Excel, Word, Outlook, PowerPoint, Access), SPSS statistical software

SELECTED PUBLICATIONS

Fryda, C., Gebhart-Morgan, L., Anderson-Knott, M., Roseberry, N., Hahn, J., Niemeier, K., Rutt, J., Miller, D. (2024). Strengthening Linkages Between Health Care and Public Health: A Novel Framework for Public Health Action in Health Care Settings to Improve Cardiovascular Disease Risk. *Journal of Public Health Management and Practice*, 30(), S80-S88. DOI: 10.1097/PHH.0000000000001899

Garcia, A., Takahashi, S., Anderson-Knott, M., Dev, D. (2019). Determinants of Physical Activity for Latino and White Middle School-Aged Children. *Journal of School Health*, 89(1), 3-10. DOI: 10.1111/josh.12706

Song, C., Rutt, J., Anderson-Knott, M. (2018). Widening the Disparity Gap: Differences in Outcomes for Racial and Ethnic Groups in Youth Substance Abuse Prevention Programming. *Journal of Child & Adolescent Substance Abuse*, 27(5-6), 264-271. DOI: 10.1080/1067828X.2018.1466749

Zimbroff, A., Schlake, M., Anderson-Knott, M., Eberle, N., Vigna, D. (2017). Beyond Lemonade Stands to Main Street Business Development: A Youth Entrepreneurship Curriculum. *Journal of Extension*, 55(3), Article 13. https://tigerprints.clemson.edu/joe/vol55/iss3/13

VOLUNTEER SERVICE

- **Track Representative,** Seward Booster Club (2024-Present)
- **Wellness Committee Member**, Seward Public Schools (2017-Present)
- **Secretary/Member,** Seward Middle School Parent Teacher Organization (2018-2025)
- **Strategic Planning Team Member**, Seward Public School District (2013-2023)
- **Secretary**, Jr Jays Baseball Organization (2012 – 2025)
- **Special Olympics Faculty Sponsor**, The Pennsylvania State University (2003-2005)
- **Special Olympics Coach**, Special Olympics (2002-2005)