Nebraska Olmstead Plan Evaluation Report

Developed by: Partners for Insightful Evaluation
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Partners for Insightful Evaluation

Nebraska Olmstead Plan Evaluation Report
November 2024

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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.

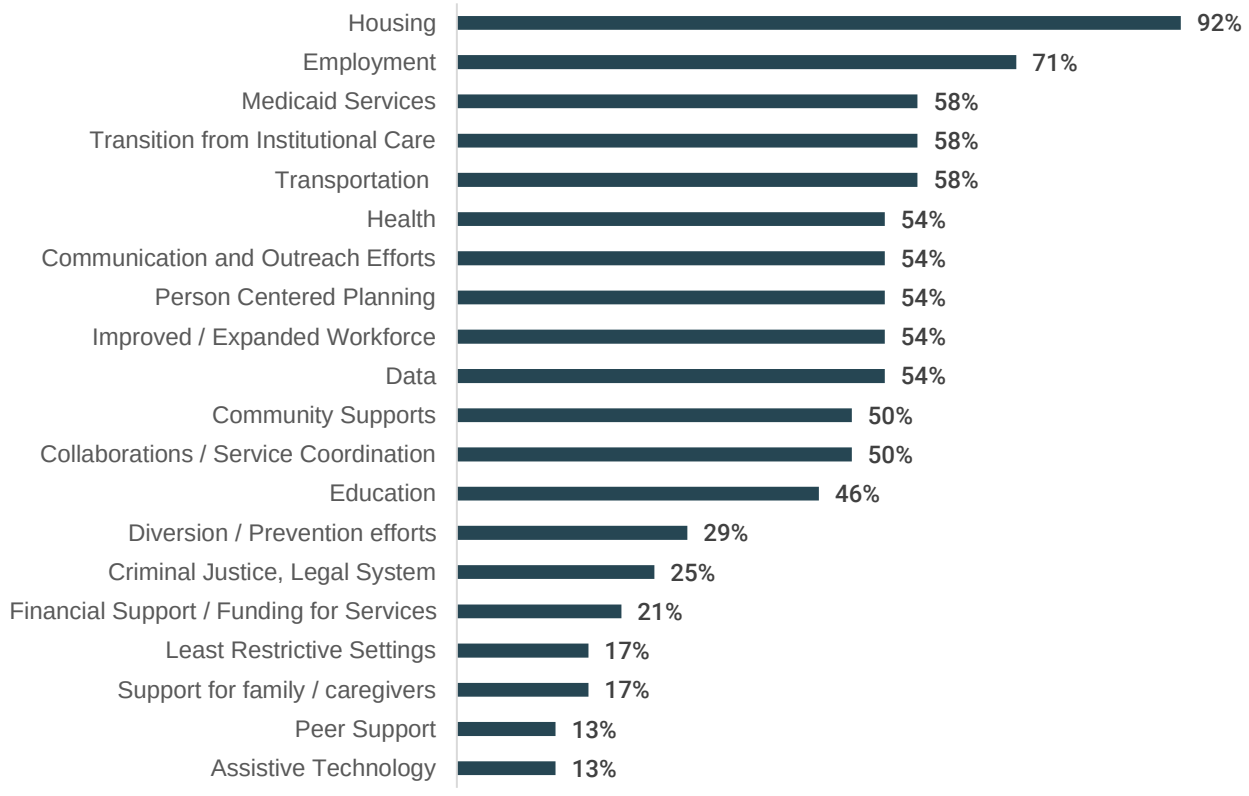
With the exception of medical care and mental health, nearly all those aspects are addressed through Nebraska's Olmstead Plan. Ultimately the vision expressed by focus group participants was seeing respect and dignity for those with disabilities. For many, that means full integration into society, which 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.

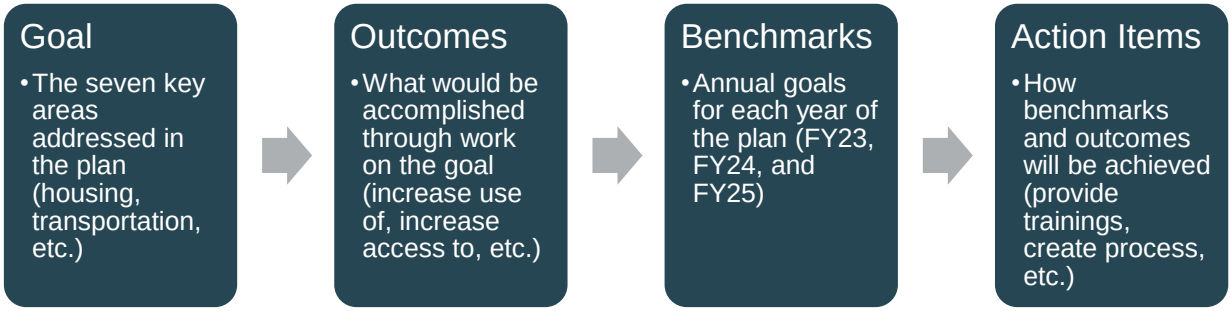
Another goal that Nebraska may want to consider is related to collaboration and service coordination. There are 12 states that had at least one priority focused on enhancing partnerships, particularly among state agencies, to better ensure they can address the comprehensive needs of individuals with 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

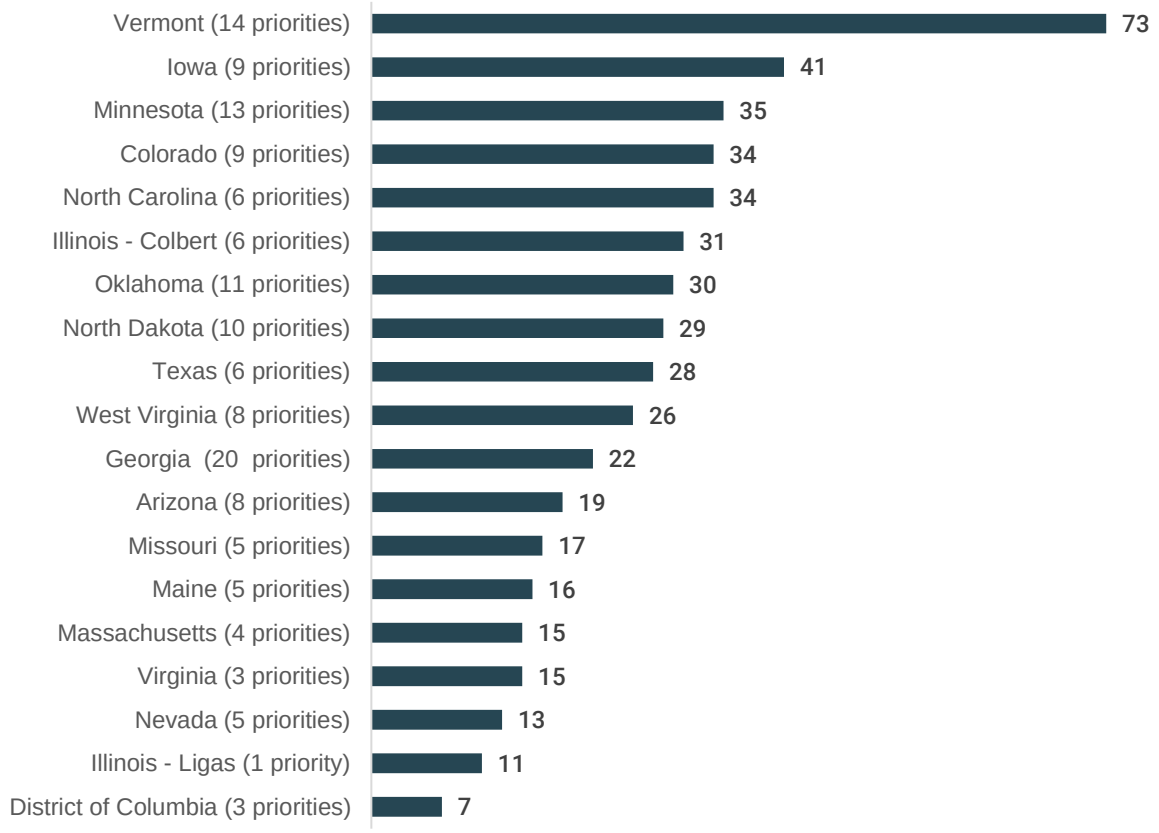
Outcomes

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).

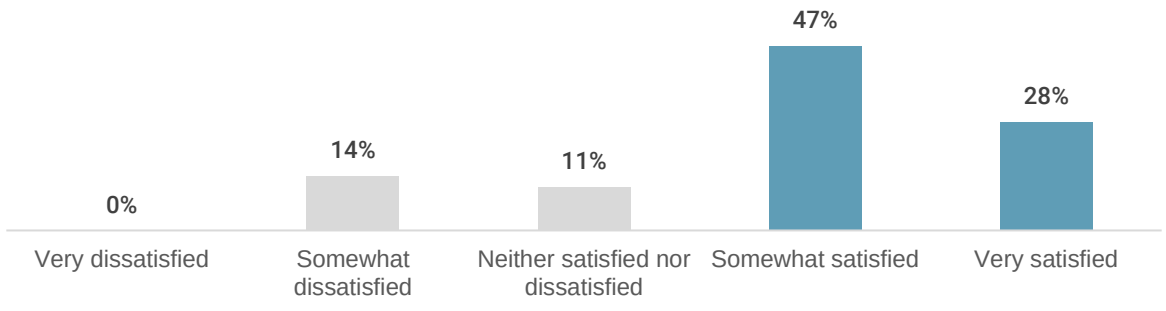
[5] Minnesota Olmstead Plan Implementation Office. (December 2020). *Minnesota Olmstead plan: Plain language version.* https://mn.gov/olmstead/assets/Minnesota%20Olmstead%20Plan%20-%20Plain%20Language%20Version_tcm1143-539438.pdf

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)

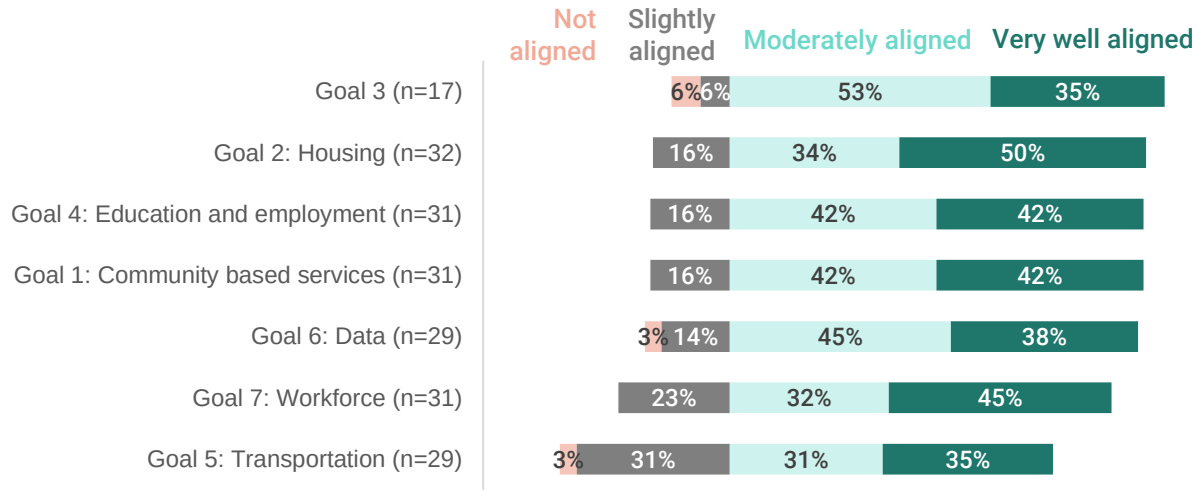


There were five who included a description for why they were dissatisfied[6]:

- 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

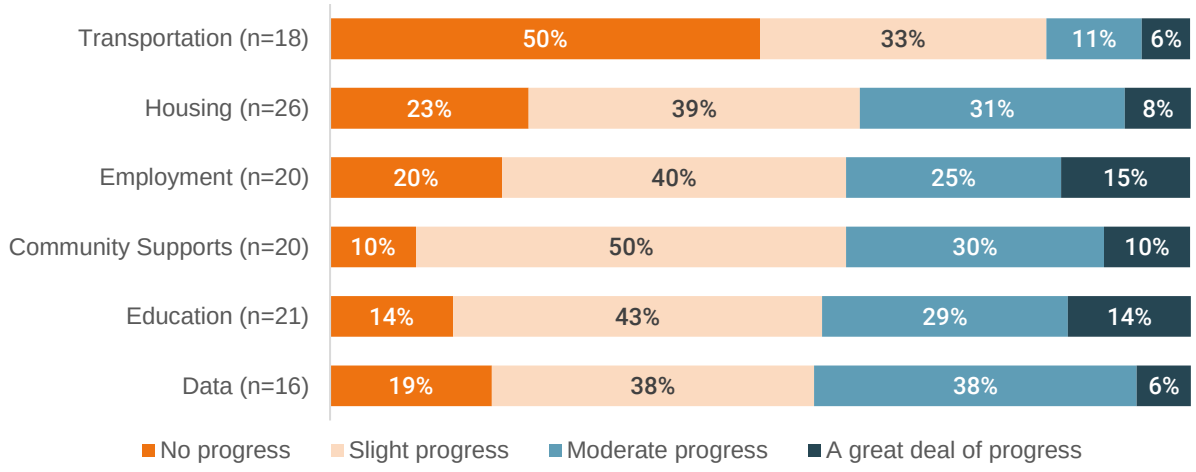
[6] The open-ended responses are included as they were written on the survey, except for text in brackets to spell out the acronyms.

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.

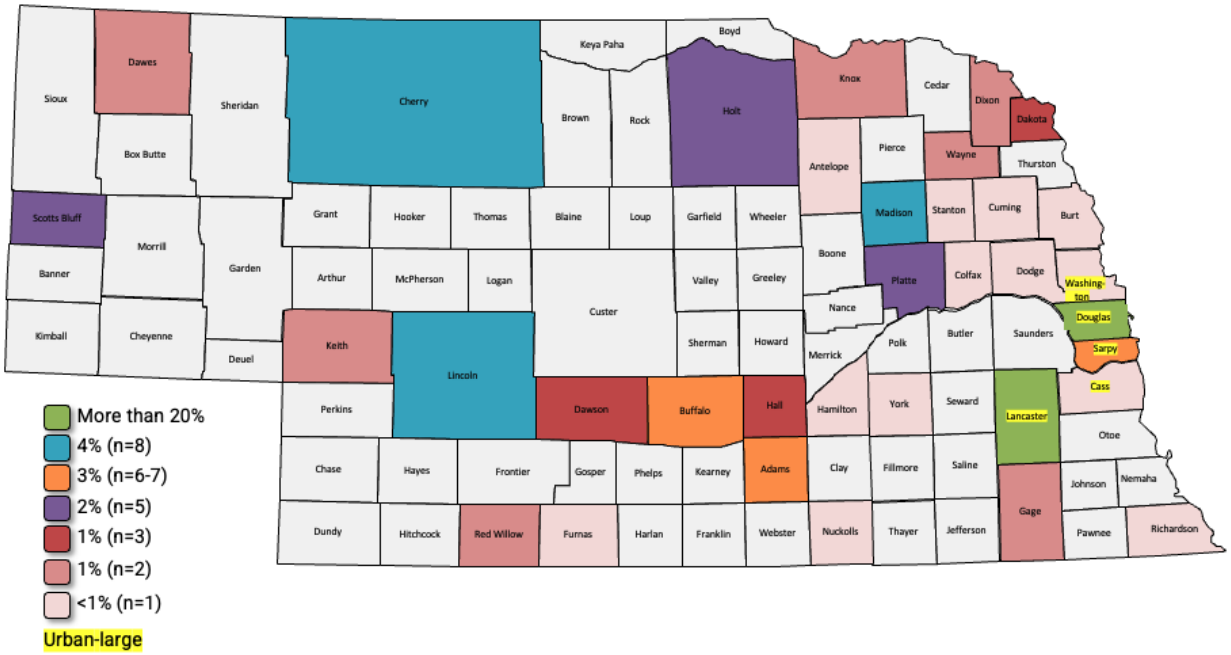
Although results shared are at the aggregate level, additional analysis was done for many of the survey questions based on where the respondent lived and how far they typically had to travel to get disability-related services and support. Survey respondents reported being from 34

[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

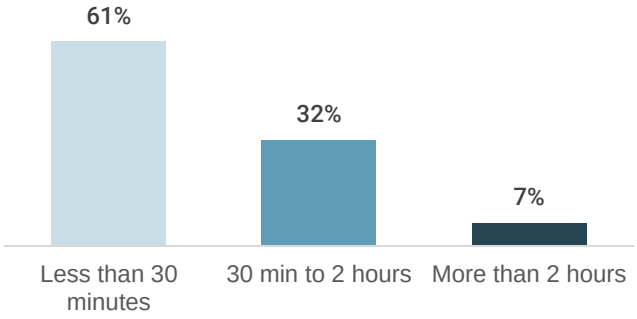


[9] Division of Public Health, Nebraska Department of Health and Human Services. *Disparities demographic data recommendations.* (Nov. 2016). https://dhhs.ne.gov/Reports/DHHS%20Demographic%20Data%20Recommendations%20Report.pdf

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

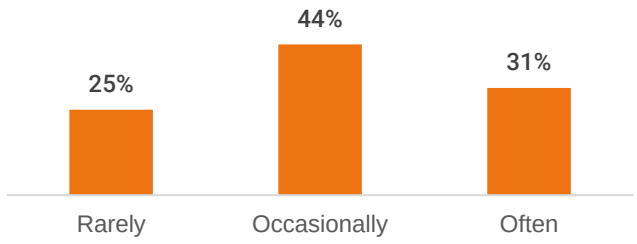
As mentioned, additional analysis was also done based on the amount of time it took individuals to get disability-related services and supports. It is important to note that the survey did not provide a definition or description for what disability-related services or supports entailed; that was left 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).

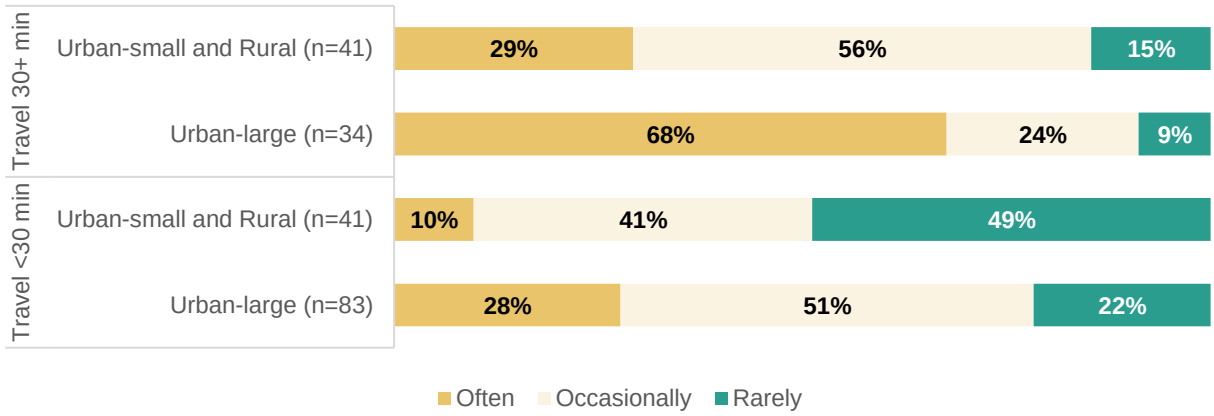
Figure 13. About one-fourth of the survey respondents "rarely" had difficulties getting access to disability-related services and supports (n=221)



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.

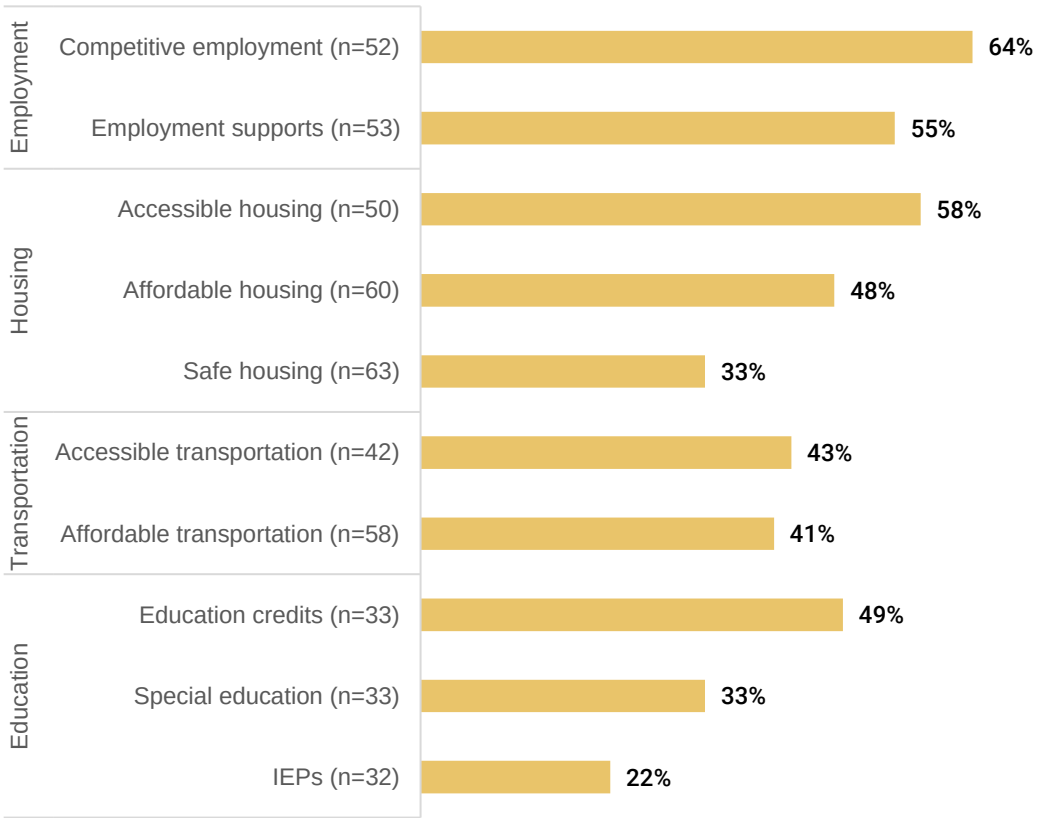
Among those who live in an urban-large county and who reported having to travel 30 minutes or more to get disability-related services and supports, 68% reported they “often” have difficulties getting access to disability-related services and supports (Figure 14). There were 28% of respondents in urban-large 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



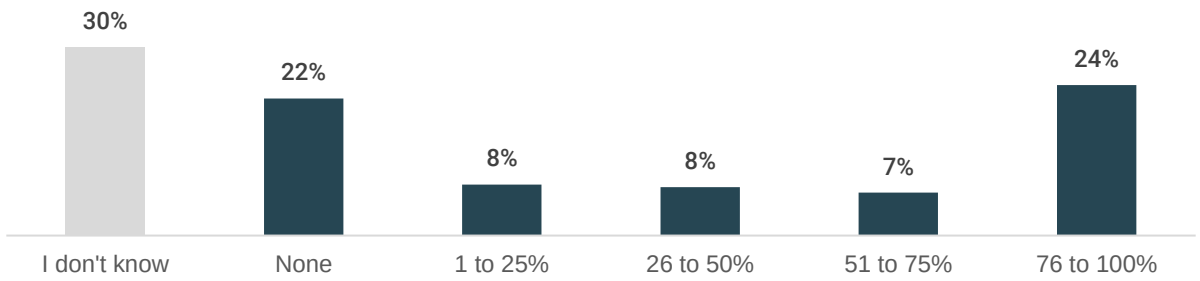
For those who reported they did not have or could not get access to certain services, analysis explored what those services might be. Results show that the areas where people were more likely to report not having access was in the areas of employment and housing (Figure 15).

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.*

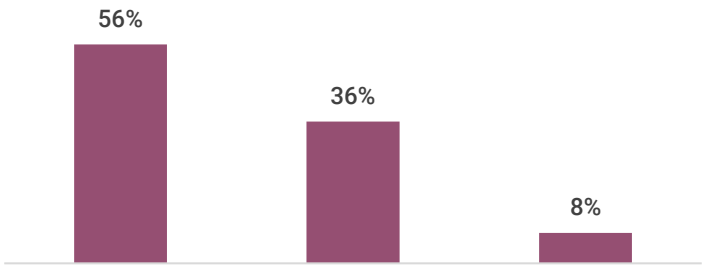
A related long-term hope for Nebraska's Plan is to have ownership across different entities. Some perceive that while agencies and advocates come together to attend meetings and provide feedback, the key coordination and action is taken by Nebraska DHHS. Over time, **efforts may be more successful if 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.

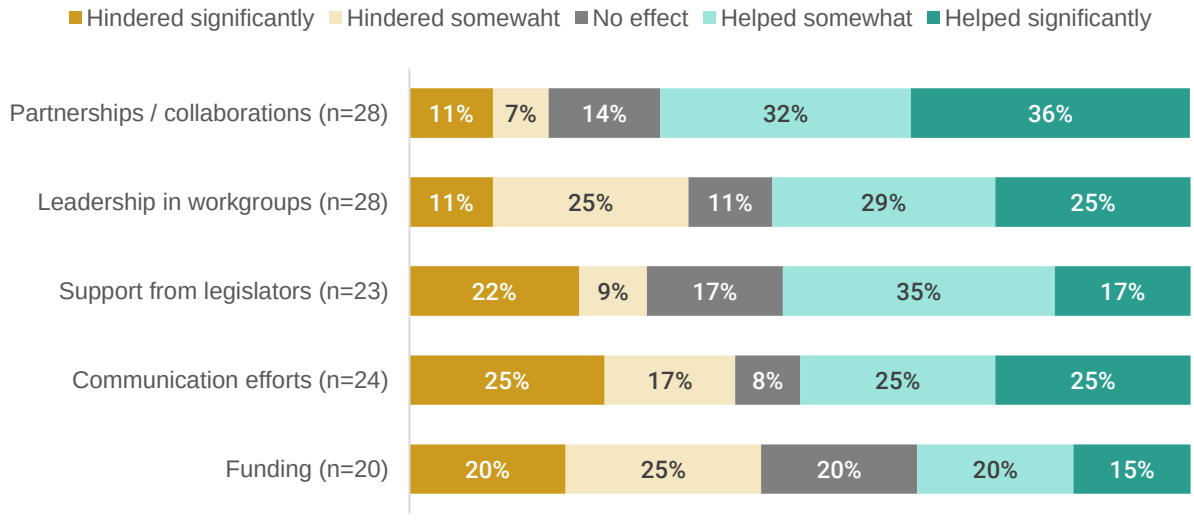
Another stakeholder noted that it would be helpful to collect data from all stakeholders to get a better sense of who is being served and who is not. *"It's hard to make those decisions without that documentation or information, but a lot of times we don't gather it."* However, the need for data must 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

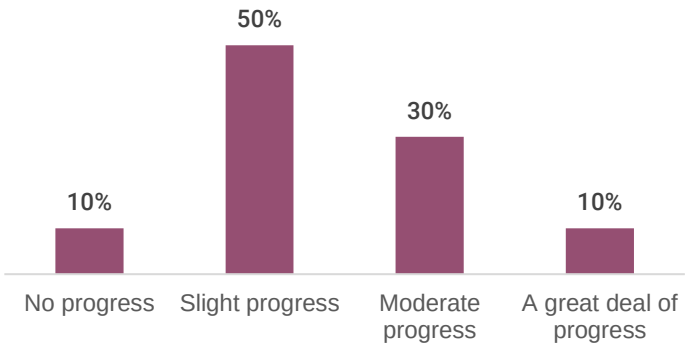
There are seven outcomes for the first goal. While five are addressed through the newly formed Community Supports workgroup, one (#7) is led by the housing workgroup and another (#3) is through the education workgroup. Based on the Olmstead outcomes monitoring system maintained by DHHS, all but two of 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

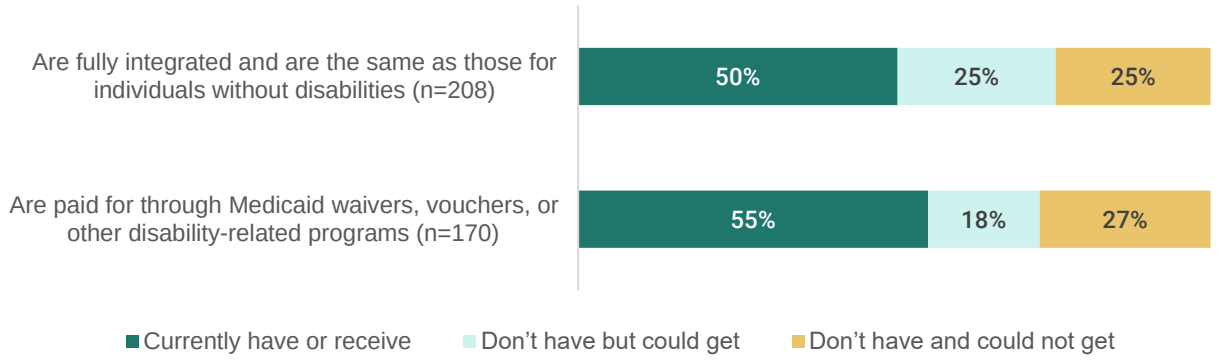
According to workgroup members (through the survey) and key partners (through the interviews), there are a variety of factors that can impact progress on ensuring individuals with disabilities can access individualized community-based services and supports that meet their needs and preferences – either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

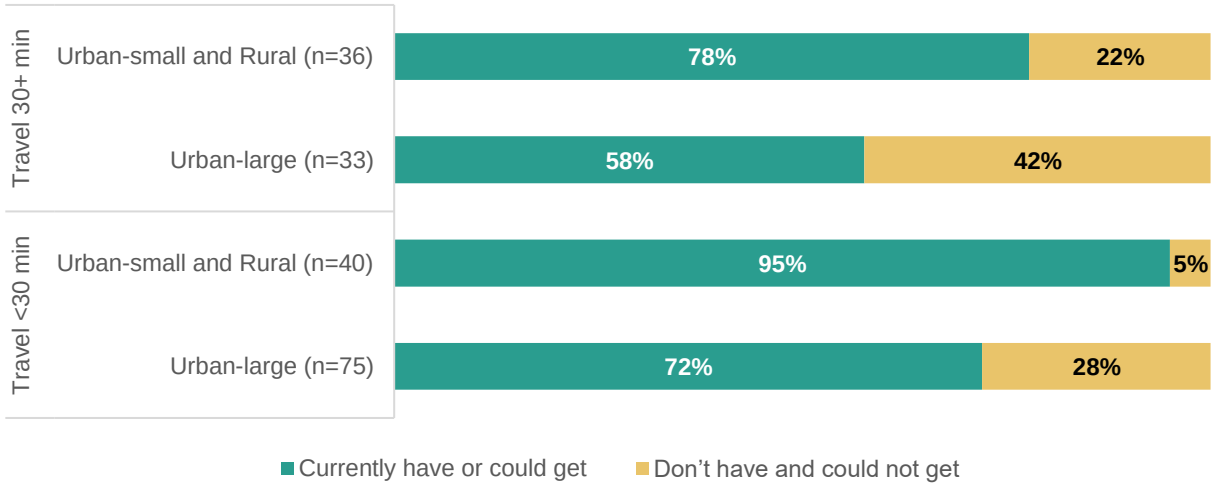
Through the survey for individuals with disabilities, about half reported they were able to access community-based services that 1) are fully integrated and 2) could be paid for through Medicaid waivers, vouchers, or other disability-related programs. However, there were also one-fourth of respondents 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.

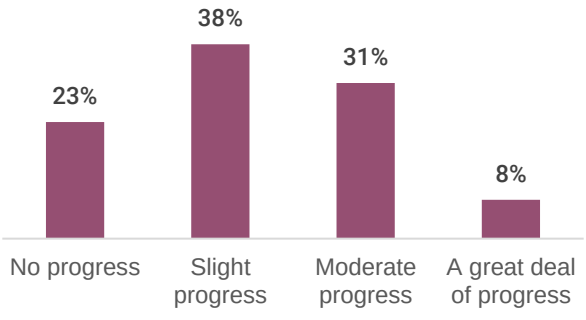
Figure 28. Nebraska achieved at least half of the FY23 and FY24 benchmarks for the housing outcomes

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

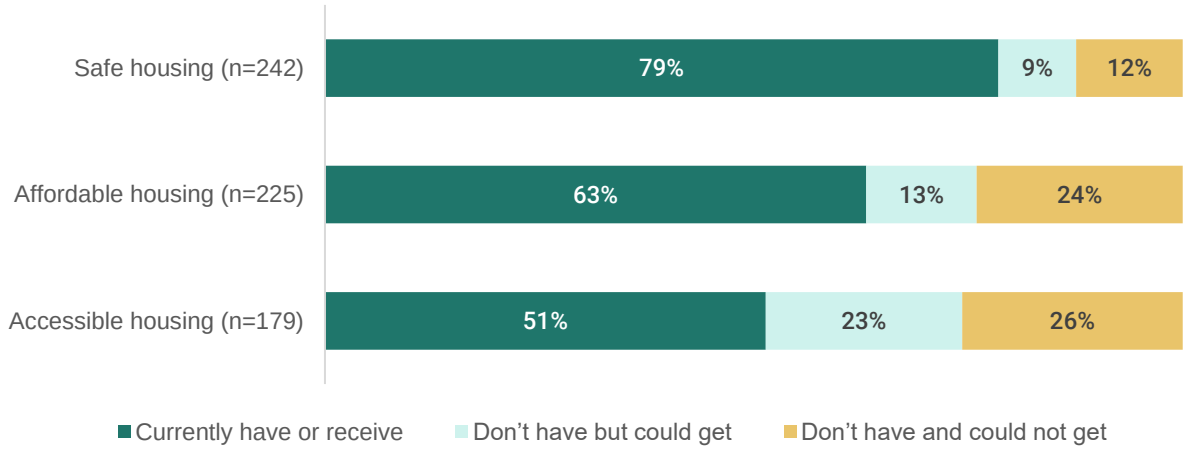
Based on input from workgroup members and key partners through the various data collected, there are a variety of factors that impact progress on housing efforts (Figure 30).

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.

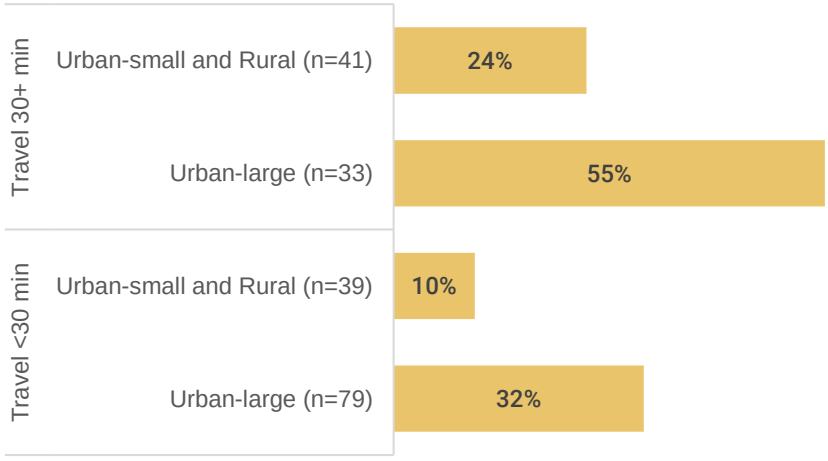
As part of the evaluation, perceptions about housing were sought among individuals with disabilities and family members/caregivers. Based on the results of the survey, safe housing was considered more available than affordable or accessible housing (Figure 31). About one-fourth of the respondents didn't 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)

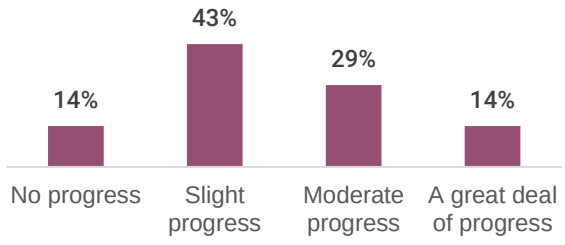
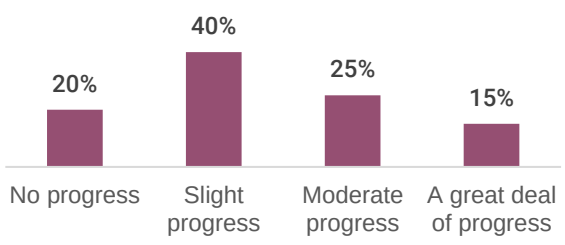


Figure 36. For the employment outcomes related to Goal 4, about 60% felt no to slight progress was made (n=20)



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).

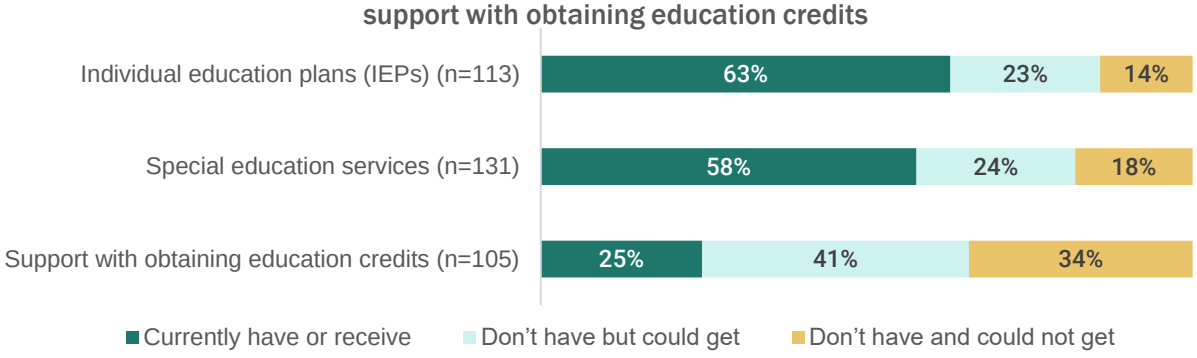
Figure 38. Many barriers were noted to addressing education as part of Goal 4

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.”

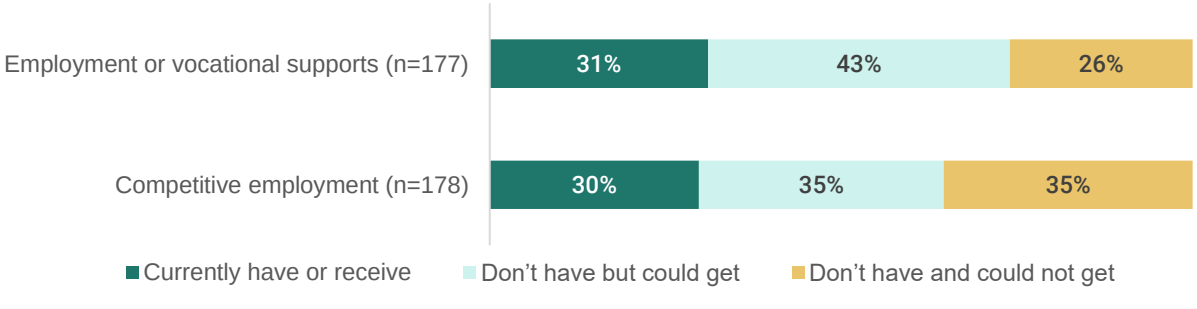
Figure 39. Survey respondents were more likely to report having or receiving individual education plans and special education services compared to support with obtaining education credits



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

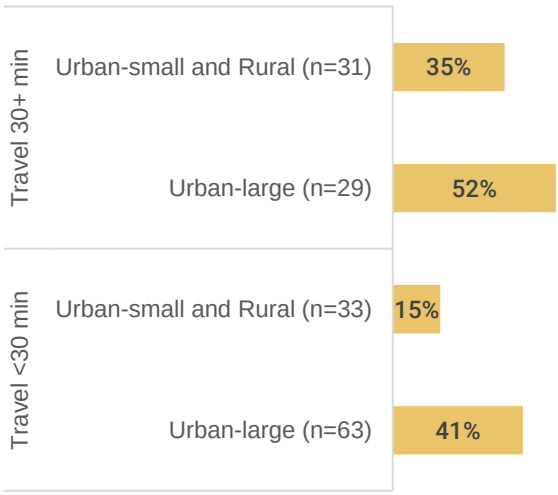


A deeper look at the data shows the same significant interaction effects where those living in urban-large counties and traveling more than 30 minutes have the biggest access problems. Among those who live in an urban-large county and who reported having to travel 30 minutes or more to get disability-related 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."*

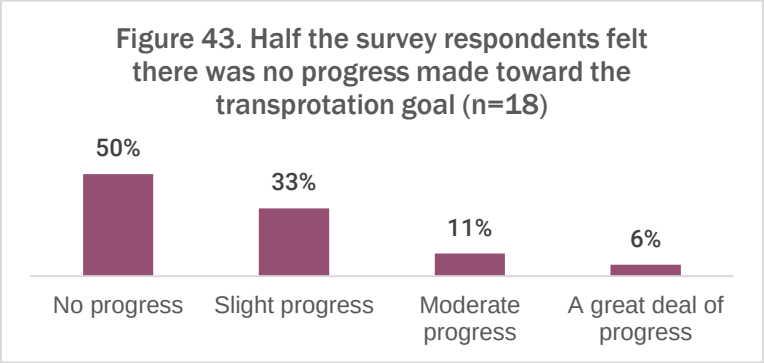
Progress Toward and Perceptions of Outcomes

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

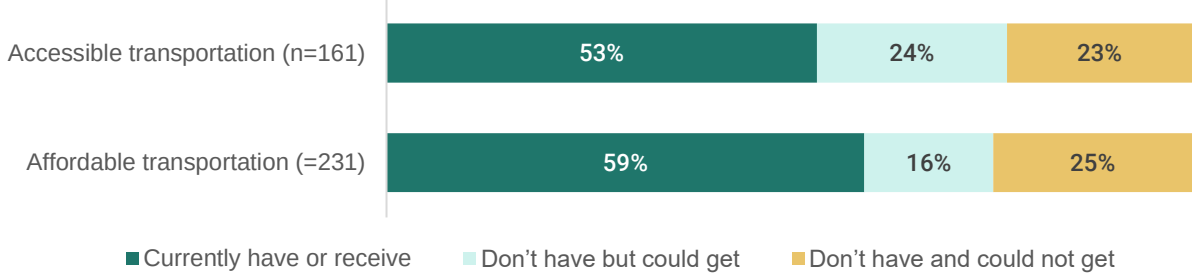
Based on input from workgroup members, key partners, individuals with disabilities, and family members/caregivers, there are a variety of factors that impact progress on transportation efforts. Most of them end up being barriers to addressing or accessing transportation (Figure 44).

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

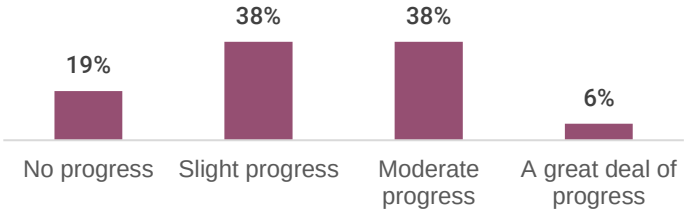
There are six outcomes for the data goal. Efforts for this area are primarily coordinated through the data workgroup, though one of the outcomes (#2) is assigned to the community supports workgroup. Based on the Olmstead outcomes monitoring system, all but one of the benchmarks set for FY23 (83%) were 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

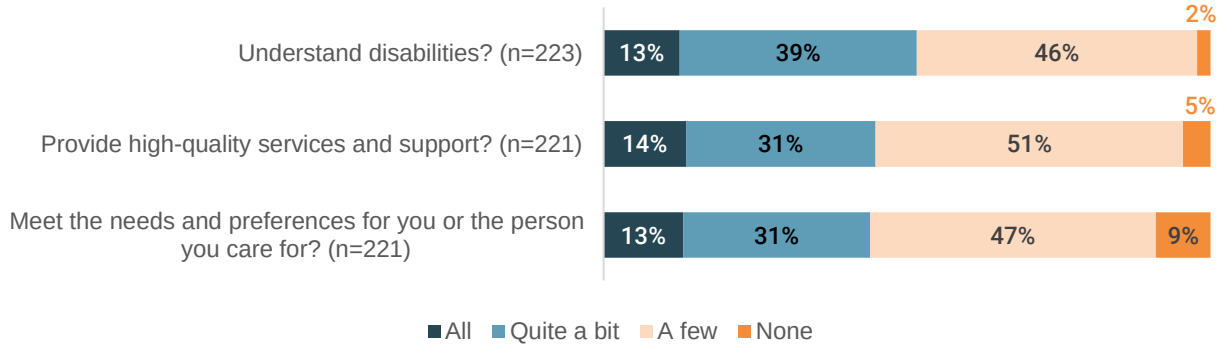
Based on input from workgroup members and key partners, there are a variety of factors that can impact the workforce for disability-related services and supports (Figure 50).

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.

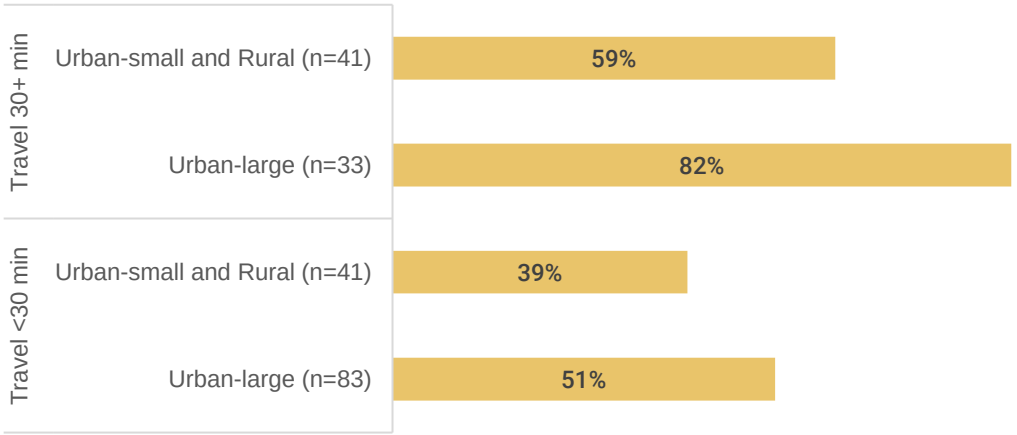
When asked about disability-related service and support providers on the survey for individuals with disabilities, about half the respondents felt that “none” or “a few” understood disabilities, provided high-quality services and supports, and met their needs and preferences (Figure 51).

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:

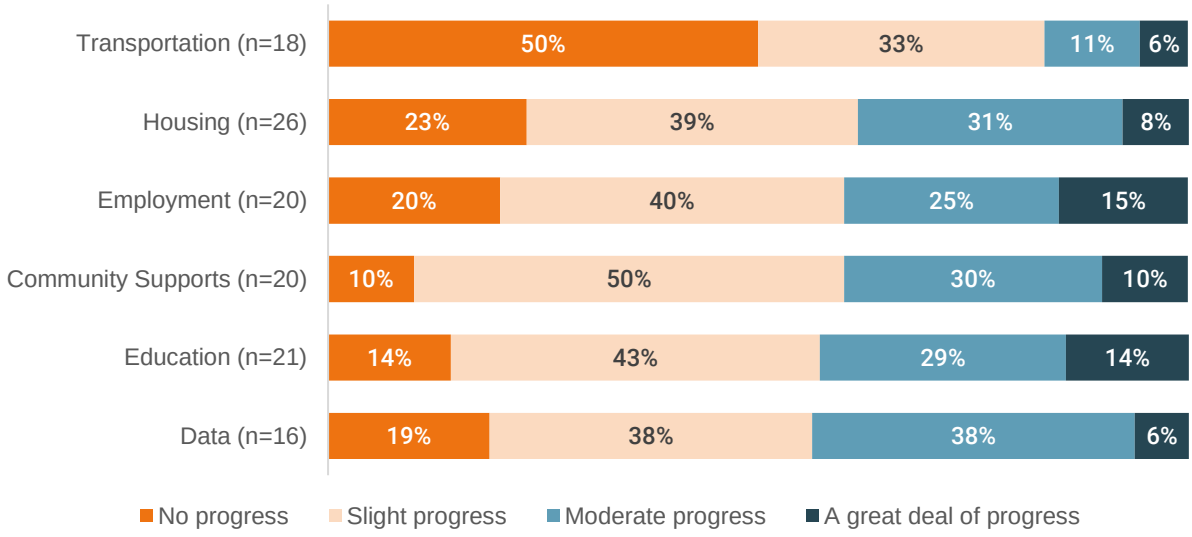
1. To what degree has progress been made among the seven goals of the Olmstead Plan?
2. What improvements and impacts have resulted from the Olmstead Plan, including collaborations between state agencies?
3. What activities and outcomes should be included in the next iteration of the Plan?
4. What are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

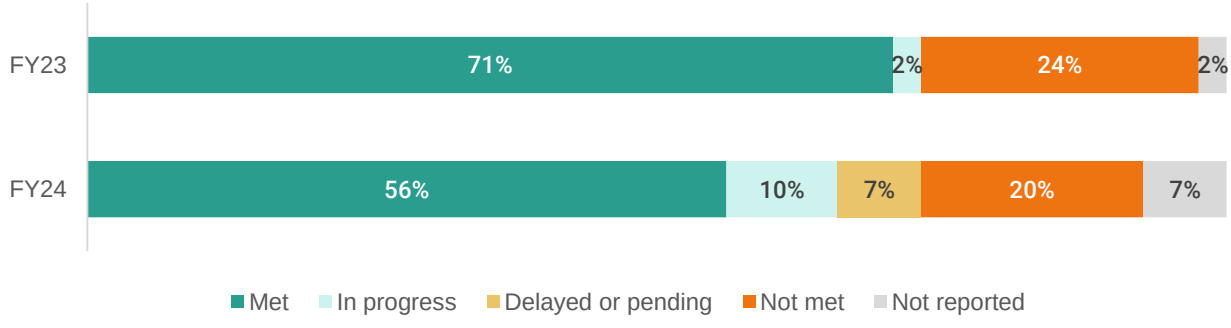
There are varied results when it comes to progress toward the goals. Across the six workgroup goal areas, on average, 10% of partner survey respondents felt there was "a great deal of progress" while 23% reported "no progress" had been made. As noted earlier in the report, the perception among key partners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



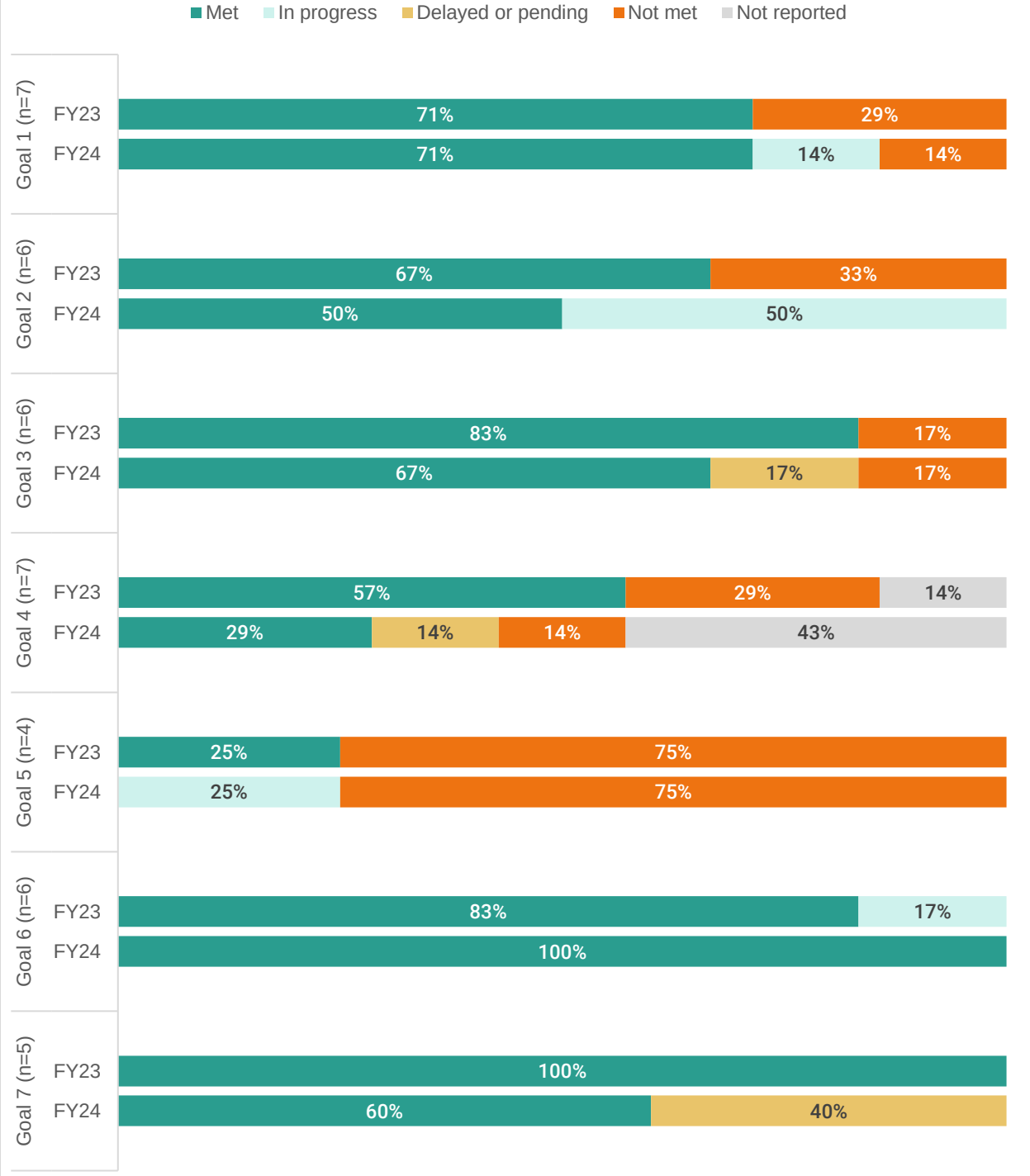
Annual benchmarks for each goal are tracked by DHHS through their Olmstead outcomes monitoring system. Among the 41 benchmarks for FY23, 29 (71%) of them were met (Figure 54). Roughly 25% of the FY23 benchmarks were not met. During FY24, there were 23 (56%) benchmarks completed.

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

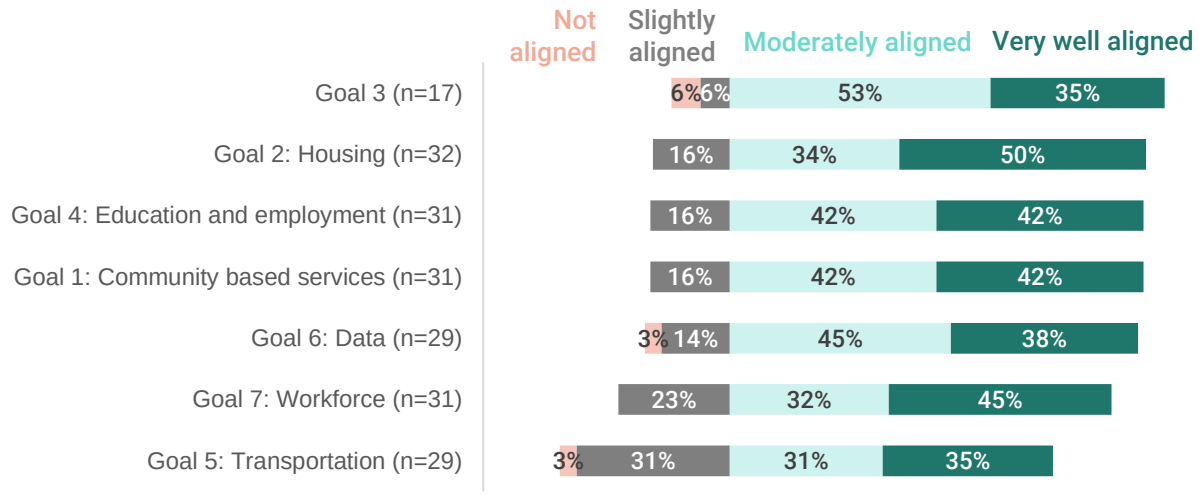
Key Facilitators	Key Barriers
• Diversity and strength in partnerships – including engagement from key state entities and new partnerships (such as nonprofits for the housing goal). • Advocacy from organizations and stakeholders. • The report developed by Dr. Lisa Mills on supported employment.	• Limited 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?

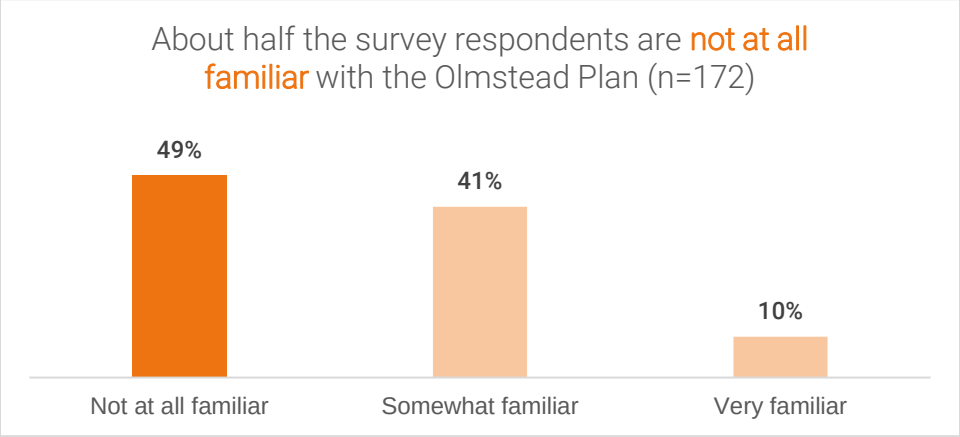
3. What are some of the key challenges that either you as the family member/caregiver or the individual with disabilities experience the most when it comes to being fully integrated in the community? (Probes: Are certain things unavailable or inaccessible? What services or aspects of living, such as 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?

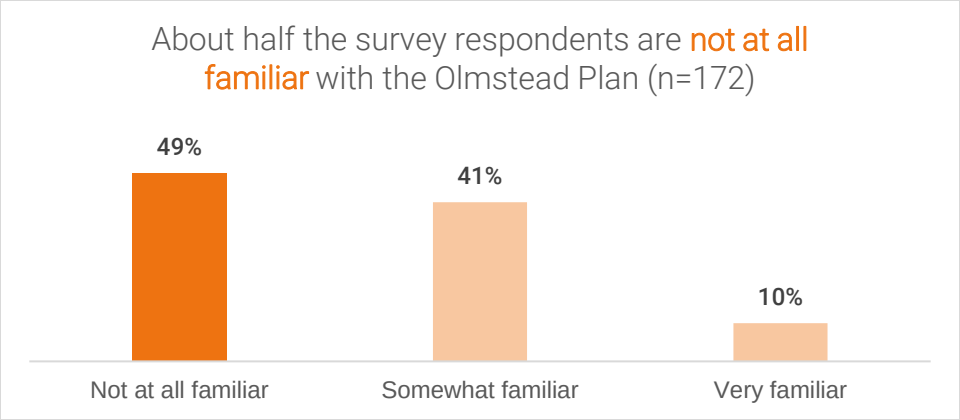
3. What are some of the major challenges you experience most when it comes to being fully integrated into your community? (Probes: Are certain things unavailable or inaccessible? What services or aspects of living, such as transportation, are hardest to obtain? Are there other barriers, such as cost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

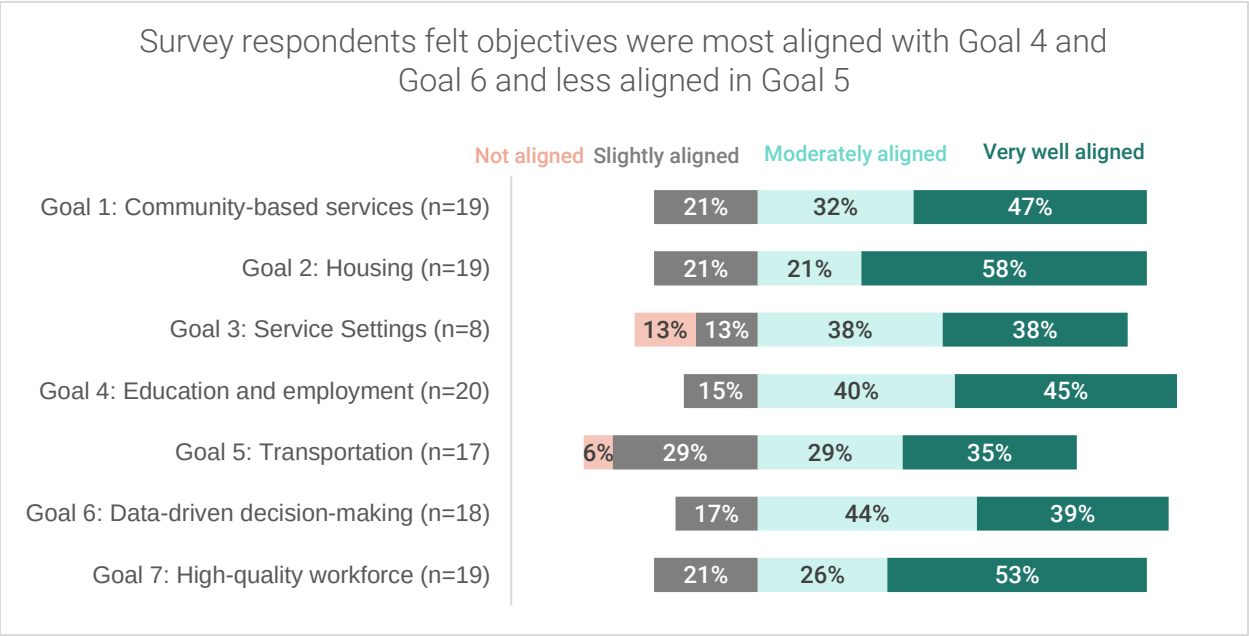
12. How well does the current workgroup meeting coordination and structure work? What would you say is working well and where could improvements be made? (Probes: is the quarterly frequency appropriate, is communication between meetings sufficient, are the number/diversity of workgroup members sufficient,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

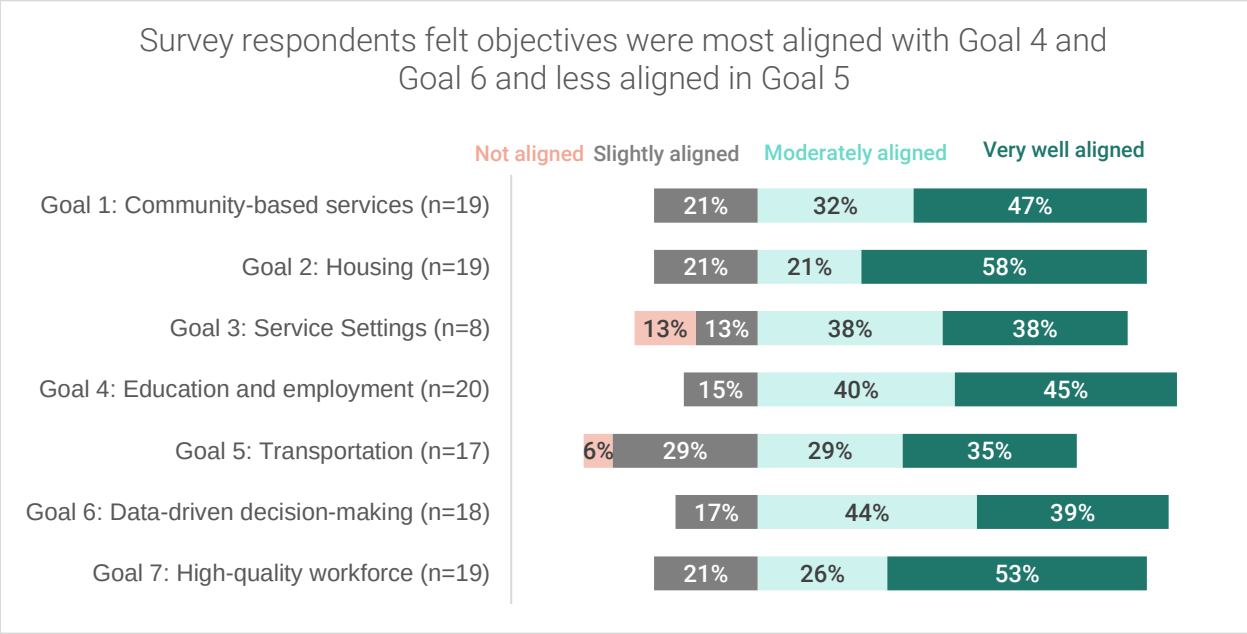
7. How well does the current workgroup meeting coordination and structure work? What would you say is working well and where could improvements be made? (Probes: is the quarterly frequency appropriate, is communication between meetings sufficient, are the number/diversity of workgroup members sufficient,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