THE STEPHEN GROUP

LB 1173 PRACTICE MODEL

An Intersectoral Approach to Reimagining Child Well-Being, Permanency, and Safety

Legislative Work Group Report

LB 1173 Child Welfare Practice Model

What is a Child Welfare Practice Model?

A practice model is a framework that highlights the vision, values, and principles that guides the approach to engaging with children and families. Practice models are developed and implemented to guide policy development, practices, clarify expectations, and improve outcomes for safety, well-being and permanency for children and families.

A new framework allows states and/or agencies to reimagine their approach to child welfare in a thoughtful, integrated model of practice.

Practice models guide the work of those involved with the child welfare system to work together to improve outcomes for children and families.

Practice models may also include specific approaches and techniques considered fundamental to achieving desired outcomes.

Additionally, models may describe organizational principles extending expectations beyond front-line practice to address issues such as agency leadership and relationships with stakeholders and the community.

Benefits of Developing and Adopting a Practice Model

A well-defined and crafted practice model provides the framework for continuity between the vision and actual practice, by:

- Creating core values and practice guidelines that will transcend leadership changes
- Policy development and changes with adherence to key principles
- Shaping the construction of training
- Preparing front-line workers with decision making
- Promoting consistency with family engagement
- Transforming agency outcomes

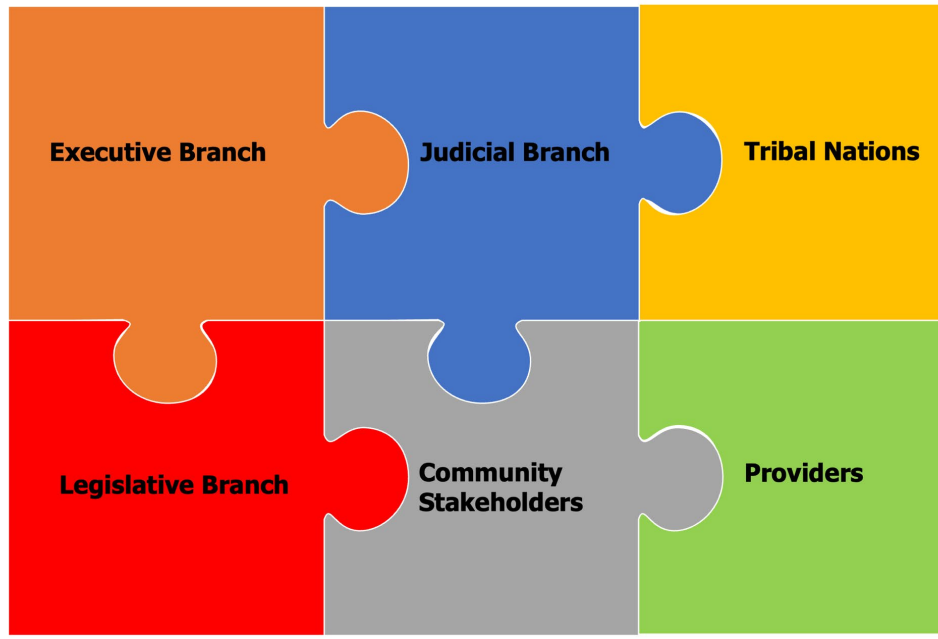
Nebraska Intersectoral Child Welfare Practice Model

Background

Legislative Bill 1173 (LB 1173) was passed unanimously by the 2022 Nebraska Legislature, tasking the three branches of state government with working together to transform child and family well-being in Nebraska.

The preamble to the bill states "in order to support the well-being, permanency, and safety of children and families in Nebraska's communities, [the state] needs to **comprehensively transform** its child welfare system." The bill further states that an **"integrated model"** will be required to achieve this transformation, "addressing all aspects of the system and strong partnerships among the legislative, executive, and judicial branches of government and community stakeholders."

LB 1173 specifically names the government entities, including each federally recognized Indian tribe within the State of Nebraska, to be included in a strategic Work Group tasked with rethinking how Nebraska approaches its at-risk children and families. The bill also requires consultation from key stakeholders, such as judges and private child welfare providers. In doing so, Nebraska took an unprecedented step towards developing a transformational, intersectoral child welfare practice model.



Beginning in February 2023, the LB 1173 Work Group met monthly to develop the following practice model, including the following required elements outlined in the legislation:

1. Statewide Mission and Vision Statements
2. Values and Practice Priorities
3. Statewide Program Goals
4. Engagement Strategies to Support Community Involvement in Child Welfare System Transformation
5. Practice Model for Child Welfare System Case Management and Service Delivery
6. Strategies That Strengthen Relationships Across Court System, Probation, Executive Branch Agencies, State Department of Education, and Community Partners
7. Strategies That Support Integration Across Agencies
8. A Strategy for Data Collection and Outcome Monitoring

This model developed by the Work Group reflects the input gathered from multiple interviews, community forums, and focus groups held across the state, and builds upon previous work done within Nebraska to improve the child welfare system.

Model Intersectoral Objective

Through consultation with key stakeholders, the LB 1173 Work Group established the following Intersectoral Objective for the Child Welfare Practice Model:

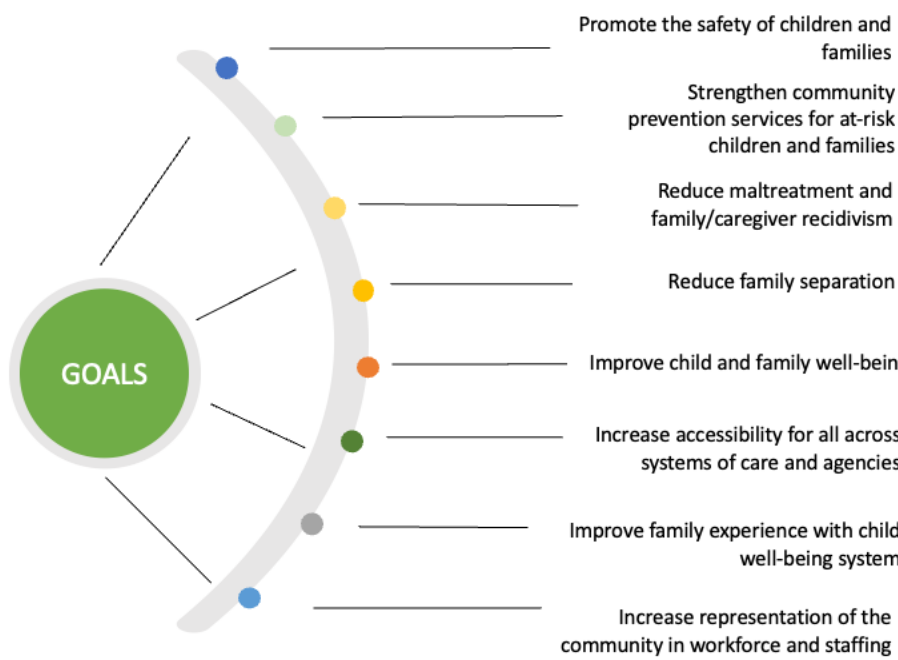
We believe that the lives of children & families can be enhanced by building strong partnerships for child & family well-being transformation that invests resources in effective & innovative ways

Model Mission, Vision, Guiding Principles, and Core Values

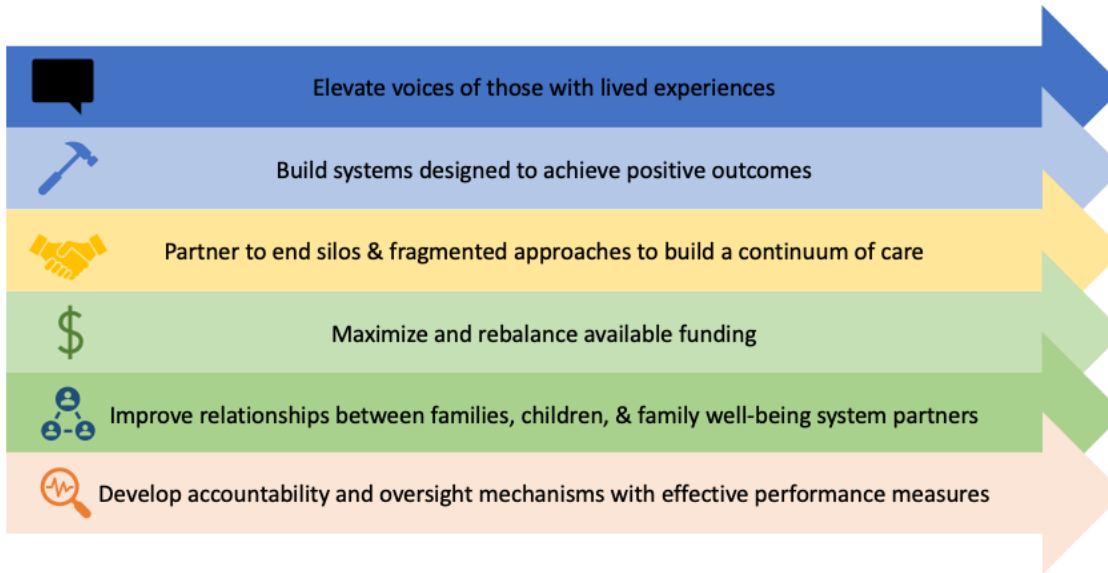
MISSION	VISION
Engaging communities to support families so they thrive, & children are safe.	**Every child in Nebraska has what they need to thrive in a safe, stable, & permanent home, sustained by nurturing relationships & strong family & community connections.** **We will strengthen families in their communities by safely reducing the need for intervention & system involvement by aligning resources more effectively.**
GUIDING PRINCIPLES	**CORE VALUES**
◊ **Authentic Partnerships:** A child well-being system that collaborates across executive branch agencies, the court system, probation, & community partners, & is designed & built with the voices of persons with lived experience & their communities, working in partnership with individuals & families. ◊ **Compassion, Empathy & Humility:** Demonstrating compassion, empathy, & humility to design systems & services that reflect & value individuals, traditions, & the personal experience of those with whom the child well-being system serves. ◊ **Honesty & Transparency:** Being open, straightforward, & truthful. This involves honesty about policies, processes, expectations, & limitations influencing people's experience & outcomes. This also involves openness between partners about system performance, acknowledging strengths & challenges, adapting when necessary, & publicly sharing information about steps to address areas needing improvement.	◊ **Collaboration:** A child well-being system that involves state partners, Tribal Nations, community & families collaborating to address the well-being & best interests of children. ◊ **Children, Youth, & Families:** Children & youth should live in a safe, nurturing, & supportive family environment. Families are the best place for children & youth to grow up & family connections should be maintained whenever possible. ◊ **Respect:** Honor & support for the inherent dignity & worth of each person served & each partner. Demonstrate empathy & kindness in all interactions. Value lived experience & diverse opinions in the work to transform & improve the child well-being system in Nebraska. Be proactive in communication. Recognize that individuals & families are experts in their own lives, listen to them about what they need to be safe & thrive. Respect cultural differences.

◊ **Empowerment:** Empower staff, individuals, families, & communities by ensuring all have the information & tools to achieve success. ◊ **Innovation:** Cultivating a learning, adaptable environment through feedback, data & innovative ideas to improve efficacy & outcomes.	◊ **Accountable:** A child well-being system that is responsible, transparent, & dependable in all its actions, & establishes clear performance standards, & support for the workforce, communities, & families it serves to achieve success. ◊ **Excellence:** High-quality service is a priority in every interaction with individuals, families, partners & communities, & a system wide commitment to identifying & acting upon opportunities to improve its performance & outcomes deepen partnerships & strengthen communities.

Model Goals



Model Strategic Priorities



NEBRASKA CHILD WELFARE MODEL OF PRACTICE

Workforce

- Our staff is the most valuable asset in the agency, and we emphasize developing a competent workforce through effective recruitment, quality training, and ongoing professional development
- We will develop a staff representative of the communities we serve, culturally, geographically, and through relevant life experience
- We believe in creating an organizational culture and climate that promotes learning and critical thinking
- We will develop skilled and responsive professionals that perform with a sense of urgency and accountability by delivering a family-centered model of practice emphasizing child safety, permanency and well-being
- We will build, support, and retain a qualified, skilled and committed workforce whose own well-being and safety are valued and prioritized
- We believe in leaders that advocate for and support an organizational culture that delivers quality child welfare outcomes

- We aspire to be culturally competent and build upon strengths of community and cultural groups

Prevention

- A robust and responsive child welfare prevention network enhanced through a number of Community Pathways, including organizations, providers, and faith communities that offer support for children, youth and families. These local resources will be utilized before a family reaches crisis, necessitating formal child welfare system involvement; a family or individual does not need to be in crisis to receive services
- The traditional governmental response after allegations of abuse or neglect can be safely replaced, when appropriate, through the infusion of a community driven approach that capitalizes on partnerships within the public and private sectors
- We will use alternative pathways, when appropriate, that are available to support families to gain access to tools, resources, and services that can help them navigate life during challenging times and reduce the number of unnecessary calls to the child welfare system hotline
- We will use a prevention system grounded in evidence-based, evidence-supported and trauma informed practices designed to allow children at risk of foster care to remain safely at home and in their communities
- Our prevention efforts will include collaboration with the education system, local schools, and teachers leveraging their roles as a vital resource for children, families, and communities

Family Engagement

- Parents have the right and responsibility to raise their own children
- It is our responsibility to understand families within the context of their own traditions, history, and culture
- When safely possible, children should be raised in their family - families should be viewed as the solution and not the problem
- We will design and deliver supports earlier to build on family strengths
- We will prioritize supporting the family unit by identifying the most prevalent issues with matching intensity and focused solutions
- We will value parents' voices and opinions when making decisions regarding the wellbeing of their children and families
- We will develop and implement family-centered and custom solutions that build on the strengths of families to meet their needs
- Peer support will be offered to families early in the process as a resource and families will be educated on the availability of this resource early in the case
- Families will be regularly informed of the status of their cases and will have access to case workers; communication and follow up with families will be a priority of case workers

Intake and Assessment – Child Safety First, and Foremost

- When a hotline call is received, the focus will be on child safety and the necessary information will be collected to make an informed decision
- The initial assessment will determine the child's risk and safety, underlying conditions and contributing factors that may impact risk of harm to the child, factors related to the child's vulnerability, and the family's protective capacities
- Safety of children is our paramount concern, and we will address it in every assessment, and every contact
- The assessment will be open and transparent to the family, sharing information about the process and the tools
- We will work with the family to build a supportive team that engages family, cultural, community and Tribal connections as early as possible
- Efforts are made to ensure that all persons working with the child and family have a shared understanding of the child and family
- Assessment is an ongoing process and will be solution-focused and family-centered
- In our response to child safety concerns, we will reach factually supported conclusions in a timely and thorough manner
- We will listen to parents, children, extended family, and community stakeholders as a necessary component in assuring safety and if we separate caregivers from children in need of protection, we will use our authority with sensitivity and respect

Teaming

- Children and families are best served through a team approach where all members have a voice and are valued
- We will build partnerships with formal and informal networks
- We are all accountable to achieve positive results for children and families
- We will respect the family's cultural, community, and other natural relationships and values to help the family meet their underlying needs
- We will work in partnership with families, communities, Tribes, faith organizations schools, and service providers to move families forward
- We will build teams by demonstrating respect, effective communication, commitment to action, following through, and building consensus on team roles and team dynamics
- Partnering with families, children, and their extended support networks as active members of the team to develop plans for the family to identify supports and build on strengths so families can overcome barriers
- We will actively and effectively coordinate and communicate with internal departments, other state agencies, Tribes, LB 1184 Investigative and Treatment Teams, and community service providers to ensure child safety, permanency, and well-being

Services to Children and Families

- A well-being platform will be developed by using principles to transform the child welfare response before a report is made to the hotline and infuse a community driven approach that capitalizes on partnerships within the public and private sectors
- We will support caregivers in protecting children in their own homes whenever possible
- Service planning will involve working with the family to create and customize plans that build on the strengths and protective capacities of the family, in order to meet the individual needs for each child and family member
- Our agency will be focused on providing trauma informed, high quality, timely, efficient, and effective services to children and families
- Services will be available regardless of geographic location for crisis and high need care cases
- Children and families will receive individualized services matched to their strengths and needs, based on the safety threats identified during the assessment process
- Relevant community partners (e.g., domestic violence, child advocacy centers, substance abuse, mental health, schools, faith communities, community providers, public health, etc.) will be engaged to assist in keeping children safe
- Services will be data-driven, coordinated and information will be shared among those providing services to the child and family. All providers working with the family will function as a team and work collaboratively to solve problems in a manner consistent with the principles of family-centered practice
- We will strive for alignment and coordination of behavioral health assessment instruments for pediatric, primary care, child welfare, and for populations across Medicaid, behavioral health and child welfare
- We will deliver efficacious, evidenced and trauma informed services designed to minimize disruptions and promote adoption success

Well-being

- Well-being is embedded in the Nebraska child welfare system and includes access to Behavioral Health and Substance Abuse outpatient services in the community, before crisis
- We will prioritize physical health, safety, mental health, emotional and cognitive development, education, learning, nurturing relationships, and social behavior
- Our focus will be on quality of life of the family and each family member's wellness, development, needs and their ability to manage stress
- We will strive to keep struggling families together, safe, and avoiding additional trauma by separation We will engage physical, behavioral health, and community partners early in the process that includes but not limited to Medicaid Managed Care Organizations, Regional Behavioral Health Authorities, peer support, and specialty providers
- The same intensity and focused solutions should apply to the family after removal to minimize the child's trauma and jumpstart the healing process based on a trauma-informed lens
- Education is a key aspect of a child's well-being and we recognize schools as an important prevention

resource and partner in helping develop and promote positive assets in children and youth, and in working with families to reduce entry into the Child Welfare System

- Medicaid Managed Care Organizations can provide more support to families and should be utilized as a resource to access needed services
- Peer support specialists can help families involved in the system find and access needed services Nebraska's families nurture, protect, and meet the needs of their children, and are well integrated into their communities

When Children are Unable to Remain in their Home

- When a removal from the home has to occur, a trauma informed response will be used with early engagement of physical, behavioral health and developmental disability partners to start the healing process
- Safely reduce the inappropriate use of non-family-based placements; when a non-family-based placement is needed, ensure children are placed in the least restrictive, highest-quality setting appropriate to their individual needs
- When children cannot remain safely with their caregiver, priority consideration for placement will be with kinship connections capable of providing a safe and nurturing home while finding safe, permanent homes for children as quickly as possible
- When safely possible, children will be placed in the community of their residence to avoid changing schools, promoting frequent visitation, and facilitate case plan completion
- Children will be placed with their siblings, unless it is not appropriate or unsafe
- If siblings are not placed together, concerted e orts will be made to promote and support visitation between siblings, unless unsafe
- Native America children will be placed in cooperation with the Tribal Nations and following the guidelines of the Indian Child Welfare Act
- We support placements that promote and maintain family, sibling and community connections, and encourage healthy social and emotional development
- Children's voices will be heard, valued, and considered in decisions regarding their safety, well-being, and permanence
- We will have an adequate array of out-of-home placement options, including those for high-needs and/or older youth and to minimize disruptions in placement
- When a removal occurs, our placements will be culturally appropriate

Permanency

- Permanency begins at the first contact and continues with a sense of urgency until permanency is achieved
- When possible, permanency is best achieved through timely reunification, permanent guardianship or relative adoption
- Focused efforts should be made to timely place children who are legally free for adoption with a prospective adoptive family
- It is our responsibility to promote lifelong connections for each child and when possible, preserve kinship, sibling and other community connections

- We value post-permanency support services as a vital support to encourage adoption and assist families to remain committed to children with special needs, so children remain stable with their new families

Transition for Older Youth

- When young adults age out of foster care, they have a permanent family or enduring connection to a caring adult committed to serving in a parental capacity and to a network of mentors and friends in the community, including those that will provide help with workforce skills
- We will arrange for appropriate, time-limited aftercare and available post-permanency services We will ensure young adults have services and supports to help live safely, be self-reliant, and function successfully independently

Engagement Strategies

ENGAGEMENT STRATEGIES: COMMUNITY INVOLVEMENT

Engagement Strategies to Support Community Involvement in Child Welfare System Transformation

Strategy 1: Transform Child Welfare System through Community-Based Prevention Services

- Data analyzed by the LB 1173 Work Group demonstrates that the majority of child maltreatment in Nebraska is due to physical neglect, which is often related to poverty, mental illness and financial stress. Thus, most of these reported cases have children and

families that can benefit by support in the community in which they live. With such support, reports of abuse and neglect may also be reduced where mandatory reporters recognize an effective community response to poverty, mental illness, or financial stress.

- Building upon and scaling successful community interventions to develop a Community Response Pathway can help keep families out of the child welfare system and enhance community well-being.

    - Local efforts such as Bring Up Nebraska and its Community Collaboratives, local community-based organizations, and Tribal Nation resources offer programs and resources that enhance protective factors and should be leveraged to promote community well-being and support at-risk families, preventing removals and keeping families out of the child welfare system.
        - **A Community Response Pathway, with Navigation, Coaching and Closed Loop Referral Technology could be established as the main prevention entry point**. Each Community Collaborative would work with and connect with the array of intersectoral partners including courts, schools, community-based organizations, service providers and other key partners to support families in need.
    - Engaging faith-based churches and organizations can also yield crucial partnerships to effectively reach at-risk families. For example, Buffalo County Community Partners is working with three churches with Spanish ministries to train in Mental Health First Aid and Wellness Action planning to help identify families with unknown mental health issues who belong to partner churches and organizations.

- Consider the **creation and funding of local family and youth programs** and community engagement events to help facilitate positive outcomes.

    - Parenting and child development education prior to birth; pre-natal support; care and support groups for teens/parents after birth identified as community needs for at-risk families.
    - Input of Tribal Nations included those common views of “community well-being” involve more community events (tournaments, dances, carnivals), cultural-based events and programs, and culture-centered activities, education, programs, families, and communities.

- As Nebraska implements its Family First Prevention Services Act Title IV-E State Plan, DHHS, in collaboration with community providers, should consider opportunities for

developing enhanced capacity for implementation of evidence-based home visiting models such as Healthy Family America, Parents as Teachers, Common Sense Parenting, and Nurturing Parenting to **increase its ability to connect at-risk families with community-based services and supports.**

- Data from DHHS indicate the effectiveness of Nebraska's Alternative Response efforts in decreasing removals of children from their homes by providing in-home interventions and connecting families and children with local, community-based services.
- **Economic development partners in communities can play an effective role in system transformation**: Chambers of Commerce or entities like the Ho-Chunk Community Development Corporation can act as a conduit for funding and community partnership.

Strategy 2: Ensure Child Welfare and Related Systems and Services Reflect Communities Served

- During stakeholder interviews, community forums, surveys, and other efforts at gaining community input, it was frequently stressed that the child welfare system and related systems must reflect the communities and families they serve and take into account the lived experiences of these individuals. This includes:
    - DHHS and the court system having workforce pipelines that represents and **value life experience and cultural competency/diversity**, not just certain education or credentials;
    - Soliciting, accepting, and incorporating the input and feedback of individuals impacted by the child welfare system and related systems; **authentic engagement in this case means co-creation**; and
    - Offering services and resources that are accessible to non-English speakers.
- Children and Families Services, the Juvenile Justice System, and other related systems must **consider and incorporate the input of individuals in the community, including those with lived experience, peer support advocates, and families involved in these systems.**
    - Timely, authentic, two-way communication between agencies and stakeholders is essential during the consideration and development of legislative and regulatory changes, including Family First Prevention and Services Act implementation.

- In making decisions, all aspects of the system need to consider culture and reflect appropriate cultural competency.
- Building trust between the community and families and state systems must be a goal of this outreach.

- **Peer support programs should be supported and promoted** throughout the state at the outset of every case to provide necessary community support to system involved families. This is a valuable asset that is often overlooked or implemented too late.

- **Establish an accessible platform for youth advocacy**; it is important that youth share what they think and that they are listened to.
- **Workforce** in child welfare and juvenile justice systems **should reflect the communities they are serving** and should receive training in cultural competency.
- **Collaborate with Tribal Nations** by improving cultural understanding of Tribal Nations, including family life, and recognizing and understanding that culture is a protective factor.
  - The Tribes do a great deal of cultural support for families using language, family, elders, ceremonies, and more. Culture is the key to healing and who Native American people are. Tribal departments have seen success when cultural and ceremonial activities have been utilized when serving families.

Strategy 3: Strengthen the Role of Tribal Liaisons at DHHS

- DHHS should **formalize its Tribal liaison roles** across all five divisions and develop a teaming model to connect Tribal Nations to appropriate multi-disciplinary services at DHHS as necessary. This model would serve as a strong connection to Tribal Nations and enable Tribal Child and Families agencies to connect more effectively to the full array of services and resources available through DHHS and the State.

Strategy 4: Address Disproportionality by Engaging Community-Based Organizations

- Across the U.S., African American, Native American and children from families with English as a Second Language (ESL), are over-represented in the child welfare system. Cultural biases may contribute to fewer prevention services, increased reporting to the system, and higher out of home placements for these populations. In Nebraska, this disproportionality was widely reported in our encounters with Nebraska child welfare stakeholders, staff, and lived experience communities.

- As Nebraska strengthens the Community Resource Pathways/prevention infrastructure, the provider **networks built should be reflective of the communities serviced**, and inclusion of diverse delivery system providers should be paramount. There should be heavy emphasis on soliciting organically grown organizations, lived experience and adult/youth peers-especially those who meet the linguistic/cultural needs of the communities.

- Investing in **culturally appropriate/regionally equitable** systems and services, especially in rural areas of state and Tribal communities will address concerns that these are currently under-resourced or lacking. Cultural and language gaps adversely impact family supports and outcomes

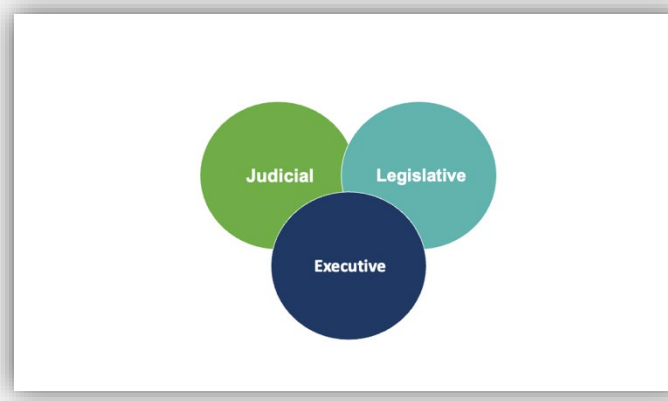
    - **Address the need for more bilingual services**, especially in rural areas of state. Translation services or availability of non-English materials are necessary not only in court but in resources, referral points, and throughout the engagement of family and children.

ENGAGEMENT STRATEGY: INTERSECTORAL ENGAGEMENT

Strategies That Strengthen Relationships Across Court System, Probation, Executive Branch Agencies, State Department of Education, and Community Partners

Strategy 1: Continue the Three-Branch Collaboration into Implementation

- The intersectoral Work Group established by LB 1173 represents multiple state agencies, the courts, Tribal Nations, and the Legislature as well as multiple stakeholder groups and providers who serve and respond to the needs of children and families.



- While LB 1173 concerns developing the initial strategies for transforming child welfare in Nebraska, continuing the Three Branch collaboration into implementation and beyond would be an effective intersectoral engagement strategy. This would be a continuation of the current Three

Branch meetings between the DHHS CEO, the Chair of the Legislative Judiciary and Health and Human Services Committees, and the Chief Justice. By engaging the three branches of state government in this work**, the responsibility for child welfare is shared across multiple systems and their component agencies, offices, and partners**. This Three Branch collaboration leverages group leadership across these systems and coordinates legislative, financial, and policy changes efficiently.

    - For example, during Virginia's implementation of the Family First Prevention Services Act, the Virginia Department of Social Services employed the Three Branch approach with great success.

- One of the unique characteristics of child welfare systems is the overlap and integration of work and responsibility between the executive and judicial branches of government. While state child welfare agencies hold responsibility for delivering services to children and families, juvenile courts make key decisions determining if children have experienced maltreatment, when family separation is a necessary, how and when children exit foster care, and whether the child welfare agency has made appropriate and necessary efforts to prevent removal or achieve permanency. In this respect, courts themselves are a component in a state's system of care.

Strategy 2: Develop Partnerships with Schools to Transform the Child Welfare System

- Local schools and Nebraska Department of Education (NDE) are essential community partners in Nebraska for identifying at-risk families and children and serving as a connection point to needed supports.

- During community engagement, a commonly heard theme was that **schools are a place communities refer to as supportive environments**, meeting families where they are, and an important partner in transforming the child welfare system. However, another common theme was that school staff may not be fully aware of issues related to the child welfare system.

- A number of reports of neglect in Nebraska from school officials are for youth that are not showing up for classes or are unable to access needed services. The child welfare system is often being used by school reporters to connect with services where all other attempts have failed, rather than when there is a real concern for the child or youth's safety from abuse. A review of current attendance and truancy laws is warranted.

- **Providing schools, especially mandatory reporters, with a clearer path to resources in the community could address the needs of children and youth, and even families**, reducing the need for future system involvement and helping these children and families reach self-sufficiency and well-being. Many states have implemented programs that have effectively engaged schools as community partners in helping address this need.

- NDE and the Nebraska Children and Families Foundation (NCFF) recently developed the Better, Together Initiative to pilot the Full-Service Community School (FSCS) strategy in Fremont, Grand Island, Schuyler, and South Sioux City.

    - This model can be done on a regional basis and maximized by leveraging the resources of the 23 Community Collaboratives through NCFF, who are already well connected with the school districts in every one of their regions. **A continuation of collaboration here, directly, and indirectly, will bring to the schools the intersectoral connection and approach that is envisioned in LB 1173.**

Strategy 3: Develop Intersectoral Relationship with Housing and Homeless Initiatives

- Many case workers, providers, stakeholders, and those with lived experience cited **housing as a significant concern and issue both for families at-risk of child welfare system involvement and for wards of the state who are preparing to transition to independence.** Unstable housing impacts children and families and also can be a barrier for individual involved in system to have children reunified.

- Since 2020, an ongoing collaboration has been in place between homeless and housing system partners to coordinate crisis response (COVID-19) and discuss funding stream planning. This group has included individuals from DHHS Nebraska Homeless Assistance, Nebraska Emergency Management, Nebraska Children and Families Foundation, the Balance of State, Lincoln and Omaha Continuums of Care, local governments (city and county), a local HUD field office, Public Health, Community Action Partnership, Legal Aid of Nebraska, and the Nebraska Investment Finance Authority.

    - This effort should be expanded to include representation from Children and Family Services, Juvenile Justice, Child Advocacy Centers, Behavioral Health, Workforce, Education, and Medicaid, to coordinate resources, address barriers, and identify solutions to stabilize families and help transitional youth towards independence as they age out of the child welfare system. For example, this group could discuss the challenges faced by youth transitioning from Youth Rehabilitation and Treatment

facilities with finding and maintaining stable housing, employment or education, and becoming independent.

- **Housing is a complex and multifaceted challenge** that impacts children and families in a multitude of ways, including truancy, delinquency, and risk of removal to the child welfare system. Intersectoral engagement such as this housing group is necessary to adequately address these issues. According to the Nebraska Indian Child Welfare Coalition (NICWA), the challenge of accessing housing services and other needed stabilization services is a real concern and challenge, particularly for transitional youth, as Tribal programs may not have connections with entities like those listed above.

Strategy 4: Increase Intersectoral Training Opportunities

- **Resources Training and Alignment:** Families in the child welfare system often require multi-system services: behavioral health services, housing services, education services, and public health services, for example. However, many CFS workers feel overwhelmed by the responsibility of knowing about all available resources. In addition, a commonly heard challenge by practitioners and stakeholders in many sectors of the child welfare and related systems was not knowing what resources are available to families and children to help support them; this can have crucial implications for families: those seeking reunification, fostering youth, or adoptive families.
    - **Intersectoral Training opportunities bring multi-system players together across systems to gain knowledge related to things like poverty, medical needs, behavioral health** and other areas that can promote well-being in the future.
    - In communities around Nebraska, intersectoral partners have realized great success through trainings such as Bridges to Poverty and through the Thriving Youth training model. Similarly, CFS undergoes trauma informed training that could be beneficial to all system partners. Community-based organizations like Community Collaboratives through Bring Up Nebraska could offer training to CFS workers, the courts, and juvenile justice practitioners to aid in awareness of local resources available.
    - Educators and mandatory reporters can receive improved training in the schools about alternative options available to reduce unnecessary school referrals for abuse and neglect.
    - **Managed Care Organizations through Medicaid** are also trained in trauma informed care and can provide trainings on Medicaid-funded services and

programs such as value-based arrangements, social determinants of health offerings, and care coordination.
    - **Regional Behavioral Health Authorities, along with the Division of Behavioral Health,** can offer valuable training on the types of behavioral health and substance abuse programs and services available, and evidence-based principles, standards, and other educational opportunities**.**
    - By implementing ongoing, community-specific training for intersectoral parties involved in the child welfare system including CFS staff, CASAs, Medicaid MCOs, housing authorities, county attorneys, judges, Child Advocacy Centers, school personnel, law enforcement, and others, the responsibility to know about resources does not fall onto one agency, and partners will be better able to education one another on and align resources appropriately to support families**.** In addition, intersectoral trainings enable stakeholders to learn about and address overlapping challenges and risk factors; for example, education stability and chronic absenteeism and their relationship to the child welfare and juvenile justice systems.
    - **Co-creation of Training Planning and Implementation:** A critical feature of Intersectoral Training is the **co-creation** of planning and implementing these trainings. During meetings with stakeholders, a concern heard from many different system players was that trainings were developed and administered without input from the systems they would impact, creating frustration and risking trainings included outdated or incorrect information. Through intersectoral training development, stakeholders can also eliminate duplication of trainings offered. **Training must also be two-way: not only should child welfare practitioners be training courts and attorneys on the handling of certain cases, but these practitioners must also understand the culture and expectation of the courts in which they will be appearing.**

- **Cultural Competency Training:** Multiple stakeholders, including key Tribal stakeholders, stress that the state system is lacking in culturally sensitive approaches to engaging families and formulating supports and interventions. NICWIC recommends **imbedding culturally sensitive training across CFS, courts, healthcare, and other state systems** to improve the relationship between providers, state agencies, Tribal nations, and other stakeholders.

Strategy 5: Build Authentic Collaboration with All Sectors and Stakeholders

- True intersectoral partnership requires authentic collaboration across the state and with all sectors and stakeholders. With training development and implementation above as an example, opportunities should be sought to engage across sectors and develop integrated models of care.
    - **Intersectoral partners should collaborate and partner with DHHS and systems across the state as the key to successful implementation of Family First Prevention Services Act (FFPSA).** A number of states have created cross-departmental integration and teams for FFPSA planning and implementation, established to understand barriers to providing effective services for individual and family needs **across sectors**. This approach included enhanced coordination with DHHS programs in behavioral health, TANF, food stamps and housing to strengthen prevention efforts by effectively coordinating services and supports to at-risk families. Outside of DHHS, this work was aimed at strengthening partnerships with other state agencies, employers, transportation entities, childcare providers, and housing services to provide smoother pathways to economic mobility.
    - In order for the LB 1173 Child Welfare Practice Model Transformation to be successful future **intersectoral partners should support, cultivate and continue to create the environment where innovative solutions to prevent overall system involvement happens at the community level with the people that children, youth and families in the community trust**. Through this approach, the overall system of care will benefit tremendously and the LB 1173 Intersectoral Vision will be realized.

- **Shared Decision-Making:** When state agencies involved in setting child welfare policy are looking to make changes in rules, policies, and important practices that will impact children, youth, families and also health and safety, they need to ensure authentic engagement and collaboration courts, county attorneys, guardian at litems, providers and organizations whose rules and policies will also impact. **Authentic engagement includes more than just providing notice. It involves providing an opportunity for those key entities to have a meaningful voice and input before final decisions are made.**
    - **Tribal nations need to be considered and involved when State statutes, regulations, and policies are developed or changed.**
    - Laws and policies around daycare assistance for families, foster parent rates, and B2i eligibility have required a lot of time and money to change. If Tribes were

included or considered from the beginning, it would prevent the need to make changes after-the-fact.

- **Innovative Partnerships:** In North Carolina, Medicaid Managed Care Organization Vaya Health offers a "Pathway to Permanency" program focused on intersectoral collaboration to better serve children and families in the Child Welfare system. Under this program, Vaya Health is working with communities, providers, families, and the child welfare agency Department of Social Services (DSS) to offer innovative solutions within the child welfare system, including:
    - Trainings for licensed foster care families on resources in the community and how to access them, including accessing medical, behavioral health and social services in the community;
    - A "Child Welfare 101" training developed in collaboration with the local DSS offices for local medical and behavioral health providers, community organizations, and stakeholders on how the local DSS offices are serving their communities and ways in which the community can come together on community support for at-risk families;
    - Identification, in partnership with birth and foster parents, of trauma-related needs of the youth via screening and assessment tools and implementation of quality therapeutic interventions to address those needs; and
    - Case management services that assist DSS in guiding families, by helping develop meaningful case plans ensuring ongoing safety and permanency in the family-like settings possible, whether with unlicensed kin, licensed foster families, therapeutic family settings, or group settings.

- **Judges/courts, county attorneys, and key stakeholders should be included in re-imaging well-being prevention efforts** going forward and their acceptance of such a system going forward is a key ingredient to success.

- **Establish trust through intersectoral collaboration:** During many engagement sessions, focus groups, and interviews, a common theme was a lack of trust among system players: DHHS, the courts, county attorneys, guardian ad litems, providers, Tribal nations, and communities, among others.

    - By purposefully employing an intersectoral approach, including for decision-making, training, program development and implementation, system partners can begin to feel included and valued, not just listened to. This inclusion can yield increased trust among sectors, and with families and the community, including in the Western and rural parts of the state.

- State agencies and other system players should improve cultural understanding of Tribal Nations, including family life; the State must be more familiar with Tribal culture in order to build strong relationships.
- DHHS and other state agencies must **improve their relationship with providers in communities**, including establishing a fair and reasonable rate/performance-based system, and allowing for true collaboration in changing policies or rules.
- State agencies, courts, and the legislature need to **engage with those with lived experience**; not just listening, but co-creating. Children and families that are or have been part of the system that is making the change must be involved in the development of any programs or services aimed at serving those like them.

- Look to develop a multidisciplinary education team model for children and youth that includes a "Handle with Care" (HWC) model when children and youth experience a traumatic system (law enforcement, CFS investigation, including removal to foster care) involved contact and/or disruption to the family unit. The HWC program is a notification system that enables law enforcement and other first responders to notify schools when a child has been at the scene of a potentially traumatic event, allowing schools and mental health partners to provide trauma-sensitive support. See, for example, Indiana Department of Health Handle with Care notification system.

Strategy 6: Shared Accountability for Children and Families Across System

- Developing more accountabilities across the system, including a system for effective data and outcome monitoring, are key components to an effective child welfare practice and finance model. DHHS should work with all providers receiving funding, including non-profit organizations, counties and municipalities, as well as other intersectoral partners to design and develop a quality measurement system that engenders confidence in policy makers, as well as providers of services.

- Integrate **meaningful, achievable performance-based outcome measures** into provider contracts and consider financial incentives for providers able to achieve performance targets. Providers need to be held accountable for more than just delivering services. In holding providers more accountable, DHHS should also look to give providers greater decision-making authority. Contracts should be re-structured in ways that align fiscal and programmatic goals and stimulate better results for children and families. In return for increased case-level decision-making authority, providers should enter meaningful performance contracts, with measurable quality outcomes and accountability.

- **Clearly define performance measures and incentives** emphasizing practices that provider staff directly control.

- When establishing performance measures, ensure that there is a clear connection between an individual's behavior and/or practices and outcomes and incentives. Without this connection, the motivation for the change in practice may be lost and the effectiveness of the performance-based system will be compromised. Effective performance measures are "outcome drivers" (the practices that lead to the outcomes). However, in establishing the assessment of the attainment of these measures, providers must not only what will "count" as meeting the expectation, but also the data collection methods and reporting requirements.

- Certain communities in Nebraska have established collaborations with intersectoral partners working together to solve case specific and systemic issues in the child welfare system, helping address issues in a particular case from a community of partners before a child or youth is removed from a home. Nebraska should continue to work on and expand these initiatives that build **strong partnerships through collaboration and a process of shared accountability across systems**. In doing so, a new system of accountability where the effectiveness of delivery, quality and outcomes can be measured is necessary and should include, at the minimum, some of the following quality indicators:
    - Trauma-informed practices;
    - Extent of Family Engagement in program development and implementation;
    - Accessibility - physically/virtually, via time of operation, and languages used – and welcoming to families;
    - How practices reflect family centeredness;
    - The collection and analysis of information related to program participation and outcome; and
    - Demonstration of fiscal responsibility in the use of funding.

- **Success Alignment**: Across sectors, Nebraska must recognize that success by one is tied to success for all. Stakeholders from different sectors should, to the greatest extent possible, align their strategies, priorities, and verbiage when undertaking efforts related to system involved youth and families. For example, chronic absenteeism connects to multiple systems including education, child welfare, health care, and housing. Intersectoral efforts to address this issues should align across agencies and stakeholders.

Strategy 7: Expand Intersectoral Efforts for Parents with Prenatal Risk or Children 0 to 5 Years of Age

- In Douglas County, Hastings, and North Platte, the Community Collaboratives have helped forge potent intersectoral partnerships to support mothers with substance use disorders and allow them to safely keep their child(ren) home with them or work to quickly return them once safe after developing Plans of Safe Care.

- Under this model, providers suspecting prenatal substance use or delivering substance-exposed newborns contact CFS, who, with intersectoral partners, **offers innovative navigation and connection to substance abuse services and programs for caregivers and families** pursuant to a Plan of Safe Care. In Lancaster County, there is also a partnership with the County Attorney, who helps hold the family accountable on following the treatment protocol, and that the child(ren) remains safely at home. Safety remains the first priority.

- Partner entities for the program in Douglas County include 211 United Way, The Bridge (Family Resource Center), Project Everlast, Local Hospitals, Home Visitation Providers, Nebraska Early Childhood Initiative, Sixpence, Children's Hospital, Douglas County Public Health, Monroe Meyers Institute, Charles Drew FQHC, along with state partners from Nebraska Department of Education, Office of Early Childhood, Head Start, Public Health, Behavioral Health, Nebraska Children and Families Foundation (NCFF), University of Nebraska Medical Center, and Medicaid.

- Expanding this program statewide would help bridge sectors to serve safely and effectively one of the highest risk populations in the child welfare system.

Strategy 8: Coordinate Intersectoral Partners to Better Serve Transition Youth

- Several stakeholders during outreach indicated that preparation for youth aging out of foster care does not begin early enough and does not involve enough key partners to effectively scaffold supports for this transition, which can result in homelessness for the transitional youth, having a child in foster care themselves, or even entrance into the criminal justice system.

- Engagement efforts are crucial to increase cross-systems communication among agencies and departments connected to child welfare, juvenile justice, criminal justice, housing, behavioral health, employment, and education. These efforts must include partnerships with the community, non-profits, advocates, and lived experience

individuals to identify alternatives strategies to interrupt the foster care-to-prison pipeline.

- Medicaid must also be involved in these discussions; as children with Developmental Disabilities age out, individuals and families need to be educated on what services are available under Medicaid and Social Security for them.
    - In addition to B2i offerings, transition age youth need timely navigation and support to secure not only health coverage, but connection to social determinants of health such as housing, employment, food, and transportation.
- Peer models that can provide guidance, support and a sense of belonging for young people in and transitioning from foster care are essential. This may include mentoring, resource navigation and community-building. The process for preparing Youth aging out of foster care with adequate housing and resources should start more than six months before transitioning out of care.

Strategy 9: Intersectoral Collaboration to Promote and Support Permanency

- While Nebraska has made marked progress in reducing entry of children into foster care, throughout the state it was shared that permanency goals were often not being met, particularly in cases involving higher need children that require more intensive support. Causes cited included parental substance abuse issues and lack of treatment options, multiple case managers assigned to a case due to high turnover, parents not able to access timely behavioral health services or parent education services, and, in a number of cases, parents not engaged in case planning causing case plan delays. Unstable housing, lack of employment, and issues of economic distress result in further delays in permanency.

- Together, intersectoral partners involved in the child welfare system should adopt the following principles for permanency from the start of each case:
    - Permanency begins at the first contact and continues with a sense of urgency until permanency is achieved;
    - Focused efforts should be made to timely place children who are legally free for adoption with a prospective adoptive family;
    - Promote lifelong connections for each child and when possible, preserve kinship, sibling and other community connections;

- Value post-permanency support services as a vital support to encourage adoption and assist families to remain committed to children with special needs, so children remain stable with their new families.

- Agency partners such as **housing, education, and intra-sectoral DHHS partners** such as the divisions of Medicaid and Long-Term Care, Behavioral Health, Public Health, and CFS should **work together to bring the same level of focus and attention to helping children and youth reach permanency and exit foster care**, as has been made in Nebraska in reducing foster care entries overall.

- **Enhance efforts by CFS, child placing agencies, and system partners to recruit, train, support, and retain foster family homes able to meet the needs of children and youth with high needs**, especially those with complex mental and/or behavioral health needs.

    - Develop a **comprehensive plan to include additional Intersectoral partner agencies and stakeholders in providing support to the CFS case workers,** including help with facilitating access to any service that the family may need to sustain permanency. This could include assistance with housing, childcare, workforce, parent education, public benefits, and other supportive services. This could also include assistance with grandparents/relatives and caregivers that may need kinship support in the community with resources, such as respite, transportation, accessing medical services through the Managed Care Organization, and school services through the local school district.

ENGAGEMENT STRATEGY: INTEGRATION ACROSS AGENCIES

Strategies That Support Integration Across Agencies

Strategy 1: Implement Best Practice Strategies for Cross-over Youth

- **Cross-over youth, those with cases in both the child welfare and juvenile justice systems, require intentional, inter-agency integration** in order to best serve them and their families. Improved protocols, communication, coordination, and training on crossover youth is needed across the state to improve outcomes for this population of youth.

- The Administrative Office of Courts and DHHS have implemented an effective Cross-over Youth Practice Model (CYPM). This CYPM should be practiced with fidelity in every

region of the state, since it leads to the best outcomes for these youth. Interviews and focus groups have revealed that there is often a lack of understanding on whose responsibility it is to obtain certain services for cross-over youth, and specific roles and responsibilities of the different agency case workers. Where there is adherence to the CYPM, these issues are addressed and communication, collaboration, and coordination of services enhances the opportunities for the best overall system outcomes.

- CFS caseworkers and Juvenile Probation front line staff must work collaboratively to serve cross-over youth, leveraging available funding, allocating responsibilities and roles appropriately, and standardizing training.

- Douglas County has developed programs specifically tailored to this population of youth, which has had positive outcomes. **The Youth Impact! Model** (Douglas County's implementation of the Crossover Youth Practice Model, as developed by Georgetown University's Center for Juvenile Justice Reform) and **Operation Youth Success** (a comprehensive, coordinated, and community-wide approach to juvenile services) are models that serve the cross-over youth and juvenile justice involved youth population well through cross-agency collaboration.

    - **Youth Impact!** is a voluntary coordinated effort of public and private agencies that have come together to address the children and youth known to both the child welfare and juvenile justice systems. In this model, Douglas County is utilizing the 1184 Crossover Team to bring members together for coordinated case planning. Using an MOU coordinated by the area Child Advocacy Center, this program binds the partners together, including parent and youth, to reduce recidivism, reduce youth from crossing over, reduce the number of youth in out of home placements, reduce use of detention, and reduce disproportionate minority contact. The LB 1184 model is used to share information on child welfare cases, including cross-over youth cases. **This model should be considered statewide, leveraging intersectoral partnerships of the existing statewide 1184 Teams to bring system partners together with the court sitting at the table to address all the needs of the youth to prevent further crisis or family destabilization, and to promote future independence.**

Strategy 2: Align Resources Across Agencies to Best Serve At-Risk Families and Children

- One of the most commonly heard themes of stakeholder engagement was that, while there are resources available, linkage to concrete supports and services and knowledge

of their availability and being able to access available supports was a considerable barrier. The misalignment or alignment of resources can make the difference between being reported to the abuse and neglect hotline or staying out of the system all together**.** Access to important and available resources can be the difference necessary to return a child home after a removal to foster care or help with permanency for a child in a foster or adoptive placement.

- This misalignment occurs even within DHHS itself and its Behavioral Health, Public Health, Children and Family Services, Medicaid & Long-Term Care, and Developmental Disabilities Divisions. Engagement across agencies, therefore, also requires engagement within DHHS to effectively align resources and serve children and families in the child welfare system. **Without integrating the availability of resources, there will continue to be barriers for at-risk families and children to access the full range of resources.** Intra-agency communication and coordination must be pursued to best serve families and keep a clear line of sight on cases and how to assist and collaborate.

- Many services families need are covered by different funding streams, including Medicaid, but courts, attorneys, law enforcement, Tribal nations and CFS case workers are not aware of the full range of these different funding streams or resources.

    - For cross-over youth, juvenile probation officers and CFS case workers might have access to different resources, creating inconsistent availability of services.
    - Tribal CFS departments have no training in how other programs work or how to access them; meaning agreement dollars may be spent on services that could otherwise be covered by existing funding.
    - Community forums, interviews with state agency staff, and focus groups highlighted that commonly unmet needs in child welfare cases or for at-risk families include housing, behavioral health, childcare, early intervention services, education services, and parenting resources for older children, yet many did not know that some of these resources exist in their communities.

- **State agencies must take identified barriers and align and integrate their resources and funding streams to better serve at-risk families and children.**

    - Medicaid MCOs in Nebraska do not appear to play a large role currently in the child welfare system, however they are a vital partner in helping address many physical and behavioral health needs.

- The DHHS Division of Public Health funds and oversees the important Nebraska Maternal, Infant Early Childhood Home Visiting program through Healthy Family America.

- The Department of Education oversees the Sixpence home visiting program, a unique public private partnership that has leveraged private and public funding to support community based early childhood programs. These programs have been proven to prevent child maltreatment, improve child health and school readiness, and improve maternal health.

- **Aligning these programs and funding streams to benefit at risk families and children prior to involvement with the child welfare system should be a priority.** Connecting them with children and families that are involved with the child welfare system is a valuable tool in maximizing prevention. Integration with Economic Assistance can also help families access crucial public benefits to stabilize themselves.

- **State agencies should establish an integrated entry point to resources to aid frontline system stakeholders (CFS workers, juvenile probation, courts, families, schools, community-based organizations, and providers) in their access and navigation.**

    - CFS workers must receive training on the availability of these resources and how to apply for them, but courts, schools, juvenile probation, county attorneys, and other system players must also be aware of these cross-agency resources and have the ability to leverage them to help children and families.
    - A closed loop resource and referral platform should be implemented to connect families with available resources, but there will need to be more education for families, individuals, providers and stakeholders on what resources are available in the community and where and how to access them – especially as the state focuses more on prevention.
    - Pediatricians and primary care physicians should be able to gain knowledge on how to access available services in their communities for struggling families they serve, or can help identify families in need and connect them to community resources, such as the Community Collaboratives or direct community/faith-based providers through a closed loop resource and referral platform.

Strategy 3: Establish Multi-Disciplinary Team-Based Approaches to Collaboratively Support Families

- Many stakeholders and persons with lived experience report an observance of reliance on universally mandated services that are often ordered through the court. Instead, reliance should rest with the expertise of a collaborative team of experts in child welfare, mental health, parenting, etc. to develop evidenced-based recommendations and treatment/reunification plans that meet a family's specific needs.

- **Existing multidisciplinary court team approaches promote tailored approaches and services to the local community to ensure effectiveness**. As a result, cases involved demonstrate higher than average rates of successful permanency.

    - The LB 1184 model, which enables multi-disciplinary teams to share confidential information across agencies when abuse or neglect has been reported and coordinate and monitor treatment for families where child abuse or neglect has been found, **should be expanded to prevention services as well**, before a report of abuse or neglect has been filed.
    - Models like **Family Treatment Courts** should be expanded in Nebraska to increase capacity for child protective services, treatment professionals, court personnel, and community partners to coordinate services
        - Two approved Family Treatment Family Courts exist currently in Lincoln, one focused on parental domestic violence and the other on parental substance use. These programs are operated under an MOU with the Administrative Office of the Courts and Probation and DHHS/CFS which allows for data sharing and have a staff Coordinator that reports to the Administrative Office of the Courts and Probation for both courts. This model could be expanded statewide as a best practice for multi-disciplinary teaming on child welfare cases.
        - Family Treatment Courts in Lancaster County have shown tremendous success in assisting families where a parent has substance use disorder; this model should be expanded to offer services to families **before a removal** as well.
    - In Sarpy County, in certain cases, the court requires CFS or Juvenile Probation supervisors to be part of a multi-disciplinary team and to also attend certain court hearings to address the impact of high staff turnover. If a case worker turns over the case is not impacted and is able to proceed efficiently and effectively as the team and lead judge remain on the case.

- Multi-disciplinary teams assembled and led by the County Attorney, like the teams assembled by the Lancaster County Attorney Office, prior to a court filing, that focus on

bringing key system members together who can focus intently on meeting the needs of a child or family is another successful model.

- **The "Through the Eyes of the Child Initiative"** is another a best practice that was touted widely throughout community engagement, creating a forum for local child welfare and juvenile justice stakeholders to collaborate with each other. Through this model, a lead judge oversees local multi-disciplinary teams, frequently comprised of a team coordinator, county attorneys, parents' attorneys, guardians ad litem, DHHS administrators, supervisors, and caseworkers, facilitators/mediators, CASA employees and volunteers, Foster Care Review Office members, therapists, clerk magistrates, probation chiefs and officers, law enforcement professionals, school employees, youth and foster parents. These **teams provide an excellent multi-disciplinary approach to issues needing attention in their communities in order to best meet the needs of children and families.**

- Including **Medicaid Managed Care Organizations (MCOs) as a part of multi-disciplinary teams provides immediate opportunity and benefit**; MCOs are the health plan experts and requiring them to share their data and expertise with CFS caseworkers and Child Welfare Placement Providers will result in big wins to enhance care coordination and access to services, improve health care outcomes, and create a path for developing electronic medical records.

Strategy 4: Enhance Collaboration, Communication and Partnership with County Attorneys

- Through the Work Group's engagement across Nebraska, many best practice or effective child welfare models involved authentic partnership, communication, and collaboration at the outset between the county attorney and CFS and/or a juvenile probation officer, even in Alternative Response cases that do not necessitate court involvement.

- County Attorneys in Nebraska are key Intersectoral child welfare partners, bringing another set of eyes and perspective to cases. They are essential to moving a case through the process in a timely manner, which is critical in reducing trauma from placements and involvement with the foster care system. They can also help ensure that necessary services are in place. However, a survey done by the Work Group indicates that in many locations, communication between CFS and county attorneys needs improvement.

- Enhancing collaboration, communication, and partnership with the County Attorneys is an area ripe with opportunity. DHHS should consider regular CFS meetings with local county attorneys to provide regular reports regarding the status of cases in their jurisdictions, including those that are non-court or Alternative Response. 1184 Team Meetings can also be used to promote transparency with intersectoral partnership and strengthen those relationships to improve outcomes for families.

Strategy 5: Leverage DHHS Tribal Liaisons for Intra-agency Collaboration

- As a continuation of Engagement Strategy 3 for Community Strategies, DHHS' Tribal Liaisons offer a considerable opportunity to increase engagement both within DHHS and with Tribal nations, which are authorized to engage in self-government, including oversight of child/family welfare infrastructures. From community input, it was emphasized that as Tribal nations, discussion of working with Tribes should be considered inter-governmental, not only intersectoral or with communities. It was also commonly shared that routine communication between state government entities and Tribal governments is lacking at times.

- Tribal Nations' cultures are not homogenous; their nuances color Tribal governmental infrastructure design and their approaches to child welfare. The state child welfare system transformation must factor in these unique considerations in planning for broader Tribal understanding, support and engagement. **Liaisons, as representatives of the federally recognized Tribes in Nebraska, are able to bring this nuance in perspective and experience to their roles within DHHS and can work within the divisions of the agency to ensure any child welfare transformation leveraging the different divisions reflects the needs of the individual Tribes.**

- DHHS Tribal liaisons oversee and are involved in intra-agency efforts related to population health, in addition to their work as liaisons, positioning them as excellent conduits of information as it relates to Tribal relations and what DHHS may be able to coordinate within DHHS and with the Tribes, what barriers that exist in their collaboration with the Tribes, and how DHHS could improve its resources to Tribal Nations.

    - Coordination between Tribal Child and Family agencies and the institutional system can foster better coordination of Tribal children between the two systems
    - Tribes do not have ready access to the providers with whom the state contracts. Allowing the Tribes to access and make referrals for these services through DHHS

contracts with these providers would be helpful in expanding the array of services available to Tribal youth and families.
    - More intensive case management for families with multigeneration experience in the child welfare system may be needed. Dominant culture case size standards may not be appropriate for Tribal programs and should be considered when working with Tribal cases.

ENGAGEMENT STRATEGY: DATA COLLECTION AND OUTCOME MONITORING

Engagement Strategies That Support Data Collection and Outcome Monitoring

Strategy 1: Collect Data that is Usable by Practitioners in Real Time

- Data systems must not only collect data but have **readily accessible, detailed, and easy to read reports** that contain accurate and timely information. Such reports should be interactive and specific for the target user, including for those making critical decisions in real time (for example, different reports for case workers, supervisors, court staff, legal and other stakeholders).
- CFS Case Managers, Supervisors, Administrators need real time data available at their finger-tips—to view dashboards, uncover backlogs, and effectively monitor performance. This information needs to be available within the case management system. **The use of technology as a decision support mechanism aligns with efforts to improve outcomes, as outcomes are impacted by productivity, focus, quality, expediency of actions, proactive interventions, visibility to risk, and awareness of gaps and needs.** Use of technology should cover this spectrum and be considered at all levels of staff within an agency.
- **Nebraska should expand the use of modern tools for business intelligence/analytics** (e.g., Tableau), which have the opportunity to leverage child welfare data for Key Performance Indicators, drill downs for regions and staff, data driven decision making, and predictive analytics.

- **This system should provide frontline staff access to relevant data reports and information at any time from any location and from any device.** Furthermore, the frontline staff must have the capability to submit documentation is real-time (including but not limited to completing forms, obtain electronic signatures, upload photographs, and upload documents). Workers must also have immediate access to supervisors and/or emergency personnel.

    - Other data that would be useable in real time includes available local resources such as beds in treatment facilities or housing options, capability to match available placements to the needs of the child, capacity and successes of foster homes, foster home limitations, including lack of foster homes in geo-graphical areas, accurate and readily identifiable location of children in foster care, including a complete journey of the child's previous placements, reasons for change, current placements, incidents at each placement (child specific, provider specific, timeliness of documentation requirements such as placement changes, face to face visitations, and medical/dental check-ups).

Strategy 2: Technology Systems Should Operate within a Master Data Management Strategy

- Technology systems should operate within a master data management strategy where **information is consolidated and not siloed across departments or agencies**. Information should be managed consistently, and the source of record should not be compromised by duplicative efforts to manage such data. Contributing agencies should be considered part of the user base and connected to agency systems for batch and transactional information processing. As such, the agency must have a data sharing strategy that offers contributing agencies and business associates an approach to participate for the purposes of enhancing the system of care.

    - DHHS (CFS, Medicaid and Long-Term Care, Behavioral Health, Public Health, Developmental Disabilities, etc.), other government agencies (Courts, Probation, Department of Education, etc.), Service Providers, and Community Agencies need streamlined information without needing to jump from system to system. Providers and state need to know how they're performing together, not only reports, but sharing information and using it together. Systems cannot gauge their performance collectively without the ability to measure data.

- With appropriate confidentiality, data sharing by intersectoral partners can improve decision-making and ensure services provided are informed by outcomes. Currently NDE is leading efforts in establishing a memorandum of understanding with DHHS, the State Court Administrator, Juvenile Probation, and others with the intent of sharing data for systems involved youth.

Strategy 3: Implement a Comprehensive Child Welfare Information System (CCWIS)

- Title IV-E agencies increasingly need information on the availability, effectiveness, and cost of services that reduce risk, strengthen families, and prevent the need for out-of-home placement. High quality data supports the delivery of effective, economical, and effective services, which support improved outcomes for clients.

- CFS staff and leadership both indicate that, by-and-large, data and reports available through N-Focus are inaccurate and not readily able to provide meaningful data in a timely manner**. Investment should be made in a CCWIS capable of collecting and reporting program, service authorization, and expenditure data at an aggregate and client-specific level.** By collecting and maintaining service provider information in a CCWIS, the Title IV-E agency can evaluate options and make informed decisions when creating a case plan and/or assessing systemic service needs.

- This system should consider variations in business processes across regions (such as quality assurance processes and protocols), as business processes may differ across regions, including activities or forms that involve different workflows or approval processes. The system should easily accommodate with configuration changes of modular components.

Strategy 4: Leverage Existing Public Data to Inform Practice

- Publicly Available Data and Dashboards using historical and recent data can be useful for case managers/providers, but this data is often under-utilized.
    - Nebraska should consider implementing data practices such as the model used in Florida, which utilizes public data to study state/Regional performance and also to get statistics information.

- Currently available data should be considered for innovative uses to prevent unnecessary removals and identify families who are appropriate candidates for prevention services. For example, Social Determinants of Health (SDOH) data broken down by zip code identifying families with housing needs could support a SDOH pilot focused on housing through the lens of family preservation.
    - Off-the-shelf technology options can be considered to utilize publicly available data in innovative ways, with Florida's model again as an example.

Strategy 5: Define Key Data and Performance Metrics Across All Systems and Use Them to Drive Innovation and Change.

- To achieve a true intersectoral approach to child welfare, performance metrics and key data tracked must be collectively agreed upon by all partners across all systems.
- This alignment of priorities and key data must prioritize focus on outcomes, rather than outputs.
- These metrics may differ from region to region as different outcomes are sought for different populations and geographic locations; metrics may also be different for Tribes.

Strategy 6: Share Critical Medicaid Member Data with CFS

- During stakeholder engagement, it was often cited that Medicaid encounter data is not being utilized for child welfare cases, but could have been of immense value to CFS workers to either reduce crisis or assist workers in identifying needed supports.
- Medicaid and child welfare data is not merged in any way to generate case management data like prescriptions filled, for example. While the data legally can be shared, though it is very sensitive, it is often lookback data on claims in foster care. **Data on individual kids on any given day is harder to get, but holds value as a powerful tool to help in case management.**
    - For example, the Work Group heard about a number of adoption disruptions that may have been prevented if CFS was made aware of a number of repeated medical or behavioral health episodes, and was able to intervene.
    - DHHS' Medicaid claim system and MCOs' claim data paid on an adopted child or youth is available because many continue to stay on Medicaid during the

adoption; this data, assuming appropriate consent, could be used in a proactive way to help adoptive families and children. Additionally, this data could be valuable to staff trying to expedite permanency planning so a child or youth can be reunified.

- Because Medicaid and CFS are both divisions within DHHS, DHHS should **identify solutions of interoperability and sharing of Medicaid data as a priority.**

- Nebraska should review the efforts of the Children's Partnership, which launched a 5-year pilot initiative to promote electronic care coordination for children in foster care and recommended six critical elements to ensure foster care electronic record initiatives achieve their fullest potential:
    - Gain further insight into how best to engage consumers through electronic records;
    - Initiatives should increase and improve communication across the care team;
    - User-centered design and testing must be more rigorous;
    - Evaluation and ongoing, iterative improvement should be strengthened;
    - Privacy challenges are real but not insurmountable; and
    - Federal and state support is needed.
- This effort could be expanded to Nebraska’s current 1184 multi-disciplinary team process where multiple teams, including investigative, treatment, and specialized service providers, are brought together through facilitation to improve the handling of child abuse and neglect cases.

THE STEPHEN GROUP

LB 1173 FINANCE MODEL

Funding Considerations to Support a Reimagined Child Welfare System

Legislative Work Group Report

Nebraska LB 1173 Finance Model

Funding Considerations to Support a Reimagined Child Welfare System

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Executive Summary

INTRODUCTION

Recognizing the need to strategically re-envision Nebraska's approach to providing child welfare services to children and families, the Legislature passed LB 1173. The legislation was passed with the intent supporting the well-being, permanency, and safety of children and families in Nebraska's communities by comprehensively transforming the state's child welfare system. To accomplish this transformation, the Legislature established the importance of creating strong partnerships among the legislative, executive, and judicial branches of government and community stakeholders in order to develop an intersectoral approach to the provision of child welfare services.

> **"Families don't live according to funding streams. To meet their needs, we must be creative."**
>
> ***Rebecca Jones Gaston, Commissioner***
> *Administration on Children, Youth and Families*
> *2023 Community Collaborations to Strengthen and Preserve Families Federal Grantee Meeting*

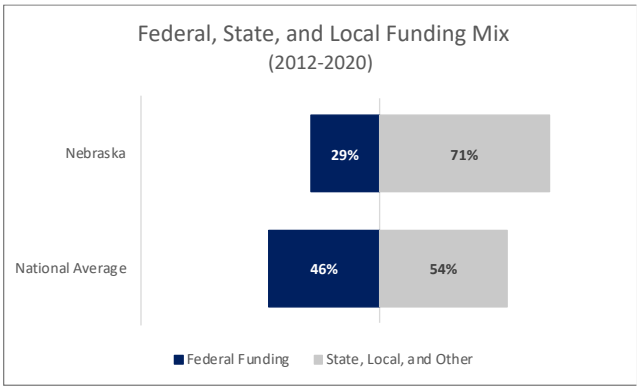
To this end, the legislation established a Work Group responsible for the development of a practice and finance model for child welfare system transformation. As part of this charge, the Work Group was required to evaluate the state's title IV-E claiming practices, identify appropriate steps to optimize federal reimbursement for child welfare system expenditures, and define opportunities and financial mechanisms for providers to pilot innovative solutions to meet program goals.

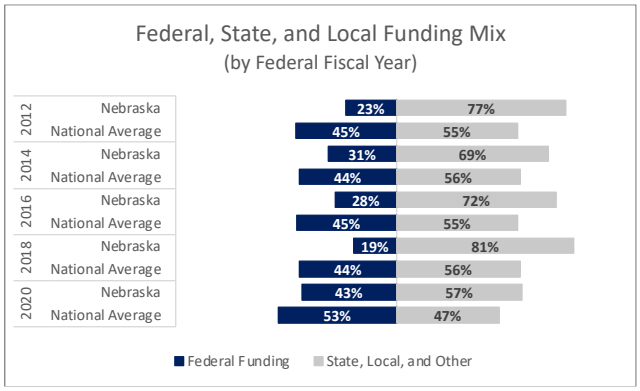
To accomplish these tasks, the LB 1173 Work Group, throught the facilitation of The Stephen Group, LLC., convened a subcommittee comprised of leaders and financial management staff from the various divisions of DHHS, representatives from the Department of Education (NDOE), the Judicial Branch, the State Supreme Court, and Juvenile Probation Services. Together, they consulted with internal and external stakeholders, providers, and others to develop this Financial Model and accompanying recommendations.

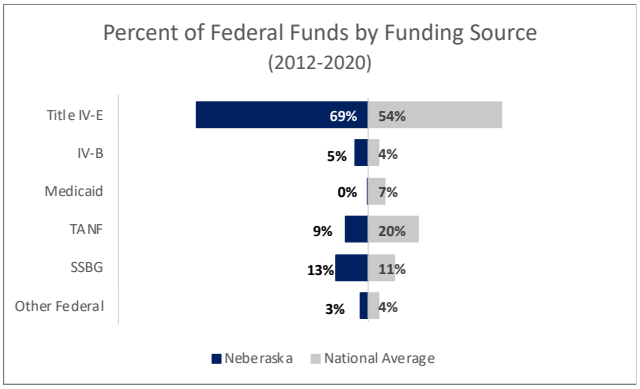
Review of Historical Federal Claims Data by Funding Source

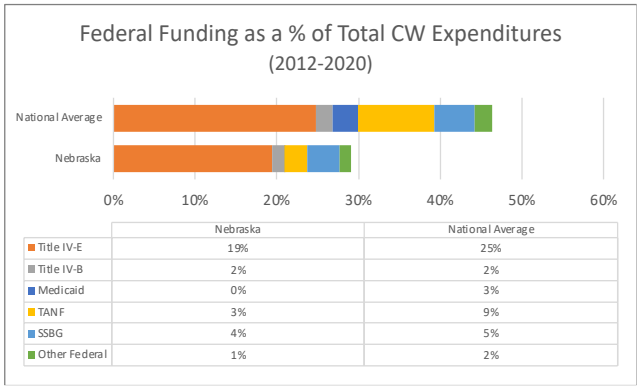
The Work Group assessed Nebraska's ability to effectively utilize available funding to the benefit of children and families by comparing available data depicting the use and mix of federal, state, and local funding sources. According to a biennial survey of state funding

conducted and published by ChildTrends[1,2], Nebraska's utilization of federal grant sources to fund child welfare services has been significantly lower than the national average over the past decade. Data available for Federal Fiscal Years 2012 through 2020 shows the percent of state and local funds expended for child welfare services were 32% higher than the national average. Of total expenditures for child welfare services, state and local funds accounted for a high of 81% in 2018 and a low of 57% in 2020.









The review of expenditure data reported to ChildTrends depicts other states having a more balanced use of federal funds. Specifically, they report higher levels of TANF and Medicaid spending for child welfare services. Additionally, between FFYs 2012 and 2020, CFS was only able to draw an average of nineteen percent (19%) of their total funding from title IV-E reimbursement. This is compared to a national average of twenty-five percent (25%) over the same eight-year period.

[1] https://www.childtrends.org/publications/child-welfare-financing-survey-sfy2020
[2] Expenditure data is reported to ChildTrends via a survey completed by each state.

Claiming for Title IV-E Prevention Services

Signed into law in 2018, the Family First Prevention Services Act (FFPSA) represents the most significant shift in federal funding for child welfare services in recent history. The act increases the focus of child welfare systems towards keeping children safely with family so as to avoid the trauma resulting from placement in out-of-home care. To meet this goal, the law provides families with greater access to mental health services, substance use treatment, and/or parenting skills courses and gives states the ability to access title IV-E federal funds to pay for these services. This significantly shifts how child welfare systems will coordinate and provide services to families and youth. As a result, it changes the role of community service providers, the way courts advocate and make decisions for families, and the types of placements available to youth placed in out-of-home care.

As one of the first child welfare systems in the Nation to receive approval for their Five-Year title IV-E Prevention Program Plan, CFS has recognized the challenges that come with implementing a large scale change to a longstanding service delivery system. While FFPSA allows title IV-E to the provision of preventative services to families and children, the law requires significant intersectoral planning, collaboration, and partnership between child welfare, Medicaid, and other existing federal funding sources to pay for the provision of these services. In particular, the Act is clear in that title IV-E is the payor of last resort for those families that are Medicaid eligible. To date, Nebraska has not realized significant federal reimbursement for the provision of prevention services through title IV-E. Data comparing state FFPSA-related reimbursements is provided in this document, below.

Out-of-Home Care Expenditures

The Work Group also reviewed statewide data related to child intakes, protective investigations, assignment to services (alternative response or in-home), entries to out-of-home care, and children achieving permanency. Though changes to state law and practice have served to significantly reduce the number of children entering care, the overall number of children exiting care has not reduced proportionally during the same time frame. As a result, the number of children in out-of-home care has remained static while those children and youth in care are experiencing increased lengths of stay. Additionally, CFS is serving approximately 1,000 additional children per month through alternative response programming.

This results in increased child welfare cost related to the additional children served while not realizing expected cost savings related to a reduction in foster care placements. We believe a reduction in out-of-home care will eventually result in a $30 million reduction to state expenditures annually, which could eventually be reinvested in prevention and capacity development initiatives described in both the Program and Finance Models. This is described in

more detail in the "Reduction to Out-of-Home Care Expenditures" section of this report. A significant portion of these reinvested funds are likely to be eligible for federal reimbursement.

Additional Findings

In completing this report, the Work Group identified several funding sources have not been used to their fullest potential. Details related to these findings are provided in subsequent sections of this document. In particular, we found:

- DHHS has not expended available TANF funding. As a result, a significant surplus has accrued.
- From 2019 to 2023, $83 million unspent dollars were returned to the Division of Behavioral Health by the RBHAs.
- CFS has not claimed federal reimbursement for eligible agency and provider (child placing agency) administrative costs. Doing so is likely to generate an additional $8-10 million in federal reimbursement annually.

Conclusion

The Work Group concludes CFS has not fully expended, maximized, or leveraged federally available funds to the degree other jurisdictions are able to. As a result, a disproportionate level of state funding has been required to operate the system. Given the availability of unexpended funding, ability to claim additional reimbursement, and potential cost savings to be realized by reducing the number of children in out-of-home care, there appears to be sufficient state funding within the existing budget to strategically transform the child welfare system and improve services to children and families without appropriation of additional state general funds.

The remainder of this section summarizes the:

- Evaluation of title IV-E Claiming Practices,
- Steps to Optimize Federal Reimbursement, and
- Financial Mechanisms to Pilot Innovative Strategies.

Subsequent sections of this document offer a detailed summary of specific initiatives and financial implications related to title IV-E Federal Financial Participation, Cross System Synergy and Collaboration, and Provider Rates and Contracts.

Evaluation of Title IV-E Claiming Practices

Through a review of statewide payment and federal claims data, eligibility determinations, placement data, state regulation and procedures, the Work Group has determined title IV-E

reimbursement has not been effectively maximized and fully realized. In fact, there are several eligible services and activities for which federal reimbursement has not been claimed at all. In particular, we found:

- Title IV-E eligible administrative expenditures have not been claimed for title IV-E Candidates.
- Through the end of FFY2022, no reimbursement for FFPSA title IV-E eligible administrative or training costs has been realized.
- Title IV-E eligible administrative and training expenditures have not been claimed for subcontracted child placing agencies.
- Proactive changes to policy and practice could result in an increase to the title IV-E penetration rate by:
    - Modifying standards related to title IV-E income eligibility determinations,
    - Expand training opportunities for judiciary and staff responsible for ensuring court order language is complete and accurate.
    - Modifying licensing requirements for relative caregivers to the fullest extent possible,
    - Reviewing Tribal foster licensing standards to ensure they meet minimum federal requirements. Accept tribal licensing standards when a tribal child is placed in a home on or in proximity to a reservation,
    - Identifying strategies to reduce placements in ineligible placement settings,
    - Creating a path to dual licensing for residential settings for residential settings serving multiple populations (DD and Medicaid),
    - Increasing the number of licensed relative caregivers by further streamlining the licensing process, providing pay differentials for licensed relative caregivers, and incentivizing child placing agencies responsible for the home when relative caregivers become licensed.

Though aggressive attention to these strategies, we estimate the penetration rate may increase by between eight and twelve percent. This could generate an increase in title IV-E reimbursement for eligible activities of between 45% and 50%.

Steps to Optimize Federal Reimbursement

This report includes several strategies to increase federal reimbursement. To realize a fully reimagined child welfare system, the Work Group recommends prioritizing these strategies in order to leverage a projected reduction in state expenditures over time and allow those funds to be reinvested into a balanced child welfare system, which prioritizes the provision of early intervention and prevention services. These reinvested state funds will then be eligible for

additional federal reimbursement. We recognize this will have to occur over an extended timeframe and understand additional research may be required to fully understand implementation requirements and realize a return-on-investment. Specific steps to take over the next one to two years are listed below. Each of these strategies are described in detail within this document:

- Implement aggressive strategies to improve the title IV-E penetration rate.
- Develop the necessary procedures to claim title IV-E federal reimbursement for all eligible services and activities.
    - Administrative costs related to traditional title IV-E candidacy,
    - Administrative and training costs related to FFPSA implementation and operation,
    - Administrative and training costs incurred by subcontract providers.
- Develop training and capacity development strategies related to FFPSA service expansion, development of provider capacity, and workforce training.
- Conduct an in-depth rate study across all for all services. Create standardized cost based rates, which will be utilized by all state agencies and DHHS divisions.
- Establish performance based contracts with providers in order to increase accountability and improve outcomes.
- Review Tribal contracts, payments, and reimbursements ensure payment equity.
- Focus on child permanency and reducing the number of children in out-of-home care.
- Review Florida's revenue maximization legislation and implement similar statutes and procedures.
- Investigate the potential return-on-investment and, when viable, establish procedures and initiate title IV-E claiming for existing costs incurred for high quality legal representation and juvenile probation services.
- Study the feasibility of transitioning to a highly efficient CCWIS-compliant data management system.
- Create a workgroup including state staff, managed care representatives, and providers to develop strategies and formulas to effectively blend or braid funding sources for evidence-based practices (EBP). Also consider the potential of having an EBP added to as a "named" service in the Medicaid State Plan or having it approved as an In-Lieu-of-Service.
- Create a Community Prevention Pathway to expand services to families identified as having children at risk of entry to foster care before they become known to the child welfare system. Engage local providers to operate these pathways and leverage allowable county funding provided by determining whether it can be certified as match.

- Collaborate with the Department of Education to enhance access to Early Intervention, Prevention, and Crisis Intervention services. Determine whether any local public funding infused into this system can be certified as title IV-E matching funds.

As these steps are completed, state funds are reinvested, and additional federal revenue is realized, remaining strategies included in the Practice and Finance Models can be prioritized and implemented.

Financial Mechanisms to Pilot Innovative Solutions

The Work Group recommends looking to fully utilize existing funding and maximize federal revenue in order to pilot innovative solutions presented in the Practice and Finance Models. In particular there are several innovations which either rely on existing funds or may be cost neutral. These include:

- **Cross-system claiming for Legal and Juvenile Probation Costs.** System expenditures for these services already exist. The only additional investment necessary will be related to the cost of establishing interagency memorandums of understanding, developing claiming protocols, implementing cost allocation strategies (which may require a random moment sample or other means to allocate costs to populations and activities), collecting and aggregating costs, and developing quarterly claims. Any reimbursement claimed should be reinvested into system improvement, service expansion, or staff capacity. It is important to note, title IV-E claiming for Legal and Probation costs are closely tied to the state's penetration rate, taking the steps required to increase the penetration rate will be vital to maximizing the potential of claiming for these activities.
- **Implement 1115 Waivers:** Use 1115 Medicaid Waivers to implement innovative service delivery systems for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED).
- **Expand Access to the Regional Behavioral Health System:** As noted in both the Practice and Finance Models, existing surplus funding may be used to expand eligibility and access to services.
- **Provision of Concrete and Economic Supports to Families:** The Work Group recommends investing surplus TANF funding to offer these supports to families experiencing financial hardship.
- **Development of a Community Prevention Pathway:** As additional title IV-E funds are claimed for eligible activates, available state funds should be reinvested in the implementation of a community-based prevention strategy capable of reaching families before they become involved with the child welfare system. Such implementation may be phased in across the state based on the availability of funds and specific needs of communities. As the pathway is implemented, DHHS should look to leverage any public funds used by the local provider and determine whether it can be certified as match.
- **Invest in the Development of Provider Capacity and Ability to Provide Evidence Based Practices:** For prevention efforts to be successful, provider capacity must be developed in order to offer evidence-based practices, especially in rural or frontier areas of the

state. As noted in this report, when clinical providers of evidence-based practices are training and being certified to provide service with fidelity to the intervention, they often are required to carry a limited number of cases. When staff are primarily reimbursed through billing for Medicaid eligible services, there is often not sufficient revenue to cover an agency's total cost. Investment will have to be made to develop capacity across the state in order to have the requisite number of clinicians capable of engaging and working with families.

Priority Area 1: Enhance Title IV-E Federal Financial Participation

TITLE IV-E INCOME ELIGIBILITY: AFDC LOOKBACK

Every year, states receive progressively less federal financial assistance for children removed from their home and placed in foster care. In 1998, 53 percent of the children in foster care were eligible for federal support through title IV-E. By 2005, the percentage had declined to 46 percent. Since then, the number eligible for federal financial assistance has continued to decline. Recent data indicates the average percentage of children eligible for federal assistance under title IV-E is approximately 41 percent. According to ChildTrends[3], Nebraska has the lowest title IV-E eligibility rate in the nation, 18%.

Recommendation

> *Legislatively advocate to eliminate the federal linkage between Title IV-E eligibility requirements and 1996 AFDC income standards.*

A child's eligibility for title IV-E foster care maintenance payments is based on multiple criteria. First, responsibility for the child's care and placement must rest with the state or tribal child welfare (title IV-E) agency. Additional eligibility criteria are related to:

- the child's age;
- how and why the child was removed from the home:
    - for children involuntarily removed from the home the court must find that the home was "contrary to the welfare of the child" and the state made "reasonable efforts" to prevent the child's removal;
- the placement setting and foster care provider for the child (placement must be licensed by the child welfare agency);
- the title IV-E agency's timely and continued "reasonable efforts" to achieve permanency for the child;
- the child's citizenship or immigration status; and
- the income, assets and other characteristics of the home from which the child was removed.

Eligibility factors related to income, assets, and characteristics of the home are linked to each state's AFDC eligibility limits in place as of July 16, 1996. Generally, this is referred to as the "AFDC Lookback." Among other AFDC-related factors in place at that time, the child must have

[3]ChildTrends (2023), Child Welfare Financing SFY 2020, A survey of federal, state, and local expenditures.

been removed from a family with income that is below the "need standard" established by the state under the AFDC program, without adjustment for inflation, and as determined using the income counting rules in effect under that program on that date. Further, the child must have been removed from a family with assets of no more than $10,000, as determined using the asset counting rules under the AFDC program.

A state must apply a two-part income test to determine whether in the month that the court proceeding to remove the child from the home is initiated, or in the month a voluntary placement agreement is signed, the child would have been considered needy under the state's AFDC program. The first step is to determine that the gross income in the home from which the child is to be removed does not exceed 185% of the state's 1996 need standard. Provided this test is met, the state must next determine that the countable income in the home of the child was 100% or need standard. Generally, counted income of a family applying for AFDC included the family's gross (earned and any unearned) income minus up to $90 in wages, childcare costs up to $175 (or $200 for child younger than age two) for an employed member of the assistance unit; and up to $50 in child support.

1996 AFDC income "need standards" for a family of three varied widely from state-to-state; from a low of $320 / month (Indiana) to a high of $2,034 / month (New Hampshire). By in large, a significant percentage of children nationally are determined to be ineligible for federal financial assistance as a result of the family's income at the time of removal.

Nebraska's 1996 need standard for a household of three was $364 per month, the third lowest in the nation. For Nebraska to receive federal reimbursement for out-of-home care costs related to a child removed from a family of three persons, the household's gross monthly income may be no more than $674 (185% of the need standard) and, total countable monthly income be no more than $364. To put this into perspective, as a result of inflation, Nebraska's AFDC lookback income standard is only 17.5% of the 2023 federal poverty standard. Income standards for families of more than three are slightly higher. For instance, Nebraska's standard for a family of four is $435 per month, 19.5% higher. Approximately fifty percent of Nebraska children placed in out-of-home foster care are ineligible for Federal title IV-E assistance as a result of this standard.

There have been multiple attempts to legislatively delink the AFDC lookback from title IV-E eligibility standards. To date, such efforts have not met with any success at the federal level. Nebraska legislators should collaborate with representatives from similarly affected states and continue to advocate for changes to this outdated, archaic eligibility requirement.

REVENUE MAXIMIZATION STATE LAW AND DEPARTMENT POLICY

As the Nebraska Department of Health and Human Services (DHHS) looks to create intersectoral partnerships supporting the LB1173 Child Welfare Practice Model, steps should be taken to ensure federal funds are fully reimbursed. In support of these efforts, a work group spearheaded by DHHS should review and, if necessary, revise interagency agreements, state laws, and department policy to ensure they are aligned with efforts to maximize federal financial participation. In doing so, DHHS will ensure activities, such as the Provision of High Quality Legal Services, title IV-E Claiming for Child Welfare / Probation Cross-Over Youth, expanded partnership with the Nebraska Department of Education, and the implementation of a Community Prevention Pathway, which may involve the use of local public funds are able to leverage these local dollars to their fullest extent.

Recommendation

> *Ensure state law and department policies align with and support efforts to maximize federal financial participation through the certification of local funds as match.*

Title IV-E, unlike Temporary Assistance for Needy Families and the Child Care Development Block Grant, maintains restrictions on the type of funds that may be used as match for reimbursement. The costs must be expended by the agency receiving the title IV-E grant or Medicaid, or another public agency, or a county-based agency that has an interagency agreement in place. A public agency may use certified public expenditures to leverage title IV-E reimbursement when those funds are paying for title IV-E eligible costs and are not used as match for other federal funds. No private provider funds can be used to match title IV-E expenditures, unless the private provider transfers funds to a public agency. The department must ensure that any local agency funds are handled in a manner to ensure title IV-E, specifically, the provisions outlined in 42 Code of Federal Regulations (CFR) 433.50 and 45 CFR 235.66(b) (1-3).

45 CFR § 235.66 Sources of State funds.

(a) *Public funds.* Public funds may be considered as the State's share in claiming Federal reimbursement where the funds:
- (1) Are appropriated directly to the State or local agency, or transferred from another public agency (including Indian tribes) to the State or local agency and under its administrative control, or certified by the contributing public agency as representing expenditures eligible for FFP under §§ 235.60–235.66;
- (2) Are not used to match other Federal funds; and
- (3) Are not federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds.

(b) *Private funds.* Funds donated from private sources may be considered as the State's share in claiming Federal reimbursement only where the funds are:
- (1) Transferred to the State or local agency and under its administrative control;
- (2) Donated without any restriction which would require their use for the training of a particular individual or at particular facilities or institutions; and
- (3) Do not revert to the donor's facility or use.

A public agency, or "local government," is defined by sections 472, 474(a)(1), and 474(a)(3)(C) of the Social Security Act, as a county, municipality, city, township, local public authority, school district, intrastate district, council of governments (whether or not incorporated as a non-profit corporation under state law), any other regional or interstate government entity, or any agency or instrumentality of a local government. The local match process currently applies to all counties having local public agencies that meet the federal requirements pursuant to 42 CFR 433.51 – Public Funds as the state share of financial participation, and 45 CFR 235.66 – Sources of State Funds provisions of services to eligible children. The local match process enables public agencies to use expended, publicly appropriated local funds as a match for earning federal funds. It is important to note, in certain, specific circumstances 45 CFR 235.66 provides for the consideration of private funds the state's share when such funds are transferred and placed under the administrative control of the state or local agency, are transferred without restriction or designation of their use, and do not revert to the donor if not expended. Though these restrictions may be limiting, DHHS and collaborating intersectoral and community partners should investigate the feasibility and potential of pursuing such arrangements when circumstances permit.

409.017 Revenue Maximization Act; legislative intent; revenue maximization program.

(3) (h) Each agency, respectively, shall annually submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives, no later than January 1, a report that documents the specific activities undertaken during the previous fiscal year under this section. The report must include, but is not limited to, a statement of the total amount of federal matching funds generated by local matching funds under this section, reported by federal funding source; the total amount of block grant funds expended during the previous fiscal year, reported by federal funding source; the total amount for federal matching fund programs, including, but not limited to, Temporary Assistance for Needy Families and Child Care and Development Fund, of unobligated funds and unliquidated funds, both as of the close of the previous federal fiscal year; the amount of unliquidated funds that is in danger of being returned to the Federal Government at the end of the current federal fiscal year; and a detailed plan and timeline for spending any unobligated and unliquidated funds by the end of the current federal fiscal year.

409.26731 Certification of local funds as state match for federally funded services.

The Department is authorized to certify local funds as state match for eligible Title IV-E expenditures more than the amount of state general revenue matching funds appropriated for such services by the General Appropriations Act. Title IV-E funds provided to the state as federal financial participation consequent to certified local matching funds shall automatically be passed through to the local entity that provided the certified local match. Notwithstanding the provisions of section 215.425,

Florida Statutes, all such federal funds earned for the current fiscal year as a result of using certified local match, except for up to five percent of such earnings that the Department is authorized to retain for administrative purposes, shall be distributed as set forth in this section and this process shall not impact the Department's allocation to any district. All the provisions of this section are based upon federal approval of the provisions as specifically limited in this section and shall not become effective if any further modifications are required of the state, unless and until federal approval has been obtained. The Department shall annually prepare a report to be submitted to the Legislature no later than January 1, documenting the specific activities undertaken during the previous fiscal year pursuant to this section.

Florida Revenue Maximization Act

In considering this recommendation, DHHS may look to legislation and policy implemented in the State of Florida. The state's Revenue Maximization Act, Section 409.017(3)(h), was implemented with the intent to authorize the use of certified local funding for federal matching programs in order to maximize federal funding local preventive services and local child development programs in this state. Through the legislation, the Legislature expects that state agencies will take proactive approach to accessing federal reimbursement.

Further, the Act supports the legislative intent of being revenue neutral with respect to state funds.

The Act establishes the authority of the Department to certify publicly appropriated, local funds as state match for eligible title IV-E expenditures. This statute gives the Department the authority to reimburse local governmental agencies with federal dollars for expenditures that are determined allowable and reimbursable under title IV-E, on behalf of dependent children who are eligible under title IV-E of the Social Security Act.

Title IV-E Eligibility Documentation

As previously mentioned, Nebraska's title IV-E Penetration rate is the lowest in the nation. While this can be largely attributed to the AFDC lookback, or need standard, there are several strategies the state should consider to increase the number of children who are ultimately determined to be title IV-E eligible. A review of national title IV-E penetration rates, AFDC needs standards, and poverty rates indicates there are several states in similar situations, each of which have a higher penetration rate. Indiana and Delaware both have slightly lower needs standards and slightly higher poverty rates but higher penetration rates. In particular, Indiana's penetration rate is 8% higher than Nebraska's.

Recommendation

> *Reinforce efforts to improve documentation supporting Title IV-E eligibility and increase the penetration rate.*

State	1996 AFDC Standard (Family of 3)	AFDC Standard StDev from National Avg.	IV-E Penetration Rate	Poverty Rate	% Placed with Relatives
Indiana*	$320	-1.223	26%	12.91%	35%
Delaware	$338	-1.165	20%	11.44%	7%
Nebraska	**$364**	**-1.080**	**18%**	**10.37%**	**34%**
Mississippi	$368	-1.067	35%	19.58%	30%
New Mexico	$381	-1.024	42%	18.55%	29%
Kansas	$403	-0.953	19%	11.44%	32%

Though Nebraska CFS presently has a performance improvement plan designed to increase the penetration rate, the rate has only experienced marginal increases over the last several years. Key strategies included in the plan include:

1. Increase the number of title IV-E eligible foster families who are available to take placement of youth in foster care. The increase in the number of eligible homes, will increase Nebraska's title IV-E penetration rate.
2. Increase the number of CFS families that DHHS is able to verify income for the month the removal petition is filed. The increase in the number of verified incomes will increase the accuracy of the information and in turn, may increase Nebraska's title IV-E penetration rate.
3. Increase the number of CFS families that DHHS is able to verify immigration status. The increase in the number of CFS families that immigration status can be verified may increase Nebraska's title IV-E penetration rate.
4. Implement a process to reduce any potential errors for the 2024 Federal Review.
5. Increase reasonable effort language in permanency hearings. The increase in the reasonable effort language, will increase the number of youth who are eligible for title IV-E.
6. Ongoing and new CFS Workers will understand the importance of IV-E, how it impacts their work and why it is important for DHHS in drawing down IV-E funding to pay for CFS Services and positions.
7. Work with tribes to determine tribal capacity to meet licensing regulations for tribal homes in meeting licensing standards. The increase in the number of eligible homes, will increase Nebraska's title IV-E penetration rate.
8. High Quality Legal Representation will allow DHHS to explore drawing down IV-E funds with the potential for reinvestment into pre-petition, candidate for foster care type legal work.
9. Implement training opportunities for staff that can enhance skills. This training could be a joint project with the Court Improvement Project (CIP) that DHHS is able to draw down IV-E funds.

The Work Group supports and recommends CFS further these efforts by implementing strategies to:

- Increase the number of licensed relative caregivers.
- Develop a process to claim title IV-E reimbursement for high-quality legal representation and probation activities related to serving cross-over youth (addressed in detail within the *Cross-System Collaboration* section of this document)
- Further partnership with the state's Court Improvement Project to reinforce the inclusion of required language in court orders.
- Continued training for staff related to the importance of title IV-E eligibility, documentation requirements, and the fiscal and programmatic impact of a lower-than average penetration rate.

- Review the client income documentation and verification requirements and compare them to other jurisdictions to ensure the process is streamlined and simplified to the greatest possible degree. Other jurisdictions, such as Alaska[4], have revised income verification and financial resource procedures to permit a signed income affidavit from the parents be acceptable documentation. Since approximately 50% of children are not eligible as a result of the family reportedly exceeding the income standard, adopting a similar approach in Nebraska may serve to increase the penetration rate.

Efforts to train staff, attorneys and judiciary on IV-E eligibility related issues, promote licensing of relative caregivers are reimbursable to the department as title IV-E administrative costs (50% FFP) or training costs (75% FFP). The Work Group recommends that DHHS should continue to leverage these federal funds to support efforts to increase the statewide penetration rate.

Licensing of Relative & Non-Relative Caregivers

When children are unable to remain in the safe care of their parent(s), grandparents, other family members, or kin frequently step forward to provide a temporary or permanent stable, loving home for them. Child welfare law and policies prioritize placing children with grandparents, relatives, or close family friends, known as kinship care. In compliance with 42 U.S.C. 671, states must "consider giving preference to an adult relative over a nonrelated caregiver when determining placement for a child, provided that the relative caregiver meets all relevant state child protection standards."

Recommendation

> *Increase the percentage of relative and fictive kin caregivers licensed as foster parents by continuing to implement and support strategies to streamline and expedite the licensing / approval process and incentive them to become licensed caregivers.*

According to the Annie E. Casey Foundation, more than 2.5 million children across America are placed with a relative or kinship caregiver. In foster care, research indicates such placements positively affect a child's well-being and permanency outcomes. Children placed with relatives or kin demonstrate fewer behavioral concerns, are less likely to disrupt from their placement, express higher satisfaction with their placement, are less likely to run away, are more likely to remain connected with their siblings, maintain their

[4] Original recommendation and example included in Casey Family Programs, "*Initial Report: Assessment of Title IV-E Eligibility and Federal Claims*", January 2019

cultural identify, and achieve better permanency outcomes. Further, children placed with relative caregivers are reported to have more positive mental health outcomes as an adult. However, relatives who foster or adopt as kin caregivers typically have far lower incomes than other adoptive or foster parents. As a result, it is critical these caregivers have access to all the financial resources they are eligible to receive.[5]

While a large percentage of children in foster care are placed with relative or kinship caregivers, only a small percentage of these caregivers have historically been licensed as foster parents. In 2017, only five percent of children in relative or kinship care nationally were residing in a licensed home.[6] While relative caregivers are sometimes hesitant to become licensed due to additional involvement of child welfare workers in their lives and additional level of scrutiny in their homes, there are also systemic barriers impacting their ability to become licensed. These barriers typically include:

- Criminal record,
- Financial stress,
- Unemployment,
- Childcare cost,
- Housing insufficiency,
- Conflicting family obligations,
- Poor communication with child welfare department,
- Department misplaced or lost paperwork,
- Paperwork expired (prior to the licensing process being completed),
- Child's caseworker unhelpful,
- Child's caseworker gave poor advice, and
- Licensing home study process took too long[7].

The ability to claim title IV-E reimbursement for children placed in relative care is inexorability tied to the licensed status of the setting where they are place. As a result, states fund a significant portion of these placements without financial assistance from the federal government. With the passage of the Family First Prevention Services Act, child welfare agencies were permitted to adopt less burdensome licensing standards for relative and kinship

[5] Evan B. Donaldson Adoption Institute. *Never Too Old: Achieving Permanency and Sustaining Connections for Older Youth in Foster Care,* July 2011.
[6]https://www.americanbar.org/groups/publicinterest/childlaw/resources/childlawpracticeonline/childlawpractice/vol-36/july-aug-2017/kinship-care-is-better-for-children-and-families/
[7] Maureen Riley-Behringer & Jamie Cage (2014) Barriers Experienced by Kinship and Non-Relative Caregivers During the Foster and Adoptive Parent Licensure and Home Study Process, Journal of Public Child Welfare, 8:2, 212-238, DOI: 10.1080/15548732.2014.893223

foster family homes to alleviate delays and barriers in the licensing process and expedite access to federal financial resources for placement with those family caregivers.

States, including Nebraska, have implemented policies and practices, especially streamlining and expediting training requirements and waiving non-safety related foster home requirements, to encourage and facilitate licensing of relative and kinship caregivers. At any given time in Nebraska, approximately eighty-one percent of children (500) who otherwise meet title IV-E eligibility criteria are residing with unlicensed relative or kinship caregivers. While the percentage of children placed with licensed relative and kinship caregivers in Nebraska has increased over the past several years, other states have made more significant progress in this capacity. For instance, in Florida, over 42% of children placed with relatives or kin are in licensed settings; more than twice the rate in Nebraska.

Increasing the percent of licensed relative caregivers should remain a key focus of CFS throughout the implementation of the LB 1173 Finance Model framework. Strategies to continue and/or be considered include:

- Provide one-time financial incentives to relative and kinship caregivers if they chose to complete licensing requirements,
- Eliminate or establish a lower per diem for unlicensed kinship caregivers,
- Provide financial supports to cover the cost and ameliorate issues in the home of a prospective relative caregiver, which may impact their ability to comply with requirements of the licensing home study,
- Provide childcare to facilitate access to training for relative/kinship caregivers,

Finally, In September 2023, the Administration for Children and Families published a final rule in the Federal Register (88 FR 66700)[8,9]. This rule amends regulations to: (1) allow a title IV-E agency to adopt one set of licensing or approval standards for all relative or kinship foster family homes that is different from the licensing or approval standards used for non-relative foster family homes; (2) require that during a title IV-E agency's periodic review in accordance with section 471(a)(11) of the Act, the agency review foster care maintenance payments to ensure that children receive the same amount of FCMP whether placed in a licensed or approved relative, kinship, or unrelated foster family home; and (3) align the definition of "foster family home" with changes made by Public Law 115-123, the Family First Prevention

[8] https://www.federalregister.gov/documents/2023/02/14/2023-03005/separate-licensing-standards-for-relative-or-kinship-foster-family-homes
[9] https://www.acf.hhs.gov/sites/default/files/documents/cb/ACYF-CB-IM-23-07.pdf

Services Act, to limit the definition of a foster family home to the "home of an individual or family," and to require that the foster parent reside in the home with the child.

This change, which becomes effective on November 27, 2023,allows a title IV-E agency to claim title IV-E federal financial participation (FFP) for the cost of foster care maintenance payments (FCMP) on behalf of an otherwise eligible child placed in a relative or kinship licensed or approved[10] foster family home when the agency uses different licensing or approval standards for relative or kinship foster family homes and non-relative foster family homes. In addition, the rule would amend the requirement that title IV-E agencies provide a licensed or approved relative and kinship foster family home the same amount of foster care maintenance payment that would have been made if the child was placed in a non-related foster family home[11].

The Work Group recommends CFS review current requirements related to the licensing or approval of relative or non-relative "fictive kin" caregivers and revise state licensing regulations to place as few burdens on such families as possible, consistent with ensuring the safety and well-being of children in foster care.

Incentivize Licensing of Relative Caregivers

Over the last two years, CFS has provided incentives to relative caregivers choosing to become licensed. Initially subsidized through COVID Relief funding, these incentives have now been largely eliminated. Given the potential for federal reimbursement for title IV-E eligible children placed with approved relative caregivers, strategies to financially incentive providers to place children in these settings when available and appropriate should be implemented.

Recommendation

> *Implement strategies to incentives both caregivers and providers when relatives become licensed and integrate evidence-based Kinship Support services into child placing agencies in order to support additional federal claiming.*

During the course of discussion, the LB1173 Financial sub Work Group discussed the potential of establishing tiered payment rates for licensed and unlicensed caregivers. Providers involved in this discussion indicated they frequently see unlicensed relative caregivers require increased support and services because:

[10] The terms "licensed" and "approved" are generally used interchangeably as they related to placement with relative caregivers.

[11] https://www.federalregister.gov/documents/2023/02/14/2023-03005/separate-licensing-standards-for-relative-or-kinship-foster-family-homes

- They are not familiar with child welfare practice, available resources, and legal requirements, and
- Have not received training related to the care for children who have experienced trauma, establishing parental boundaries, and creating trust-based relationships.

In particular, the following strategies have proved to be effective in Nebraska and other jurisdictions:

- Provide one-time incentive payments to relative caregivers when they are licensed or approved.
- Eliminate or reduce payments to unlicensed caregivers. For instance, Florida is transitioning to a tiered payment rate with reduced payment to relatives who do not become licensed.
- Incentivize providers to license relative caregivers by offering additional payment or bonuses when relative caregivers become licensed.
- Establish a contractual measure requiring child placing agencies to obtain a waiver of licensing requirements for relative caregivers, which clearly documents the reason the family has chosen to not pursue licensing.

Finally, CFS should continue to implement an evidence-based Kinship Caregiver program approved by the title IV-E Federal Clearinghouse and ensure the program is integrated into or collaborates with child placing agencies in order to provide additional supports to relative caregivers regardless of their licensing status. The cost of providing these services to caregivers is eligible for reimbursement under FFPSA, even when the child is not otherwise title IV-E eligible.

Children Placed through Letters of Agreement and with Shared Living Providers

Nebraska CFS and Juvenile Probation Services (JPS) continues to use Letters of Agreement (LOAs) to place and establish payment rates with providers for difficult to place children. Similarly, children are also placed with Shared Living Providers (SLPs). Maintenance payments for children who would otherwise be eligible for federal reimbursement under title IV-E are not being claimed for LOA or SLP placements. Federal reimbursement for the cost of these placements is not available as the providers are not licensed by CFS. Further, placement in these settings may also be detrimental as often the child is placed in a home without specialized training, there is a lack of provider accountability, and providers are not contractually held to therapeutic or child welfare permanency-related outcomes.

During a 2021 review of LOA placements completed by TSG[12], CFS staff and leadership indicated they do not have a standardized process outlining when the agency should enter into an LOA, including threshold criteria regarding children that would trigger consideration of an LOA's necessity. Thus, LOAs do not correspond to a given level of care. The placement is what it takes to incentivize the agency and foster parent to take on the challenge of caring for children who require extensive, intensive supervision due to medical, behavioral, mental health diagnosis or other complex needs. Further, at the time of the review, CFS staff reported that the LOA process is ad hoc, and crisis driven. Providers use this as leverage to drive up costs and CFS has no standardized process to identify when to use a LOA or what the specific expectations are for care for children receiving service at this level. This has resulted in higher costs for the state and reduced permanency outcomes for children in care.

Recommendation

> *Reduce the number of children placed through LOAs or with SLPs and implement policies and procedures to ensure eligible Title IV-E maintenance and administrative costs are federally claimed for eligible children and youth who are.*

Though CFS has taken steps to reduce the number of children placed through LOAs by adding a level of care (tier) to the foster care payment structure and submitting a waiver to cover the cost of Medicaid-eligible children placed in Therapeutic Foster Care[13]. CFS must focus on eliminating any remaining barriers to receiving federal payment for children placed in these settings. Specific strategies to be considered may include:

- Establish a dual license process for providers licensed by other divisions within the state,
- Phase in contractual requirements requiring providers paid under an LOA to become licensed,
- Limit placement with SLPs to those youth who have developmental disabilities,
- Create a standardized process for establishing acuity-based payment rates outside the normal payment level which clearly outlines how the payment was calculated and identifies which portions of the rate are related to title IV-E maintenance or administration and whether additional payment may be justified for the provision of other wraparound supports or services.

[12] Nebraska Treatment Family Care and Foster Care Rate Analysis, 2021, The Stephen Group, LLC.

[13] Nebraska's Treatment Foster Care Services is scheduled to be implemented in late 2023 and will be a wrap-around model of care that provides intensive, highly coordinated, trauma- informed, and individualized services to children and youth in foster care (CYFC), up to age 19 who have complex mental health and/or substance use disorders that are causing functional impairment to a degree that puts them at risk of meeting criteria for placement in a more restrictive setting (e.g., psychiatric residential treatment facility.

- CFS may consider reviewing the process on the child-specific rate setting process Indiana uses when placing children of acute behavioral or medical needs who require supervision in excess of the typical caregiver ratio. Though used with licensed providers, the process developed by the Indiana Department of Child Services (DCS) Rate Setting Unit clearly justifies the payment of rates outside established payment limits, documents the processes used to calculate those rates, and supports the reasonable nature of these rates and supports federal claiming of foster care maintenance and related administrative costs for title IV-E eligible children.

Develop QRTP Residential Capacity in the State

To support placement of children of higher acuity and levels of need, CFS may desire to collaborate with residential providers to fund the development of one or more Qualified Residential Treatment Programs (QRTPs). Doing so may not just serve to reduce the number of children placed through LOAs, but may also reduce the number of children placed out-of-state.

Develop Strategies to Support Multi-Agency Licensing and Access to Residential Settings

To further support claiming, CFS should consider co-developing a process to license homes serving youth also served through the Division of Developmental Disabilities and the Division of Medicaid and Long Term Care. This may support federal claiming for children placed in homes for children with more acute or specific programmatic needs. For instance, the State of Indiana has implemented state policy which permit title IV-E approved Residential Treatment Facilities to also be Medicaid reimbursable Psychiatric Residential Treatment Facilities (PRTFs). Further, the state also developed a separate set of program standards and licensing requirements for DCS funded residential settings capable of serving children with developmental disabilities. As licenses for both these residential setting are issued by the title IV-E agency, the state is able to claim federal reimbursement for an eligible child.

Title IV-E Administrative Cost Claiming

CFS has not claimed federal reimbursement for all eligible title IV-E administrative costs. This includes expenditures related to both traditional title IV-E candidacy and administrative costs for eligible expenses incurred by contracted child placing agencies. Federal reimbursement for these costs may be claimed for the current quarter and retroactively for the seven (7) previous quarters.

Federal financial participation (at a rate of 50%) may be claimed for administrative costs expenditures necessary for the proper and efficient administration of the title IV–E plan as identified at 45 CFR 1356.60(c). Reimbursement is available regardless of whether the child is

actually placed in out-of-home foster care and becomes eligible for title IV-E foster care benefits. Such costs include:

- The determination and redetermination of eligibility, fair hearings and appeals, rate setting and other costs directly related only to the administration of the foster care program under this part are deemed allowable administrative costs under this paragraph. They may not be claimed under any other section or Federal program.
- The following are examples of allowable administrative costs necessary for the administration of the foster care program:
    - Referral to services;
    - Preparation for and participation in judicial determinations;
    - Placement of the child;
    - Development of the case plan;
    - Case reviews;
    - Case management and supervision;
    - Recruitment and licensing of foster homes and institutions;
    - Rate setting; and
    - A proportionate share of related agency overhead.
    - Costs related to data collection and reporting.

Recommendation

> *Implement fiscal procedures to ensure all eligible and reimbursable Title IV-E administrative costs are claimed for foster care candidates as well as for child placing agencies.*

Reimbursement is limited to those individuals reasonably viewed as candidates for title IV-E foster care maintenance payments consistent with section 472(i)(2) of the Social Security Act.

A candidate for foster care is federally defined as a child who is at serious risk of removal from home as evidenced by the title IV-E agency either pursuing his/her removal from the home or making reasonable efforts to prevent such removal. It is important to note, a child may not be considered a candidate for foster care solely because the title IV-E agency is involved with the child and his/her family. In order for the child to be considered a candidate for foster care, the title IV-E agency's involvement with the child and family must be for the specific purpose of either removing the child from the home or satisfying the reasonable efforts requirement with regard to preventing removal.

There are three acceptable methods to document a child is a candidate for title IV-E foster care benefits. These methods are described in the Federal Child Welfare Policy Manual[14] at Section 8.1D, Question #2:

1. A defined case plan which clearly indicates that, absent effective preventive services, foster care is the planned arrangement for the child.
    a. The decision to remove a child from home is a significant legal and practice issue that is not entered into lightly. Therefore, a case plan that sets foster care as the goal for the child absent effective preventive services is an indication that the child is at serious risk of removal from his/her home because the title IV-E agency believes that a plan of action is needed to prevent that removal.
2. An eligibility determination form which has been completed to establish the child's eligibility under title IV-E.
    a. Completing the documentation to establish a child's title IV-E eligibility is an indication that the title IV-E agency is anticipating the child's entry into foster care and that s/he is at serious risk of removal from home. Eligibility forms used to document a child's candidacy for foster care should include evidence that the child is at serious risk of removal from home. Evidence of AFDC eligibility in and of itself is insufficient to establish a child's candidacy for foster care.
3. Evidence of court proceedings in relation to the removal of the child from the home, in the form of a petition to the court, a court order or a transcript of the court's proceedings.

Should the title IV-E agency determine that the child is no longer a candidate for foster care at any point prior to the removal of the child from his home, subsequent activities will not be allowable for reimbursement of costs under title IV-E.

CFS also reports not claiming for title IV-E eligible administrative expenditures for contracted child placing agencies (CPAs). Department leadership reports claiming for these costs was previously done, but was stopped as a result of auditor concerns questioning the rate methodology and determination that expenses incurred by the CPAs were clearly related to title IV-E administrative activities. The Work Group recommends financial management staff review all claims in relation to the methodology to set administrative payment rates used by the Rate Setting Committee to determine whether there is sufficient documentation and justification to claim these expenses on an ongoing basis. A review of these rate setting documents indicates there is a high probably that a claim for these expenditures can be made.

[14] https://www.acf.hhs.gov/cwpm/publichtml/programs/cb/lawspolicies/laws/cwpm/policydsp.jsp?citID=79

As previously mentioned, the state will have the ability to claim expenditures for the current quarter and retroactively for the seven (7) previous quarters.

A review of title IV-E administrative claims submitted by Nebraska for the past three federal fiscal years indicates the state has not claimed federal reimbursement for expenditures related to children and youth considered to be foster care candidates. CFS has recently initiated administrative claims for candidacy-related expenditures for the quarters ending March and June 2023. Federal financial participation (FFP) was approximately $1.5 million for quarter ending March 2023 and $2.3 million for the quarter ending June 2023. The department should seek retroactive claims for the eligible periods prior to January 2023. FFP for these periods may total as much as $7.5 to $10 million. Going forward, continued reimbursement for these administrative costs may total $6 to 8 million annually.

Leverage Training Opportunities to Create a Pathway to Child Welfare Employment

Since the late 1980s, the training provision of title IV-E of the Social Security Act has been a major public funding source supporting both staff training and the opportunity for current and prospective employees to earn BSW and MSW degrees. Using these federal funds to support social work education has been instrumental in educating and encouraging workers to pursue child welfare careers. Training opportunities may be short-term or long-term; long term includes degree education for those preparing for child welfare work.

The federal government provides enhanced federal match of 75 percent for title IV-E eligible training and universities typically provide the required match through expenditures on faculty, overhead, and curriculum development. Funds may be used for direct financial assistance (stipends) to students, salaries and benefits of university instructors, curriculum development, materials and books, field instructors, distance education, and evaluation of the program. The department should continue to look to leverage funding to develop the capacity and capabilities of the child welfare force, in terms of both the number of workers and knowledge workers bring to the field. In doing so, the department may also look to work in partnership with other entities, such as Managed Care Organizations (MCOs) to develop training programs capable of benefiting multiple fields. Ultimately, increased investment in staff and their professional development will serve to increase recruitment and retention of qualified staff, lessen turnover, reduce cost, and improve outcomes.

Training can look to create multiple entry points and pathways for individuals at different points in their lives and careers. Specific innovations the state may look to include:

- Engaging youth while still involved in secondary education to educate them and promote the benefits of pursuing working in child welfare,

- Providing training to persons with lived experience to develop peer mentors,
- Working with undergraduate students to promote education in social work or other related fields capable of working in child welfare,
- Establishing ongoing educational opportunities for current workers.

Implementation of a Modern Child Welfare Information System

The Administration for Child and Families (ACF) published the new federal Comprehensive Child Welfare Information Systems (CCWIS) rule to promote the development of modern information systems better positioned to support the needs of child and family service systems. Traditionally, SACWIS systems were large, cumbersome data systems which were difficult to tailor to the specific needs of a state. These systems are now outdated and not aligned with current child welfare policy and practice. In Nebraska, staff frequently describe difficulties using N-Focus (the state's data management system), accessing information, and extracting reliable, up-to-date, usable data capable of driving system-wide performance and improving outcomes.

Recommendation

> *Invest in a modern child welfare system capable of streamlining work efforts, supporting staff, providing real-time accurate data, and informing decision making.*

The advent of CCWIS served to promote the use of a modular system with an integrated information framework capable of being modified to support the unique needs of jurisdictions using the system. Ultimately, a CCWIS compliance system can serve to improve child welfare outcomes by enhancing data interoperability, promoting system modularity, and improving data quality. Overall, a modern CCWIS system is capable of:

- Providing child welfare staff with up-to-date, real time information to inform and support decision-making,
- Supporting cross-departmental collaboration among human service, health, and education agencies
- Encouraging innovation,
- Facilitating communication with courts and legal services, and
- Promoting continuous quality improvement.

Because CCWIS systems are modular in nature, system modifications and improvements can be readily made when policies or workflows change or are updated. In total, transition from SACWIS to CCWIS will serve to better support workers and outcomes by improving workflow

and offering access to data capable of driving performance and outcomes for children and families.

As part of its child welfare transformation efforts, the Work Group recommends CFS consider investing in the modernization of the current N-Focus system, by either updating the system or transitioning to a CCWIS-compliant data framework. The Work Group recommends hiring an experienced firm to complete comparative and cost-benefit analyses of these options to determine the most efficient path forward.

Fully Implement title IV-E Claiming for Prevention Services

Though Nebraska has one of the earliest FFPSA implementation dates in the nation (10/1/19), the state has reported comparatively low expenditures and federal reimbursement for services since this time. During the first two federal fiscal years (FFY'20 and FFY'21) Nebraska was eligible to claim federal reimbursement for approved prevention activates, the department did not submit claims for any services, training, or administrative services[15]. During FY'2022, CFS reported serving an average of 719 children per quarter and received federal reimbursement of $47,892. There were no federal claims submitted by the state for eligible training or administrative expenditures[16].

In comparison during FFY 2022,

- North Dakota served an average of 60 children per quarter and received $164,314 in federal reimbursement.
- Iowa served an average of 373 children per quarter and received $5,172,317 in federal reimbursement. It is important to note that while only $312,810 in federal reimbursement was received for the provision of evidence-based interventions, ***the state was able to receive FFP totaling $4,850,507 for administrative expenditures of $8,896,315 during the fiscal year.***
- Kansas served an average of 905 children per quarter and received $4,864,108 in federal reimbursement. The majority of this reimbursement, $4,208,234 was for the direct provision of evidence-based services.

[15] Federal Title IV-E Programs Expenditure and Caseload Data, Federal Fiscal Years 2020, 2021, and 2022. Retrieved from, https://www.acf.hhs.gov/cb/resource-library?f%5B0%5D=type%3Areport
[16] https://www.acf.hhs.gov/sites/default/files/documents/cb/fy-2022-title-iv-e-prevention-services.xlsx

- Illinois claimed administrative and training costs in excess of $52,000,000 while incurring only $328,093 in expenses for evidence-based services to an average of 1,290 children per quarter.

The following table provides an overview of all states receiving FFP for prevention services during Federal Fiscal Year 2022. It is important to note, some jurisdictions may have funded implementation activities and services using other funding sources such as Medicaid, Family First Transition Act (FFTA) funding, or American Rescue Plan Act of 2021 (ARPA) funds, which were available as a result of the COVID-19 pandemic. Therefore, it may not be fully reflective of total state expenditures for prevention services or related administrative or training activities. Finally, the Average Number of Children Served reported in the data represents the average number of children served per quarter rather than a unique count of children served per year. As a result, the calculated FFP per Child Served may be overrepresented. The value is shown only for comparison, rather than as a representation of actual federal reimbursement per child.

State	Plan Effective Date	EB Service Expenditure	Average # of Children Served per Quarter	Agency Expenditures		Total Expenditures and Federal Reimbursement		Avg. FFP / Avg # Children Served / Quarter
				Administration	Training	Total	FFP	
Arkansas	Oct 2019	2,820,931	405	826,196	-	3,647,127	1,823,565	4,500
Wash. DC	Oct 2019	2,468,144	465	12,485,232	-	14,953,376	7,409,012	15,951
Illinois	Oct 2021	328,093	1,290	51,608,013	589,647	52,525,753	26,262,880	20,355
Iowa	Oct 2020	643,620	373	8,896,315	-	9,539,935	5,172,317	13,885
Kansas	Oct 2019	7,798,059	905	1,293,341	18,405	9,109,805	4,864,108	5,378
Kentucky	Oct 2019	19,177,971	2,220	8,046,425	579,200	27,803,596	13,926,335	6,272
Maine	Oct 2021	178,255	9	290,074	-	468,329	234,167	26,019
Maryland	Oct 2019	-	-	1,481,436	-	1,481,436	740,718	N/A
Michigan	Oct 2021	-	233	629,622	-	629,622	314,811	1,350
Nebraska	Oct 2019	71,112	719	-	-	71,112	47,892	67
N. Dakota	Apr 2020	247,330	60	81,293	-	328,623	164,314	2,750
Ohio	Oct 2021	2,459	15	74,440	13,195	90,094	45,048	3,054
Oklahoma	Oct 2021	-	159	226,095	-	226,095	113,048	713
Tennessee	Apr 2021	56,700	2	-	-	56,700	28,350	16,200
Utah	Oct 2019	812,820	117	1,743,143	53,140	2,609,103	1,304,554	11,126
Virginia	Jul 2021	334,465	12	2,791,688	237,739	3,363,892	1,682,974	146,346
W. Virginia	Oct 2019	61,501	5	-	-	61,501	30,752	6,150
Total		**35,001,460**	**6,987**	**90,473,313**	**1,491,326**	**126,966,099**	**64,164,845**	**9,184**

It is important to note, administrative expenditures may include the cost of implementing data management systems to facilitate required data collection and federal reporting. These systems may be an integral part of the state's strategy to implement or expand their Comprehensive Child Welfare Information System (CCWIS).

As the Practice Model is implemented and a reimagined child welfare system realized, the Work Group believes it is imperative that expenditures for all eligible prevention services are federally claimed.

Priority Area 2: Cross-System Synergy and Collaboration

HIGH-QUALITY LEGAL REPRESENTATION OF CHILDREN AND FAMILIES

The Children's Bureau provided guidance to title IV-E agencies in 2017 emphasizing the importance of high quality legal representation in helping ensure a well-functioning child welfare system. This guidance cited numerous studies and reports pointing to the importance of competent legal representation for parents, children, and youth in ensuring that salient information is conveyed to the court, parties' legal rights are protected and that the wishes of parties are effectively voiced. There is evidence to support that legal representation for children, parents and youth contributes to or is associated with:

Recommendation

> *Expand the availability of high quality legal services to children and families by implementing a process to claim federal reimbursement for eligible activities.*

- Increases in party perceptions of fairness;
- Increases in party engagement in case planning, services and court hearings;
- More personally tailored and specific case plans and services;
- Increases in visitation and parenting time;
- Expedited permanency; and
- Cost savings to state government due to reductions of time children and youth spend in care[17].

In 2019, the Children's Bureau issued revised and new federal policies allowing title IV-E agencies to claim federal financial participation (FFP) for administrative costs of independent legal representation provided by attorneys representing children in title IV-E foster care, children who are candidates for title IV-E foster care, and their parents for "preparation for and participation in judicial determinations" in all stages of foster care legal proceedings. These policies were further clarified in 2020, verifying administrative costs for paralegals, investigators, peer partners, or social workers may be claimed as title IV-E foster care administrative costs to the extent they are necessary to support an attorney providing independent legal representation to prepare for and participate in all stages of foster care legal

[17] *Twenty Years of Progress in Advocating for a Child's Right to Counsel*, https://www.americanbar.org/groups/litigation/committees/childrens-rights/articles/2019/spring2019-twenty-years-of-progress-in-advocating-for-a-childs-right-to-counsel/.

proceedings for candidates for title IV-E foster care, youth in foster care and his/her parents and for allowable office support staff and overhead expenses.

Under these expanded policies title IV-E agencies may claim administrative costs for preparation for and participation in judicial determinations by an attorney providing independent representation to a child in title IV-E foster care, and his/her parents. Such activities and expenses must be necessary to carry out the requirements in the IV-E plan. (See 45 CFR 1356.60(c)(2)(ii). Examples of foster care legal proceedings include:

- Hearings related to judicial determinations that it is contrary to the welfare of a child to remain in the home;
- Hearings related to a child's removal from the home;
- Hearings related to judicial determinations that the agency provided reasonable efforts to prevent removal and finalize the permanency plan;
- Permanency hearings
- Hearings related to progress on case plans; and
- Appeal proceedings related to judicial determinations required under title IV-E.

Additionally, federal reimbursement is available for administrative activities for agency or independent attorneys to prepare for and participate in judicial determination for all stages of foster care legal proceedings. Examples of foster care legal proceedings include:

- Independent investigation of the facts of the case, including interacting with law enforcement;
- Meeting with clients or making home or school visits;
- Attending case planning meetings;
- Providing legal interpretations;
- Preparing briefs, memos, and pleadings;
- Obtaining transcripts;
- Interviewing and preparing their client and witnesses for hearings;
- Hearing presentation;
- Maintaining files
- Supervising attorneys, paralegals, investigators, peer partners or social workers that support an attorney in providing independent legal representation to prepare for and participate in all stages of foster care legal proceedings; and
- Appellate work in reference to foster care legal proceedings.

During the course LB1173 Work Group activities, community forums, and focus groups, state court representatives, judiciary, attorneys, and tribal representatives have all expressed the need to pursue claiming for eligible legal services in the state.

The Work Group recommends CFS immediately look to implement policy supporting claiming for legal services to children and families across the state. Doing so will require careful planning, policy development, modifications to the department's Cost Allocation Plan, creation of cost collection and data management processes, statewide training for participating attorneys, implementation of a cost allocation process or random moment sample (RMS) for participating attorneys and staff, and ongoing quality management efforts to verify the accuracy of cost data collected and resulting claims for Federal Financial Participation (FFP). As part of the implementation strategy, CFS and participating legal service providers should consider a reinvestment strategy, which will require federal reimbursement be used to expand the availability of legal services to children and families. This is a central strategy in Florida's recently created legal claiming implementation strategy.

It is important to note, federal reimbursement is linked to both the state's title IV-E (traditional) candidacy and eligibility penetration rates. Given the present low nature of the eligibility penetration rate, it will be imperative CFS focuses on increasing the rate in order to fully realize the potential benefits of the program. As there will be initial and ongoing administrative cost associated with the claiming effort, it is recommended a cost / benefit analysis be completed to provide a clear indication as to whether and when federal reimbursement to the state will exceed the cost of implementing the claiming process.

Finally, on September 21, 2023, the Administration for Children and Families released a Notice of Proposed Rule Making (NPRM) pertaining to the ability to claim title IV-E Federal financial participation for the administrative cost of attorneys providing legal representation[18]. DHHS and CFS should monitor and integrate any changes resulting from this NPRM into their strategy to claim reimbursement for the provision of high quality legal representation.

Title IV-E Claiming for Juvenile Probation Services

In every jurisdiction, child welfare agencies serve a population of youth involved in both the child welfare and juvenile justice systems. Typically referred to as "crossover youth", they face

[18] https://www.federalregister.gov/documents/2023/09/28/2023-20932/foster-care-legal-representation

unique challenges as a result of their involvement in multiple system which frequently result in significantly negative outcomes. In particular, studies have found[19]:

- Maltreated youth are 47% more likely than their peers to become involved in the juvenile justice system due to their increased risk of arrest and case petition.
- Crossover youth's cases are also more likely to be petitioned by the court than those of non-crossover youth.
- Crossover youth face harsher court outcomes and are more likely to be removed from their homes or detained.
- Crossover youth are more likely to come from challenging familial circumstances and are more likely to be younger at first entry into the juvenile justice system.
- Crossover youth are more likely to suffer from substance abuse, have mental health issues, and face educational difficulties.
- Crossover youth are less likely to receive appropriate treatment or face service interruptions in the event they ineligible for certain services when transitioning between systems.
- Female crossover youth, who are at greater risk of pregnancy, have access to few gender-specific programs that address their specific needs.

Recommendation

> *Improve outcomes for crossover youth involved in both child welfare and juvenile probation services by enhancing collaboration between CFS and JPS and claiming Title IV-E for reimbursable administrative functions.*

As a result of these barriers, crossover youth are more likely to experience recidivism and face difficulties as they transition to adulthood. This leads to additional burden of cost on public systems in both the short- and long-term.

LB1173 Work Group members, including the Judicial Branch, Juvenile Probation Services Division (JPS) staff, and the University of Nebraska Law Center, have all expressed the need for improved collaboration between child welfare and juvenile probation services in the state. For those youth involved in both systems, title IV-E reimbursement is available for youth adjudicated delinquent if they meet all of the federal foster care criteria and are placed with a foster family or in a residential childcare institution that meets the definition in federal law. In

[19] *Improving Multisystem Collaboration for Crossover Youth*, https://crownschool.uchicago.edu/student-life/advocates-forum/improving-multisystem-collaboration-crossover-youth.

addition, reimbursement is available for 50% of the cost of title IV-E administrative (such as salaries of caseworkers and administrators, office space, etc.) and 75% of the training costs associated with the serving these children. These eligible expenses are presently being incurred by JPS and title IV-E reimbursement should be considered if it is able to generate a return on the investment necessary to compile the claiming documentation.

To support improved outcomes for these vulnerable and often underserved youth, there must be improved collaboration between CFS and JPS. Financially, such collaboration can cover a portion of the probation officers' activities of and preventing the need for out-of-home placement by providing community supervision of youth on probation.

Requirements and limitations related to claiming reimbursement for JPs-related activities are similar to those described in the *Legal Services* section of this Financial Framework. Given there are only 125 to 150 crossover youth identified in the state at any given time, the opportunity for federal reimbursement is likely to be limited by the current title IV-E penetration rate. A review of recent title IV-E eligibility determinations in the state indicated that none of the crossover youth placed in out-of-home care were determined to be title IV-E eligible. In order to capitalize on this opportunity, CFS will likely first have to ensure administrative claiming for traditional title IV-E candidacy costs and claiming for FFPSA eligible prevention services are fully developed and implemented. It is again recommended a cost / benefit analysis be completed to verify at what point claiming opportunities will exceed required implementation costs.

Additional Financial Resources to Consider for Crossover Youth

In addition to expanding title IV-E for this population, CFS and JPS should work collaboratively with staff the Division of Medicaid and Long Term Care to ensure claiming under the following Medicaid services is also realized to the largest possible extent.

Targeted Case Management (TCM) permits federal reimbursement program for probation departments, public health clients, public guardian clients, aging and adult services, outpatient clinic patients and at-risk children and adults. This reimbursement would be additional funding that the State could use to expand their services or maintain current services. TCM is defined as reimbursable services which assist an eligible person that is provided access to needed medical, social, educational and other services. TCM reimburses for health services provided to at risk children or adults on probation.

Medicaid Administrative Claiming provides a quarterly reimbursement for Medicaid related activities provided to youth on probation. The quarterly revenue allows the probation department to improve the public's access to the Medicaid Program, improve the use of Medicaid Services by the eligible Medicaid population, and improve the delivery of Medicaid

Services. Examples of reimbursable activities include outreach, eligibility determination, and referring, scheduling, monitoring care, arranging transportation, and providing translation services.

Create Medicaid Blended and/or Braided Funding Strategies for FFPSA Interventions

FFPSA was passed with the intention of leveraging existing Medicaid payment for mental health, substance abuse, and in-home parenting services when the family is Medicaid eligible. The Act is clear in that jurisdictions are to consider title IV-E the "payor of last resort" when coordinating the provision of these interventions. However, claiming Medicaid reimbursement provides a set of challenges which CFS and providers must work in collaboration with The Division of Medicaid and Long Term Care and contracted Managed Care Organizations to overcome.

Nebraska CFS has worked to braid funding for Family Centered Treatment (FCT) and Healthy Families America (HFA), two evidence-based services included in the State's Title IV-E Prevention Plan. Presently, therapeutic components of FCT are being billed to Medicaid and MIECHV and TANF funding is being accessed to support the provision of HFA. However, it will be critical to expand efforts to blend and braid funding to support the provision of evidence-based prevention services provided under through FFPSA.

Nationally, Medicaid reimbursement has not traditionally covered the full cost of providing the service and, therefore, frequently results in a lack of capacity for therapeutic services to children. Given the intent to significant increase access to such interventions within the proposed Practice Model, this lack of capacity will become significantly more impactful as CFS looks to serve more families with a broader array of evidence-based prevention services across the state. LB 1173 Work Group members and providers have expressed this concern, alike. In order to build capacity for evidence-based services, rates must be structured to support the practice, so that

Recommendation

> *Maximize reimbursement for Medicaid eligible services by creating collaborative strategies and opportunities to include specific interventions as named services in the State's Medicaid Plan, blend and braid funding sources, claim interventions as an in-lieu-of (ILO) service, obtain Medicaid waivers, or access other third-party payment sources.*

more providers can implement them with fidelity and achieve the model's proven results[20].

For the purposes of this LB 1173 Financial Model Framework, a Medicaid covered service assumes that all recipients of the service are:

1. Medicaid eligible. *However, under FFPSA, services may be offered to families that may have private insurance and/or be uninsured or underinsured. For those that do not meet Medicaid eligibility requirements other funding sources should be considered.*
2. Services billed meet all the requirements of the current Medicaid State Plan.
3. Providers delivering services are Medicaid providers and contracted with Medicaid MCO plans.
4. Services are pre-authorized by Medicaid Managed Care plan.
5. Service limits have not already been exhausted in the prior twelve months .
6. Recipient meets "Medical Necessity."
7. Non-clinical services (i.e., home visiting) may have "in lieu of services" that may be reimbursable by the health plan.

If any of these assumptions is untrue, it is presumed the cost of services will **not** be reimbursed by Medicaid. In addition, there are requirements of the evidence-based practices (EBPs) that fall outside the traditional "coverage and limitations" of the Medicaid scope of services. In particular, several practice areas have been identified which may not be funded through traditional Medicaid reimbursement rates but are required under FFPSA. These include:

- **Service requirements**: activities beyond the scope of service reimbursed by Medicaid.
- **Staffing requirements**: Provider/practitioner requirements that may preclude the service from being Medicaid reimbursable. Practitioner credentials and salary requirements that are not possible within the current Medicaid rate structure.
- **Training and supervision requirements**: Case consultations and supervision activities beyond the basic accreditation, regulatory and licensing standards.
- **Fidelity monitoring requirements**: Activities to support fidelity to the EBP.

Examples of each of each of these factors include:

1. **Service Requirements** (beyond traditional therapy approaches and outside Medicaid coverage and limitations). Typical examples of non-reimbursable activity include:
    a. Sessions in excess of Medicaid daily limits (Medicaid),

[20] The Stephen Group would like to thank Andry Sweet, President and CEO, Children's Home Society of Florida, for providing additional insights related to barriers and strategies related to the implementation of Medicaid-funded services and blended and braided funding.

b. Sessions in excess of Medicaid annual limits (i.e., weekly sessions)
c. On call responsibilities (24/7): this is not typically a requirement for community mental health outpatient services, but is for several EBPs.
d. Caseload limits: for a traditional community mental health outpatient service model, caseloads are generally 20-30 clients. This supports bi-monthly visits (26 sessions/year) and all of the associated travel, documentation, management and supervision.
    i. With many EBP's caseloads are capped at lower levels (i.e., 10-12, meaning providing more services and greater intensity to fewer clients), but this also means more services that will be beyond the scope or limitations of the Medicaid program.
    ii. There may be activity in one or all of the following areas:
        1. Crisis intervention/after-hours support
        2. Collateral contacts (school, day care, other agencies involved in the child's case)
        3. Care coordination (necessary in cases where no case manager is assigned, i.e., in home family support, prevention).
        4. Participation in multi-disciplinary staffing/case reviews in consultation with other professionals involved in the case.
        5. Requirements for parent education, support groups, socialization events, etc.
        6. Requirements for community resource development and networking
e. Additional documentation requirements: If any of the services are covered by title IV-E under FFPSA, there are documentation requirements regarding services delivered to eligible title IV-E populations. Further, other jurisdictions have found that Medicaid documentation requirements are different than the intervention-specific documentation requirements supporting training and fidelity components of the model. These conflicting requirements can be burdensome, interfere with the clinician's ability to effectively implement the model to fidelity, and ultimately reduce the ability of the clinician to provide services to families.

2. **Staffing Requirements** (outside of the required provider qualifications of Medicaid), this affects what services are reimbursable and expenses not covered by the Medicaid rate.
    a. Staffing qualifications less than Medicaid State Plan: For several EBP's, such as Family Centered Treatment (FCT) and Multisystemic Therapy (MST), the practice requires services to be provided by a "bachelor degreed professional" or, in some cases, a "paraprofessional". However, under Nebraska's current Medicaid

State Plan, a master's level clinician must provide or supervise the service in order for it to be reimbursed by Medicaid. This is true even if the evidence-based intervention does not require this level of education to provide the service[21].As a result, service capacity is severely limited due to a lack of qualified providers.

b. Staffing qualifications exceed Medicaid State Plan: Medicaid requires a master's degree or licensed clinician for most community behavioral health services. The rate supports an annual salary for the clinician of approximately $40K. However, once a clinician is trained in an evidence-based practice, to be competitive, they should be making a significantly higher salary. Unless the rate for Medicaid is increased for EBPs, costs will likely have to shift to other funding sources, or may result in higher turnover, which affects EBP fidelity.

3. **Training and Supervision Requirements** (beyond traditional therapy approaches)
    a. Training costs: These are hard costs of the training (paid to the EBP developer).
    b. Trainee time in training: This is the time that therapists must spend in training for the EBP that may not be covered under the current Medicaid rate structure.
    c. Additional supervision requirements: Under normal accreditation standards and Medicaid requirements, master's level clinicians receive monthly 1:1 supervision and monthly group supervision. Several of the EBP's require weekly supervision.
    d. Requirements for on-site Train the trainers and or Site Credentialing: Some EBP's require (or strongly encourage) sites to develop their own train the trainer capacity and/or be credentialed as a provider "site". These are additional costs not covered under the current Medicaid rate structure.
4. **Fidelity Monitoring Requirements**
    a. Case consultations: This is the time that practitioners must spend in case reviews and consultation in pursuit of their credentials with the EBP, including review of video-taped sessions and reflective supervision with an EBP trainer, to assess treatment fidelity.
    b. On Site Reviews: These are reviews of a provider site to assess organizational compliance and treatment fidelity. This requires practitioner and management preparation and participation in reviews that are not covered by the current Medicaid rate structure.
    c. Board certification review: Practitioner application or presentation to board for final approval of certification.

[21] Please refer to Section 4.D. of the Practice Model Supporting Documentation, "*Medicaid State Plan Amendments Should Be Considered to Reduce Barriers and/or Cover Additional Services as Part of a New Child Welfare System*" for additional information and specific examples where other states have relaxed such requirements.

d. Data collection and submission: Several EBPs require the submission of data for ongoing evaluation of outcomes and treatment efficacy. This is also required for treatment fidelity monitoring.

As a result, it is important that, in planning to expand access to prevention services funded through FFPSA, CFS' approach to cost allocation planning and revenue maximization considers the following:

- Evidence-based practice requirements, including staffing, service delivery, training and supervision and fidelity monitoring responsibilities to support model fidelity,
- Funder requirements including client eligibility, provider eligibility, and service reimbursement coverage and limitations, and
- Identification of opportunities to blend and braid funding sources. This will involve close intra-agency collaboration with the Division of Medicaid and Long Term Care.

It is recommended CFS collaborate with the Division of Medicaid and Long Term Care, as well as Medicaid Managed Care Organizations and providers to convene a statewide work group capable of analyzing each evidence-based practice to be implemented, identify the components of the service, which is billable to Medicaid, and develop strategies for maximizing the Medicaid reimbursement for eligible services components. An example of an approach taken by the State of Florida for Nurse Family Partnership is provided, below, and an example of an In-Lieu-of Service (ILOS) recommendation for Functional Family Therapy (FFT) developed by Florida's FFPSA Blended and Braided Funding Work Group, made up of state child welfare and Medicaid staff, provides, and managed care organization representatives, is included as an attachment to this document.

In addition, it is recommended the Medicaid State Plan be revised and, where possible, education requirements be relaxed for service professionals in order to maximize workforce capacity and service accessibility for evidence-based services such as FCT and MST.

Finally, the Work Group also recommends DHHS look to invest in developing provider capacity to provide evidence-based practices across the state. As it is difficult for providers to recoup the cost of recruiting, training, and credentialling staff to provide evidence-based services with fidelity to the individual model, DHHS must seek to work with contracted providers to develop the staff capabilities required to provide prevention services to families, especially in remote, rural areas of the state.

Together, these recommendations will not only serve to increase program capacity, but serve to support sustainability through the improved ability to recruit and retain highly qualified staff capable of implementing EBPs with fidelity.

NFP® COSTS:	Salary	FTE	Wages	Benefits/ Taxes	Operating*	Indirect	Total
Medical Director	$ 300,000	0.01	$ 1,500	$ 405	$ 286	$ 219	$ 2,410
Licensed Clinical Nurse Manager	$ 100,000	0.13	$ 12,500	$ 3,375	$ 2,381	$ 1,826	$ 20,082
NFP® Registered Nurse: BSN or MSN)	**$ 80,000**	**1.00**	**$ 80,000**	**$ 21,600**	**$ 15,240**	**$ 11,684**	**$ 128,524**
Intake/referral coordinator	$ 40,000	0.10	$ 4,000	$ 1,080	$ 762	$ 584	$ 6,426
Admin/Data Entry Clerk (data collection req.)*	$ 36,000	0.13	$ 4,500	$ 1,215	$ 857	$ 657	$ 7,229
QA/Compliance	$ 46,000	0.10	$ 4,600	$ 1,242	$ 876	$ 672	$ 7,390
*Reuires position to fulfill data collection and reporting requirements (1 per 8 RNs)							**$ 172,062**

UNIT COST ESTIMATE	Hours	
Direct Service Hours (per Direct Service FTE)	1640	
Total Direct service Hours (per Program)	1640	
UNIT COST (DIRECT SERVICE HOUR)	**$ 104.92**	Cost divided by direct service FTE hours (bolded positions only)
UNIT COST (PER FCU SESSION)	**$ 372.43**	Cost / # sessions (including Everyday Parenting)

Medicaid Service (Code) Rate	Rate
Targeted Case Management T1017	$ 48.00
Family Training/Counseling	$ 64.00

Caseload assumption	21	Caseload per direct service FTE (ave caseload * unitlization rate)
Utlization rate:	85%	Based on caseload turnover expectations
Ave caseload:	25	Mid Point of model EBP (unique clients)
Episode of care	33	Mid Point of model EBP (months)
Sessions	22	Mid Point of model EBP (Sessions)
Session Duration:	75	Mid Point of model EBP (Minutes)
Families served/year	21	Total served
Estimated cost per family	$ 8,193	Per family per episode of care

DIRECT CARE ACTIVITY (HOURS)	DIRECT SERVICE HOURS	TOTAL	MEDICAID	NON-MEDICAID	COMMENTS
Home Visits (NFP Curriculum)***	578	$ 60,641	$ 36,992	$ 23,649	# sessions * # families. Assumes an average of 2 sessions per month per family on caseload (session length: 60-90 min, average 75)
Additional Supervision required for fidelity	84	$ 8,813		$ 8,813	Traditional supervision monthly covered by Medicaid rate; NFP requires weekly case consultation and team supervision (2 hours/week), est. 7 additional hours per month
Care coordination/TCM	504	$ 52,877		$ 52,877	Estimated 2 hours per month per family on caseload (participation in CBC case staffings, collateral contacts, care coordination), including travel. Not TCM reimbursable: cap 20.
Community Advisory Board Participation	24	$ 2,518		$ 2,518	Estimated 1 hour to prepare for meeting and 1 hour per month to participate
Documentation (FSFN)	450	$ 47,212		$ 47,212	Estimated approx. 1.75 hours per month per family on caseload
***Difference between unit cost and rate reimb.	**1640**	**$ 172,062**	**$ 36,992**	**$ 135,070**	
			21.5%	**78.5%**	

Session Model Rate: FCU® Florida			
Costs	$ 172,062	Family Care Specialist(S), plus supervision and management of program	
Total sessions	462	# sessions * # families served	
Session Rate:	$ 372.43		
Full rate (if reimursable by one source only)	$ 372.43		
Blended rate (Medicaid eligible):			
Medicaid	$ 80.07	21.5%	
Other fund sources (4E or CSC)	$ 292.36	78.5%	
	$ 372.43	100.0%	
Blended rate (Non-Medicaid eligible):			
4E	$ 186.21	50.0%	
Other fund sources (SAMH or CSC)	$ 186.21	50.0%	
	$ 372.43	100.0%	

TRAINING/FIDELITY/CREDENTIALING	Online/On Site	Assumes 2 Train the Trainers
UNIT 1: Orientation - self study		*40 hours(nurses) and 50 hours (supervisors)*
UNIT 2: Training on practice model		*25 hours over 3.75 days in Denver (nurses); 33 hours over 4.75 days (supervisors)*
UNIT 3: Distance education and training		*10 hours (nurses)*
UNIT 3: Supervisory training/annual refersher		*20 hours over 3 days in Denver (supervisors) - annual event*
Ongoing consultation with NFP consultant		
Range (depending on modality)	$ -	*Recommendation: Cost reimbursement*

ROI Calculation		
Success rate	75%	Remain stable in home/community
Cost avoidance DCF/CBC	$ 19,000	Based on $19,000/year case mgmt, non-room and board costs
	$ 19,000	
Adjusted cost avoidance	$ 14,250	Assumes % success
Cost of intervention	$ 8,193	1 episode of care
ROI	$ 1.74	for every $1 invested
ROI Documented	$ 1.37	https://www.wsipp.wa.gov/BenefitCost?AreaSelection=BC&SearchQueries%5B0%5D.paramType=KEYWORD_ANY&SearchQueries%5B0%5D.paramJoin=AND&SearchQueries%5B0%5D.valueString=
ROI documented (by developer)	**$5.70**	for every $1 dollar invested
		https://www.nursefamilypartnership.org/wp-content/uploads/2020/08/NFP-Benefits-and-Costs.pdf

Provision of Concrete Supports

Factors related to poverty, resulting in economic and material hardships, including the inability to meet basic housing, nutrition, transportation, and medical needs are significant predictors of future child welfare involvement. Increased access to economic and concrete supports is associated with decreased risk for neglect and physical abuse. A growing body of research-based evidence has demonstrated that alleviating economic insecurity and providing resources parents need to thrive has a strong positive correlation preventing child maltreatment, involvement with the child welfare system, and placement in out-of-home care.

Recommendation

> *Fund the provision of concrete supports to families experiencing material hardships to lessen the impact of poverty and other financial stressors which ultimately lead to their involvement with child*

For instance, a study published in 2021[22] found that States' total annual spending on local, state, and federal benefit programs per person living below federal poverty limit, which included the sum of (1) cash, housing, and in-kind assistance, (2) housing infrastructure, (3) childcare assistance, (4) refundable Earned Income Tax Credit (EITC), and (5) Medical Assistance

[22] Puls HT, Hall M, Anderst JD, Gurley T, Perrin J, Chung PJ. State Spending on Public Benefit Programs and Child Maltreatment. Pediatrics. 2021 Nov;148(5):e2021050685. doi: 10.1542/peds.2021-050685. Epub 2021 Oct 18. PMID: 34663680.

Programs, was inversely associated with all maltreatment outcomes. For each additional $1000 states spent on benefit programs per person living in poverty, there was an associated -4.3% difference in reporting. 4.0% difference in substantiations, -2.1% difference in foster care placements, and -7.7% difference in fatalities. In 2017, extrapolating $1000 of additional spending for each person living in poverty ($46.5 billion nationally, or 13.3% increase) could have resulted in 181,850 fewer reports, 28,575 fewer substantiations, 4,168 fewer foster care placements, and 130 fewer fatalities. In Kentucky, a statewide investment in prevention services totaling $9.6 million over a three-year period (SFY'19 through SFY'21) resulted in decreased out-of-home care expenditures of $58.1 million annually; a 6:1 return on the state's investment. In 2022, Kentucky's state budget includes $1,000 in flexible funds for families participating in Kentucky's family preservation program to meet concrete needs and prevent removal.

Rather than to continue citing additional research and outcomes, we recommend reviewing the following, linked document developed by Chapin Hall at the University of Chicago. The document provides a comprehensive summary of national research demonstrating the impact of providing economic and concrete supports to families: https://www.chapinhall.org/wp-content/uploads/ECS-and-FFPSA-BriefFINAL-4.13.23.pdf

Evidence related to the impact of providing of such supports is strongly supported by the inclusion of multiple evidence-based programs on the title IV-E Clearinghouse which include the provision of, or referral to, concrete and economic supports to families[23]. Further, the tie between poverty and child welfare has been reinforced in multiple states, including Texas, Kentucky, Washington, Vermont, and Montana, where recent policy changes preventing or limiting the ability to remove children for solely poverty-related factors have been implemented.

As part of an expanded prevention strategy, CFS should implement prevention programs through FFPSA and leverage available funds, such as the TANF surplus, to ensure families do not become involved with child welfare services solely due to poverty-related or economic factors. Investment in the provision of these resources will serve to ultimately play a significant role in reducing child welfare expenditures in the state.

[23] Ryan, J. P., & Schuerman, J. R. (2004). Matching family problems with specific family preservation services: A study of service effectiveness. Children & Youth Services Review, 26(4), 347–372.

INVESTMENT OF TANF SURPLUS

The Temporary Assistance for Needy Families (TANF) block grant is the primary source of funding for states to provide basic cash assistance for families with children when they face a crisis or have very low incomes. The program was established with the statutory purpose of increasing state flexibility in meeting four goals:

1. To provide assistance to needy families with children so that they can live in their own home or the homes of relatives;
2. To end the dependency of needy parents on government benefits through work, job preparation, and marriage;
3. To reduce the incidence of out-of-wedlock pregnancies; and
4. To promote the formation and maintenance of two-parent families. States may use TANF funds in any manner "reasonably calculated" to achieve any of these goals.

Recommendation

> *Leverage existing TANF surplus funds to fund the implementation of innovative services to promote primary, secondary, and tertiary prevention services to at risk families and children.*

An updated study published by the Center on Budget and Policy Priorities found states only spend a little more than one-fifth of their combined federal and state TANF dollars on basic assistance for families with children. States continue to use their considerable flexibility under TANF to divert funds *away from* directly supporting families and toward other, often unrelated, state budget areas. Cash assistance to families struggling to make ends meet by way of short-term concrete supports can improve children's long-term outcomes while also providing parents with the assistance they need to remove barriers and move to self-sufficiency. In doing so, states could also promote racial equity and child well-being[24].

[24] Azevedo-McCafferty, D., Safaw, A., To Promote Equity, States Should Invest More TANF Dollars in Basic Assistance, Retrieved from https://www.cbpp.org/research/income-security/to-promote-equity-states-should-invest-more-tanf-dollars-in-basic#ftn1 July 13, 2023.

As described in the LB 1173 Practice Model report, the vast majority of reports to Nebraska's Child Abuse and Neglect Hotline come are generated through the education system. Though a significant number of these reports are subsequently screened out, these families frequently present risk factors, which may be effectively addressed through an enhanced system of primary and secondary prevention services. The Work Group recommends CFS partner with the Nebraska Department of Education (NDE) to expand services to families demonstrating risk factors for abuse and neglect across the state to provide an access point to prevention services. This pathway could be, in part, funded through FFPSA as many of these families would potentially meet an expanded definition for eligibility under the program. As part of the prevention funding strategy, funding provided by public agencies other than CFS should be reviewed to determine whether it is able to be certified as matching funds to draw down title IV-E FFP.

Recommendation

> *Enhance partnership with the Nebraska Department of Education to expand the provision of intervention and central navigation services to children and families in crisis.*

Additionally, in the LB 1173 Practice Model Report, we support implementation of the full-service community schools (FSCS) pilots, which support site coordinators in the school systems capable of providing central navigation, readily identifying the changing needs of students, and coordinating access to community resources to address those needs. As identified in our Report, these Pilot initiatives have provided very positive outcomes for children and youth in the school system.

According to NDE, costs for these services total *$125,000 per school.* FSCS are specifically effective in providing tailored wraparound services to schools with higher concentrations of poverty. If the FSCS model were implemented statewide in schools where more than 60% of students qualify for free or reduced price lunch, for example, NDE estimates the total cost would be **$18,500,000**. However, significant cost efficiencies could be achieved through partnership with local school districts and regional coordination of the most rural sites, thereby reducing the total investment needed to expand this very effective program.

The Work Group has recommended as a strategy in the Practice Model the FSCS model be expanded. Additional families could also be served by providing funding for direct early intervention services that may require major policy changes at the federal, state, and local levels. During our LB 1173 Community Forums, stakeholders identified how effective the Early Development Network (EDN) services are in terms of a family-centered, early

identification/assessment and case management service coordination function. The NDE Office of Policy and Strategic Initiatives has recommended a study to establish a reasonable case rate for EDN services and, based on the study, implement the recommendations to provider greater access to EDN services for families. The NDE has estimated that this enhancement could cost $5,000,000. This service coordination enhancement should be considered as part of the LB 1173 Practice Model implementation.

The Work Group recommends DHHS work directly with the NDE and other intersectoral agency partners to support the braiding and blending of available funding to support:

- Mental health for families, educators, and students,
- School nurses, school psychologists, social workers, and other non-academic support staff to provide services in schools,
- Full-Service Community Schools

COMMUNITY RESPONSE PREVENTION PATHWAY

Multiple states have begun to leverage FFPSA funding to create and promote Community Pathways to reach the most vulnerable population of children at risk of entering foster care. These public and private partnerships serve as a gateway to access funded prevention services outside of the traditional child welfare service paths. Within this model, private agencies perform required FFPSA administrative functions including gathering information to support eligibility determination, developing and/or maintaining child specific prevention plans, conducting on-going safety and risk assessments, tracking and transmitting service participation and other data required for federal claiming and reporting, and delivering and/or referring families to identified evidence-based, culturally appropriate prevention services. They also accept responsibility for working directly with at-risk families and children, determining the type of services needed, partnering with service providers, community services, public agencies (TANF, housing, childcare, etc.), law enforcement, legal community representatives, and Tribal partners to enhance cross-system collaboration and improve access to available resources services. The title IV-E agency maintains responsibility for verifying family and child eligibility, collecting and reporting required data to the federal government, and processing claims for federal reimbursement. The development and operation of a Community Response Prevention

Recommendation

> *Leverage existing partnerships and community provider service infrastructures to provide early intervention to families in need and build an effective Community Pathway to prevention services.*

Pathway is an eligible title IV-E administrative cost under FFPSA and reimbursable to the state at 50% federal financial participation.

The Work Group has recommended in the LB 1173 Child Welfare Practice Model the leveraging of community providers and the existing infrastructure of the Bring Up Nebraska prevention effort to establish an effective community response pathway to prevention services. DHHS and Nebraska Children and Family Foundation (NCFF) have partnered to develop a network of Community Collaboratives, which serve to keep children safe, support strong parents, and help families address life challenges before they become a crisis. The Collaboratives are well established in their communities and capable of serving as the foundation on which an expanded community can be built. As part of the initiatives, Collaboratives are embedded with several Tribes, which serves to support the provision of culturally responsive services and meet the unique needs of Tribal families.

DHHS and NCFF have partnered to successfully blend a mix of state, local and private funds to serve and support families. In 2022-2023, the Collaboratives operated on a $6.7 million budget. Of these funds, 48% ($3.25m) were private funds, 35% ($2.3m) were public funds, 8% ($539k) were private funds specifically earmarked for housing efforts, and the final 8% ($521k) came from public community schools. NCFF presently serves approximately 10,000 families and children annually through its system of Community Collaboratives at an approximate average cost of $670 per individual served.

The foundation estimates a $9.2 million investment would expand access to central navigation and support services to families with children at risk of entering out-of-home care and potentially allow the Community Collaboratives to reach an additional 30,000 children and families statewide. Efficiencies of scale associated with the expanded system will reduce the average cost per individual served to approximately $530. The following table provides a description of proposed activities and projected costs.

Activity	Description	Amount
Navigation Services	Increase capacity central navigation staffing	$2,542,713
Support Services	Housing, Utilities, Health Services, Parenting Skills, etc.	6,300,977
Technology Capacity	Expand and standardize client tracking & reporting	216,370
Training	Staff training for EBPs and culturally responsive engagement	115,000
Lived Engagement Stipends	Stipends to youth and parent peer mentors	115,000
Total		**$9,290,060**

As DHHS seeks to expand access to child abuse and prevention services through the development of a Community Response Pathway, as much as 50% of related expenditures may be eligible for federal financial participation (FFP) through title IV-E. Going forward, and as part of the Finance Model, the Work Group recommends a comprehensive assessment be completed to determine:

- Number of additional families and children to be served and the percent of families served through the Community Collaborative who would be eligible for title IV-E funded prevention services under a proposed expanded definition.
- Federal Financial Participation (FFP) available for the provision of title IV-E administrative activities (family / child assessment, case planning, service referral, case management, service referral, etc.), training costs, and the provision of approved evidence-based interventions.
- Determine whether any local funding provided by county governments or public agencies may be able to be certified as match to draw down additional title IV-E FFP.
- How to continue to leverage private investment while maximizing federal financial participation, consistent with some of the strategies outlined in this Finance Framework. To this end, innovative funding strategies and new fiscal policies may need to be developed to ensure DHHS complies with all federal requirements.

Medicaid Funded Services and 1115 Waivers

The proposed LB 1173 child welfare Practice Model recommends expanding the provision of Behavioral Health services including those for Mental Health, Substance Use Disorder, adults with serious mental illness (SMI), and children with serious emotional disturbance (SED).

In November 2018, CMS issued a "State Medicaid Directors" letter that outlines "existing and new opportunities for states to design innovative service delivery systems for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED). The letter includes a new opportunity for states to receive authority to pay for short-term residential treatment services in an institution for mental disease (IMD) for these patients" thereby integrating IMD exclusions with community-based delivery systems – a critical advance for state flexibility at that time. In order for states to receive greater flexibility in the design of their SMI/SED/SUD strategies and benefits they must agree "good quality of care in IMDs, improve connections to community-based care following stays in acute care settings, ensure a continuum of care is available to address more chronic, on-going mental health care needs of beneficiaries with SMI or SED, provide a full array of crisis stabilization services, and engage beneficiaries with SMI or SED in treatment as soon as possible."

Nebraska has the opportunity to fund the provision of innovative behavioral health services to the child welfare system through the development of Medicaid 1115 waivers and implementation of innovative Medicaid and behavioral health models.

Medicaid 1115 Waivers

State 1115 waiver designs must address: 1) earlier identification and engagement in treatment (including improved data-sharing between schools, hospitals, primary care, criminal justice, and specialized mental health providers to improve communications); 2) integration of mental health care and primary care that can help ensure that individuals with SMI or SED are identified earlier and connected with the appropriate treatment sooner; 3) improved access to services for patients across the continuum of care including crisis stabilization services and support to help transition from acute care back into their communities; 4) better care coordination and transitions to community-based care; and, 5) increased access to evidence-based services that address social risk factors including services designed to help individuals with SMI or SED maintain a job or stay in school. Waivers approved under the expanded spending authorities must be budget neutral.

Options for State Medicaid Managed Care Models for Child Welfare[25]

In 2021 Casey Family Programs and the Center for Health Care Strategies presented the learning experience "Medicaid 401: Introduction to Managed Care in Medicaid for Child Welfare". Five models of how states could address delivery system and payment models for Medicaid services addressing infants, children, youth, and families engaged with Child Welfare were presented as follows:

- **Integrated MCO:** Financing and management of physical and behavioral health care are integrated (even if BH management is subcontracted out by prime managed care contractor). Example: Tennessee
- **Behavioral Health Carve Out:** BH services are financed and managed separately from physical health care. Example: California, Pennsylvania
- **Integrated with a Partial Carve Out:** Financing and management of physical health and an "acute care" behavioral health benefits are integrated and behavioral health beyond "acute" is carved out in a separate financing and management arrangement. (Example: Michigan)
- **Population Carve Out:** Financing/management of BH is in a separate arrangement for a specific population. Example: New Jersey

[25] https://www.casey.org/media/Medicaid-401-Introduction-to-Medicaid-Managed-Care-for-Child-Welfare-PPT-1.pdf

- **Specialty Managed Care Arrangement for health and behavioral health for a specific child population.** Examples: Texas, Florida, Georgia, Kentucky, West Virginia, and Arizona for the foster care population.

Examples of Innovative Service Delivery Models funded through these strategies are included in the LB 1173 Work Group report accompanying the proposed Practice Model.

Leveraging and Expanding Access to the Regional Behavioral Health System

We have had the opportunity to meet with individuals from the Regional Behavioral Health Authorities (RBHAs) in the community and were presented with details about the value the system could bring to children and families in Nebraska. We have also met with Nebraska Division of Behavioral Health staff and reviewed detailed program and cost information. Through these interactions and review, we believe that there are untapped resources and value that the regional behavioral health system could bring in the future to many children, youth and families that are either in foster care or at risk of child welfare involvement.

- The statewide RBHAs are established by Nebraska Revised Statute 71-801-818 and are responsible for the development and coordination of adult and children's publicly funded behavioral health services within their region primarily funded by SAMHSA Block Grant funds, state, funds, local funds, private insurance, and self-pay.
- The population RBHAs serve is any child or adult with a behavioral health need who is not a Medicaid beneficiary. Financial access to services is based on state determined Income Guidelines, private insurance coverage, or self-pay.

While there is variation across the RBHAs (some direct deliver services or contract them out to private providers willing to work with them) they all deliver the Professional Partnership Program. This program is designed to assist families with a child experiencing Severe Emotional Disturbance through a fidelity Wrap Around model and is needs/strengths based.

> "Regional Behavioral Health Authority services would be more available for low income families if the department's financial guidelines were reviewed and increased to current economic conditions so more people could be served and the Cliff Effect would not hinder individuals and families seeking needed mental health services.
>
> *FOCUS GROUP PARTICIPANT COMMENT*

Expansion of the Regional Behavioral Health Authority System offers it the opportunity to be a vital partner in the future child welfare transformation for children and families struggling with Behavioral Health, Substance Abuse Disorder and Serious Emotional Disturbance issues. The delivery system for these services could be anchored in the strengths of Nebraska's Certified Community Behavioral Health Clinics/CCBHCs, Federally Qualified Health Centers/FQHCs, and the Regional Behavioral Health Authorities. The operational model would include a standardized scope of work, Evidence Based Practices, an agreed upon standardized assessment instrument that determines acuity levels and service needs, a standardized treatment planning method, and a direct relationship with or provider of fidelity Wrap Around services. Bi-directional care coordination between these entities and the Managed Care Organizations would be embedded in a Memorandum of Agreement

To support this expansion, DHHS/Medicaid should consider developing and implementing a comprehensive Behavioral Health, IMD Exclusion, Substance Use Disorder, and Serious Emotional Disturbance 1115 Waiver based on a standardized assessment of acuity levels and carved out from the existing managed care program. The covered population would include all eligible infants, children, youth, and adults who upon standardized assessment are determined to have a high level of acuity/severity/persistence. Services definitions should be evidence-based to the maximum extent possible and include mobile crisis services, inpatient, residential, day programs, outpatient, fidelity Wrap Around services, evidence-based prevention services, and Social Determinants of Health /In Lieu of Services.

In addition, Nebraska Medicaid could consider a waiver administrative platform of an Administrative Services Organization (similar to Alaska, as described in the Practice Model accompanying report). The ASO model could provide the state more direct oversight of and accountability for the behavioral health delivery system for high acuity/high cost infants, children, youth, and adults. An augmented Fee For Service rate for specified services coupled with a single provider revenue cycle (compared to multiple MCOs) could provide an incentive for more credentialed private sector providers[26] to become Medicaid providers.

Finally, Nebraska Medicaid could also consider embedding this waiver within the existing managed care contract model (similar to an approach in Kansas) thereby inheriting the existing strengths and challenges of that system. This approach would also be expedient and rely on the

[26] The Marly Doyle Behavioral Health Center of the University of Nebraska (established by LB 608) reports that there was an increase of 32% of psychiatric prescribers and 39% of psychologists and mental health therapists between 2010 and 2020. https://nebraska.edu/nuforne/marley-doyle

existing MCO capacities for care coordination of high acuity/high costs individuals which, based on community comments across the state, would have to substantially improve.

Thus, the Work Group sees significant untapped potential for the RBHA system to be a pivotal part of the future LB 1173 child welfare system transformation, and identifies the following opportunities for Nebraska to consider moving forward:

- Consider the Professional Partnerships program as the statewide HUB (or a participant HUB with the CCBHCs and FQHCs based on regional variations) for fidelity Wrap Around within the recommendation for a Medicaid BH/IMD/SUD/SED 1115 waiver. Note that currently the RBHA Professional Partnership Program serves approximately 1,000 children on an annual basis at a cost of approximately $6 million of non-Medicaid funds (SAMHSA, state funds) across the state.[27] Further note the need to establish a DHHS system-wide definition of case management services. Presently, children and youth in foster care, who could benefit from Professional Partnership services, are not eligible because CFS case workers are assumed to provide Fidelity Wrap Around services as part of their case management responsibilities. The Work Group, however, believes that this interpretation of the definition of case management may be flawed. We also note that Juvenile Justice Crossover youth are also case managed by staff and, nonetheless, are currently eligible and receiving the Professional Partnership program services.[28]
- RBHAs are well positioned in their communities/region to provide or partner with Mobile Crisis teams based on Paramedic/EMT participation such as the models we learned about in the Kearney and Omaha regions sponsored by Lutheran Family Services.
- Between FY 2019 and FY 2023, DBH provided a total of $435,435 million in SAMHSA Block Grant and state general fund dollars for RBHA services with a total of $351,591 million expended during this time period. Several RBHA directors we spoke with indicated the current state Financial Income Guidelines for RBHA services eligibility was often too high for struggling families whose income was just above current guidelines, falling within the "Cliff Effect."[29] We recommend that DHHS/DBH consider developing a method that balances currently appropriated RBHA funding with new and revised Financial Income Guidelines that are more flexible in managing over or under budget

[27] Source: DBH Spreadsheet: 8/29/23

[28] This understanding comes from several community meetings including caseworkers. We could not find any statute or rule supporting the omission of CFS "wards" of the state from the Professional Partnership program.

[29] "The cliff effect refers to the sudden and often unexpected decrease in public benefits that can occur with a small increase in earning." National Council of State Legislators: https://www.ncsl.org/human-services/introduction-to-benefits-cliffs-and-public-assistance-programs

expenditures throughout the Fiscal Year. From 2019 to 2023 $83 million unspent dollars were returned to DBH by the RBHAs. This fact alone leads us to conclude that there is enough funding in the current RBHA system to accommodate important behavioral health services, like the Professional Partnership Program for many more children, youth, and families in Nebraska that are at risk of or system involved and struggling mental illness or substance abuse. Future funding considerations must take this into account so DHHS maximizes available funding before requesting additional funding to meet these needs.

Leverage Increased Public Grant Funding for Home Visiting Services

The Consolidated Appropriations Act, 2023, Public Law 117-328, included a 5-year reauthorization of the Maternal, Infant, Early Childhood and Home Visiting (MIECHV) Program. The language included in the final bill reflected the Child Home Visiting Reauthorization Act of 2022 (H.R. 8876) and, among other stipulations, provides the first-ever funding increase for MIECHV and phases in a state-matching requirement beginning in FY24. Under these changes, federal funding will double over the duration of the five 5 years and will be required to provide a 25% match for additional federal funding.

Recommendation

> *Ensure expanded MIECHV funding is fully realized through the development and investment of matching funds.*

The new law established "base funding" under MIECHV, which will not be subject to the new state match. Nationally base funding was set at $500M in FY23. Matching funds will be available beginning in FY 2024, with increasing amounts through FY 2027. The federal government will contribute 75% of the funding and states and jurisdictions will contribute 25% in non-federal funds. Starting in FY 2025, awardees can apply for additional matching funds. These funds include any matching funds that HRSA did not distribute to awardees in the previous fiscal year, as well as any matching funds that were not used by awardees in prior fiscal years and were returned to HRSA. To apply for additional matching funds in FY 2025, should any become available, awardees must submit a statement expressing interest in receiving additional matching funds by September 6, 2023.

In Nebraska base funding for MIECHV increased by approximately $500,000, from $1.2m to $1.7 million. Matched funds available to the state are estimated to be approximately $775,000 in FFY'24, $1.12m in FFY'25, $1.7m in FFY'26, and $2.5m in FFY'27. To draw the down all available funds, the State the match requirement will total approximately $850,000 by Fiscal Year 2027. The state match is above the established maintenance of effort based on non-

federal, MIECHV-eligible spending by the MIECHV-lead agency. In Nebraska, the maintenance of effort will be $1.1 million.

As one of the three approved prevention service categories under FFPSA, home visitation is one of the primary means to reduce the likelihood of future involvement with the child welfare system. Home visitation services have been shown to have a positive impact on children, families and communities. Programs like Healthy Families America (HFA) serve to strengths parent-child relationships, promote healthy child development, and enhance family well-being. The program results in fewer low-birth-weight babies, and a reduction in the recurrent of maltreatment. Children participating in the services are less likely to have behavioral issues, or receive special education services. In addition, participating families are less likely to be homeless, are more likely to participate in education and training, demonstrate more positive mental health, and report lower levels of parental stress.

According to the National Home Visiting Center, studies have found a return on investment of $1.80 to $5.70 for every dollar spent on home visiting. This strong return on investment is consistent with established research on other types of early childhood interventions. DHHS should ensure new MIECHV funding is fully realized over the next several years. Further access to MIECHV funded services should be integrated into the state's child welfare prevention model to ensure available funds are fully leveraged and utilized with the most vulnerable populations.

Reducing the Impact of the Benefits Cliff to Support Movement to Self Sufficiency

Access to public assistance benefits is often based on the financial eligibility of the recipient or recipient's household. A "Benefits Cliff" occurs when small increases to the recipient's income result in a significant loss in benefits. In these cases, working a few more hours per week, receiving raise, or adding a second income earner, families may end up losing access to cash benefits, food assistance, Medical benefits, or childcare subsidies. As a result, families end up worse off financially and the goals of economic independence and financial stability are undermined. The threat of encountering Benefits Cliffs forces individuals receiving public assistance to make job and career decisions based on short-term financial considerations. This not only impacts the family, but also hurts businesses who experience turnover, struggle to fill vacant positions, and have difficulty retaining workers. In the aggregate, places undue burden on taxpayers, who bear the cost of the elevated need for public benefits.

While some public benefits programs are subject to strict federal eligibility requirements, others permit state governments to define eligibility. States also have the opportunity to apply for waiver programs to gain additional flexibility. Florida, Colorado, Ohio, and several New

England states have made changes to benefit programs with the explicit intention of reducing benefit cliffs facing families.

For example, Ohio's "Benefit Bridge" pilot enabled six counties' departments of Job and Family Services to test approaches to minimize the impact of benefits cliffs. It is largely based on the success of efforts in Allen County, which paired TANF Prevention, Retention, and Contingency supports with job coaching assistance and financial incentives benchmarked to employment goals for a limited number of TANF participants. In addition, in 2021, Ohio increased the initial eligibility threshold for childcare subsidies from 130 percent of the federal poverty level to 142 percent until 2023, allowing more working families to access this important benefit. The subsidy requires copayments, which allow cost-sharing between government and families who earn more while keeping program budgets at reasonable levels.

As poverty is so closely tied to child neglect, reducing the effect of the Benefits Cliff by identifying supportive transitions from public benefits to self-sufficiency can serve to provide necessary supports to families which increase economic independence through employment, promote long-term success for families and children, and improve successful outcomes for families and children. We recommend DHHS review financial eligibility criteria of public benefits programs and conduct a feasibility study to determine the potential cost-benefit ratio of changing eligibility criteria for certain public benefit programs in Nebraska.

Access to Childcare

Nebraska's childcare regulations disregards income guidelines for youth involved in the CW system and provides exceptions for families with other extenuating circumstances. Unfortunately, these exceptions do not apply to children temporarily sheltered with a relative or non-relative kinship caregivers (informal placements) because the child is not formally removed from their primary caregiver by CFS.In many cases, the inability to access subsidies the child would otherwise be eligible for if they had remained with their parents negatively impacts the relative caregiver's ability and willingness to accept responsibility to care for the child. In these instances, the only alternative is to remove the child, which results in increased CFS workloads and expenses which could otherwise be avoided. The Work Group recommends additional research be completed by DHHS to determine what statutory changes would be necessary to permit relative caregivers to access childcare subsidies based on the parent's income (or other other critiera), determine whether these changes are allowable under federal program standards, and develop a plan to implement changes which will support the ability of relatives to care for children informally placed in their care.

DEVELOPMENT OF PROVIDER WORKFORCE CAPACITY

Passage of the Family First Prevention Services Act significantly shifted the focus of child welfare systems from a lens of intervention to one of prevention. In doing so, the need and demand to access a different array of evidence-based programs was created. While using rigorously evaluated evidence-based prevention programs, doing so requires a better-trained and a more qualified workforce with specialized or advanced degrees. By 2025, the U.S. Department of Health and Human Services Health Resources and Services Administration Bureau of Health Workforce National Center for Health Workforce Analysis projects there will be shortages for psychiatrists, clinical, counseling and school psychologists, mental health and substance abuse social workers, school counselors and marriage and family therapists of more than 10,000 full time employees[30].

Given the projected workforce shortfall, recruitment and retention challenges will limit provider ability to implement and sustain the provision of these evidence-based practices and require ongoing investment in professional development as positions experience turnover.

It is recommended DHHS seek to use remaining Family First Transition Act (FFTA) funds and title IV-E training funds available through FFPSA to develop a statewide strategy and plan designed to create a qualified workforce, and retool the capacity of community providers to offer evidence-based programs.

[30] National Projections for Supply and Demand for Selected Behavioral Health Practitioners: 2013-2025, (November 2016) U.S Department of Health and Human Services Health Resources and Services Administration Bureau of Health Workforce National Center for Health Workforce Analysis, https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/behavioral-health-2013-2025.pdf

Priority Area 3: Provider Rates and Contracts

Provider Rate Setting Process and Frequency

U.S. Child Welfare systems serve millions of children with costs exceeding $26 billion annually. Rates for services, especially for out-of-home maintenance payments, vary substantially across states and over time. Despite being part of a social safety net, foster care maintenance rates have declined in real terms since 1991 in many states, not keeping pace with inflation, leading to lower real rates in 2008 compared to those in 1991[31].

Recommendation

> *Develop and execute a standard rate setting process at regular intervals designed to rebase provider payments based on the reasonable and allowable cost of service provided.*

Considering the impact of recent inflation rates and the subsequent "Great Resignation" on the ability of child welfare programs and service providers to recruit, hire, and retain qualified staff, it is likely that rates have fallen even further behind in the past two years in states, like Nebraska, not engaging in a regular rate setting process. For instance, Indiana utilizes an annual rate setting process for residential care and child placing agencies based on the actual cost of services. Between calendar years 2021 and 2022, the mean payment rate for residential foster care increased by 17% ($395.58 to $464.36 per day[32]) and then by an additional 35%, to $627.05, in 2023[33]. Similarly, child placing agency administrative payment rates increased 5.87%, from $55.02 to $58.25, between 2021 and 2022, and then again by11.48%, to $64.90, in 2023. In Wisconsin, the average administrative payment to Child Placing Agencies increased by 8.5% ($6.25) between 2021 and 2023, the average daily rate paid to residential facilitates increased by 29.5% $139.11, and the average daily rate paid to group homes increased by 29.7% ($68.73). For the sake of comparison, summaries of 2021 and 2023 Indiana Residential Treatment Rates by Licensing Category[34] are provided as attachments to this report.

Rate shortfalls affect state Child Welfare agencies' ability to recruit and retain foster parents and to implement effective programs to serve these children. Further, factors affecting

[31] Goldhaber-Fiebert JD, Babiarz KS, Garfield RL, Wulczyn F, Landsverk J, Horwitz SM. Explaining variations in state foster care maintenance rates and the implications for implementing new evidence-based programs. Child Youth Serv Rev. 2014 Apr 1;39:183-206. doi: 10.1016/j.childyouth.2013.10.002. PMID: 24659842; PMCID: PMC3960086.
[32] Indiana residential foster care rates includes payment for services such as nursing support, education, and independent living, which are outside the scope of traditional foster care maintenance.
[33] It is important to note, the increase between 2022 and 2023 was driven largely by a change in the rate setting methodology and by increases to a small number of outlier rates, both of which were pandemic driven and may be temporary/
[34] Indiana DCS rate data extracted from KidTraks/I-Rate (Indiana's rate and payment system).

sustained funding for existing services, like foster care maintenance rates, are also likely important contextual factors for implementing and sustaining the provision of evidence-based programs. As a result, it is critical that an effective process be developed to review, rebase, and establish provide rates that cover the cost of services while providing a basis for the development of system capacity across the areas of prevention, in-home services, and out-of-home care.

Nebraska providers, as well as state staff, have long discussed the need to review and revise rates across all aspects of the service continuum. Providers report being paid disparate rates for similar services by different Nebraska agencies, such as CFS or JPS, and rates that do not cover the cost of providing the contracted service. With the imminent expansion of prevention services across the state, it is imperative CFS look to ensuring all payment rates are sufficient to cover the cost of providing the service, based on the actual cost of care, and rebased on a regular interval to ensure they are keeping pace with market conditions. Further, state agencies utilizing similar providers to provide similar services to similar client bases, should collaborate to develop a joint approach to establishing rates that are equal regardless as to which agency ultimately funds the service.

CFS should implement a rate-setting period aligned with Nebraska's biennial budget cycle. Intermittent years' cost and resulting rates may be projected using collected cost data and applying a cost-of-living-adjustment (COLA) to compensate for any changing factors, which impact the cost of providing service. States, including both Indiana and Ohio, apply a COLA in their rate-setting model to compensate for the lag between the time provider expenditures were incurred and reported, and the rate for the coming year calculated. A carefully constructed rate setting model, will permit department leadership to develop and submit sufficient budget requests, which are backed by recent cost data and allow providers to be equitably compensated.

The development and implementation of rate setting methodologies are largely the responsibility of the state, as long as federal cost principles and regulations articulated in the Federal Uniform Guidance are followed. Jurisdictions across the country utilize varied models and consider a number of factors when establishing payment rates. While there is not one optimal approach that should be followed, it is recommended a committee including both state staff and providers, be convened to research existing models and jointly create a new rate setting methodology. Specific components and options used in various rate setting models reviewed[35] include:

- **Calculated Rates**: Standard statewide rates by category of service or provider specific rates by category of service.

[35] Rate setting models reviewed include Ohio, Wisconsin, Michigan, New York, Illinois, North Carolina, and Indiana,

- **Cost Report Format**: Models reviewed each used different cost report formats and cost categories. Instructions accompanying each report clearly defined how cost was to be allocated, categorized, and reported.
- **Frequency**: Many states require cost reports to be submitted annually. However, there is no federal requirement related to this standard.
- **Audit Requirement**: Most states required audited financial statements to accompany the report at the time it is submitted. Some states, like Ohio, require the report to be audited by a state-approved independent accounting firm prior to submission. Cost report instructions typically required agencies to follow OMB Uniform Guidance (Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards)when completing their report(s).
- **Staffing Ratio:** Rate setting models used in New York and Indiana capitated the number of direct child care and case management staff based on licensing standards and other criteria including type of facility, size of residential units, number of children cared for, and acuity of children in care.
- **Fringe Benefits:** States varied in the decision to capitate fringe benefits. Some had fixed caps based on a reasonable percent of wages, others apply a variable cap which changes annually based on the median fringe benefit rate (by percent) incurred by agencies operating in the state.
- **Administrative Expenditures:** States varied in the decision to capitate administrative expenditures. Some had fixed caps based on a reasonable percent of program cost, others apply a variable cap which changes annually based on the median administrative cost (as a percent of program costs) incurred by agencies operating in the state.
- **Cost of Living Adjustment (COLA):** A variety of methods are used to apply a COLA to calculated rates. Approaches used typically consider the time gap between when reported costs were incurred and established rates based on those costs were made effective.Some approaches were based solely on the inflation rate (Ohio), while others applied a mixed COLA based on the Consumer Price Index (CPI) and Employment Cost Index (ECI). Indiana also applies a Rate Year Adjustment to (typically 50% of the calculated COLA) to cost reports. This additional adjustment allows agencies to invest in expanded services and cover unanticipated increases to expenses.
- **Profit Margin:** Illinois and Indiana provide consideration to for-profit providers permitting a profit margin to be realized. The profit margin is typically added to a calculated base rate as a percent. Indiana has recently began to provide not-for-profit agencies with an Operating Margin to support standardization of the rate models applied to for-profit and not-for-profit agencies

The Work Group has identified several factors, which should be considered when developing an effective rate-setting system:

1. Costs must be reported through a consistent and easily understood process. Providers must have a solid understanding of federal / state requirements surrounding cost allowability and federal claiming for reimbursement. They should be trained to complete the cost report accurately and a method for validating the accuracy of the report established by the contracting organization. User-friendly systems tended to be "straight line" reporting structures, which also required the least training.
2. The structure of the system should ensure all benefiting services and activities receive an equitable allocation of cost.
3. Determination of cost reasonableness is incumbent on the agency establishing rates. The methodology used may integrate specific checks into the rate system to determine whether costs are in line with expected parameters (for instance, fringe benefits may be limited to a specific percentage of salary) or an external review used to validate costs. In either case, clear guidelines for these determinations must be set and maintained.
4. Limits for specific costs should be considered. While many rate-setting methodologies utilize upper-end limits to fringe benefits and administrative costs, some apply similar factors to direct-care staff ratios and other service-related factors. Caution must be used in applying these caps as factors outside the control of the provider or contracting agency may influence cost.
5. Factors related to cost adjustments must be determined. Applying a Cost of Living Adjustment is typical in most rate setting systems reviewed.
6. Decisions should be made as to how often payment rates will be recalculated and whether performance-based measures revised / renegotiated annually.
7. State agency staff and providers should jointly develop a rate setting methodology and present it to the larger provider community for comment and feedback. Clearly understanding how cost will be used to create payment rates across various levels of care will result in increased provider "trust" and stronger collaboration.

Finally, DHHS may consider establishing a forum to permit providers and other stakeholders to provide regular input to the rate setting process. Indiana, for instance, holds a public comment period and hearing annually to communicate ideas, suggestions, or other comments regarding the residential foster care (RTSP) and child placing agency (CPA) rate setting process.

The public comment period is open for a minimum of thirty (30) days prior to the hearing. The hearing is held on or about the third Friday in January at an address specified in a notice posted by the department on the department's website. Notice of the public hearing is posted on the department's website for a period of at least thirty (30) consecutive days immediately before

the scheduled hearing date. The department also sends electronic notice of the public hearing to providers currently under contract with the department. The hearing is open to the public, and the department accepts comments, suggestions, and feedback related to annual review cost-based rates set by the department.

TRIBAL CONTRACTS AND FUNDING

Tribal members participating in the LB 1173 Work Group identified several concerns regarding the level of child welfare funding available to tribes. Specifically, leaders expressed that, traditionally, tribal children in child welfare have been "funded at levels lower than non-tribal children." While funding appears to have been somewhat equalized in recent years, additional research is needed to fully develop a set of recommendations related to the provision equitable child welfare funding for Native families and children. Tribal leaders provided the following input related to the need for additional services in their communities :

- Tribal families face barriers related to poverty, housing availability, and employment. Frequently, supportive services, concrete goods, or economic supports would serve to minimize or overcome these factors. Financial resources are often not available to these families unless they are involved in the formal child welfare system.
- A prevention pathway tailored to Tribal needs should be implemented in their communities. This pathway should be staffed by culturally representative individuals who have received specific training regarding available services, interventions, and programs, how those programs work, and how to access them.
- Prevention programming should include culturally appropriate interventions selected to meet the specific needs of each tribal community.

- A statutory change to Nebraska law is required to allow families to enter into Tribal Customary Adoptions and still receive a state adoption subsidy for the family who are adopting a state ward.
- Tribes require assistance establishing title IV-E eligibility for children entering out-of-home care.
- Tribes require assistance recruiting and retaining licensed foster parents. Foster parents in tribal communities need designated support workers, respite care, and culturally specific training and support. The Nebraska Indian Child Welfare Coalition reports there are currently no tribal title IV-E eligible foster homes.
- Court and legal services are underfunded. There is a need for quality legal representation of children and families involved in the child welfare system. NICWC reports the desire to establish a legal advocacy program similar to that available in Hennepin County, Minnesota. NICWC further reported they have applied for grant funding to support a Tribal Liaison program to represent Tribes in ICWA cases when they are too far or lack the resources to be fully involved in their cases. As the program is implemented CFS should partner with NICWC to determine how additional state or title IV-E funding may be used to support program expansion and sustainability beyond the grant funding period.

Recommendation

> *Collaborate with NICWC to ensure child welfare funding to tribal entitles is equitable, tribal families children have culturally relevant access to concrete and economic supports, a tribal pathway to prevention services is developed, quality legal representation is available to families, and Title IV-E is accurately established for tribal children.*

In October 2023, Nebraska Department of Health and Human Services (DHHS) Division of Children and Family Services (CFS) with the support of the Nebraska Court Improvement Project, the Winnebago Tribe of Nebraska, the Omaha Nation, and the Ponca Tribe of Nebraska was awarded a $2.5 million grant to support efforts to reduce the number of indigenous children involved in the child welfare system.

The grant will help develop and implement a plan to strengthen best practices in Indian child welfare services to preserve families of federally recognized American Indian and Alaska Native Tribes; protect children, and ensure that children remain connected to their families, communities, and culture.The project was developed with the intent of :

- Improving compliance with the Federal and State Indian Child Welfare Act (ICWA)

- Increasing tribal capacity to meet community needs around prevention, safety, permanency, and well-being
- Enhancing relationships between state and tribal partners

The Work Group recommends DHHS leverage this unique opportunity and integrate the development of culturally-based prevention services, analysis of Tribal funding, and development of tribal foster parent capacity into the collaborative grant planning efforts.

PERFORMANCE-BASED CONTRACTING

State and local governments have paid private, voluntary agencies to provide child welfare services since the early 1800s. Until the mid-1990s, public child welfare agencies used noncompetitive, quasi-grant arrangements to purchase services from private, typically nonprofit, agencies. In 1997, the federal government passed the Adoption and Safe Families Act (ASFA), and then, implemented Federal Child and Family Service Reviews (CFSRs). Together, these federal reforms require states to achieve improved performance on child and family outcomes including child safety, timely permanence and well-being. The new federal mandates came at the same time that states were seeing escalating costs for out-of-home care driven by increases in the numbers served, the length of stay and the unit costs of care. State child welfare budgets were increasing but still not keeping up with demand. National surveys found that during the 1990s, most states increased their reliance on contracted social services to cope with new constraints on public resources .

Recommendation

> *Integrate meaningful, achievable performance-based outcome measures into provider contracts and provide financial incentives for providers able to achieve performance targets.*

As private agencies have assumed a larger role in many states, public administrators realized that private agencies needed to be held accountable for more than just delivering services. To hold private agencies more accountable, public agencies needed to give them greater decision-making authority. Contracts were then re-structured in ways that would align fiscal and programmatic goals and stimulate better results for children and families. In return for increased case-level decision-making authority, private agencies for the first time entered into performance- or risk-sharing contracts and were held accountable for specified outcomes and system improvements. Since that time, practice, policy, and fiscal considerations have set the stage for an increase in these new types of contractual relationships; these new contracts in

over half the states include performance targets and fiscal incentives or disincentives tied to performance standards .

Research findings indicate that the transition to performance-based or other risk-sharing contracts has not been without challenges for both public purchasers and their contractors. There are mixed findings in terms of the effectiveness in meeting fiscal and programmatic goals. The quality of the contracts has also been an issue. In some cases, contracts combined vague service obligations, poorly defined outcomes and performance measures, and poorly specified roles and responsibilities of public and private agency workers. The result in many initiatives was that an inexperienced purchasing agent did not attain the expected results, which in turn, placed the provider agencies at some level of financial risk due to their poor performance .In addition, private agencies lamented the fact that contracts were too often designed "in a silo" by the public agency with little understanding of what it would take for the private agencies to succeed; contract negotiations, if they happened at all, failed to engage both sides in a dialogue about how the contracts would actually be implemented and how inevitable challenges would be handled. In short, it is not only difficult to consistently attain new performance measures and client-level outcomes and manage risk; it has also not been easy to shift the "business as usual mindset" and embark on a whole new process of "partnering" to achieve shared accountability for results.

To support efforts required to implement performance based contracts, several published studies recommend similar strategies to establishing a tiered, performance based contracting environment capable of driving outcome improvements:

#1: Establish a Culture of Collaboration, Trust and Cooperation*.* In the early stages of planning for the use of performance-based contracting (PBC), it is important for leadership to model trust in collaborative partners and build upon existing frameworks for collaboration. That is, the mission-driven solution for child welfare should be a theme evident throughout the system of care, not just part of the contract negotiation approach. The establishment of a shared vision and shared commitment to common goals attenuates the inevitable challenges of partnership. The culture of collaboration should include an underlying recognition of the fact that implementing and achieving system change isn't easy and that collaboration and cooperation doesn't mean that those involved will always agree. The use of a neutral third-party facilitator may be helpful in developing a framework for partnership, a shared vision and, as discussed later, in changing the culture of contracting.

#2: Convene the Right Parties. PBC planning and negotiation should be an inclusive process, including not only executive leadership, but also the staff responsible for providing and supervising services and those charged with quality assurance/improvement. Service providers

should be involved in planning/developing PBC performance measures in order to generate adequate "buy-in" on the part of those most directly responsible for implementing the change in practices.

#3: Change the Culture of Contracting / Equalize the Power Differential. The traditional "culture of contracting" typically involves an unbalanced power structure in which the contractor delineates performance objectives/outcomes and sub-contracted providers simply "comply". With PBC, although the state-mandated performance measures are non-negotiable, the additional PBC incentive measures are negotiable (prior to implementing the contract) and ideally are developed in a collaborative manner. For equitable negotiation processes to occur, all parties must be open to coming to the table as partners, with the contractor giving up the power position while still maintaining authority. Strategies to support a more equitable balance of power and sense of "fairness" in the negotiation process include the use of a third-party facilitator and transparent /open administration procedures.[36]

#4: Engage in Active Project Management. Project management is essential even in the planning/development phase of PBC. Leadership must consider timing and assess the readiness of the collaborative partners –those involved need to recognize or accept the idea that change is needed[37]. When the timing is right, leadership should begin with a clear program design/project description so that collaborative partners are able to quickly and clearly see "the big picture" of what the group wants to achieve and how. A clear theory of change makes the case for the intended changes in the organization [38].

 # 5: Clearly Define Performance Measures / Assessment / Incentives Emphasizing Practices that Staff Directly Control. When establishing performance measures, there should be a clear connection between an individual's behavior/practices and outcomes/incentives; without this connection, the motivation for the change in practice may be lost and the effectiveness of the PBC will be compromised. Accordingly, performance measures may actually be "outcome drivers" (the practices that lead to the outcomes). Performance measures must be clearly defined in a manner that can be understood not only by those involved in the development process, but also those who will be responsible for the implementation (front-line staff). Similarly, assessment of attainment of PBC measures should be clear, defining not only what will "count" as meeting the expectation, but also the data collection methods and reporting

[36] Straus & Layton, 2002; Susskind & Cruikshank, 2006.
[37] Petersilia, 1990
[38] Rogers, Wellins, & Conner, 2002

requirements. In terms of tiered or incentive payments, everyone involved should have a basic understanding of what is incentivized and how incentives will paid.

#6: Develop and Implement a Coherent Communication Strategy. Communication is critical to keep all partners "in the know" and needs to be actively addressed across all staff levels. A comprehensive approach to communication is important during all phases of PBC, but perhaps most critical post-implementation since questions tend to arise after implementation.

 # 7: Provide Training and Technical Assistance. Training and technical assistance for the implementation of PBC needs to begin prior to the start date and continue throughout the duration of the contract period, being mindful of staff turnover. The contractor should take primary responsibility for training prior to and during the launch of PBC, with subcontractors becoming increasingly engaged/responsible for training across the duration of the contract year(s). Initial training should be designed to 1) increase understanding the intent of the PBC performance measures, 2) breakdown performance measures into specific practices, 3) address assessment and reporting requirements/issues, and 4) clarify the incentive structure, emphasizing how it builds on existing contract dollars and specifying how much subcontractors can earn through meeting performance measures. Ongoing training should be organized around PBC measures so that the relevance of the material is apparent[39].

#8: Engage in subcontractor-driven Project Management. While the contracting agency is responsible for the overall management of the PBC process, certain aspects of project management remain the responsibility of (or are best handled by) subcontractor leadership. For example, since subcontract agency leadership are closely attuned to the specific needs, abilities, and attitudes of their staff, they are in a better position to determine if incremental goal setting for meeting performance objectives is necessary or identify training required to meet PBC outcomes.

#9: Consider Data Management Issues. The consideration of data management issues is not necessarily limited to the evaluation phase (e.g., potential problems should be considered early on when determining measurement of a PBC outcome). Issues to consider include trust in the data source(s), data availability and ease of access, and potential problems with data entry and reporting schedules (e.g., accuracy, consistency, and timing) [40].

#10: Use Data to Inform and Strengthen Quality Improvement Efforts. Data collected to monitor performance measures can be used to strengthen the quality assurance and

[39] Joyce & Showers, 2002
[40] Pindus, Zielewski, McCullough, & Lee, 2008

improvement systems within the Lead Agency and service providers. PBC enhances current state/federal reporting requirements by integrating collaboratively developed, organization-specific measures. Monthly reporting tied to disbursement can encourage the timely use of performance and accountability data to proactively guide practice improvement (e.g., discussions about strategies and desired practice changes in order to meet performance expectations in the following month). Quality management (QM) processes should evaluate not only performance, but also staff understanding of the PBC design and key measures.

#11: Integrate Data Sharing into Project Management and Communication Strategies. Data sharing should not just be an isolated evaluation or QA process; it should also be integrated in project management and communication strategies. That is, leadership can share PBC data to document/communicate progress toward performance expectations, acknowledge successes, and inspire continued work towards targets that have yet to be attained. To be most effective, data should be shared in a timely manner with the right people, giving ample time to process/synthesize the information presented and to engage in meaningful discussions about progress barriers and next steps.

No Eject / No Reject Contract Clause

As the department and provider community pursue the development and implementation of performance-based contracts, implementing some iteration of a *No Eject / No Reject* contract clause may be considered. Several states, including Iowa, Texas, Colorado, and Texas have implemented similar standards for specific residential facility types or specially contracted beds. Some of these agreement include guaranteed payments whether the contracted beds are filled or not. These contract clauses serve to increase placement availability, allow children to be placed close to home, promote the continuity of treatment and services, and ensure a guaranteed revenue stream for the provider.

Complete an Enhanced Review of Placements in Tier 4 and Higher Levels of Foster Care

CFS program and financial management staff recommend implementing a process to complete an enhanced review placements of youth in Tier 4 and higher levels of care. Youth are frequently placed in these higher tier placements when options at lower levels of are not readily available, providers resist taking the child at a lower level of care, or children stay in higher levels beyond that which is programmatically necessary. CFS should establish a process to review and objectively determine whether placement at higher cost placements are programmatically necessary, in the best interest of the child, and if continued placement at these levels supports permanency efforts.

TECHNOLOGY ENHANCEMENTS TO SUPPORT MONITORING AND REPORTING OF PROVIDER OUTCOMES

Title IV-E agencies increasingly need information on the availability, effectiveness, and cost of services that reduce risk, strengthen families, and prevent the need for out-of-home placement. High quality data supports the delivery of effective, economical, and effective services, which support improved outcomes for clients.

CFS staff and leadership both indicate that, by-and-large, data and reports available through N-Focus are inaccurate and not readily able to provide meaningful data in a timely manner. As previously stated, investment should be made in a CCWIS capable of collecting and reporting program, service authorization, and expenditure data at an aggregate and client-specific level. Federal law mandates that the CCWIS maintain all federal data required to support the efficient, effective, and economical administration of the programs under Titles IV-B and IV-E of the Act. This includes data required for:

- Ongoing federal child welfare reports (AFCARS, NYTD data elements),
- Case Management (client interactions, case plans, recommended services, placement information, foster care provider licensing information, abuse and neglect reports, case plans, and placement histories),
- Title IV-E eligibility determinations (factors used to demonstrate the child would qualify for AFDC under the 1996 plan, placement licensing and background check information, and court findings),
- Authorizations of services and other expenditures that may be claimed for reimbursement under Titles IV-B and IV-E including documentation of services authorized, records that the services were delivered, payments processed, and payment status, including whether the payment will be allocated to one or more federal, state, or tribal programs for reimbursement, and the payment amount allocated. It is important to note that financial information may be maintained in a financial system exchanging data with CCWIS.
- Support of state or tribal laws, regulations, policies, practices, reporting requirements, audits, program evaluations, and reviews.

As Nebraska pursues the implementation of a modern, modular CCWIS, attention should be given to the fact that the system reporting should include the capability to capture data necessary to generate provider-specific reports, in real time. By collecting and maintaining service provider information in a CCWIS, the title IV-E agency can evaluate options and make informed decisions when creating a case plan and/or assessing systemic service needs.

Funding the Expansion of Prevention Services in Nebraska

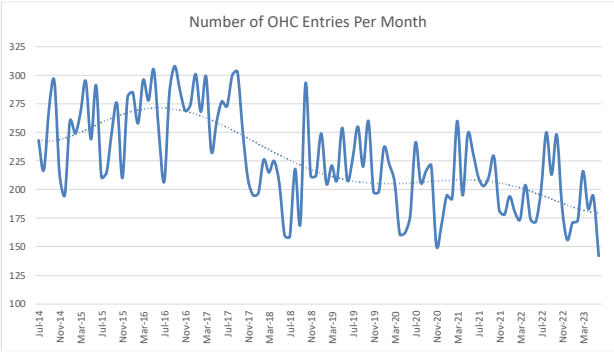
Funding for the vast majority of the recommendations included Practice Model and Financial Framework may be derived from a combination of reductions to out-of-home care and increased federal claiming under title IV-E (traditional and FFPSA), leveraging the reduction of out-of-home care expenditures, and innovative use of Medicaid Waivers. While these strategies are described above, the following provides additional information related to some of these opportunities.

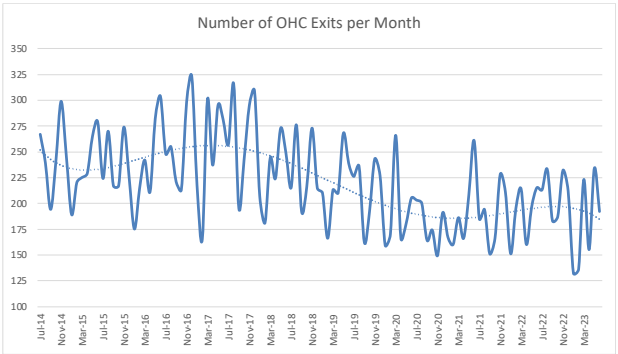
Increased Title IV-E Administrative Claiming

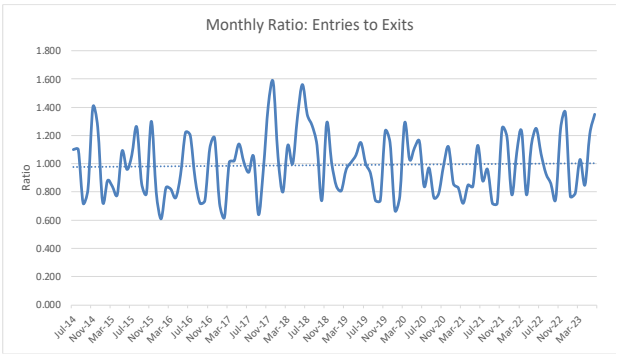
As previously described, CFS has not fully accessed available administrative title IV-E funding reimbursement for traditional candidacy services. Though a significant portion of these administrative costs are likely to shift between traditional candidacy and FFPSA candidacy under title IV-E, it is estimated the reimbursement for these administrative costs are likely to average $2,000,000 per quarter. As these expenses are largely covered by state funds, we estimate continuing these claims will lead to the availability of approximately $8,000,000 annually to invest in the provision of prevention services to children and families in the state. Additional opportunities exist related to expanded claiming for FFPSA related activities and administrative costs.

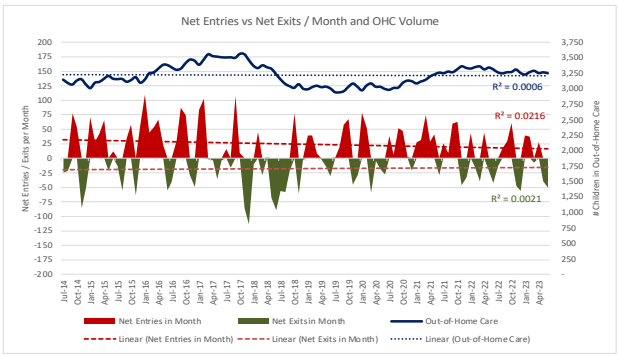
Out-of-Home Care Expenditures

As described in the LB 1173 Practice Model report, over the past ten years, the number of child removals has reduced by 25% annually. Unfortunately, because exits from out-of-home care have reduced at a similar rate, there has not been an overall reduction to the number of children served in out-of-home care during this period. The following graphs depict the net impact of the reduction of both entries and exits from foster care.









A concerted effort to move children from out-of-home care to permanency is necessary and will result in a significant reduction to state costs. The chart, below, provides an estimate of funds available for reinvestment in prevention services if there is a reduction to the number of children in out-of-home care. The estimate is based on the following assumptions:

- Total Reduction of 1,200 youth in OHC,
- Reductions are straight-lined over 60-months,
- Reductions occur from foster and relative placements,
- There will always a core set of children needing more intensive placement options,
- Based on total average claims,
- Estimated cost reduction per 20 children: $53,682,
- 20% Penetration Rate
- Estimated federal share of claimed expenses: 45%,
- Assumes no changes to penetration rate or other efforts to maximize title IV-E reimbursement for out-of-home care.

Month	OHC Reduction	# Children in OHC	Monthly OHC Cost Reduction	Cumulative OHC Cost Reduction	Estimated OHC Cost Reduction to Reinvest
12	240	2,947	$644,184	$4,187,197	$3.81m - $3.89m
24	480	2,707	$1,288,368	$16,104,602	$14.6m - $14.9m
36	720	2,467	$1,932,552	$35,752,217	$32.5m - $33.2m
48	960	2,227	$2,576,736	$63,130,040	$57.4m - $58.7m
60	1,200	1,987	$3,220,920	$98,238,072	$89.3m - $91.3m

Over the five year period, the projected reduction to out-of-home care costs should total approximately $98 million. Of this, it is estimated that approximately $90 million will be available for investment in prevention services. Should this reduction to out-of-home care be

sustained, the state will have approximately $33-$36 million dollars in funding available for ongoing investment annually.

Fully Utilize Available SAMHSA Block Grant Funding

Between FY 2019 and FY 2023, DBH provided a total of $435,435 million in SAMHSA Block Grant and state general fund dollars for Regional Behavioral Health Authorities (RBHAs) services. Of these funds, only $351,591 million was expended. Eligibility for available services appears to be limited as a result of current state Financial Income Guidelines for RBHA services. We recommend that DHHS/DBH consider developing a method that balances currently appropriated RBHA funding with new and revised Financial Income Guidelines that are more flexible in managing over or under budget expenditures throughout the Fiscal Year. Over a four-year period, 2019 to 2023, $83 million was left unspent and returned to DBH by the RBHAs.

Attachments

ATTACHMENT 1: NURSE FAMILY PARTNERSHIP BLENDED FUNDING EXAMPLE

NFP® COSTS:	Salary	FTE	Wages	Benefits/ Taxes	Operating*	Indirect	Total
Medical Director	$ 300,000	0.01	$ 1,500	$ 405	$ 286	$ 219	$ 2,410
Licensed Clinical Nurse Manager	$ 100,000	0.13	$ 12,500	$ 3,375	$ 2,381	$ 1,826	$ 20,082
NFP® Registered Nurse: BSN or MSN)	**$ 80,000**	**1.00**	**$ 80,000**	**$ 21,600**	**$ 15,240**	**$ 11,684**	**$ 128,524**
Intake/referral coordinator	$ 40,000	0.10	$ 4,000	$ 1,080	$ 762	$ 584	$ 6,426
Admin/Data Entry Clerk (data collection req.)*	$ 36,000	0.13	$ 4,500	$ 1,215	$ 857	$ 657	$ 7,229
QA/Compliance	$ 46,000	0.10	$ 4,600	$ 1,242	$ 876	$ 672	$ 7,390
*Reuires position to fulfill data collection and reporting requirements (1 per 8 RNs)							**$ 172,062**

UNIT COST ESTIMATE	Hours	
Direct Service Hours (per Direct Service FTE)	**1640**	
Total Direct service Hours (per Program)	**1640**	
UNIT COST (DIRECT SERVICE HOUR)	**$ 104.92**	Cost divided by direct service FTE hours (bolded positions only)
UNIT COST (PER FCU SESSION)	**$ 372.43**	Cost / # sessions (including Everyday Parenting)

Medicaid Service (Code) Rate	Rate
Targeted Case Management T 1017	$ 48.00
Family Training/Counseling	$ 64.00

Caseload assumption		
	21	Caseload per direct service FTE (ave caseload * unitlization rate)
Utlization rate:	**85%**	Based on caseload turnover expectations
Ave caseload:	**25**	Mid Point of model EBP (unique clients)
Episode of care	**33**	Mid Point of model EBP (months)
Sessions	**22**	Mid Point of model EBP (Sessions)
Session Duration:	**75**	Mid Point of model EBP (Minutes)
Families served/year	**21**	Total served
Estimated cost per family	**$ 8,193**	Per family per episode of care

Session Model Rate: FCU® Florida			
Costs	$ 172,062		Family Care Specialist(S), plus supervision and management of program
Total sessions	462		# sessions * # families served
Session Rate:	$ 372.43		
Full rate (if reimursable by one source only)	$ 372.43		
Blended rate (Medicaid eligible):			
Medicaid	$ 80.07	21.5%	
Other fund sources (4E or CSC)	$ 292.36	78.5%	
	$ 372.43	100.0%	
Blended rate (Non-Medicaid eligible):			
4E	$ 186.21	50.0%	
Other fund sources (SAMH or CSC)	$ 186.21	50.0%	
	$ 372.43	100.0%	

TRAINING/FIDELITY/CREDENTIALING	Online/On Site	Assumes 2 Train the Trainers
UNIT 1: Orientation - self study		*40 hours(nurses) and 50 hours (supervisors)*
UNIT 2: Training on practice model		*25 hours over 3.75 days in Denver (nurses); 33 hours over 4.75 days (supervisors)*
UNIT 3: Distance education and training		*10 hours (nurses)*
UNIT 3: Supervisory training/annual refersher		*20 hours over 3 days in Denver (supervisors) - annual event*
Ongoing consultation with NFP consultant		
Range (depending on modality)	$ -	*Recommendation: Cost reimbursement*

ROI Calculation		
Success rate	**75%**	Remain stable in home/community
Cost avoidance DCF/CBC	**$ 19,000**	Based on $19,000/year case mgmt, non-room and board costs
	$ 19,000	
Adjusted cost avoidance	**$ 14,250**	Assumes % success
Cost of intervention	**$ 8,193**	1 episode of care
ROI	**$ 1.74**	for every $1 invested
ROI Documented	**$ 1.37**	https://www.wsipp.wa.gov/BenefitCost?AreaSelection=BC&SearchQueries%5B0%5D.paramType=KEYWORD_ANY&SearchQueries%5B0%5D.paramJoin=AND&SearchQueries%5B0%5D.valueStrings=
ROI documented (by developer)	**$5.70**	for every $1 dollar invested
		https://www.nursefamilypartnership.org/wp-content/uploads/2020/08/NFP-Benefits-and-Costs.pdf

DIRECT CARE ACTIVITY (HOURS)	DIRECT SERVICE HOURS	TOTAL	MEDICAID	NON-MEDICAID	COMMENTS
Home Visits (NFP Curriculum)***	578	$ 60,641	$ 36,992	$ 23,649	# sessions * # families. Assumes an average of 2 sessions per month per family on caseload (session length: 60-90 min, average 75)
Additional Supervision required for fidelity	84	$ 8,813		$ 8,813	Traditional supervision monthly covered by Medicaid rate; NFP requires weekly case consultation and team supervision (2 hours/week), est. 7 additional hours per month
Care coordination/TCM	504	$ 52,877		$ 52,877	Estimated 2 hours per month per family on caseload (participation in CBC case staffings, collateral contacts, care coordination), including travel. Not TCM reimbursable: cap 20.
Community Advisory Board Participation	24	$ 2,518		$ 2,518	Estimated 1 hour to prepare for meeting and 1 hour per month to participate
Documentation (FSFN)	450	$ 47,212		$ 47,212	Estimated approx. 1.75 hours per month per family on caseload
****Difference between unit cost and rate reimb.*	**1640**	**$ 172,062**	**$ 36,992**	**$ 135,070**	
			21.5%	**78.5%**	

Functional Family Therapy® – In Lieu of Service

In lieu of: Inpatient or Residential Treatment

Procedure Code: TBD.Suggested option: H0400 (FACT), use a different modifier for each EBP.
Rate Recommendation: Negotiate a case rate: per diem, weekly or monthly.Per Diem minimum: $40.98 (*see rate calculation Table 1*)

Service Description: Functional Family Therapy (FFT®) is a short-term, family-focused, community-based treatment for youth who are either "at risk" for or who manifest antisocial behavioral problems such as conduct disorder, oppositional defiant disorder, and disruptive behavior disorder, violent acting-out and substance abuse disorders.Co-morbid behavioral or emotional problems, such as anxiety or depression, may also exist as well as family problems, such as communication and conflict issues.FFT has been applied to a wide range of families with at-risk, pre-adolescent and adolescent youth in various multi-ethnic, multicultural contexts.Interventions are conducted at home, in school, in outpatient settings, and at times of transition, from a residential placement.

Additional EBP requirements:

- CRISIS RESPONSE: as defined in the FFT® model
- EPISODE OF CARE: Duration of treatment is an average of 4 months with an expected range of 3 to 5 months
- CASELOAD: FFT caseloads range from a minimum of 5 active families to no more than 15 active families, with the average, considering travel time, collaterals, documentation, and assessments, of 10-12 families per therapist

Service Limits	Medical necessity applies
Service Type	Per Day
Prior Authorization	Prior Authorization is not required
Eligible Members	Members age 11 through 18 with maladaptive externalizing or internalizing behaviors.
Provider Type	Master's Level behavioral health practitioner under the supervision of a licensed behavioral health clinician.The practitioner must be an employee or contractor at an agency that has a certified FFT® team.

	Rendering practitioners must complete an initial training by an approved FFT® certified/competent trainer and then pass competency, or actively be participating in ongoing training, supervision, and coaching by competent FFT® experts to ensure fidelity.
Service Location	Member's home, provider office, or other community setting
Procedure Code	TBD or suggested option
Reimbursement and service limitations	Medicaid reimburses 1 unit per day for 365 or 366 days per state per fiscal year
Service Delivery Requirements	Provider is operating under a duly licensed/certified FFT® program in good standing and delivering care in accordance with all program and staffing requirements of FFT® Service delivery documentation requirements as defined in the Health Plan's EBP Services protocol handbook*

TABLE 1: Rate Calculation

	Salary	FTE	Salary Costs	Benefits/ Taxes	Operating Costs	Indirect	Total Costs
Medical Director	$ 300,000	0.01	$ 4,000	$ 1,080	$ 762	$ 672	$ 6,514
Clinical Director	$ 90,000	0.14	$ 12,857	$ 3,471	$ 2,449	$ 2,159	$ 20,937
Clinical Supervisor	$ 70,000	1.00	$ 70,000	$ 18,900	$ 13,335	$ 11,757	$ 113,992
Therapist	$ 55,000	4.00	$ 220,000	$ 59,400	$ 41,910	$ 36,951	$ 358,261
Intake and D/C Specialist	$ 46,000	0.29	$ 13,493	$ 3,643	$ 2,570	$ 2,266	$ 21,973
Administrative support/data analyst	$ 33,000	0.29	$ 9,680	$ 2,614	$ 1,844	$ 1,626	$ 15,763
Compliance/QA specialist	$ 46,000	0.29	$ 13,493	$ 3,643	$ 2,570	$ 2,266	$ 21,973
						COST OF 1 TEAM	**$ 559,414**

	FFT
Salary of Therapists	$ 55,000
Cost of model (1 therapist)*	$ 139,853
Traditional unit rate assumptions (41 weeks, 22 units/week)	$ 155.05
Ave Caseload (or as limited by EBP)	11
Utilization assumption	85%
Daily rate calculation (Available slot/day)	**$ 40.98**

EPISODE OF CARE	4	months
NUMBER OF CLIENTS SERVED ANNUALLY	112	
COST PER CLIENT EPISODE OF CARE	**$ 4,986**	

ASSUMPTIONS

300	Medical Director (1:____ clients)
4	Therapist to Supervisor ratio
7	Supervisor to Director ratio
150	Intake specialist (1:___ clients)
150	Admin/Data ratio (1:___ clients)
150	Compliance/QA Specailist (1: ____ clients)
11	Clients on caseload
85%	Utilization rate (ave)
27%	Benefits/Taxes (as a % of salary costs)
15%	Operating costs (occupancy, travel, training, data/comm) as a % of total personnel costs
12%	Indirect (as a % of all direct personnel and direct operating costs)

UNIT COST ASSUMPTIONS

2080	paid work hours in a year
-280	less 14 vacation, 12 holiday, 9 sick
-72	less training and professional development (6 hours/month)
-40	less lost producivity (no shows, missed appts), ave 3-4 hours/month
-24	less lost producivity (FMLA, turover, time to hire ave 2 hours per month per FTE position)
-24	less administrative agency requirements (Time and attendance, accreditation req.)
1640	Available direct service hours to client
41	Available work weeks
40	Hours per full work week
-5	Less Travel (1 hour/day)
-5	Less Documentation (1 hour/day)
-8	Less non billable activities (staffings, collateral contacts, additional assessments required by EBPs, on call, crisis de-escalation)
22	Available "billable hours" to funder

ATTACHMENT 3: INDIANA DCS RESIDENTIAL TREATMENT SERVICE PROVIDER RATES

2021 Indiana DCS Residential Treatment Services Provider Rates

TYPE OF HOME		#	DAILY RATE						
License Type	Program Service Category	Count	Min	1st Quartile	Mean	Median	3rd Quartile	Max	StDev
Group Home	Emergency Shelter	*10*	$ 215.08	$ 242.47	**$ 337.28**	**$ 276.26**	$ 400.39	$ 719.23	$ 157.28
Group Home	Open Residential	*16*	$ 217.70	$ 249.49	**$ 393.34**	**$ 312.24**	$ 586.48	$ 586.48	$ 159.57
Group Home	Open Residential plus Emergency Shelter	*7*	$ 215.08	$ 248.12	**$ 344.78**	**$ 274.61**	$ 362.79	$ 701.95	$ 175.34
Group Home	Independent Living / Residential Step Down	*1*	$ 322.11	$ 322.11	**$ 322.11**	**$ 322.11**	$ 322.11	$ 322.11	
Group Home	Sexually Maladaptive Youth	*9*	$ 319.99	$ 364.27	**$ 387.95**	**$ 364.27**	$ 416.40	$ 459.60	$ 44.51
Group Home	Teen Mom and Baby	*2*	$ 295.92	$ 298.66	**$ 301.41**	**$ 301.41**	$ 304.15	$ 306.89	$ 7.76
Group Home	Developmental and Intellectual Disabilities	*11*	$ 207.22	$ 380.32	**$ 415.07**	**$ 380.32**	$ 474.89	$ 557.41	$ 94.17
Child Caring Institution	Emergency Shelter	*21*	$ 227.75	$ 305.67	**$ 400.48**	**$ 382.51**	$ 465.35	$ 731.48	$ 122.52
Child Caring Institution	Open Residential	*7*	$ 215.05	$ 254.46	**$ 267.52**	**$ 266.00**	$ 281.84	$ 318.97	$ 32.22
Child Caring Institution	Open Residential plus Emergency Shelter	*7*	$ 227.75	$ 288.55	**$ 374.97**	**$ 328.21**	$ 359.03	$ 773.71	$ 182.33
Child Caring Institution	Independent Living / Residential Step Down	*2*	$ 213.41	$ 235.70	**$ 258.00**	**$ 258.00**	$ 280.29	$ 302.58	$ 63.05
Child Caring Institution	Staff Secure / Intensive Residential	*19*	$ 306.98	$ 349.00	**$ 403.71**	**$ 364.42**	$ 424.10	$ 584.91	$ 88.76
Child Caring Institution	Sexually Maladaptive Youth	*10*	$ 326.81	$ 347.18	**$ 379.81**	**$ 364.50**	$ 420.39	$ 446.57	$ 43.59
Child Caring Institution	Drug and Alcohol	*7*	$ 330.63	$ 333.96	**$ 367.11**	**$ 337.17**	$ 401.88	$ 430.30	$ 43.88
Child Caring Institution	Teen Mom and Baby	*3*	$ 220.07	$ 257.24	**$ 281.45**	**$ 294.40**	$ 312.14	$ 329.88	$ 56.04
Child Caring Institution	Developmental and Intellectual Disabilities	*10*	$ 391.36	$ 426.30	**$ 459.52**	**$ 477.66**	$ 477.66	$ 507.17	$ 40.89
Child Caring Institution	Short-Term Diagnostic and Evaluation	*6*	$ 241.16	$ 363.83	**$ 362.48**	**$ 379.97**	$ 396.06	$ 413.91	$ 62.59
Child Caring Institution	Stabilization and Diagnostic Services	*2*	$ 497.51	$ 564.20	**$ 630.89**	**$ 630.89**	$ 697.58	$ 764.27	$ 188.63
Private Secure	Secure Treatment	*26*	$ 312.26	$ 375.81	**$ 441.46**	**$ 416.36**	$ 487.66	$ 702.30	$ 105.97
Private Secure	Drug and Alcohol	*2*	$ 323.95	$ 347.43	**$ 370.91**	**$ 370.91**	$ 394.39	$ 417.87	$ 66.41
Private Secure	Developmental and Intellectual Disabilities	*10*	$ 421.80	$ 471.20	**$ 473.57**	**$ 471.20**	$ 471.20	$ 560.48	$ 34.35
Private Secure	Sex Trafficking	*1*	$ 525.99	$ 525.99	**$ 525.99**	**$ 525.99**	$ 525.99	$ 525.99	
Private Secure	Short-Term Diagnostic and Evaluation	*4*	$ 348.80	$ 353.61	**$ 366.32**	**$ 355.92**	$ 368.63	$ 404.66	$ 25.78
Statewide	**All Facility Types**	***193***	**$ 207.22**	**$ 319.52**	**$ 395.58**	**$ 380.32**	**$ 455.00**	**$ 773.71**	**$ 114.75**

2023 Indiana DCS Residential Treatment Services Provider Rates

TYPE OF HOME		#	DAILY RATE						
License Type	Program Service Category	Count	Min	1st Quartile	Mean	Median	3rd Quartile	Max	StDev
Group Home	Emergency Shelter	*14*	$ 237.00	$ 352.89	**$ 714.66**	**$ 572.19**	$ 814.95	$ 2,836.32	$ 648.10
Group Home	Open Residential	*18*	$ 268.43	$ 360.47	**$ 508.23**	**$ 544.63**	$ 661.82	$ 661.82	$ 150.38
Group Home	Open Residential plus Emergency Shelter	*8*	$ 237.00	$ 321.76	**$ 696.51**	**$ 396.66**	$ 490.74	$ 2,836.32	$ 872.70
Group Home	Independent Living / Residential Step Down	*2*	$ 548.62	$ 603.69	**$ 658.75**	**$ 658.75**	$ 713.82	$ 768.88	$ 155.75
Group Home	Sexually Maladaptive Youth	*5*	$ 432.40	$ 630.40	**$ 715.92**	**$ 713.51**	$ 759.81	$ 1,043.47	$ 221.88
Group Home	Teen Mom and Baby	*1*	$ 382.26	$ 382.26	**$ 382.26**	**$ 382.26**	$ 382.26	$ 382.26	
Group Home	Developmental and Intellectual Disabilities	*10*	$ 308.82	$ 537.35	**$ 583.72**	**$ 537.35**	$ 698.17	$ 722.62	$ 129.57
Child Caring Institution	Emergency Shelter	*23*	$ 307.08	$ 532.18	**$ 748.14**	**$ 637.91**	$ 792.02	$ 2,282.67	$ 463.83
Child Caring Institution	Open Residential	*8*	$ 244.94	$ 334.62	**$ 408.69**	**$ 408.48**	$ 504.61	$ 527.98	$ 106.81
Child Caring Institution	Open Residential plus Emergency Shelter	*10*	$ 341.67	$ 436.45	**$ 700.97**	**$ 612.84**	$ 652.55	$ 1,898.09	$ 452.40
Child Caring Institution	Independent Living / Residential Step Down	*2*	$ 328.16	$ 333.84	**$ 339.52**	**$ 339.52**	$ 345.20	$ 350.88	$ 16.07
Child Caring Institution	Staff Secure / Intensive Residential	*15*	$ 397.21	$ 493.39	**$ 620.16**	**$ 568.67**	$ 759.42	$ 993.33	$ 181.13
Child Caring Institution	Sexually Maladaptive Youth	*9*	$ 411.09	$ 454.54	**$ 608.92**	**$ 591.14**	$ 692.53	$ 900.49	$ 171.26
Child Caring Institution	Drug and Alcohol	*9*	$ 321.78	$ 511.96	**$ 567.40**	**$ 575.98**	$ 622.40	$ 841.91	$ 144.25
Child Caring Institution	Teen Mom and Baby	*2*	$ 331.65	$ 402.27	**$ 472.90**	**$ 472.90**	$ 543.52	$ 614.14	$ 199.75
Child Caring Institution	Developmental and Intellectual Disabilities	*11*	$ 438.30	$ 557.62	**$ 591.08**	**$ 557.62**	$ 651.55	$ 766.56	$ 91.71
Child Caring Institution	Short-Term Diagnostic and Evaluation	*8*	$ 417.93	$ 489.50	**$ 642.18**	**$ 624.39**	$ 793.95	$ 874.48	$ 181.43
Child Caring Institution	Stabilization and Diagnostic Services	*2*	$ 597.30	$ 600.64	**$ 603.98**	**$ 603.98**	$ 607.31	$ 610.65	$ 9.44
Private Secure	Secure Treatment	*29*	$ 395.88	$ 499.05	**$ 617.25**	**$ 546.27**	$ 739.65	$ 1,096.34	$ 182.85
Private Secure	Drug and Alcohol	*1*	$ 507.82	$ 507.82	**$ 507.82**	**$ 507.82**	$ 507.82	$ 507.82	
Private Secure	Developmental and Intellectual Disabilities	*11*	$ 437.00	$ 642.32	**$ 778.50**	**$ 642.32**	$ 724.91	$ 1,411.37	$ 323.78
Private Secure	Sex Trafficking	*2*	$ 820.97	$ 825.81	**$ 830.66**	**$ 830.66**	$ 835.50	$ 840.34	$ 13.70
Private Secure	Stabilization and Diagnostic Services	*1*	$ 739.65	$ 739.65	**$ 739.65**	**$ 739.65**	$ 739.65	$ 739.65	
Private Secure	Short-Term Diagnostic and Evaluation	*5*	$ 417.11	$ 426.35	**$ 533.09**	**$ 445.69**	$ 541.40	$ 834.92	$ 175.82
STATEWIDE	**ALL FACILITY TYPES**	***206***	**$ 237.00**	**$ 450.40**	**$ 627.05**	**$ 575.98**	**$ 687.27**	**$ 2,836.32**	**$ 333.81**

THE STEPHEN GROUP

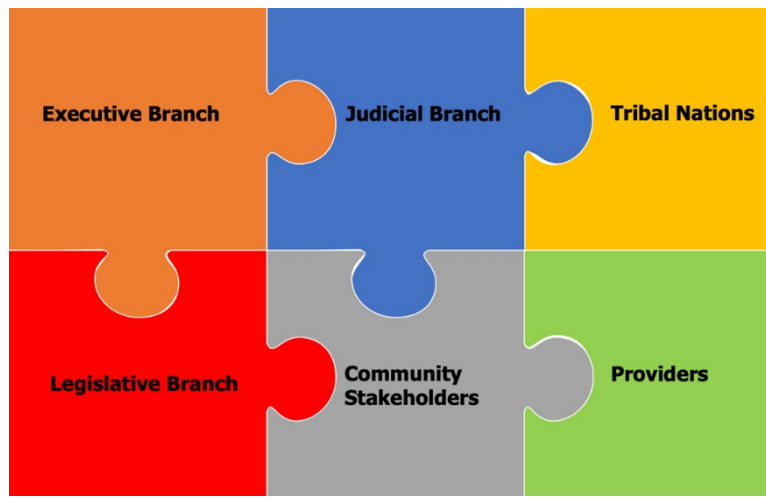
LB 1173 WORK GROUP

Strategies and Recommendations Supporting the Practice and Finance Models

Legislative Work Group Report

LB 1173 Work Group Members (2023)

- **Tony Green**, Director of Nebraska Department of Health and Human Services (DHHS), Division of Developmental Disabilities; Interim Director of DHHS, Division of Behavioral Health; and Interim Director of DHHS, Division of Children and Family Services
- **Kevin Bagley**, Director of DHHS, Division of Medicaid and Long-Term Care
- **Charity Menefee**, Director of DHHS, Division of Public Health
- **Dr Brian Maher**, Commissioner of Nebraska Department of Education
- **Corey Steele**, The State Court Administrator; and representative of the state Judicial Branch
- **Alexis Zendejas**, Omaha Tribe Representative
- **Miskoo Petite**, Winnebago Tribe Representative
- **Danielle Lepointe** Santee Sioux Tribe Representative
- **Stephanie Pospisil**, Ponca Tribe Representative



Intersectoral Engagement

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Executive Summary

The LB 1173 Work Group reports consist of the Practice Model, Finance Model and Supporting Report. These documents reflect the input gathered from multiple interviews, community forums, focus groups held across the state, intersectoral finance subcommittees, stakeholder input, surveys and builds upon previous work to improve the Nebraska child welfare system.

LB 1173 was passed so Nebraska could take a comprehensive, bottom up and strategic approach to child welfare, as opposed to crisis-driven, reactive policymaking. As such, the development of the recommended Practice and Finance Models was very inclusive. This innovative approach was important to ensure that all people involved throughout the child welfare ecosystem understood the reality and challenges that exist today across the system.

To support this effort, LB 1173 also directed the state to hire subject matter experts to assist the Strategic Leadership Group and Work Group in developing the model and supporting recommendations. In this case, The Stephen Group filled this role.

A key focus of these recommendations is to move Nebraska toward an integrated model to support child welfare. Presently, children and families regularly pass through several systems of care that often are not coordinated. This is a case where each entity is focusing on delivering the services it provides instead of focusing on the overall welfare of that child or family.

This re-designed system involves quickly identifying potentially at-risk youth, and making sure there is capacity to access the right services at the right time to keep children safe and develop future well-being. It involves strengthening relationships across court system, probation, executive branch agencies, state department of education, and community partners to support integration across agencies, as well as data collection and outcome monitoring. The Practice Model provides the following engagement strategies to support transformation:

Community Involvement	1. Transform Child Welfare System through Community-Based Prevention Services 2. Ensure Child Welfare and Related Systems and Services Reflect Communities Served 3. Strengthen the Role of Tribal Liaisons at DHHS 4. Address Disproportionality by Engaging Community-Based Organizations
Intersectoral Engagement	1. Continue the Three-Branch Collaboration into Implementation 2. Develop Partnerships with Schools to Transform the Child Welfare System 3. Develop Intersectoral Relationship with Housing and Homeless Initiatives

	4. Increase Intersectoral Training Opportunities 5. Build Authentic Collaboration with All Sectors and Stakeholders 6. Shared Accountability for Children and Families Across System 7. Expand Intersectoral Efforts for Parents with Prenatal Risk or Children 0 to 5 Years of Age 8. Coordinate Intersectoral Partners to Better Serve Transition Youth 9. Intersectoral Collaboration to Promote and Support Permanency
Integration Across Agencies	1. Implement Best Practice Strategies for Cross-over Youth 2. Align Resources Across Agencies to Best Serve At-Risk Families and Children 3. Establish Multi-Disciplinary Team-Based Approaches to Collaboratively Support Families 4. Enhance Collaboration, Communication and Partnership with County Attorneys 5. Leverage DHHS Tribal Liaisons for Intra-agency Collaboration
Data Collection and Outcome Monitoring	1. Collect Data that is Usable by Practitioners in Real Time 2. Technology Systems Should Operate within a Master Data Management Strategy 3. Implement a Comprehensive Child Welfare Information System 4. Leverage Existing Public Data to Inform Practice 5. Define Key Data and Performance Metrics Across All Systems and Use Them to Drive Innovation and Change. 6. Share Critical Medicaid Member Data with CFS.

In addition, the Finance Model provides the following strategies to expend, maximize, and leverage federally available funds to balance the disproportionate level of state funding that has historically been required to operate the system:

Enhance Title IV-E Federal Financial Participation	1. Legislatively advocate to eliminate the federal linkage between Title IV-E eligibility requirements and 1996 AFDC income standards. 2. Ensure state law and department policies align with and support efforts to maximize federal financial participation through the certification of local funds as match. 3. Reinforce efforts to improve documentation supporting Title IV-E eligibility and increase the penetration rate. 4. Increase the percentage of relative and fictive kin caregivers licensed as foster parents by continuing to implement and support strategies to streamline and expedite the licensing / approval process and incentive them to become licensed caregivers. 5. Implement strategies to incentives both caregivers and providers when relatives become licensed and integrate evidence-based Kinship Support services into child placing agencies in order to support additional federal claiming. 6. Reduce the number of children placed through LOAs or with SLPs and implement policies and procedures to ensure eligible Title IV-E maintenance and administrative costs are federally claimed for eligible children and youth who are.

	7. Implement fiscal procedures to ensure all eligible and reimbursable Title IV-E administrative costs are claimed for foster care candidates as well as for child placing agencies. 8. Invest in a modern child welfare system capable of streamlining work efforts, supporting staff, providing real-time accurate data, and informing decision making.
Cross-System Synergy and Collaboration	1. Expand the availability of high quality legal services to children and families by implementing a process to claim federal reimbursement for eligible activities. 2. Improve outcomes for crossover youth involved in both child welfare and juvenile probation services by enhancing collaboration between CFS and JPS and claiming Title IV-E for reimbursable administrative functions. 3. Maximize reimbursement for Medicaid eligible services by creating collaborative strategies and opportunities to include specific interventions as named services in the State's Medicaid Plan, blend and braid funding sources, claim interventions as an in-lieu-of (ILO) service, obtain Medicaid waivers, or access other third-party payment sources. 4. Fund the provision of concrete supports to families experiencing material hardships to lessen the impact of poverty and other financial stressors which ultimately lead to their involvement with child welfare services. 5. Leverage existing TANF surplus funds to fund the implementation of innovative services to promote primary, secondary, and tertiary prevention services to at risk families and children. 6. Enhance partnership with the Nebraska Department of Education to expand the provision of intervention and central navigation services to children and families in crisis. 7. Leverage existing partnerships and community provider service infrastructures to provide early intervention to families in need and build an effective Community Pathway to prevention services. 8. Ensure expanded MIECHV funding is fully realized through the development and investment of matching funds.
Provider Rates and Contracts	1. Develop and execute a standard rate setting process at regular intervals designed to rebase provider payments based on the reasonable and allowable cost of service provided. 2. Collaborate with NICWC to ensure child welfare funding to tribal entitles is equitable, tribal families' children have culturally relevant access to concrete and economic supports, a tribal pathway to prevention services is developed, quality legal representation is available to families, and Title IV-E is accurately established for tribal children. 3. Integrate meaningful, achievable performance-based outcome measures into provider contracts and provide financial incentives for providers able to achieve performance targets.

Finally, the following strategies and recommendations are contained in this Work Group report supporting the LB 1173 Practice and Finance Models:

Enhance Primary Prevention	I.A Develop and Support an Effective Community Pathway for At Risk Children and Families

Strategies By Creating a Community Response Pathway	I.B Establish a Warm Handoff to the Community Response Pathway for Screened Out Calls I. C Establish a Family Support Warm Line I. D Use the Community Response Pathway as Referral Source for Certain Families Seeking Economic Assistance at DHHS I.E Involve Community Response Pathway in Coordination with the Medical Provider Community as a Pathway for Parents with Pre-natal Risk or Children 0 to 5 Years of Age I.F Leverage Existing Community Collaborative Structure as the Community Response Pathway Hub I.G Shift Child Abuse Hotline Practice to Connect Reporters with Supportive Family Resources through the Community Response Pathway I.H Develop a System to Measure the Quality of Service and Work of the Community Response Pathway I.I Consider Expanding Primary Prevention Approach to Schools and Ensure Connection to Community Response Pathway I J Expand the Reach of Evidence Based Home Visiting Programs Aligned with Community Response Pathway I.K Focus on Adding Home Visiting and Parenting Classes for those Families with Children After Kindergarten I.L Expand Efforts to Educate Families about Critical Prevention Focus Statewide I.M Consider Utilizing Community Pathway as a Standalone Evidence Based Intervention Meeting Title IV-E Federal Clearinghouse Standards in Future I.N Continue Focusing on Reducing Disparities, Including Offering Services Through the Community Response Pathway That Are Tailored to Meeting Families Cultural/Linguistic Needs
More Focused Effort on Permanency	II.A DHHS Continue to Provide Alternative Response II.B More Focused and Coordinated Effort Is Needed on Enhancing Timely Exits from Foster Care, Including Sustained Engagement of Intersectoral Partners
Develop Skilled and Responsive Workforce	III.A Work Group Recommended Strategies for CFS New Worker Training III.B Work Group Recommendation for CFS Caseload III.C Work Group Recommendation for CFS Salary III. D Workgroup Recommendations for More Effective Recruitment, Selection, and Retention III.D.1 Recruitment III.D.2 Selection III.D.3 Retention
Maximize the Value of Existing Medicaid and Create Additional Opportunities and Innovation to	IV.A Medicaid Managed Care Organizations Need to Be Held Accountable in the New Child Welfare System IV.B Preventative Care Collaboration: Medicaid Managed Care Organizations Should Collaborate with Pediatricians IV.C Expand Efforts to Educate Communities About Medicaid Managed Care Organization Services to Children and Families Statewide IV.D Medicaid State Plan Amendments Should Be Considered to Reduce Barriers and/or Cover Additional Services as Part of a New Child Welfare System

Meet Gaps in Service	IV.E Consider Medicaid Provisions Where Evidence Can Be Demonstrated on Financial Budget Neutrality IV.F Consideration Should be Given for a Future Specialized Foster Care Medicaid Managed Care Organization Program as Part of Child Welfare Practice Transformation IV.G Create Solutions Where Intersectoral Partners Can Share Critical Member Data IV.H Areas of Opportunity
Enhance the Accessibility of Behavioral Health Services for Children, Youth, and Families Engaged with the Child Welfare System	V.A Consider Existing and Effective State Models for Medicaid Behavioral Health/Substance Use Disorder/Serious Emotional Disturbance Waivers in Future Child Welfare Transformation V.B Recommendations for Future Child Welfare Transformation V.B.1 Consider Aligning Behavioral Health (Mental Health and Substance Use Disorder) Services Definitions Across All Departments V.B.2 Consider Assessing all Existing State Plan Amendment and Waiver Services Definitions and Credentialing Requirements V.B.3 Consider Developing and Implementing a Comprehensive Behavioral Health, Institutions for Mental Diseases Exclusion, Substance Use Disorder, and Serious Emotional Disturbance 1115 Waiver V.B.4 Consider a Waiver Administrative Platform of an Administrative Services Organization V.B.5 Expand Opportunities for the Regional Behavioral Health Authority System to be a vital partner of the future child welfare transformation V.B.6 Consider the Professional Partnerships program as the Statewide HUB V.B.7 Consider Developing a Method that Balances Currently Appropriated Regional Behavioral Health Authority System Funding with New and Revised Financial Income Guidelines that are More Flexible
Additional Child Welfare Practice Recommendations	VI.A Increase Efforts to Address Disproportionality VI.B Continue to Expand Authentic Engagement of Those with Lived Experience VI.C Continue to Engage Tribal Nations During LB 1173 Transformation VI.D The Crossover Youth Practice Model is Effective and Aligned with the LB 1173 Child Welfare Practice Model and Should Continue To Be Implemented in every Region Statewide VI.E Consider Implementing Douglas County Youth Impact! Initiative Statewide for Cross Over Youth VI.F All child welfare system stakeholders should continue to collaborate and work on LB 42 to redefine the definition of Neglect VI.G Enhance Collaboration, Communication and Partnership with County Attorneys VI.H Concrete and Economic Supports As Part of New LB 1173 Child Welfare Transformation VI.I Enhance Family Peer Support VI.J Consider Expansion of Lancaster Family Treatment Drug Court Model VI.K Consider Improvements to the N-Focus system Functionality to Guide Future Case Worker Decision and Support VI.L Consider Changes to Drug Testing Policy that Promotes Safety and Accountability

These strategies and recommendations align with the goals set forth in LB 1173 and have the potential to bring about a substantial transformation in Nebraska's child welfare system. The Statewide Leadership Group and the Work Group are fully prepared to collaborate with the legislature, the Governor, DHHS, and all other relevant groups and agencies to facilitate the adoption of these changes. We eagerly embrace the chance to shed light on a critical aspect of our society: the safety and well-being of our children. With a renewed commitment to transforming this system, we can position Nebraska as a trailblazer on the national stage in the realm of child welfare.

We would like to thank all those who gave their time, expertise, experience, and passion to participate in the inclusive process culminating in these reports.

Purpose and Scope

During the 107th Nebraska Legislative Session, LB 1173 was introduced in the Health and Human Services committee in response to the perceived need for a strategic, as opposed to reactive, approach to re-envisioning the child welfare system, setting forth a vision, a practice model, and a finance model to help guide the broad range of stakeholders necessary to transform child welfare. In testimony related to LB 1173 during its introduction, it was stated repeatedly that child welfare is not only under the direction of the Department of Health and Human Services, Division of Children and Family Services, but lies with the Judicial Branch, communities, Tribal Nations, public health, private child welfare providers, community-based organizations, faith-based organizations, and others.

Legislative Bill 1173 was passed in April of 2022. Its preamble lays forth the finding of the Legislature that Nebraska "in order to support the well-being, permanency, and safety of children and families in Nebraska's communities, needs to comprehensively transform its child welfare system." It states further that this transformation will require an "integrated model addressing all aspects of the system and strong partnerships among the legislative, executive, and judicial branches of government and community stakeholders."

To further this vision of an integrated model, LB 1173 established in statute a Child Welfare Strategic Leadership Group, comprised of the chairperson of the Judiciary Committee of the Legislature; the chairperson of the Health and Human Services Committee of the Legislature; the Chief Justice or the Chief Justice's designee; and the Chief Executive Officer of the Department of Health and Human Services (DHHS) or such officer's designee. In addition, the bill established a Child Welfare Practice Model Work Group (Work Group), listing, non-exclusively:

1. The DHHS Director of the Division of Behavioral Health or the director's designee
2. The DHHS Director of the Division of Children and Family Services or the director's designee
3. The DHHS Director of the Division of Developmental Disabilities or the director's designee
4. The DHHS Director of the Division of Medicaid and Long-Term Care or the director's designee
5. The DHHS Director of the Division of Public Health or the director's designee
6. The Commissioner of the Nebraska Department of Education (NDE) or the commissioner's designee
7. The State Court Administrator

8. A representative of the state Judicial Branch to be appointed by the Chief Justice; and
9. Representatives from each federally recognized Indian tribe within the State of Nebraska, appointed by each tribe's Tribal Council or Executive Committee

In undertaking their responsibilities in the bill, the Work Group was required to consult with a wide range of stakeholders, including, but not limited to, key stakeholders, judges from separate juvenile courts and judges of county courts sitting as juvenile courts, private child welfare providers, individuals with lived experience in the child welfare system, the Children's Commission, the Inspector General of Child Welfare, the Foster Care Review Office (FCRO), child advocacy centers, law enforcement, and county attorneys.

This broad and diverse array of stakeholders, under the direction of the strategic leadership group, was tasked with developing practice and finance models for the state of Nebraska child welfare system. The LB 1173 Child Welfare Practice Model (Practice Model), as outlined in statute, is to contain statewide mission and vision statements, values and practice priorities, program goals, engagement strategies, and data collection strategies. The Finance Model is to include an evaluation of the state's Title IV-E claiming practices, steps to optimize federal reimbursement for child welfare, and opportunities and financial mechanisms for providers to pilot innovative solutions to meet program goals.

Importantly, LB 1173 takes a broad definition of "child welfare system," including children *and* families receiving, or persons providing or effecting in- and out of home case management, physical and behavioral health care, youth rehabilitation and treatment center services, adoption or guardianship services, prevention services, court and probation services, and education or training services. This definition, combined with the composition of the Work Group and required consultative stakeholders, underscores the span and scope of LB 1173, implicating many more systems than solely what is provided through Children and Family Services.

Building On Prior Effort and Success

Several initiatives have taken place in Nebraska over the past several years related to child welfare and efforts to address needed reforms. In developing the elements required under LB 1173, the Strategic Leadership Group and Work Group sought to build upon these past efforts, as outlined in the methodology section of this report, leaning upon a rich pool of resources and past work. The result is a framework for practice and finance that is truly intersectoral and comprehensive, reflecting the diverse viewpoints, findings, and experiences of child welfare practitioners,

executive agency leadership, Tribal agencies and individuals, individuals with lived experience in the child welfare system, public health professionals, and national policy experts.

Methodology

Overview

To comport with the spirit of LB 1173, it was critical at the outset to facilitate engagement strategies with a number of key system stakeholders, to include, at a minimum, judges from separate juvenile courts, private child welfare providers, individuals with lived experience in the child welfare system, the Nebraska Children's Commission, the Inspector General of Nebraska Child Welfare, the FCRO, child advocacy centers, law enforcement, county attorneys, NDE, and all Nebraska DHHS divisions.

To engage these stakeholders, a plan was developed to conduct structured interviews, focus groups, and other methods of qualitative data collection for the purpose of consultation, evaluation, and input related to the design and implementation of the recommended practice and finance models. Through this engagement, the Work Group was able to understand to what extent these different system players share common values, priorities, and goals for the families and children involved or at-risk of involvement in the child welfare system.

The Stephen Group (TSG), a consulting group with extensive child welfare experience, was hired as external consultants as outlined in LB 1173. TSG assisted the LB 1173 Work Group to facilitate, coordinate, and manage an inclusive process, conduct detailed interviews, assess the current state child welfare system, review other state models, analyze available quantitative and qualitative data, provide monthly status reports to DHHS leadership, accept continuous input and direction from the Work Group and DHHS leaders, and include information obtained from the community and key stakeholders in developing any findings and recommendations related to a reimagined child welfare system of care in Nebraska.

The overall process was one of collaboration and partnership from all entities involved as Nebraska moves to practice and finance models that are truly transformative with improved outcomes for all of Nebraska's children and families involved with the child welfare system.

Research and Evaluation

In order to lay a foundation of understanding the current state of child welfare in Nebraska as well as previous work done, information requests were sent to DHHS to

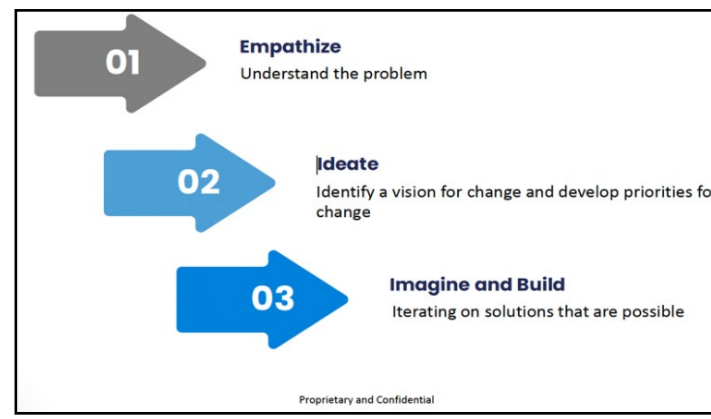
gather data, reports, state funding information, and other resources. Work was also done to assemble other necessary background information. This process included the review of numerous reports, statutes, best practice briefs, as well as other materials, along with a detailed assessment of current child welfare practices, functions, conditions, and partners.

This background work enabled the Work Group from the outset to (1) gain an understanding of the current policies and practices; (2) gather participant and stakeholder input identifying what is working, what is not working, what is missing, what can be eliminated, and what can be improved with current policy and practice; and (3) integrate the Work Group's findings to inform its recommendations.

Project Kickoff

The LB 1173 project kickoff occurred February 8, 2023, at the Salvation Army Kroc Center in Omaha, with morning, afternoon, and virtual sessions held to maximize attendance. Over 100 stakeholders participated in the sessions, representing a diverse array of backgrounds and roles within the child welfare system, including tribal members, foster parents, law enforcement, housing officials, public health officials, community representatives, county judges, individuals with lived experience, education professionals, probation officers, child welfare program providers, and CASA workers.

Design Thinking Model



During this kick-off event the background of LB 1173 was introduced, and attendees were engaged in an exercise using design thinking, a method for innovation, a human-centered framework, that guides innovators through deeply understanding problems, to collaboratively and iteratively developing ideal solutions. In several breakout sessions, attendees were directed to 1. Understand the problem, 2. Ideate on the vision for the new child welfare system, 3. Identify priority areas for system reform; and 4. Begin to build the solution framework.

Engagement

Following this kickoff meeting, the Work Group conducted community forums, interviews, listening sessions, surveys, and focus groups throughout Nebraska over 10 months with key individuals and stakeholder groups (see Appendix A for the full list of engagement sessions and surveys). All community forums around the state occurred in two sessions, typically 2-4 PM and 6-8 PM, and had a virtual option to maximize the number of community members and other stakeholders able to participate.

Engagement of state, Tribal, and local agency stakeholders was planned at the very outset of the project, with outreach to various stakeholders, including key DHHS managers from programs including child welfare, child care, public health, economic assistance, Medicaid, and behavioral health; the judiciary including the Supreme Court, the Administrative Office of Courts, the Court Improvement Project, the Juvenile Services Division, and Juvenile and County Court judges; representatives of the four Tribal Nations headquartered in Nebraska; leadership and managers from private service provider agencies; key leadership and managers from NDE; members of the Nebraska Children's Commission; Nebraska Children and Families Foundation (NCFF); leadership and staff from the Inspector General of Nebraska Child Welfare; leadership and staff from the FCRO; leadership and staff from Nebraska child advocacy centers; representatives of law enforcement agencies; county attorneys; key legislators or legislative staff; and representatives of the Office of the Governor.

In addition, a critical piece of the LB 1173 Work Group outreach strategy was to leading child welfare organizations including, the NCFF, the Anne E. Casey Foundation, Casey Family Programs. the Nebraska Urban Indian Health Coalition, Head Start and more. Several community forums were held in conjunction with the NCFF's Bring Up Nebraska effort, with Community Collaboratives co-hosting sessions in Kearney and Columbus. Engagement with these diverse entities provided the Work Group with myriad lenses through which to understand current challenges and multifaceted approaches to empowering creative child welfare system transformation.

Another key accomplishment of the community forums was the outreach to and participation from many of the state's grassroots organizations, such as the Compete Institute of Socioeconomic Policy and Education. Essential community organizations like these, often founded by those with Lived Experience, provide a unique boots-on-the-ground view of the child welfare system's impact on families. Focus groups included youth with lived experience in the child welfare system,

parents with lived experience in the child welfare system, and foster and adoptive parents.

Representation from the state's sovereign nations was also a cornerstone of the community forums and overall outreach strategy that supported the collection of meaningful experiences and insight. For example, one engagement session held on the Winnebago Reservation focused on "Community Well Being" with Tribal Leaders and the Nebraska Community Collaboratives, including Central Area Community Collaboratives. Detailed notes from Tribal participants were also taken by Michelle Parker, Community Projects Coordinator of the Ho-Chunk Community Development Corporation. As another example, the Nebraska Indian Child Welfare Coalition (NICWIC) provided the Work Group with challenges for Tribal nations in the child welfare system as well as recommendations, which have been incorporated throughout the Work Group's development of the practice model and this accompanying report. Through this engagement and the engagement of grassroots organizations, the Work Group sought to gain a full understanding of the issue of disproportionality in the child welfare system in Nebraska and glean strategies to address the causes and contributors to disproportionality in the system.

May 31 Kearney Community Forum

Connections made at the community forums almost always led to additional one-on- one meetings with key participants, offering greater illumination into general, personal and population specific child welfare experiences. For example, in several follow up meetings with Tribal Nation stakeholders, the Work Group culled vital information about the very distinct infrastructures among the sovereign nations' child welfare systems. During each forum or focus group, attendees were given an email address to submit comment or feedback following the meeting (info@stephengroupinc.com).

Collaborative Framework Development

As these engagement sessions and individual meetings occurred throughout the state, the Work Group held monthly meetings to discuss the project, learning and insights from stakeholder engagement, and to hear from experts on topics such as prevention work in communities, disproportionality in the Nebraska child welfare system, juvenile probation in Nebraska, Medicaid and behavioral health services,

and education efforts in Nebraska. The full Work Group meeting schedule, with agendas, presentation, and materials, can be found on the Reimagine Well-being Work Group website[1]. Work Group meetings and their related materials were subject to the Open Meetings Act and comported with these requirements, including required notice and the opportunity for public comment. These meetings drew the attendance of not only voting members of the Work Group, but also ex-officio non-voting members, DHHS staff, and members of the public, with the option of attending and participating virtually.

All meetings were streamed online, and meeting minutes, monthly status reports, and presentations were posted on the website created for the LB 1173 project "Re-Imagine Well-Being." Through this website, the public was able to track the progress of the project and also submit comments through a link provided on the site. Status reports prepared monthly include that month's accomplishments, highlights from the month's stakeholder interviews, focus groups, and/or forums, emerging issues/key themes, and planned activities for the next month. As community forums were held, the Work Group gathered contact information for attendees to ensure they were informed of future meetings and the progress of the work as it evolved, with an opportunity to provide input. To review all of the project's monthly status reports, see the Reimagine Well-being Work Group website.[2]

June 1st Work Group Meeting

Through providing these multiple opportunities for participation through in-person and virtual meetings, opportunities to submit comments and feedback, and a concerted effort to reach a wide range of stakeholders, the development of the LB 1173 Practice Model Vision, Mission, Values, Practice Priorities, and System Goals was a co-creation effort between the LB 1173 Work Group and stakeholders. Previous work in Nebraska was incorporated into the model's draft components and built upon with input from community outreach specific to LB 1173. Best practices research and child welfare practice models were shared with the Work Group as well. Following this background and the completion of multiple interviews, focus groups, and surveys, the Work Group discussed stakeholders' thoughts about the appropriate mission, vision, values, priorities, and goals for the State's child welfare

[1] https://dhhs.ne.gov/Pages/LB-1173-Child-and-Family-Well-Being-Working-Group.aspx
[2] Ibid

system. The Work Group and other critical stakeholders then reviewed this summary and drafted a proposed Nebraska Child Welfare Vision document with vision and mission statements, practice values and priorities, and system goals. These draft statements were then taken around the state to community forums and meetings with stakeholders to solicit feedback and adopt a final version.

Finance Sub-Work Group

In addition to the LB 1173 Work Group, a finance subgroup with focused objectives was also developed to tackle the discrete pieces of the LB 1173 Finance Model. Members of this subgroup possessed a range of areas of finance expertise, including Child and Family Services (CFS) contracts, CFS rates, Behavioral Health Finance, Medicaid Long Term Care Finance, Development Disabilities Finance, Probation Finance, Education Finance, the Governor's Budget Office, the Legislative Fiscal Office, child welfare providers, people with lived experience, Regional Behavioral Health Authorities, Child Care Association representatives, federal partners, other CFS staff, and Nebraska policy organizations. This group met regularly to develop and work on the following priorities:

- **Priority Area 1:** Title IV-E Maximization
- **Priority Area 2:** Cross-System Collaboration: Coordination of Services and claiming (blended and braided funding) across divisions
- **Priority Area 3:** Provider Rates and Contracts

As the finance subgroup discussed and developed recommendations related to these areas, their efforts encompassed requirements of LB 1173 including:

- Evaluation of Title IV-E Claiming Practices
- Steps to Optimize Federal Reimbursement
- Financial Mechanisms to Pilot Innovative Solutions

Regular progress updates were provided to the Work Group members and stakeholders attending the Work Group Meetings. During these meetings, they were offered the opportunity to ask questions, provide comments, and have discussions pertaining to key findings and each recommendation being presented. Updates on this work, including progress reports, next steps, and upcoming meeting dates were also included in monthly status reports.

Work Group Meetings & Presentations

Monthly LB 1173 Work Group meetings were an opportunity for the Work Group and stakeholders to hear from subject matter experts, ask questions, provide input,

move deliverables forward, discuss critical concepts for developing the Practice and Finance Models under LB 1173. Below is a schedule of Work Group meetings beginning in February along with agenda items and presentation titles. Full presentations from each Work Group meeting can be found on the Reimagine Well-being Work Group website.[3]

March	
Agenda Topics & Presentations	• **Role of Work Group:** "Nebraska LB 1173 Reimagining Child and Family Well-Being in Nebraska" presentation, The Stephen Group • **Child Welfare Practice Model:** "Child Welfare Practice and Finance Models – State Examples"; presentation by The Stephen Group • **Work Group Meeting Calendar** • **Report Framework/Highlights of LB 1173 Kickoff/Report/Discussion** • **Finance Framework and Approach**, Andrew Keck, Deputy Director of Finance, DHHS, and David DeStefano, The Stephen Group
April	

Agenda Topics & Presentations	• **Practice Strategy Presentations**
	  ○ Collective Engagement: "*Collective Engagement*" presentation, CEO Smith, DHHS; "Prevention"
	  ○ Prevention: "*Community Well Being Collaboratives*" presentation, Jennifer Skala, Executive Vice President Nebraska Children and Families Foundation
	  ○ Family First Prevention Services Act: "*FFPSA Implementation in Nebraska*" presentation, Jamie Kramer, DHHS Children and Family Services Administrator
	  ○ Public Health: Presentation by Charity Menefee, DHHS Director of Public Health
	  ○ Best Practices: "*Community Pathways and Innovations*" presentation, The Stephen Group
	• **Work Group Discussion of Practice Strategies**
	• **Finance Update**, David DeStefano, The Stephen Group
	• **Mission, Vision, Values, Priorities:** draft based on stakeholder meetings, findings from previous and ongoing work on the child welfare system in Nebraska, The Stephen Group

May	

Agenda Topics & Presentations	• **Practice Strategy Presentations**
	  ○ "Children and Family Services: Case Management Work Flow" presentation, Suzanna Borowski, Protection & Safety Administrator, Children and Family Services, DHHS
	  ○ "Nebraska Juvenile Justice System Map" presentation by Kari Rumbaugh, Assistant Deputy Administrator for Juvenile Services, Administrative Office of the Courts & Probation

[3] https://dhhs.ne.gov/Pages/LB-1173-Child-and-Family-Well-Being-Working-Group.aspx

	• **Disproportionality**
	  ○ "Safe, Strong, Supportive: A journey through Nebraska child protection system" presentation, Steve Ellis, Data Advocacy Analyst, Casey Family Programs
	  ○ "Disproportionality in Nebraska Child Welfare: The Community Speaks" presentation, Sharon R. Williams, The Stephen Group
	• **Finance Work Group Updates**, David DeStefano, The Stephen Group

June	
Agenda Topics & Presentation	• **Finance Update**, David DeStefano, The Stephen Group • **Themes**, John Stephen, The Stephen Group • **Case Study, Behavioral Health Best Practices**, Richard Kellogg, The Stephen Group • **Future State of Data**, Greg Brockmeier, CFS Deputy Director Analytics, Planning and Evaluation, Children and Family Services, DHHS
July	

Agenda Topics & Presentations	• **Emerging Themes**, John Stephen, The Stephen Group
	• **Medicaid**
	  ○ Overview, Director Kevin Bagley, Director, Medicaid & Long-term Care, DHHS
	  ○ MCO Presentation, Heath Phillips, CEO & Plan President, Nebraska Total Care
	  ○ Medicaid Best Practice, Lorraine Martinez, The Stephen Group
	• **Finance Update**, David DeStefano, The Stephen Group
	• **Future State Discussion**, Carisa Schweitzer Masek, Deputy Director Population Health, Medicaid, & Long-term Care, DHHS

August	
Agenda Topics & Presentations	• **Emerging Themes**, John Stephen, The Stephen Group • **Training Recommendations**, John Cooper, The Stephen Group • **Finance Update** • **Regional Behavioral Health System Overview**, Tony Green, Director of Behavioral Health, DHHS • **Professional Partners Program**, Patti Jurjevich, Regional Administrator, Region 6 Behavioral Healthcare • **Future State Front End Prevention**: "Community Pathways Prevention: Future State Prevention Model" presentation by John Stephen and David DeStefano, The Stephen Group
September	
Agenda Topics & Presentations	• **Themes from Lincoln Community Forum** • **Education as Primary Prevention**, Dr. Zainab Rida and Lane Carr, Department of Education • **LB 1173 Final Report Framework**, John Stephen, The Stephen Group
October	

Agenda Topics & Presentations	▪ **Draft Child Welfare Practice Model, Finance Model and Supporting Report**
November	
Agenda Topics & Presentations	▪ **Finalize Child Welfare Practice Model, Finance Model and Supporting Report**

Key Highlights &Themes

Over several months, the were 8 community forums held across the state, and several meetings, interviews, focus groups, and other stakeholder engagement activities, resulting in contact with well over 700 individuals across the state of Nebraska. Throughout each meeting, stakeholders offered their vision for the future transformed state of child welfare in Nebraska and shared the barriers in current state to achieving this vision. Participants in these sessions were then asked to rank vision and barrier priorities for action.

Following this process over several months, key highlights and themes emerged throughout these sessions and were taken back to the Work Group meetings each month to demonstrate what was being heard across the state and to ensure these themes were reflected in the final work products of the Work Group. **Workforce, Prevention, Cultural Competency, Family Engagement, Well-Being, Services to Children and Families, Authentic Collaboration with Community Members, and Intersectoral/Stakeholder relations** emerged as categories of themes. These themes and highlights were integral to the development of the Practice Model, Finance Model, and other recommendations.

Below are the Priority Themes the Work Group heard throughout this process.

Workforce	
+ CFS staff turnover is a challenge in many areas of Nebraska, causing case delays, gaps in knowledge about cases as it is handed from worker to worker, and creating frustration for families, both birth and foster/adoptive. + Staff shortages making it a challenge to keep up with parental inquiries about children's status after placement + Communication issues with CFS case workers in the Omaha region in returning calls to families and updating on case plan + State child welfare staff should respect and understand culture and traditional values.	+ CFS and JPO case workers would benefit from knowing expectations/culture of the courts they are working in; would benefit from their supervisors (with knowledge of the court) attending with them for mentoring and guidance as needed. + More focus needs to be paid to case worker safety in the field: cultural issue that everyone thinks CFS can solve all problems. + Offering employment incentives could help recruit/retain younger skilled professional workers. + Adapt training requirements for people with requisite experience.

Workforce	
+ CFS case workers are not given enough on the job training and case worker burnout/trauma are also issues; need support from supervisors, lack of diversity is an issue. + Trainings/provision of tools for case workers to connect families to resources would be helpful; need for more in-service training on Economic Assistance or Social Supports and on what MCOs can do/assist with. Closed loop referral resources connecting case workers to social services in the community would be a valuable resource tool. + CFS training not adequately preparing case workers to be in the field; low training relevance and application to the job. + Training on the effects of poverty across systems would be beneficial.	+ Workforce/turnover - Increase longevity, stability, decrease turnover, increase diversity of staff/better recruitment, support, professional development, training + Review current CFS training model to ensure workers are receiving quality learning + Comprehensive review of current CFS training recommended. Suggest developing caseworker Toolbox ex. Crossover Policy, "Medicaid 101/How MCOs work," "Economic Assistance 101," accessing Social Determinants of Health (SDOH), Intellectual and Developmental Disabilities and Autism fundamentals + CFS documentation requirements are labor and time-intensive, current technology worsens this issue. N-Focus often requires duplicative information and a time consuming manual process
Prevention	
+ Need for a robust community-based prevention system + Need for a prevention pathway, including a warm line, resources to refer to in the community, without threat of retaliation for parents; this will require more resources and training at local level, including proper screening and assessment tools. Hub prevention resource concept for parents but also MCOs, schools, even DCF hotline + Local prevention pathways to divert hotline calls are critical strategy, but there will need to be the development of a referral structure, additional resources, need for creativity/flexibility on funding of these services and building the infrastructure to implement them.	+ Substance Abuse, Mental Health, and Child Welfare; filing a petition should not be used as the only way to get needed services + Local prevention pathways to divert hotline calls are a critical strategy, but there will need to be the development of a referral structure, ”warm line,” additional resources, need for creativity/flexibility on funding of these services and building the infrastructure to implement them + Funding prevention services is a potential barrier: to fund prevention services, need to identify entities that can get private funding/foundation funding and use for federal match for FFPSA and other federal funds. + Community Collaboratives have built a foundation for a future enhanced prevention model.
Cultural Competency	
+ Invest in culturally appropriate/regionally equitable systems and services/need for more bilingual services, especially in rural areas of state	+ Families with limited English proficiency may not be receiving adequate services/supports. For example, courts have limitations on interpreter services,

Cultural Competency	
+ For representatives of Winnebago, Santee, and/or Omaha tribes, common views of "community well-being" includes more community events (tournaments, dances, "carnivals"), cultural-based events and programs, and culture-centered activities, education, programs, families, and communities. + "Come to the Tribes" when developing the trust needed; respect the strength of the Tribal Nations; need to build services "inside the Tribal culture" + Culture is a protective factor, but with multi-generational child welfare involvement, trauma-informed approach and more intensive case management may be needed	telehealth services are not available for families/youth with English as a second language. + Outreach to Tribal Nations needs to be better coordinated/strategic; outreach to Tribal Nations needs to be individual to the tribe, not treated like approaching other types of communities—they are sovereign nations. Each Tribal Nation needs liaison or point person but need to make sure this is coordinated throughout efforts; more attention has been paid to Tribal involvement by state agencies + Gap in standardized training on cultural competency. + Cultural/language gaps adversely impact family supports
Family Engagement	
+ Broader community support, resources, and involvement for high-risk and special ed children and biological/foster families + Peer support for families is a valuable option for families in Nebraska, but there is often a delay in having peers put in place + Parents sometimes do not know about family peer support, nor do they fully appreciate this service, until months after their child has been removed + Trauma sensitivity in all services and supports to children and families	+ Family Engagement is critical in building protective factors and in reducing the risk of removal + Parents also need to be held accountable: for truancy, child support, meeting case plan elements. + Families should be viewed as the solution + Supports should be designed and delivered with the family early to build on family strength. + Families should be kept together whenever safe to do so
Well-Being	
+ Lack of mental health and substance abuse services (especially in rural areas of Nebraska) + Enhance support for social determinants of health (housing, transportation, food…) + Poverty and lack of resources should not be grounds for removal + Address significant service/support resource access issues in rural counties + There is a need for a statewide community resource page: statewide with county and community data that is streamlined, accessible with cultural translations on food banks, housing help, transportation, etc.	+ Medicaid coverage and benefits are unknown, knowledge of resources across systems and within communities are often unknown as well, including how to access services + Medicaid Managed Care Organization care coordination benefit is often underutilized or unknown + Economic Assistance (EA) eligibility staff are important assets at the front end to help families in need but not easily accessible to CFS staff early on in the process + Need for more mobile crisis response services, especially in rural communities

Well-Being	
+ Lack of resources in rural Nebraska. "There is little in our community to tell parents where to go"	+ Substance Use Disorder (SUD) treatment initiation needs to be expedited/aligned with removal/reunification court orders + Need for greater access to SUD treatment services

Services to Children and Families
+ Access to quality childcare/early education services is an issue for many families involved in the child welfare system and should be addressed–licensing requirements and sustainability for childcare providers are cited as issues needed more statewide attention. + Need for better education in the schools about mandatory reporting – "is it necessary to always call in a report to the hotline?" Could there be an alternative that allows for a timely community response and services to meet social or behavioral health need or the need for parent education? + Multi-Disciplinary Team concept from beginning of case to end works well, especially in rural areas where resources are scarce + Resources should be accessible where parents/families are already going (school, medical centers); co-creation of resources should be considered + Parenting and child development education prior to birth; pre-natal support; care and support groups for teens/parents after birth

Authentic Collaboration with Community and Stakeholders	
+ Need to build trust/communication and collaboration with all stakeholders and partners in the community + Involve schools in system re-design + Uniform concern on DHHS enacting policies that impact entire child welfare process without real "meaningful" engagement and collaboration with courts," This theme was also heard from law enforcement and county attorneys	+ Building trust with families is a theme throughout the state. + Families are blamed if they can't engage in required services because of a lack of providers so they end up back in front of the Court. + The need for authentic engagement and ethical partnership with youth + Value lived experience + Value peer support services + Listen to families - co-creation of plans of care

Intersectoral/Stakeholder Relations	
+ Inter and Intra-agency communication and coordination is needed to best serve families and keep a clear line of sight on cases and how to assist and collaborate. + Institution of statewide training/collaboration between CFS and school districts is strongly encouraged + Define key data and performance metrics in collaboration with system partners and use them to drive innovation and change across all systems	+ More collaboration is needed between the agencies who are involved in the child welfare system. This includes legal parties, law enforcement, community stakeholders, probation, and education. More collaboration with all of Nebraska state services. Teamwork across the board; should be about the child and all involved. + Providers would like to have access to on-going system of record that can be shared across systems with proper consent

Intersectoral/Stakeholder Relations	
+ Improve relationship with providers, including fair and reasonable rate/performance-based system + Shared accountability across systems + Technology enhancements needed to support caseworkers/interagency partners/providers + Structured and routine training for school system administrators/educators and mandatory reporters on alternatives to mandatory reporting/referral options + Alignment of agency resources (e.g., Medicaid, CFS, Education, Housing, Behavior Health, Developmental Disabilities, etc.) + Improved coordination between Tribal Child and Family agencies and the institutional system to foster better coordination of Tribal children between the two systems + Enhance current training to include initiatives such as cross-over youth policy, and training on culture and expectation of the Courts, County Attorneys before starting Hearings + Where crossover youth are concerned, there is an effective crossover youth practice model in place. Need for this practice model to be followed more regularly, especially in reviewing cases involving institutional care and lengths of stay to assure least restrictive placements. Need uniformity of training and combining resources needed between juvenile probation and CFS	+ Tribes want more recognition that they are not just communities, but sovereign nations and have their own "agencies" under the law, so any intersectoral focus on LB 1173 should include the Tribal Nations as an "Agency" partner + There is a need for clear lines of responsibility between Juvenile Probation and CFS + Stronger communication and collaboration with the Early Care and Education system - Need to better promote Early Care and Early Education programs for children, including: Six Pence, Head Start, Early Head Start, Migrant Education, Healthy Family America, MIECHV programs. + Some providers agree they are paid without having to show meeting measurable performance outcomes but want to be sure that data is transparent and accurate in future if CFS develops a more performance-based system of contracting. Need to restore trust + Judges and County Attorneys open to learning more about FFPSA/Community Collaboratives/prevention work so as to become comfortable with the focus on front end diversion + High level of hotline referrals from school districts may be rooted in risk of legal reprisals for failure to report suspected abuse/neglect. Education will be needed for effective alternative response where safety is not an issue

Recommendations and Strategies for Future Transformation

One of the key objectives to LB 1173 in beginning a future transformation is the design and development of the new Practice and Finance Model, which will provide the guidance, impetus and strategic compass for the *integrated model* that will be the backbone of Nebraska's future child welfare transformation. The legislation passed envisions these models of practice as addressing all aspects of the system and strong partnerships among the three branches, Tribal Nations, and community stakeholders.

In fulfilling this objective, as demonstrated above, the LB 1173 Work Group heard from hundreds of individuals and families, including those with lived experience, organizations and community stakeholders related to how certain areas of child welfare practice needed to change to truly enhance the well-being of Nebraska's children and families. In addition, detailed presentations were provided at monthly Work Group meetings from intersectoral partners, such as the Judicial Branch, DHHS Divisions, Department of Education (NDE), and community stakeholders on areas of focus and future innovation for the new LB 1173 vision and transformation.

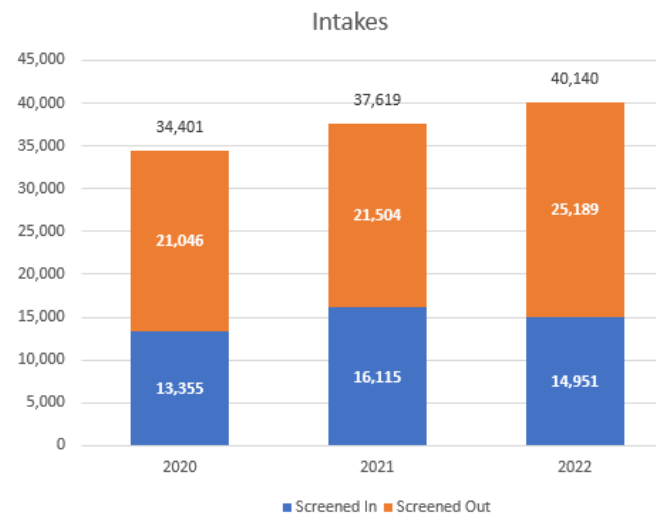
We outlined many of these thoughts and ideas into common themes that are listed above in "Key Highlights and Themes". After receiving this input and hearing the many themes that guided the development of our practice and finance models, we asked TSG to identify additional recommendations and strategies that were aligned with the implementation of the future Practice and Finance Models and could be considered in the future child welfare transformation, as envisioned in LB 1173. In the following sections, we provide these recommended strategies as follows:

1. Enhance primary prevention strategies by creating a Community Response Pathway so that more and more children at risk of entry or re-entry into the system and their families are provided services that meet their needs in the community
2. Continue efforts with alternative response, and in-home evidence-based interventions, including developing enhanced capacity for implementation of Families First Prevention Services Act, while Focusing on Increasing Exits to Permanency
3. Develop skilled and responsive workforce made up of professionals to deliver a family-centered model of practice that emphasizes child safety and well-being and accountability
4. Maximize the value of existing Medicaid and create additional opportunities and innovation to meet gaps in service
5. Enhance the Accessibility of Behavioral Health Services for Children, Youth, and Families Engaged with the Child Welfare System
6. Additional child welfare practice strategies that align with this intersectoral Child Welfare Practice Model

These strategies support the LB 1173 Practice and Finance Models and offer detailed research, best practices, and community input to help guide the beginning stages of the Nebraska Child Welfare System Transformation.

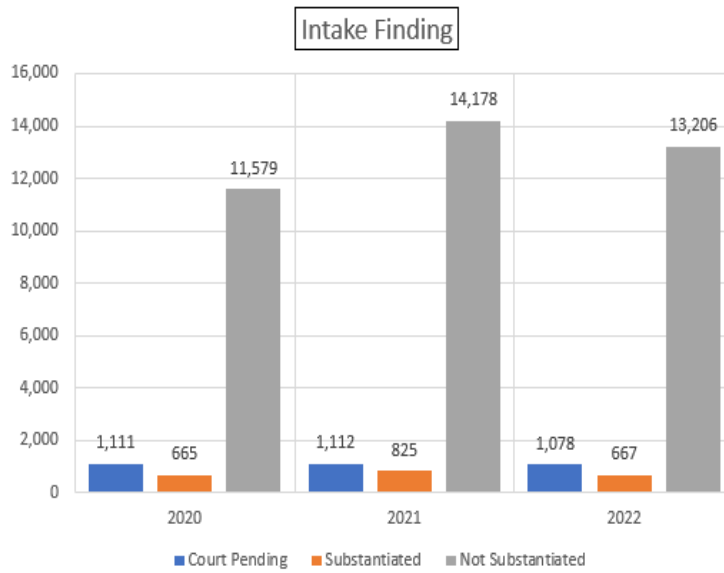
I. Enhance primary prevention strategies by creating a Community Response Pathway

Enhance primary prevention strategies by creating a Community Response Pathway so that more and more children at risk of entry or re-entry into the system and their families are provided services that meet their needs in the community. In the last three years, Nebraska has averaged over 37,000 reports to the child abuse and neglect hotline. As can be seen by the data received by DHHS,



approximately 60% of those calls are screened out, meaning there was not enough evidence to meet the criteria needed to be referred for traditional or even alternative response. During that same time period, only about 5% of the cases screened in resulted in a substantiated finding of abuse and neglect.

Although policy and practice dictate an investigatory approach to child maltreatment, the data shows that families come to the attention of the child welfare system in a wide range of circumstance, but the majority of child maltreatment in Nebraska is due to neglect, which is often related to poverty, mental illness and financial stress. Cases of actual abuse, which are most appropriately served by actions that address immediate safety concerns, such as removal*, actually represent a minority of cases in the state child welfare system* as demonstrated in the table below:



Maltreatment Types - Screened In	2020	2021	2022
Abuse Maltreatment Category	2,600	3,447	3,121
Neglect Maltreatment Category	9,084	10,991	10,334
Dependency	470	543	475
Sexual Concerns Maltreatment Category	1,214	1,620	1,334

This pattern has been consistent for years in Nebraska and has not changed. Thus, most of these reported cases that are screened out are for children and families that could benefit by support in the community in which they live. With such support, reports of abuse and neglect may also reduce where mandatory reporters recognize an effective community response to poverty, mental illness or financial stress.

Additionally, a number of children and families today suffering with these same issues are "at risk" of entering the system and may need the same level of support in the community to prevent that from occurring. An effective primary prevention system, therefore, can reduce entries into the child welfare system as well as being an effective referral pathway to a community response after a child has entered the system.

LB 1173 Prevention Vision: Enhance Protective Factors

LB 1173 Practice Model's prevention vision is aimed at promoting a collective, strength-based approach that can help increase family assets, enhance child development, and reduce the likelihood of child abuse and neglect. It is based on engaging families, programs, and communities in building key protective factors, which are characteristics that make a parent or caregiver, child, or family more likely to thrive despite whatever risk factors they might face, such as:

- **Parental resilience:** Managing stress and functioning well when faced with challenges, adversity, and trauma.
- **Social connections:** Positive relationships that provide emotional, informational, instrumental, and spiritual support.
- **Knowledge of parenting and child development:** Understanding child development and parenting strategies that support physical, cognitive, language, social and emotional development.
- **Concrete support in times of need:** Access to concrete support and services that address a family's needs and help minimize stress caused by challenges; and,
- **Social and emotional competence of children:** Family and child interactions that help children develop the ability to communicate clearly, recognize and regulate their emotions and establish and maintain relationships.

The following practices may be implemented in Nebraska to aid in enhancing primary prevention strategies and are supportive of the LB 1173 Practice Model.

Develop and Support an Effective Community Pathway for At Risk Children and Families (I.A)

In the current child welfare approach, the majority of services are provided after abuse and neglect is reported. In substantiated cases, most resources are directed toward out-of-home care, reunification, adoption, or another permanency option, rather than on "front-end" primary prevention prior to public child welfare intervention. Child welfare agencies are challenged to respond effectively to complex needs of children and families for a variety of reasons, and there is often a lack of collaboration among intersectoral partners in the primary prevention area further limiting family awareness and access to local services and resources.

Today, states are developing more integrated community pathway models for family support and prevention services to be delivered to meet the goals of the Family First Prevention Services Act (FFPSA). FFPSA allows federal Title IV-E funds to be used by states on the "front end" evidence-based interventions prior to involvement in the foster care system. These community pathways support the delivery and planning for evidence-based prevention services for a child who does not have an open case with the child welfare agency and does not require immediate child welfare intervention but meets the state's definition of candidate for foster care.

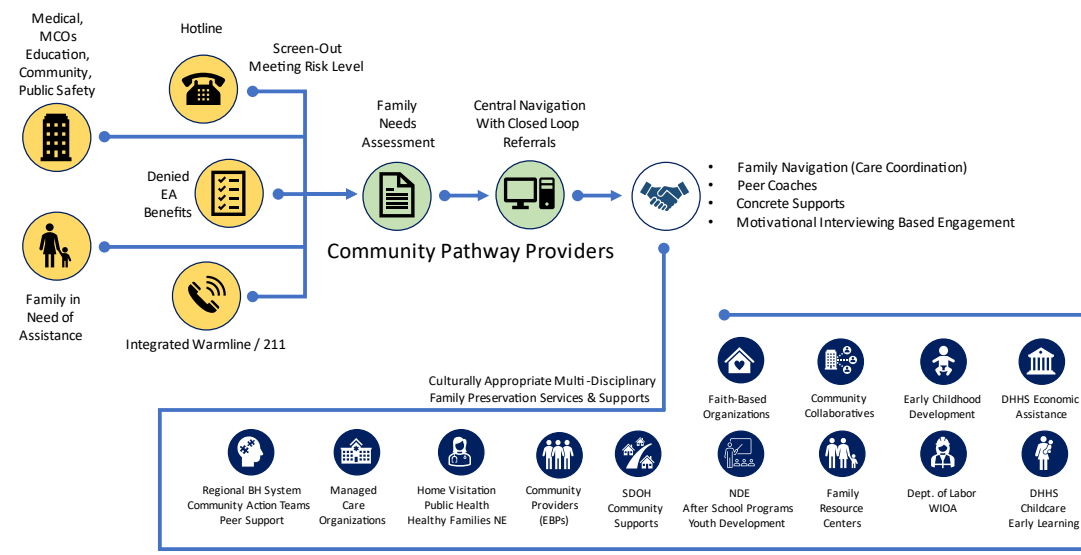
For example, in Connecticut, the child welfare agency is contracting with an outside Care Management Entity (CME) to work with families and local providers to manage service provision to families that are reported through the abuse and neglect hotline with children experiencing behaviors, conditions, or circumstances that are likely to have adverse impacts on a child's development or functioning, but do not present immediate safety concerns. In Washington D.C., families that have had substantiated abuse and neglect reports but are low or moderate risk, and families with high levels of risk but no substantiated finding are referred by the child welfare agency to one of five community collaboratives. These collaboratives provide case management using motivational interviewing to connect families to specific services based on their needs. In New York state, children who meet the criteria for enrollment in the state's Healthy Families America (HFA) program, can be referred to Healthy Families New York (HFNY) by the state child welfare system after an abuse and neglect report, or can enter into the community pathway. This allows the State to be eligible to draw down federal Title IV-E funds without even having a report of abuse and neglect, if the individual is referred to HFNY by some other entity.

These referrals can be parents with no or poor compliance with pre-natal care, a single parent, primary caregiver under 21 years of age, or a caregiver with inadequate income meeting the HFNY eligibility criteria. The Community Pathways can also offer coaching and referral paths to many services for families in the community *outside the child welfare system* where families feel more trust to access help and support.

As part of the LB 1173 Practice Model's focus on enhancing primary prevention services, and the goal of reducing unnecessary system involvement or removals to foster care, the Work Group recommends a Community Response Pathway that would include a coordinated and *integrated* service model for "at risk" children, youth, and families in a community. In recommending this pathway, the Work Group remains mindful that child safety must be the paramount priority.

In this new primary prevention system, the Work Group envisions a system where families are not only being referred to an evidence-based program provider like HFA, by the system, but also one where mandatory reporters in the community, (such as schools, law enforcement, medical professionals, and other community organizations and stakeholders) could directly refer families in need to the community pathway provider, with the family's consent. The following figure illustrates the Work Group's future vision:

Community Response Pathway: *LB 1173 Future State Prevention Model*



How a Community Response Pathway Would Work

After referral, the pathway would conduct a family needs assessment and provide central navigation, through a closed loop referral connection, for a family, child, or youth to access services. Specifically, the pathway would offer navigation through a care coordination lens with peer coaching and could make referrals to a vast number of partner agencies or organizations in the community to help this family through a particular crisis. The Work Group envisions these organizations all coming from multi-service sectors that are offering both publicly and privately funded resources that are available in the community to the family, such as the Regional Behavioral Health Authority System, Medicaid Managed Care Organizations, home visiting providers, evidence based program providers, social service nonprofits, faith based organizations, family resource centers, workforce programs funded by the Department of Labor, Child Care, early learning and development and screening, educational assistance and afterschool programs offered by the NDE, and/or DHHS, DHHS economic assistance programs. An example of this vision is a referral by the navigator to the child's Medicaid Managed Care Organization to provide important medical and behavioral health care coordination, and to an Early Development Network (EDN) service coordinator to provide early childhood development resources and case management. The referral could also include a transportation service to meet emergent needs, home repairs from a local church whose parishioners have volunteered to offer these needed services, as well as connection to the Department of Labor's Workforce Investment Opportunity Act vendors to provide job skill development, training and apprenticeship opportunities for a parent struggling to pay living expenses for a family and needing a good job.

The community pathway could also offer important concrete supports, could help a family through a very difficult eligibility process for services they qualify for, such as TANF, SNAP or Medicaid. The community pathway's services would be culturally appropriate and allow for meeting families where they are in the most appropriate community setting and service to meet their needs. The navigation services with closed loop referral technology, would also allow for tracking of outcomes, not only outputs, and provide appropriate measurement and success tracking for the state and other intersectoral partners.

Establish a Warm Handoff to the Community Response Pathway for Screened Out Calls (I.B)

In the Work Group's proposed community response pathway model, the community pathway will work with the CFS hotline and offer a path to services for families in need of services through a new and structured process developed at the hotline.

Today, CFS does not have a uniform process for reviewing calls that are screened out by the hotline intake worker or to determine which screened out reports are appropriate to be sent to the community response pathway vendor for outreach to the family or outreach to the reporter, with appropriate confidentiality protections and in an effort to voluntarily assist the family.

Although CFS screens out on average over 20,000 calls a year, not all of these reports would need to be referred to the community pathway. In this process, CFS would design an additional screening tool prioritizing calls with criteria that could include, but not limited to factors such as:

- A primary caregiver under the age of twenty-six (26) years old
- A child in the household under the age of three (3)
- A primary caregiver who is the legal guardian of minor(s) in the residence
- A pregnant female

The community response pathway would then provide the outreach and navigation services to these families in order to offer education on available resources in their geographic region. The navigator would connect the family by providing information or meeting directly with the family to assist with navigating the referral to specific resources in the community.

The Work Group has reviewed similar models in its state best practice assessment, considering states that are putting more structure around the screen out process. For example, New Hampshire launched a model in July where a community navigator receives a warm handoff from the child welfare agency and the navigator provides prompt outreach to the families and offers resources to supportive services in their community. The process begins with the navigator receiving the report from the state and making prompt contact with the family. Once contact with the family is made, the navigator works on establishing rapport with the family and an understanding about specific supports the family may benefit from. The navigator offers appropriate community resources/referrals or other supportive services to the family based on their self-reported need. Additionally, in this model, the vendor provides information to educate callers reporting from their professional role, including but not limited to: local resources available to families; how the resource operates and how a family can connect with the services; what the family can expect when working with the community support service; skills and techniques of how to approach families to offer support; techniques on how to engage with a family to get them to better connect with a service; and information on the success of a warm handoff approach.

The Work Group supports this model and believes it should be considered as part of the implementation of LB 1173 Practice Model. Should such a recommended system be implemented in Nebraska, however, the Work Group would strongly recommend that the community response pathway provider, not the state, be the organization that tracks and monitors the data related to the referral and provides de-identified information and data back to the state. The state should then monitor the impact that this new process has had on the number of abuse and neglect calls to the hotline in the future.

Establish a Family Support Warm Line (I.C)

During the Work Group's research, it found a number of states that offer a "Warm Line", or well-recognized centralized call line for parents in need of services. A Warm Line is a free phone-in service where callers can talk confidentially to a family support professional to get help with everything from coping strategies, child behaviors, family dynamics, household management and emotional distress, to gaining access to tools, resources, and services that can help navigate life during challenging times. The ultimate goal of establishing a Family Support Warm Line is to serve as a support to families during times of increased stress and to reduce the number of calls to protective services. Through this warm line, families can be directed to critical resources, including the more community driven navigation and peer coaching that exists today within the Nebraska Community Collaboratives.

The Work Group is aware that Nebraska currently offers similar services through 211, Boystown and 988. The Work Group would recommend that any future effort of the state in funding a more centralized Family Support Warm Line, be aligned with and not duplicative of these services with the goal of reducing confusion for families, while at the same time assisting them with meeting needs and reducing the risk of crisis or involvement with the child welfare system. It may also make sense to include this future statewide warm line within the environment of the existing community response pathway and not outside of it.

Use the Community Response Pathway as Referral Source for Certain Families Seeking Economic Assistance at DHHS (I.D)

There are a number of families in Nebraska each year that apply for Economic Assistance (TANF, SNAP, Child Care) and are either denied, pending an application review, or provided some assistance but have additional barriers that could destabilize their families, impact the lives of their children, and lead to future entry into the child welfare system. The Work Group believes that a number of these families could benefit from this approach where there is a voluntary referral from the DHHS economic assistance to the community response pathway for navigation

and peer coaching to help the family through a particular crisis with an approach that centers on the whole family. If an assessment determines additional risk factors, a referral to the community pathway may lead to mitigating these risks for the family and their children.

Involve Community Response Pathway in Coordination with the Medical Provider Community as a Pathway for Parents with Pre-natal Risk or Children 0 to 5 Years of Age (I.E)

In order to receive Child Abuse Prevention and Treatment Act (CAPTA) funds, states are required to ensure that they operate programs relating to child abuse and neglect that include the following:

- Policies and procedures (including appropriate referrals to child protection services systems and for other appropriate services) to address the needs of infants born and identified as being affected by substance abuse or withdrawal symptoms resulting from drug exposure or Fetal Alcohol Spectrum Disorder (FASD), including a requirement that health-care providers involved in the delivery or care of such infants notify the child protective services (CPS) system of the occurrence of such condition of such infants; and,
- The development of a plan of safe care (POSC) for infants born and identified as being affected by substance abuse or withdrawal symptoms or FASD to ensure the safety and well-being of such infant following his or her release from the care of health-care providers, including through addressing the health and substance use disorder treatment needs of the infants and affected family or caregivers.

The POSC is a document created jointly by a pregnant or parenting person and their provider to promote the safety and well-being of infants with prenatal substance exposure and their families. A POSC helps to coordinate existing and new services and supports, such as addiction and mental health recovery, parenting education, early intervention, and postpartum care. A POSC can be part of any family service plan that covers both the parents' and the infants' needs.

In 2022 in Nebraska there were 181 reports of abuse and neglect made to the hotline related to substance exposed infants and over 86% of the calls were screened in for investigation. In 2021 there were 242 such cases and in 2020 279. In a number of these cases infants were removed to foster care after a safety and risk assessment. The state, however, led by DHHS, is currently focusing its efforts around a more robust community response to these cases, as well as cases where

medical and other providers have become aware of substance abuse issues that warrant prevention and intervention before an infant or child is removed to foster care. Currently, CFS is working in two regions of the state in offering innovative navigation and connection to substance abuse services and programs for caregivers and families where there is evidence of substance abuse exposure either prenatally or after a POSC has been developed. In Hastings and North Platte, CFS is working with a number of entities in the community where pre-natal binders outlining care are put together for expectant mothers and Nebraska Community Collaboratives are providing navigation, coaching and connection to substance abuse treatment services.

Substance Exposed Infants Screened by Hotline	2020	2021	2022
Screened In	245 (87.8%)	221 (91.3%)	156 (86.2%)
Screened Out	34 (12.2%)	21 (8.7%)	25 (13.8%)
Total	**279**	**242**	**181**

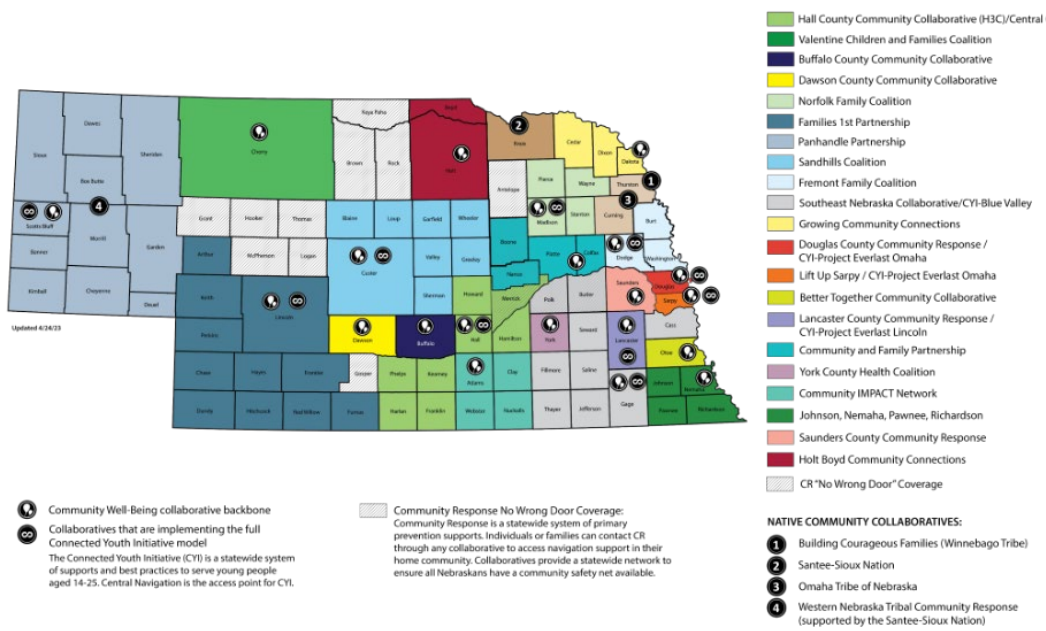
In Douglas County, CFS is working within its own division as well as with 211 United Way, The Bridge (Family Resource Center), Project Everlast, local hospitals, home visitation providers, Nebraska Early Childhood Initiative, Sixpence, Children's Hospital, Douglas County Public Health, Monroe Meyers Institute, Charles Drew FQHC, along with state partners from Nebraska Department of Education, Office of Early Childhood, Head Start, Public Health, Behavioral Health, Nebraska Children and Families Foundation (NCFF), University of Nebraska Medical Center, and Medicaid. CFS is developing a model where these individuals and families are referred by the Medical and other providers to the "Help Me Grow" program, substance abuse treatment providers, and also connected to community response and family resource centers that will provide further navigation to services such as: legal coaching, housing utilities, behavioral health, transportation, financial education, food, child care, before- and after-school care, family literacy, social emotional practices, (RinR) education services, mentoring, as well as referral to existing early childhood and home visiting programs, such as HFA, Parents as Teachers or Family Connects. This coordinated effort is occurring in the pre-natal, infant, and early childhood development area, and this level of coordination with the medical provider community should lead to reductions in child welfare system involvement in the future.

The Work Group envisions, as part of the future LB 1173 practice transformation, that the community response pathway would include this level of coordination and support for moms with prenatal risk factors and parents with children aged 0 to 5 in every region of Nebraska, where there are signs of substance abuse exposure or

substance abuse issues needing attention during the pre-birth and early years of a child's development. The Work Group also believes that where there has been a removal of an infant to foster care, the courts, county attorneys, and GALs involved could also find benefit in the community pathway provider being part of the multi-disciplinary team working together to reunify the infant with his or her mother or caregiver, so as to reduce the length of stay during these important early years.

Leverage Existing Community Collaborative Structure as the Community Response Pathway Hub (I.F)

Nebraska has a unique opportunity to leverage the existing community collaborative structure as the Community Response Pathway Hub. Through its Bring Up Nebraska community-based prevention effort, Nebraska has already in place the foundation for an effective and innovative locally based community pathway that can serve to keep children safe, support strong parents, and help families address life challenges before they become a crisis. Through this initiative, Nebraska DHHS and the NCFF have blended funding to design and develop a system of community collaboratives across the state that come together and provide the support that families need in the community. This partnership has developed into over 23 community collaboratives across Nebraska today that are well established and embedded into the fabric of the community.



These community collaboratives have implemented partnerships focused on prevention strategies unlike other single entities in Nebraska and have a common

vision and mission to really help serve these families in crisis in their own communities and keep them out of system involvement through their collaborative model. NCFF has been an instrumental partner in this initiative, along with other foundations, businesses, community leaders and community-based organizations.

The Work Group has also been provided status updates on a number of their meetings, as well as presentations of their workplans in the communities they represent and has observed the positive feedback received from stakeholders in all of the community forums to increase statewide prevention efforts through this effort. The Work Group believes that the continued support of the Nebraska Community Collaboratives, including that of NCFF, DHHS and individuals and organizations in the communities the collaboratives represent, will be a key component of the new and reimagined child well-being system in Nebraska.

In fact, since 2020, with the convening of state partners and partners with lived experience, the collaboratives have taken part in the development of a strategic transformation plan for child and family well-being. The plan will be used as the backbone for the development of a statewide strategic plan for community well-being with prioritized goals, strategies and action plans that are well aligned with the engagement strategies and LB 1173 Practice Model. This statewide plan was developed through an inclusive process between the Nebraska Community Collaboratives, lived experience partners, and over 20 system partners including DHHS and NDE. The shared vision of their strategic plan is for Nebraska to have the most robust community well-being prevention model in the nation by 2025. From all we have seen, with the right legislative, financial and community support, there is no doubt this vision can be realized.[4]

From our research, the Nebraska Community Collaboratives have brought together a coalition of service providers and other community representatives to work together more intentionally to help families. Such community response initiatives engage families before they are referred to child protection and help them access concrete needs, such as rent and utility payments, and provide referrals to services and support in the community. As mentioned, funding has been provided to these collaboratives through a blend of public and private dollars, including from DHHS, NCFF, and local funders and service providers. These stakeholders view these local collaborations as critical partners in prevention of child welfare involvement. The Work Group would like that vision to continue.

[4] Nebraska's Statewide Plan for CWB - Google Docs

In this newly re-imagined community pathway structure, the community response pathway builds a continuum of community-based supports and resources that strengthen families and prevent child maltreatment. Reform efforts would place the highest priority on starting early and linking families to local support and resources in a more intentional and effective manner to support families throughout a child's lifespan. The prevention practice principles that would support improved outcomes for children and families would include:

Prevention Practice Principles	
Mobilized Multi-Sector Community Impact	**Strong Families**
Mobilized communities that view child and family safety and well-being **as a community responsibility** supported through the strategic use of both public and private resources act on the belief that oversight and shared accountability is essential. This will include **a structured process to collaborate with a cross sector group that is committed to a common framework for solving complex social problems**. The framework includes infrastructure/governance, shared measurement, mutually reinforcing activities, and continuous communication. An integrated family support system across the public and private community groups, schools, agencies, courts, and other relevant intersectoral entities located in the communities to be served	**Families that are stable and have the skills and capacity to provide** for their children's well-being, including their health, mental health, relationships, and education
Promotive and Protective Factors	**Primary Prevention**
The **protective factors** are the conditions or attributes of individuals, families, communities, or the larger society that mitigate risk and promote healthy development and well-being. These factors include knowledge of child, parent, adolescent development, social connections, social emotional competency, concrete supports in time of need, and resilience. The Nebraska Youth Thrive™ and Families Thrive - or known as Youth and Families Thrive – is the model already developed in Nebraska that teaches the information and skills needed to help children, youth and families build protective and promotive factors that research determined is optimal for healthy growth and development. The **promotive factors** are the strengths that help to buffer and support children, youth and families at risk and the conditions that actively enhance wellbeing (See Youth and Families Thrive : Training : Connected Youth Initiative (neconnectedyouth.org))	A **universal approach that addresses the community context and touches every family in the community** to ensure basic needs are met. This means ensuring access to early childhood education, housing, jobs with living wages, and positive informal supports – all the things that families need to grow healthy, thriving kids
Youth and Family Leadership, Partnership, and Empowerment	**Equity**

Prevention Practice Principles	
Intentional **opportunities for people to have a voice in decisions affecting them** by prioritizing lived voice to design, develop and implement policies and practices	Addresses issues of **equity in the community** and in the work to ensure equitable access to basic needs services and supports
Accountability	
Accountability is shared, to the community and to each other, including families	

Prevention Practice Key Components
• An **infrastructure, leadership and environment** that would support the community-based prevention system in that community and a common vision and mission. This would include a structure with mission, vision, goals and strategies, and a community driven business plan that can also support sustainability of resources to include funding, and receipt and expense of public expenditures, including appropriate reporting, accounting and accountability.
• A **safe and accessible location in the community** for families to meet. This could include schools, businesses, and other locations that are known to the community and where a family would feel safe.
• A **central navigation system** is the function by which families and youth are matched to appropriate services, referrals are shared across a number of partners and data is tracked. This support system provides for the type of coordination and connection to community based, faith-based prevention and other social services a family may need, including housing, food, neglect/basic needs, pregnant/parenting, resources, and substance abuse.
• A key aspect of navigation, and a theme that the Work Group heard at every one of the LB 1173 community forums, is to educate families about the services that are already available and funded in the community to address certain needs so as to maximize available funding before additional funding is used to fill gaps. Examples of this include connection to a Medicaid Managed Care Organization that provides additional medical, behavioral health and social service care coordination for Medicaid members, regional behavioral health entities that provide connection to behavioral health services in a community, or workforce programs already funded by the Department of Labor and Workforce Investment Opportunity Act to help those that are unemployed or underemployed develop job skills.
• Both **formal and informal coaching** exists to help families and youth to set, work toward and attain goals. Preferably, coaches that possess appropriate "lived experience" with the child and family serving system to support families, including, but not limited to, experience as a caregiver who has needed and accessed appropriate public resources/services to support themselves and their children, this can be, but does not necessarily have to be experience with CFS directly
• **Concrete and/or economic supports are** available to families if there is a need to "fill gaps" through flexible supportive funding. The need for support in areas such as childcare, housing and transportation have been raised as some of the highest needs for many of the families that are at risk of de-stabilization. An example the Work Group heard is the Freemont Family Coalition, the Community Collaborative in the Freemont area, that provides up to two months of rental assistance for a family member who is struggling with paying bills and is seeking employment in the community, and $450 rent with Section 8 housing vouchers. Recent peer reviewed studies have demonstrated the positive impact of providing both concrete and economic support to families and its ultimate connection to reduction in child welfare system

Prevention Practice Key Components
involvement and expenditures. **These studies are referenced in the Finance Model Framework.**
• **Expertise in community trainings and resources** for specific populations and provide consultation to coaches.
• **An array of prevention strategies** that support family driven service delivery, partnership, and leadership opportunities. These initiatives, for example, could include Sixpence, Rooted in Relationships, Community Response, Communities for Kids, Beyond School Bells, System of Care, and Connected Youth Initiative as well as **community solutions** and strategies to meet community identified needs and priorities
• **Technology** that would support a closed loop referral system that make referrals to entities that can accept in an interoperable manner, that also allows for self-navigation for families to navigate on their own, and provides the backbone for standardized reporting on outcomes; and
• **Tribal Nation participation** – Embrace the philosophy that connection to culture is a strong protective factor and the belief that Tribes know what is best for their children. Include and involve all voices in the community and tailor services around meeting their needs

Shift Child Abuse Hotline Practice to Connect Reporters with Supportive Family Resources through the Community Response Pathway (I.G)

As indicated above, approximately 60% of the calls to the abuse and neglect hotline are screened out without a uniform process or approach to community response for families that could benefit by some contact with a community provider or organization. From what the Work Group has learned from our interviews with CFS Hotline staff, many of the calls that are screened out go without any further engagement or response. The Work Group has also heard that many of these mandatory reporters would have preferred referring a family to more supportive services in the community. Thus, a more structured visible and effective community response system could result in more and more families receiving help in their communities before a more intrusive and traumatic investigative response.

Develop a System to Measure the Quality of Service and Work of the Community Response Pathway (I.H)

Developing more accountabilities across the system, as well as system for effective data and outcome monitoring were not only key themes the Work Group heard during the community forums but were key components of what the Legislature wanted contained within the LB 1173 practice and finance models. Thus, assuming the Child Welfare Transformation Work Group focus more effort and funding at the front end by providing more resources to the Nebraska Community Collaboratives to meet the priorities and goals of the new practice model, the Work Group recommend that there also be a system in place that measures the quality of service

and the outcomes in providing support to at risk families in the community through the community pathway vendor. Assuming the pathway is the Nebraska Community Collaboratives, DHHS should work with NCFF and other funders, such as counties and municipalities, as well as other intersectoral partners to design and develop a quality measurement system that engenders confidence in families, funders and staff of these programs and raises the level of professionalism expected of the different community Pathways across the regions. This expectation will define and promote quality practice.

In doing so, however, differences of each of the Nebraska Community Collaboratives' offerings will need to be considered. There exists a different depth of the services provided, and their commitment to the principles outlined above are not defined by any one or even multiple funding sources. However, assuming the state of Nebraska continues to be a substantial funder, a system of accountability where the effectiveness of delivery, quality and outcomes can be measured is necessary. This can include the requirement to collect data on quality indicators such as:

- Trauma-informed practices
- Family Engagement in program development and implementation
- Accessibility - physically/virtually, via time of operation, and languages used – and welcoming to families
- Administrative practices reflect family centeredness
- How the Collaborative is engaged in community strengthening and collaborative relationships
- How the Collaborative engages families in community strengthening and supports their leadership development.
- The Collaborative recognizes and affirms families' existing strengths and resilience, and is responsive to their concerns and priorities
- Staff members work with family members in relationships based on equality and respect, recognizing their existing strengths, resilience, and resources
- The Collaborative enhances families' capacity to support the healthy cognitive, social, emotional, and physical development and overall well-being of their family members
- The Collaborative collects and analyzes information related to program participation
- The Collaborative collects and analyzes information related to program outcomes
- The Collaborative respects, values, and embraces the diversity of families, including their ethnicities, cultural traditions, languages, values,

socioeconomic status, family structures, religion and spirituality, individual abilities, immigration status, and other aspects
- The Collaborative demonstrates fiscal responsibility in the use of concrete support services by maximizing the use of all available resources before such funding is utilized

Consider Expanding Primary Prevention Approach to Schools and Ensure Connection to Community Response Pathway (I.I)

Including schools, where children are in a safe learning and nurturing environment, in any future child welfare system transformation was a major theme during all our community forums, and local schools and NDE are valuable intersectoral system partners in Nebraska. Moreover, school officials in Nebraska make up over 27% of all mandatory abuse and neglect reports in Nebraska (10,924/27%/2022). A number of these reports of neglect are for youth that are not showing up for classes or are unable to access needed services and the child welfare system, therefore, is being used by the school reporter to offer services where all other attempts have failed, rather than when there is a real concern for the child or youth's safety from some form of abuse. Thus, providing schools, especially mandatory reporters, with a clearer path to resources in the community that could address the needs of these children, youth, and families, could serve to reduce the need for future system involvement and help these children, youth and families reach self-sufficiency and well-being.

Many states that have experienced similar issues have developed models that focus on bringing a social service and community connection to the schools in order to be a resource for children and families in need of support. For example, Communities in Schools (CIS) is a national organization that ensures every student, regardless of race, gender, ability, zip code, or socioeconomic background has what they need to realize their full potential in school and beyond. See State Strategies for Investing in Community Schools (learningpolicyinstitute.org) CIS works by bringing community resources directly into schools through embedding a trained local coordinator whose sole focus is helping connect students with additional support to help them learn, advance in grade level and graduate. For more than four decades, CIS has demonstrated measurable success in creating equitable outcomes for schools and students of color and students that live in impoverished communities. During the 2021-2022 school year, 99 percent of students enrolled in CIS programs remained in school through the end of the school year, with 97 percent of K-11 students being promoted to the next grade, and 95 percent of seniors graduating or receiving a GED.

Since 1991, the state of Kentucky has utilized a model called Family Resource Youth Service Center Kentucky (FRYSCKy) where community based non-profit family resource centers are embedded in local schools to help at-risk students succeed in school by helping to minimize or eliminate non-cognitive barriers to learning. Today FRYSCs are the largest school-based family support network in the United States with approximately 850+ centers in over 98% of the schools that serve a majority of children in free or reduced lunch programs. They are strengthened by the connection to the family resource center and all its community partnerships and provide vital programs, services and referrals to students and their families. They have become a critical partner in the Kentucky school system.

In Nebraska, NDE and NCFF recently developed the Better Together Initiative to pilot a similar Full-Service Community School (FSCS)[5] strategy in Fremont, Grand Island, Schuyler, and South Sioux City. A FSCS school has a site coordinator who is either a staff member of the school or a partnering entity and is dedicated to extending the capacity of the school by assisting students and families overcome barriers to learning, building relationships with school staff, coordinating with parents and classroom volunteers, scheduling services and programs, and coordinating services such as food pantry, basic needs pantry and winter clothing drives. FSCSs provide comprehensive academic, social, and health services for students, students' family members, and community members that will result in improved educational outcomes for children. These services all include similar activities that the Nebraska Community Collaboratives currently coordinate and navigate. A 2020 to 2021 School Year evaluation of the FSCS pilots was provided to the Work Group by NCFF. The report showed improved school attendance, child supports, such as dental, eyeglasses, after school and summer program participation, and direct college/career connections at the middle and high school levels. (See Appendix B).

The most critical component of a successful FSCS site is the site coordinator who can provide central navigation, readily identify the changing needs of students and rally community resources to address those needs. FSCS are particularly effective in providing tailored wraparound services to schools with higher concentrations of poverty. If Nebraska were to leverage this strategy in schools with higher than 60% of students identified for free or reduced-price lunch, the total number of schools would be approximately 123 schools, according to NDE. Of note, this model does not have to result in the hiring of new site coordinators in all of these schools. Rather, it can be done on a regional basis and can also be maximized by leveraging

[5] National Center for Community Schools (NCCS) was established by Children's Aid in 1994 to answer the nationwide call to build schools that surround students with support.

the resources of the 23 Nebraska Community Collaboratives, that are already well connected with the school districts in every one of the regions. A continuation of collaboration here, with a FSCS enhancement will bring to the schools the intersectoral connection and approach envisioned in LB 1173.

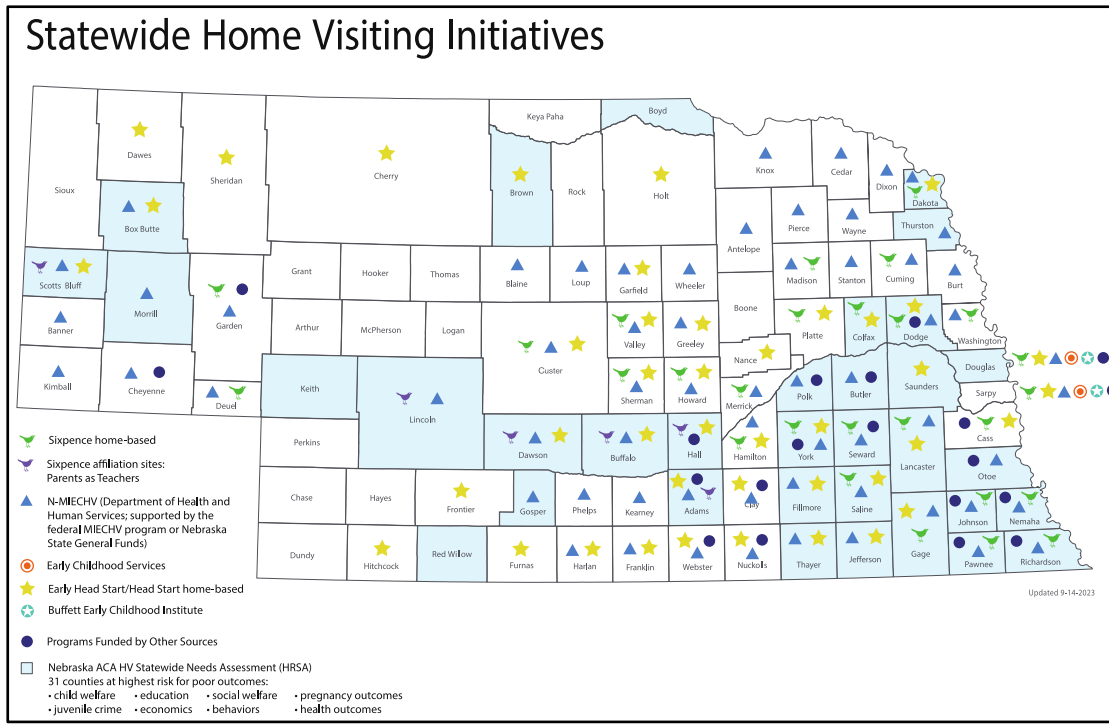
Expand the Reach of Evidence Based Home Visiting Programs Aligned with Community Response Pathway (I.J)

Nebraska was an early leader in implementing home visiting, an evidence-based intervention in which trained professionals provide in-home services to at-risk families when a mother is pregnant or when a child is first born. Home visiting programs have been proven to prevent child maltreatment, improve child health and school readiness, and improve maternal health. Nebraska communities are implementing home visiting models through a variety of funding streams and initiatives, including: the Nebraska Maternal, Infant Early Childhood Home Visiting (N-, MIECHV), which is largely federally funded; The Sixpence Program, a unique public private partnership that has leveraged private and public funding for community based early childhood programs, and other early childhood programs receiving federal and private funding, including Buffet Early Childhood Institute, Early Head Start/Head Start, and Early Steps to School Success. Home visiting is a powerful intervention that holds promise for reducing child maltreatment across the state, but it is not reaching all the families who could benefit. Targeting these interventions to more and more communities with high rates of child maltreatment and connecting the service providers to each of the community pathway as an effective intervention strategy could also go a long way toward supporting families before maltreatment occurs.

Home visiting programs either funded directly by or through the DHHS, Division of Public Health already go through an extensive evaluation with six targeted benchmark areas that include 19 different performance indicators. The following are the targeted benchmarks:

- Maternal and Newborn Health
- Maltreatment, Injury and Emergency Room Visits
- School Readiness and Achievement
- Domestic Violence and Crime
- Family Economic Self-Sufficiency
- Coordination of Referrals and Resources

For a map of communities that are currently implementing home visiting and where there are gaps in services, see below:



More information can be found here: https://dhhs.ne.gov/Pages/Data-and-Benchmarks.aspx including previous reports on the benchmark data. There is also an abundance of data nationwide that shows the effectiveness and positive outcomes of home visiting models for early childhood that serve families with pregnant women and children from birth to kindergarten entry (that is, up through age 5) overall.[6]

The Work Group recommends, as part of the LB 1173's intersectoral objective, that there is a more focused effort on these effective evidence-based home visiting models, like Healthy Families America (HFA), starting prior to birth, which means that there are engagement opportunities here for many partners to work together to ensure that these important voluntary programs can be presented to pregnant moms in the early pre-natal stages. Hospitals, Medicaid managed care organizations, doctors, local public health departments, courts, childcare agency staff, community organizations should all collaborate on an overall state-wide plan to allow for greater engagement and awareness to increase access and availability of home visiting programs statewide. For example, when a mom has her first prenatal appointment with her physician, and the physician believes that she is a

[6] What is Home Visiting Evidence of Effectiveness? | Home Visiting Evidence of Effectiveness (hhs.gov)

good candidate for the HFA Nebraska program, the physician can refer her to that program. If mom is on Medicaid, her Medicaid managed care organization could also connect mom to the local HFA Nebraska provider once they become aware and deliver care coordination services. If mom is the subject of a child abuse and neglect case, where the courts are involved, the court can ask the question as to whether mom has been referred to the area HFA Nebraska provider. Additionally, the community pathway can have connections to the local home visiting programs and can also make referrals through its own system of navigation.

Finally, if the division of Medicaid and Long-term Care at DHHS becomes aware of a Medicaid member where a family could benefit from home visiting, the Division of Public Health could be notified and provide information to the family about an available program. All intersectoral partners should look to ensure and promote education, awareness and access to these important programs.

Focus on Adding Home Visiting and Parenting Classes for those Families with Children After Kindergarten (I.K)

One of the gaps in service the Work Group heard during community forums is the availability of home visiting and parenting classes for families with children after kindergarten, since most of the home visiting programs have eligibility that runs out at age 3 or 5. Programs such as Common Sense Parenting and Nurturing Parenting are offered in some communities in Nebraska and are approved evidence based programs on the National Child Welfare Clearinghouse. However, they are not currently in the approved Nebraska Title IV-E FFPSA plan. This is a program area DHHS, and community stakeholders should consider expanding on as part of its future transformation.

Expand Efforts to Educate Families about Critical Prevention Focus Statewide (I.L)

As the LB 1173 Practice Model is implemented, all Intersectoral partners should be made aware of all the important components of this more focused and robust primary prevention system and response. The Work Group has heard that families, reporters, courts, even CFS staff are often unaware of important programs in a community that could be used to assist a family. Knowledge of the new community response pathway system and its partners, local community-based organizations, and the work they do on behalf of families, as well as providers and stakeholders in a community that are part of the system response need to be identified in a clear, succinct manner. In addition, available in the language that the families speak.

Moreover, in relation to the Tribal Nation understanding, involvement and participation, Tribes must be made aware of those building strategic plans in the various areas of prevention of health and social disparities. Overall, Tribal communities will also need resources to implement effective prevention programs, but also must understand what exactly prevention is, how important it is to work prevention ethically in all areas. The state of Nebraska has an opportunity in this venture to have those conversations with Tribes on the front end of the legislative work, recognizing that Tribal communities are not all the same and do not face the same number of disparities.

For the LB 1173 Child Welfare Practice Model transformation to be successful, future intersectoral partners must support, cultivate and continue to create the environment where innovative solutions to prevent overall system involvement happen in the community with the people that children, youth and families' trust. Moreover, if this community pathway has the support and resources to help these families, the Work Group believes the overall system of care will benefit tremendously and the LB 1173 vision of (state vision here) will be realized.

Consider Utilizing Community Pathway as a Standalone Evidence Based Intervention Meeting Title IV-E Federal Clearinghouse Standards in Future (I.M)

In 2018, the Family First Prevention Services Act (FFPSA) amended the Social Security Act to allow States and Tribes to use Federal title IV-E funds that were previously set aside for foster care expenses for services designed to prevent children from entering foster care. The amendment of the Act established the Title IV-E Prevention Services Program, which provides optional funding for certain time-limited prevention services, including in-home parent skill-based programs. States and Tribes with an approved title IV-E prevention plan may claim title IV-E reimbursement for a portion of trauma-informed mental health services, substance use treatment, and in-home parent skill-based programs for up to 1 year. To qualify for reimbursement, programs must be rated promising, supported, or well-supported by the Title IV-E Prevention Services Clearinghouse or have an approved designation through an independent systematic review process. Nebraska has an approved Title IV-E FFPSA Plan, but it does not include currently include any connection to a Community Response Pathway.

As mentioned earlier in this section, a few states have received approval to implement a Community Pathway to identify and serve families with risk factors that could lead to entry into the child welfare system. These risk factors are identified in the states Title IV-E Prevention Plan, and they are the initial qualifying criteria for

FFPSA eligible service delivery. Through this community pathway, families with children having these risk factors are referred by the child welfare agency or come into contact directly with the Community Pathway through community-based providers and entities. Once the Pathway refers the family to the particular evidence-based prevention service, consistent with the development of a child specific prevention services plan, the service delivery will qualify for drawing down federal dollars for the qualifying intervention, not to mention the Title IV-E administrative claiming that would be allowed (see LB 1173 Finance Model). Thus, the Federal Childrens Bureau, Administration of Children, Youth and Families has approved state Title IV-E Plans that have included families that do not come into contact with the state child welfare agency but meet certain risk factors.

In addition, at least one state, Indiana, has an approved Title IV-E Prevention Plan where the State is evaluating, as an FFPSA evidence-based practice, the state agency's own family preservation services model.[7] In Indiana, this includes families that have come into contact with the state child welfare agency through an abuse and neglect allegation and were assessed and referred to any in-home service that was approved as a "promising practice" by the California Clearinghouse. If this evaluation and subsequent review by the state and Federal Clearinghouse determines that the state's own intervention meets Federal Clearinghouse standards of "promising," "supported" or "well supported" criteria, Indiana's own family preservation services system will qualify for Federal Title IV-E funds as an evidence-based intervention in and of itself.

Nebraska is planning to submit an Amendment to its Title IV-E Prevention Plan in March of 2024. The Work Group would like to see Nebraska DHHS consider in the future, after engagement with stakeholders, a similar evaluation of the Nebraska Community Response Pathway system of navigation, coaching, concrete supports, and closed loop referral as its own standalone evidence-based intervention. This could allow more flexibility in approach and in drawing down additional federal funds to support the effort.

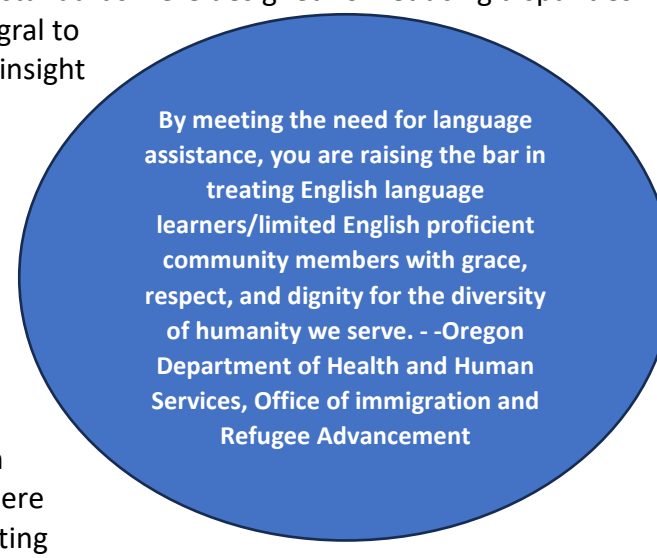
Continue Focusing on Reducing Disparities, Including Offering Services Through the Community Response Pathway That Are Tailored to Meeting Families Cultural/Linguistic Needs (I.N)

A December 2019 American Bar Association (ABA) Report: Race and Poverty Bias in the Child Welfare System: Strategies for Child Welfare Practitioners, identified that nationally, African American, Native American and children from families with

[7] https://www.in.gov/dcs/files/ProviderSummary_INFPS_Evaluation_2021_02_22.pdf

English as a Such disproportionality exists in Nebraska's child welfare system and is discussed in more detail later on in the Additional Child Welfare Practice Strategies section of this report. However, as the state focuses on co creation of a more prevention oriented and family/child/community supportive child welfare infrastructure, the ABA report offers several solid recommendations. Exercising cultural empathy contributes to better awareness' varying backgrounds/cultures and ESL. Exposure to individuals from other cultures can mitigate biases, reduce stereotyping and enhance consideration of provision of wholistic services tailored to families' cultural/linguistic needs.

Additionally, for ESL populations, the reframing of the US Department of Health and Human Services' Cultural and Linguistically Appropriate Standards (CLAS) for specific application in child welfare can provide guidance for delivery of culturally empathetic support. Though these standards were designed for reducing disparities in healthcare delivery, and are integral to Medicaid programming, they offer insight into development of practices to support ESL and other culturally distinct populations. For example- CLAS encourages building provider networks that are reflective of the communities serviced in a health plan's service area. As Nebraska is strengthening the Community Pathways infrastructure-the inclusion of diverse delivery system providers should be paramount. There should be heavy emphasis on soliciting organically grown organizations, Lived Ex and adult/youth peers-especially those who meet the linguistic/cultural needs of the communities.



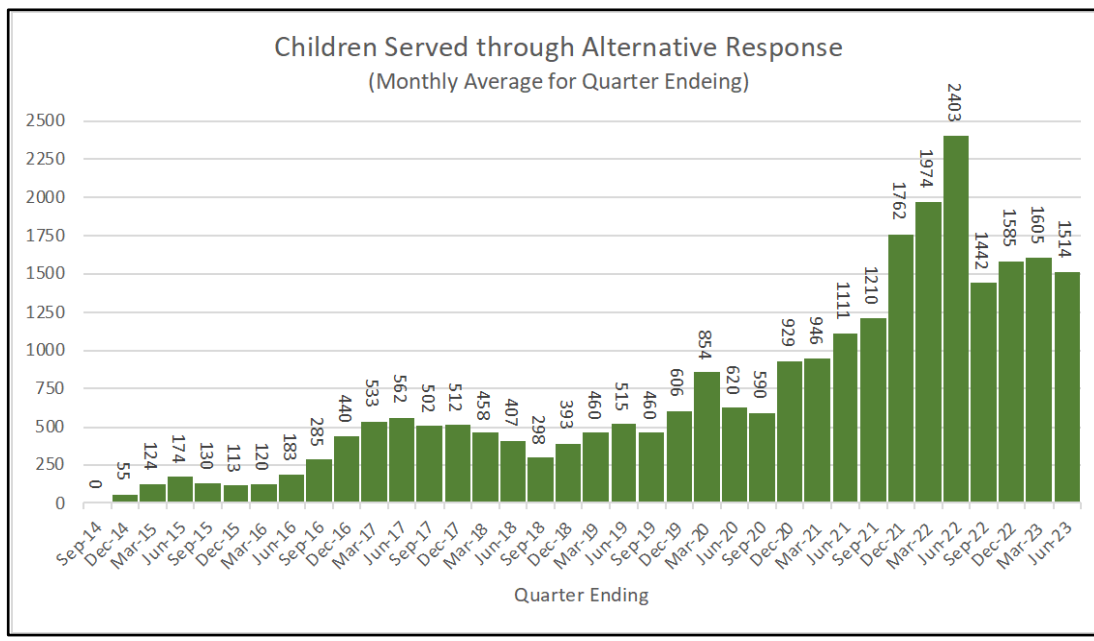
II. Continue Efforts with Alternative Response, and In-home Evidence-Based Interventions

Continue efforts with alternative response, and in-home evidence-based interventions, including developing enhanced capacity for implementation of Families First Prevention Services Act, while Focusing on Increasing Exits to Permanency. Many of the prior reforms in Nebraska have sought to strengthen in-home supports when children are assessed to be safe in their own homes and where alternatives to removing a child can exist safely. In such cases, these in-

home services serve to build parental capacity without disrupting family routines and relationships.

Alternative Response

For example, Alternative Response was introduced in certain Nebraska counties in 2013 and then expanded statewide in 2017. It is another approach to serving families, while reserving investigations for severe physical or sexual abuse, or when imminent risk for severe maltreatment exists. This non-investigatory track has been applied to families that are identified as low- or moderate-risk, unless subsequent information reveals the need for an investigatory approach.



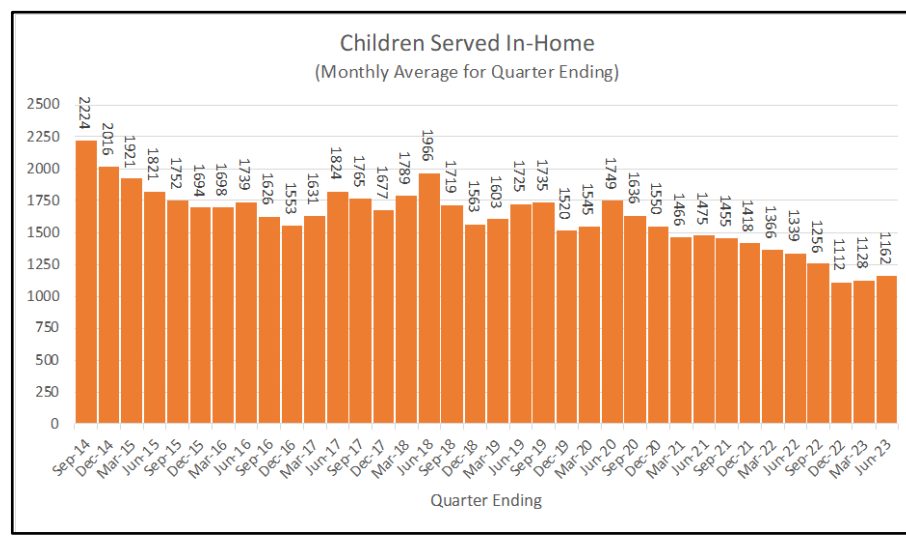
As can be seen by the above chart, Alternative Response has increased substantially since 2014 in Nebraska. Additionally, once families are put into the Alternative Response track in Nebraska, the data shows that there is a very low % of reports of continued abuse and neglect to the CFS hotline within 12 months after entry into Alternative Response. In 2020, for example, there were over 5,517 youth that were in Alternative Response in Nebraska. Out of those youth, only fifty-eight had a substantiated report of abuse within the 12 months following the Alternative Response track. In 2021, there were over 10,768 youth in AR and 247, or 2.29% had substantiated reports of abuse in neglect within 12 months of the AR track. In 2022, there were 12,581 youth in AR and only 284, or 2.26% had substantiated reports of abuse and neglect within 12 months following the Alternative Response track.

In-Home Services

Child welfare in-home services are different than Alternative Response, as they can include a continuum of prevention-related supports and programs for higher risk children designed to enhance the protective capacity of caregivers and improve the conditions that may contribute to safety and risk concerns for children (e.g., mental health concerns, substance use, parenting practices). In-home services may be voluntary non-court involved or court ordered and can encompass an array of supports, interventions, and programs, ranging from transportation and housing assistance to intensive family preservation services and approved evidence-based programs under FFPSA. In a 2022 statewide gap analysis conducted by Chapin Hall, it was found that:

- 291 different mental health, substance use, and in-home family service programs are available in Nebraska. In-home family service and mental health programs were the most commonly reported.
- Of all programs reported, 71% were considered evidence-based programs, and they are most prevalent in the Eastern Service Area (ESA) with fewest in the Western Service Area (WSA).

As can be seen in the chart here, DHHS has continued to use In-Home services for a significant number of children and families with



substantiated reports of abuse and neglect for a number of years now, although the numbers overall have decreased with the introduction of Alternative Response in 2017.

Additionally, DHHS presented its updated Title IV-E FFPSA plan to the Work Group and indicated that it planned to roll out, as part of its FFPSA program, the following evidence-based programs, which are already in place in Nebraska, by May of 2023:

Healthy Families America (HFA), Parents as Teachers (PAT), and Family Centered Treatment (FCT).

By June of 2024, DHHS plans to expand its service array to include more focus on the Western Service region and newer Evidence Based Practices (EBPs) such as Trauma-Focused Cognitive Behavioral Therapy, Multisystemic Therapy, and Parent-Child Interaction Therapy, with full statewide service of all approved FFPSA EBPs by April of 2025. To enhance its capacity to deliver effective in-home services, DHHS also plans to look at additional evidence-based programs during this time frame such as:

In-Home Parenting Evidence-based Programs that Address Gaps/Needs

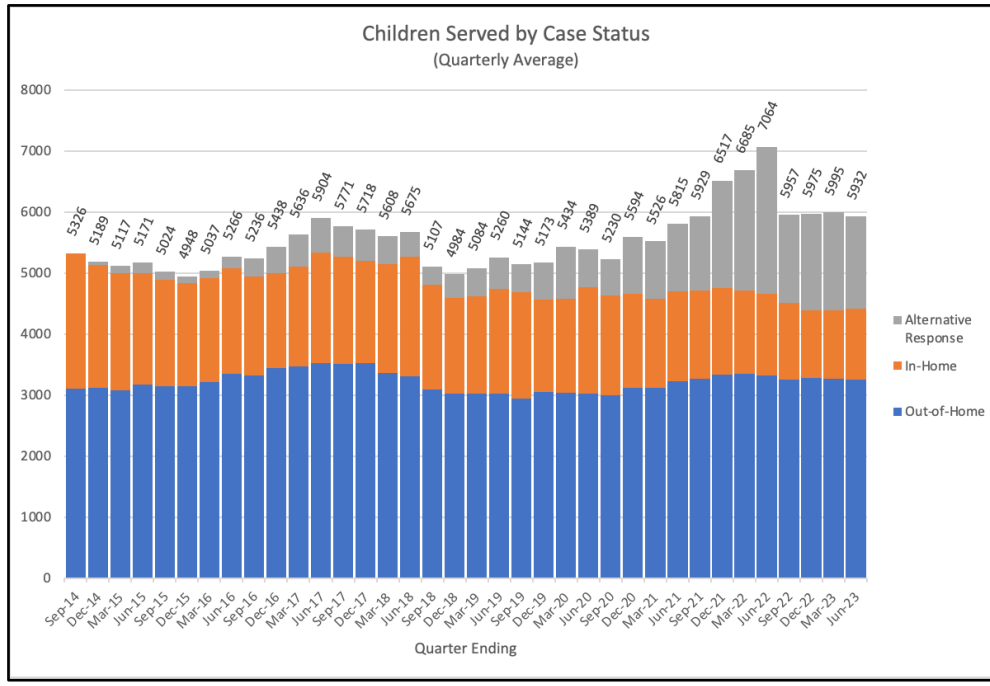
- Common Sense Parenting – promising
- Effective Black Parenting Program – promising
- On the Way Home – promising
- Strong African American Families – well-supported
- Circle of Security – does not meet criteria currently
- Families and Schools Together – promising
- Motivational Interviewing – well-supported EBP Tool

Clinical Evidence-based Programs that Address Gaps/Needs

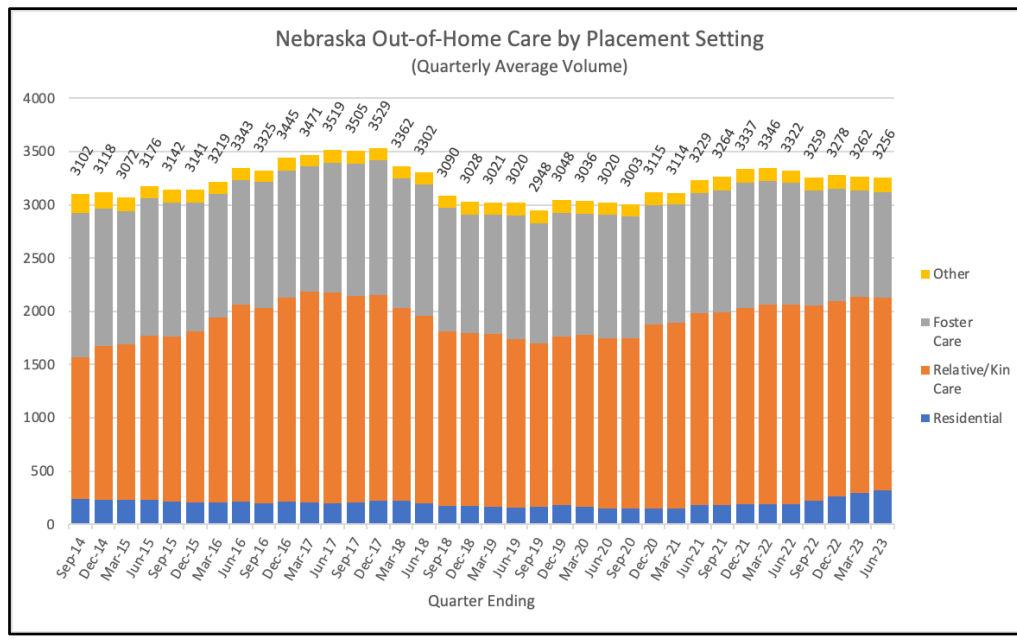
- EMDR – supported
- Child Parent Psychotherapy (CPP) – promising
- Motivational Interviewing – well-supported

This Focused Effort Has Resulted in Reductions in Foster Care Entries

Despite the delay in FFPSA roll out in Nebraska (see Financial Framework section on claiming practices) a review of overall Nebraska child welfare system entry data clearly demonstrates that the focused approaches of in-home services and Alternative Response have proven to be effective in reducing entries to foster care. Specifically, our review of the data shows that the number of children served per year has increased by approximately 1,000 per month since the quarter ending December 2015. The majority of these additional children are being served through Alternative Response, since the number of children in out-of-home care hasn't changed substantially, and the number of children being served with in-home services has been reduced.

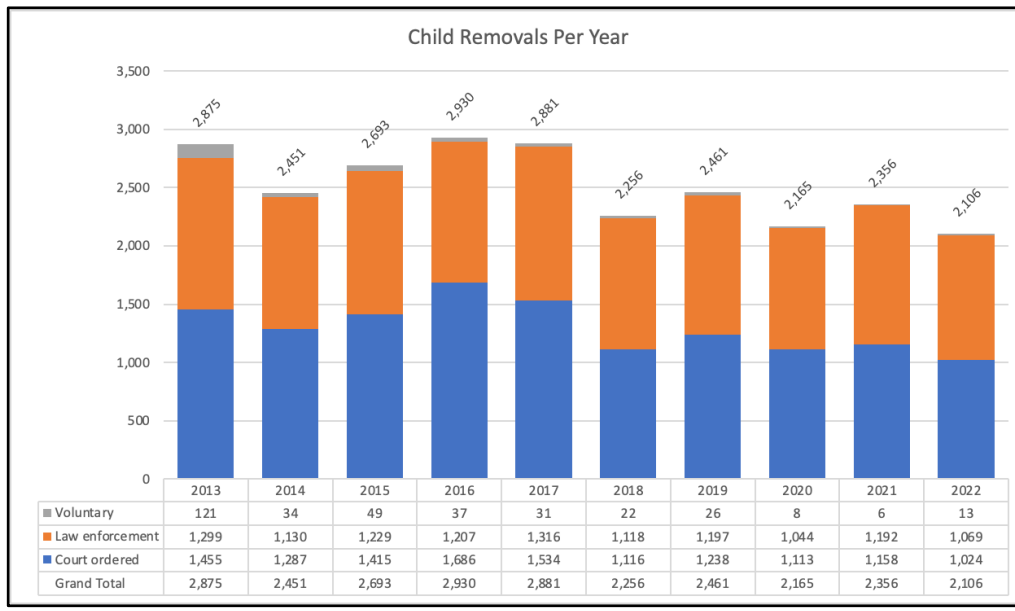


Overall, the number of children in out-of-home care has increased slightly since the quarter ending September 2014. During this period, the number of children in out-of-home care placed with relatives has increased by 36% while the number of children served in foster care has decreased by 27%. The number of children served



in residential out-of-home care has increased by 31%. However, this equates to only seventy-five children in this relatively small placement cohort.

Since 2014, the number of child removals per year has decreased by almost 27% - see below chart. During this period, the number of voluntary removals has been reduced by 89% (108 children / year).



	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Voluntary	121	34	49	37	31	22	26	8	6	13
Law enforcement	1,299	1,130	1,229	1,207	1,316	1,118	1,197	1,044	1,192	1,069
Court ordered	1,455	1,287	1,415	1,686	1,534	1,116	1,238	1,113	1,158	1,024
Grand Total	2,875	2,451	2,693	2,930	2,881	2,256	2,461	2,165	2,356	2,106

From our review of prior reports and discussions with front line CFS staff engaged in both Alternative Response and in-home services in Nebraska, including implementation of FFPSA, a substantial amount of careful planning, training, and development has occurred to ensure that these approaches are executed with fidelity and without compromise to child safety. Legislation has also specifically exempted cases with specific criteria related to a report that make many cases ineligible for Alternative Response, such as cases involving domestic violence, sexual assault, and other cases where there is a safety risk. Legislation in 2020 (LB 1061) has also created an Alternative Response Advisory Committee under the umbrella of Nebraska Children's Commission to examine the DHHS efforts at Alternative Response and to make recommendations to the legislature and the DHHS.

DHHS Continue to Provide Alternative Response (II.A)

It is the Work Group's recommendation that, in the future, as DHHS continue to develop a focused strategy on providing comprehensive prevention services as outlined in this report, DHHS continue providing its Alternative Response efforts and non-court and court ordered in-home service programs, while at the same time

ensure that key LB 1173 key Intersectoral partners, including families, those with lived experience and Tribes, county attorneys, be included in future program policy-related decisions with authenticity and transparency. Adherence to a new LB 1173 child welfare practice model throughout continued implementation will serve to enhance collaboration and engagement and Nebraska will be able to build on its prior success. In particular:

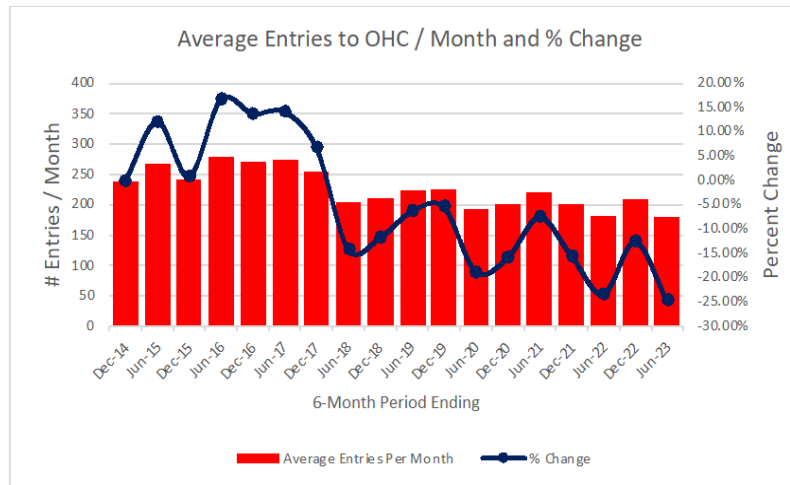
- DHHS should work closely with the Nebraska Children's Commission, Alternative Response Advisory Committee in considering all of its recommendations, including continuing to meet with the Advisory Committee to discuss the best and most feasible ways to measure outcomes related to Alternative Response and the development of much more robust and transparent data system around implementation of Alternative Response.
- DHHS should also make specific data on Alternative Response metrics and outcomes regularly available to the legislature, courts, county attorneys, GALs, and other Intersectoral partners; Specifically, DHHS should track data on how many families decline Alternative Response services and make improvements to N-Focus to capture this data more easily than having to do manual reviews. This data could also allow for continued review, discussions, and collaboration with stakeholders around the best and most effective engagement strategies in the future, including possibly adding a family peer support component to outreach.
- DHHS should ensure more effective collaboration and communication with county attorneys when opening and closing Alternative Response and non-court voluntary in-home cases and provide information on Alternative Response and voluntary in-home cases at 1184 meetings.
- DHHS should also work closely with the county attorneys to ensure that either the county attorneys or child advocacy centers are notified when a family refuses to engage in Alternative Response or voluntary non-court case, after a substantiated report of abuse and neglect, and the CFS case worker plans to close out the case. These stakeholders should be given an opportunity to review and consult with the CFS case worker about any other action that could potentially enhance future child safety and/or mitigate any potential risk, including the county attorney calling a staffing. Here is one comment from our county attorney survey that is apposite: "We have workers that are not familiar with these families or the services in the area, yet they are making decisions on these families with no input from anyone in the community. If I did not constantly monitor intakes and follow up with

DHHS, numerous children and families who need assistance would fall through the cracks."

- In rolling out future changes to its FFPSA plan, including adding to the proposed service array, meeting additional gaps in service, and before submitting any amendments to the current FFPSA Plan, including changes to the definition of "candidacy," DHHS should engage and include key Intersectoral partners, in-home service providers, families and individuals with lived experience and Tribes in decision making.

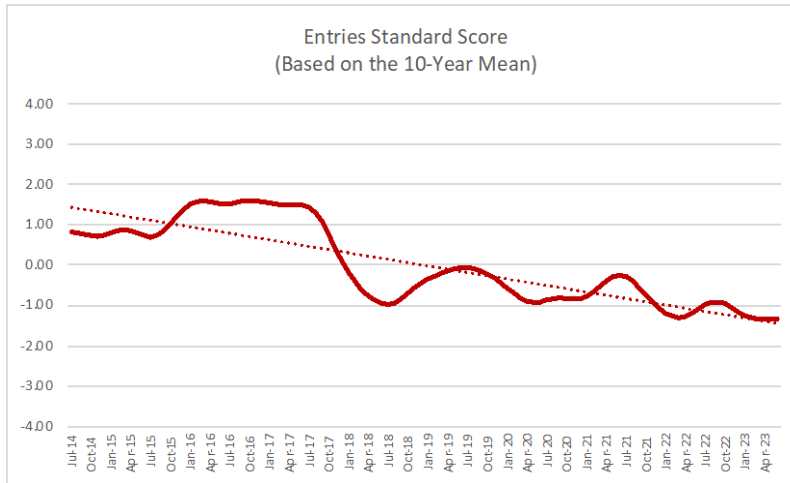
More Focused and Coordinated Effort Is Needed on Enhancing Timely Exits from Foster Care, Including Sustained Engagement of Intersectoral Partners (II.B)

Out-of-home care was reviewed by the Work Group to assess whether and how alternative response efforts and prevention efforts have impacted the child welfare system as a whole. Between July 2014 and June 2023, the number of entries to out-of- home care reduced from an average of 239 to 180 children per month (25%). This reduction in entries largely correlates with the implementation of Alternative Response programming and its subsequent expansion in mid-2017. It is important to note, in 2017 CFS also modified drug testing policies, which relaxed testing standards and may have also contributed to a reduction in entries to out-of-home care.

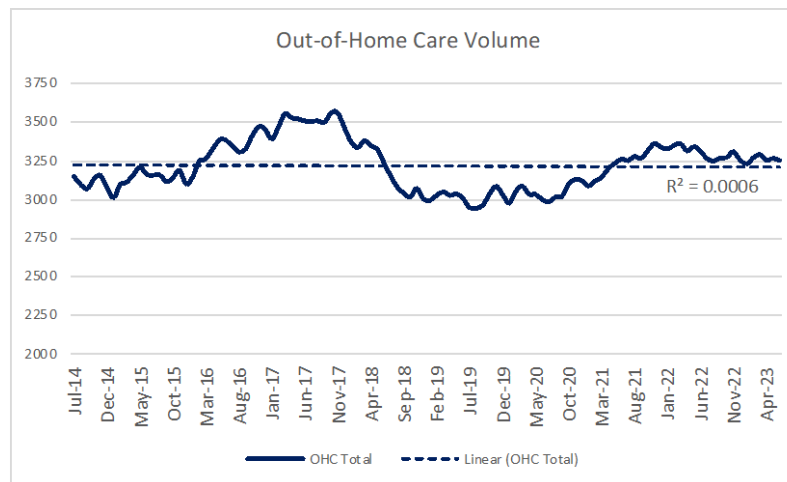


The correlation between the expansion of Alternative Response programming, changes to the drug testing policy and the impact on removals is clearly depicted in

the chart below. To determine when significant changes to the rate of entries occurred, monthly removal data was statistically smoothed and standardized based on the deviation from the ten-year mean removal rate. The resulting graph provides an indication as to when changes to the rate occurred and how large those changes were in relation to the mean. A significant reduction in removals occurred in July of 2017 then continued on a slight downward trend over the next five years with slight fluctuations over the period.

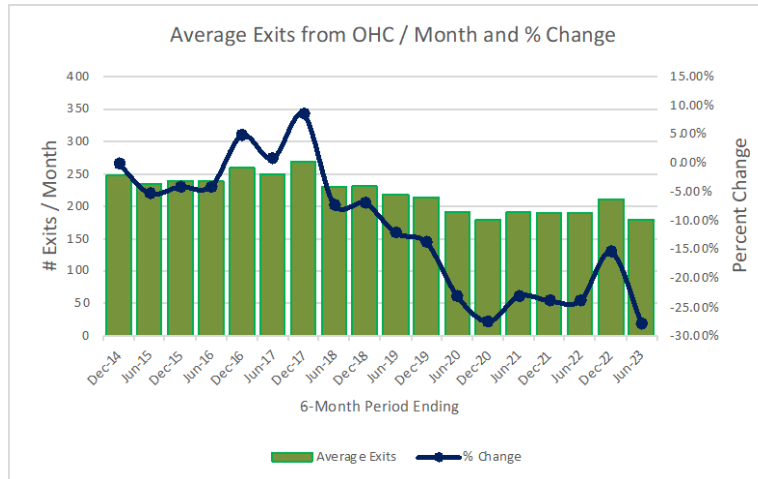


However, during this period, while the number of children entering care per month has been significantly reduced, the number of children remaining in foster care has not fallen proportionately. As a result, the Work Group continued their efforts by reviewing statewide permanency (exits from out-of-home care) data. Over the last four years, the total number of exits per year has remained steady, from 2,277 in 2020, to 2,224 in 2023 (6-month data, extrapolated to a full calendar year).

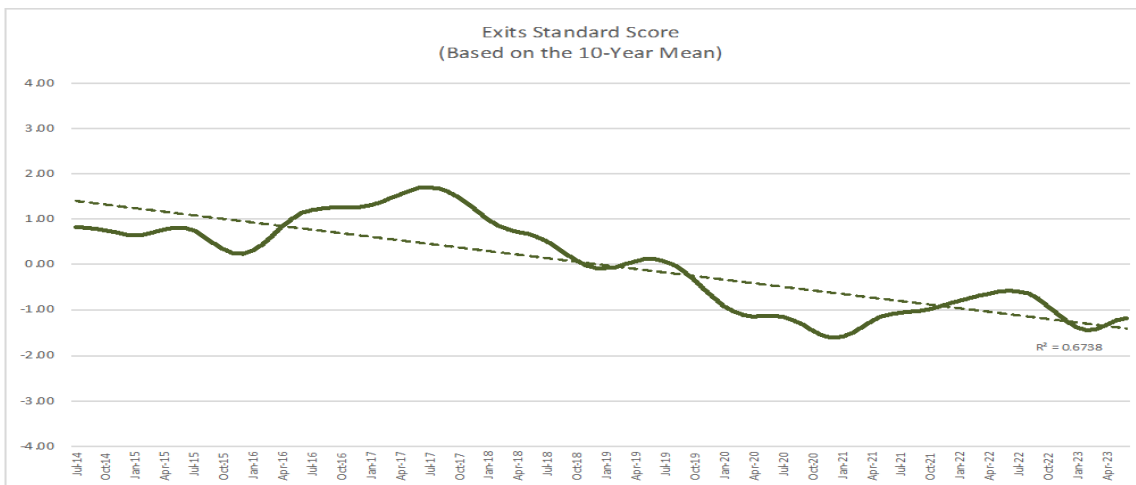


Calendar-Year	<6	6-12	13-18	19-24	25-30	31-36	37-48	49-60	>60	Total-Exits
2020	550	495	351	287	222	153	125	50	44	2,277
2021	468	380	380	301	225	108	113	65	59	2,099
2022	476	420	387	282	221	117	179	72	61	2,215
2023 (6-mo.-Data-Extrapolated-to-a-Full-Year)	512	438	322	300	172	152	144	104	80	2,224

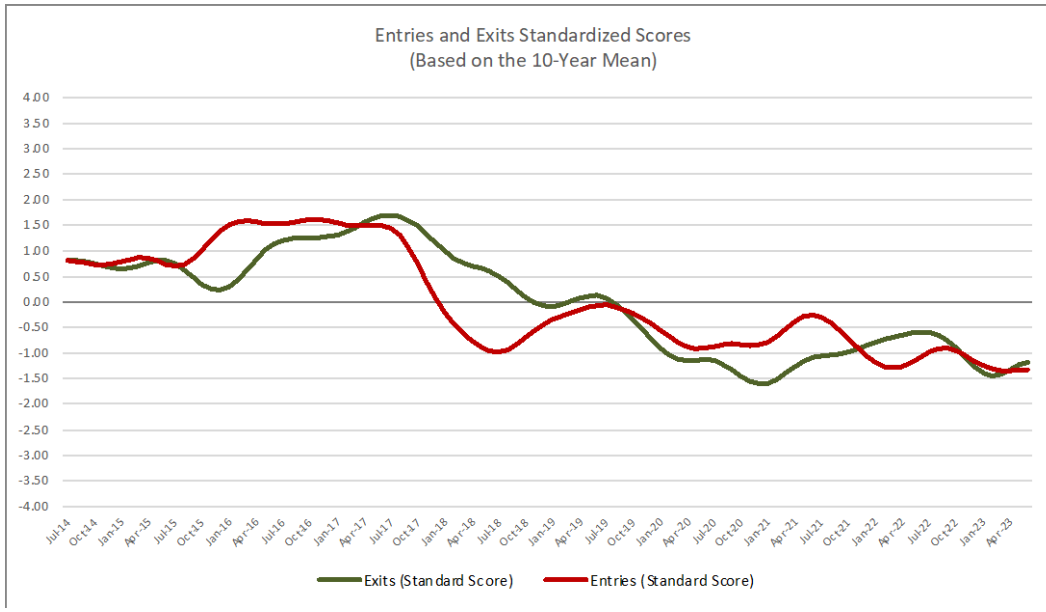
Data for the past ten (10) years shows the overall number of exits from out-of-home care has fallen from an average of 248 children per month during the ten-year period covering July 2014 through June 2023. This equates to a 28% reduction in exits per month.



Using a similar data smoothing and graphing approach, changes to the rate of exits are clearly depicted.

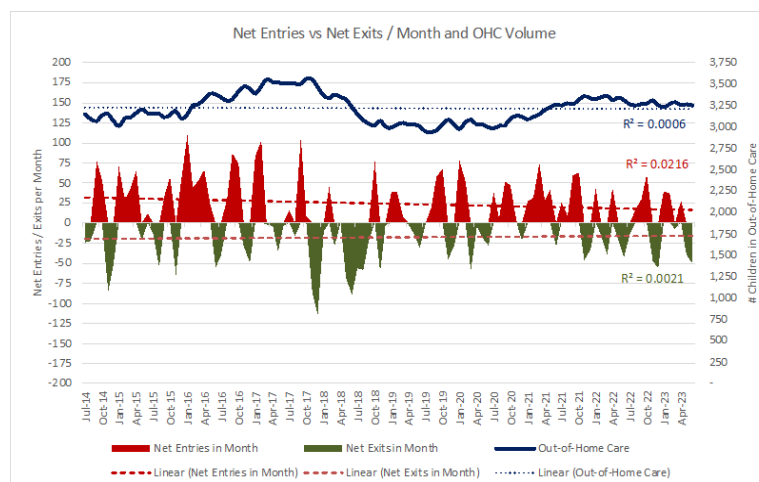


Overlaying the statistical entry and exit charts, provides a visual comparison of the similar reduction to both entries and exits from out-of-home care over the time period is clearly shown.



As a result, over the period reviewed net entries and exits to care remained fairly equal and the resulting number of children in out-of-home care was not impacted by the changes to state child welfare practice.

What that tells us is that children are staying in foster care in Nebraska for longer periods of time. This aligns with what we heard during our interviews and focus groups in the field with many CFS staff, child placing agencies and other stakeholders.



We heard that many of these cases where permanency goals are not being met involve higher needs children that require more intensive support. The future Treatment Foster Care model and roll out should help address some of these cases in a timelier way. We also heard other factors such as continued parental substance abuse issues, including lack of access to effective treatment; Multiple case managers assigned to a case, due to high turnover; Parents not able to access timely behavioral health services, or parent education services; and, in a number of cases parents not

engaged in case planning and, thus, a case plan not filed timely enough. In addition, unstable housing, lack of employment and issues of economic distress result in further delays in permanency.

In the LB 1173 Practice Model we outline the following practices that will help in increasing the time to permanency:

- Permanency begins at the first contact and continues with a sense of urgency until permanency is achieved.
- Focused efforts should be made to timely place children who are legally free for adoption with a prospective adoptive family.
- Promote lifelong connections for each child and when possible, preserve kinship, sibling, and other community connections.
- Value post-permanency support services as a vital support to encourage adoption and assist families to remain committed to children with special needs, so children remain stable with their new families.

In future child welfare transformation efforts, DHHS, along with intersectoral partners, should work together to bring the same level of focus and attention to helping children and youth reach permanency and exit foster care, as has been made in Nebraska in reducing foster care entries overall.

The following are some additional engagement strategies that are aligned with the LB 1173 Practice Model that should be considered:

- Enhance efforts by CFS, child placing agencies, and system partners to recruit, train, support, and retain foster family homes able to meet the needs of children and youth with high needs, especially those with complex mental and/or behavioral health needs. That would enable such youth to remain safely in their communities in the least restrictive environments. Access to such resources needs to be made more readily available throughout the state. Engagement strategies for enhancing access to behavioral health, substance abuse, concrete and economic supports, and social determinants of health are included in this Report and should be part of LB 1173 Implementation going forward. Additionally, DHHS has a detailed roadmap for FFPSA implementation that includes an array of evidence-based programs that will enhance the state's ability to reunify a child and youth with plans in place and access to necessary services and supports.
- LB 1173 implementation should include a comprehensive plan to include additional Intersectoral partner agencies and stakeholders in providing

support to the CFS case workers including help with facilitating access to any service that the family many need to sustain permanency. This could include assistance with housing, childcare, workforce, parent education, public benefits, and other supportive services. This could also include assistance with grandparents/relatives and caregivers that may need kinship support in the community with resources, such as respite, transportation, accessing medical services through the Medicaid managed care organization, school services through the local school district, etc.

- Support from the community where the child and family live, whether it involves navigation, coaching, or help with active parenting. The community can help the case worker in helping a family build the foundations needed to ensure children and families are safe and are thriving.
- Review and consider strategies that have been adopted by states, including the work of Casey Family Programs, and best practice strategies brought by Annie E. Casey Foundation to states that center around permanency planning tools and resources that help case workers and supervisors understand factors that are barriers to permanency and help address through teaming, facilitation, practice, and planning.
- Replicate court multidisciplinary team models that focus on early intervention and timely treatment and services, like the Lancaster Family Drug Treatment Court that has developed some outstanding outcomes to reducing the time to permanency for many cases since 2014.

These efforts will further curtail the number of children and families that are involved with the child welfare-system in Nebraska, thus, allowing for an overall reduction in trauma for children, youth, and families, while at the same time increasing the funding that can enhance all of the key prevention efforts.

III. Develop Skilled and Responsive Workforce

Nebraska needs to continue to cultivate a skilled and responsive workforce made up of professionals to deliver a family-centered model of practice that emphasizes child safety, well-being, and accountability. Training is critical to the development of a skilled child welfare workforce and to achieving the outcomes of safety, permanency, and well-being for children and their families. Child welfare case managers provide a unique and essential service to support children and families. The job of a child welfare case manager is part of a complex and challenging field that exacts significant mental and emotional demands (Kothari et al., 2021; Annie E. Casey Foundation, 2003). As a result, the field has seen significant levels of turnover

for more than three decades (Lipien et al., 2020). A solid base of new worker training is pivotal to child welfare worker retention.

Workforce Training

To professionalize the child welfare workforce, new trainees should not only be better prepared in the knowledge and skill acquisition from their initial training but have the ability to demonstrate their understanding of the complexities of working with child welfare-involved families upon completion.

Ultimately, child welfare performance is measured on the decision-making and actions taken by child welfare workers. The Nebraska child welfare workforce must be equipped with a solid base of new worker training that prepares staff for the complexities and demands of the position and promotes critical thinking and sound decision-making.

Front-line child protection professionals deal with family environments that are constantly shifting, requiring finely tuned decision-making skills and considerable ability to engage families (DePanfilis, 2018). Front-line workers must connect with families who have reason to be suspicious and they must listen carefully and empathically. At the same time, they need to conduct a thorough assessment and think critically to assess the truth and ensure children's safety. They must keep track of an array of different procedures and the necessity to document each one of them. They must engage and work with diverse professionals with varying goals, perspectives and values, and prepare if necessary to testify in court.

They sometimes make the wrenching decision to remove children from their home to protect their safety. They must keep their emotional bearings while confronting human misery and dysfunction. It is not surprising then that child welfare research suggests that child protective services workers can experience considerable stress. One study found that almost half of workers in their sample had a high risk of compassion fatigue (Conrad & Kellar-Guenther, 2006), and others have reported that a number of child welfare workers report clinical levels of emotional distress related to secondary traumatic stress (Bride, Jones & McMaster, 2007; Cornille & Meyers, 1999).

Given the demands of working with families in child protection, transferring knowledge gained in training into practice to bolster a worker's skills and confidence is essential (Liu & Smith, 2011). New worker training sets the stage and foundation but is only the beginning of new knowledge and skill development. Agencies need to acknowledge and prepare new workers that pre-service training is just the beginning and learning is an ongoing journey.

Nebraska Children and Family Services Child Protection & Safety New Worker Training Overview

CFS Child Protection and Safety (CP&S) new worker training is developed and delivered by the University of Nebraska (Lincoln) Center on Children, Families, and the Law (CCFL) through a contractual relationship. The long-term relationship has culminated over 700 years of child welfare experience by the CCFL team. CCFL is led by a training administrator and a well-rounded team of experts to include training manager, curriculum designer, industrial psychologist, attorney, trainers, and field training specialists (FTS). Each of the field training specialists has practical child welfare field experience, including at least two years of CFS experience. The selection and hiring of the FTS position is a joint decision between CCFL and CFS. All training content and curricula is developed in collaboration between CCFL and CFS and external training content must be approved by CFS.

The curriculum designer is a specialty and important position offered by CCFL because it prioritizes instructors' practice based on the needs of the trainees. The primary goal of curriculum design is aligning learning strategies, content, and experiences to improved learning results. The CCFL trainers improve the environment of their classroom by using a curriculum design, since the design allows for more organization and efficiency in their training sessions and material.

CP&S New Worker Training is required by each Child and Family Services Specialist prior to being assigned cases. CP&S New Worker Training has the goal of preparing case managers to intervene as authorized to provide safety for Nebraska's children, families, and communities and to consistently move children in the Department's care to permanency and well-being (Nebraska DHHS-DCFS Child Protection & Safety New Worker Training 2022).

CCFL uses a blended-learning model that incorporates instructor led training, distance learning, and experiential training. The experiential learning includes role play simulation and field training activities. The training is conducted over a 14-week period and new training classes are offered monthly in both east (Omaha) and west (various locations).

CP&S New Worker Training is offered in training "blocks" over the 14-week period for a total of 296 hours. All new workers regardless of stage of service are required to complete training blocks A through I. Additionally, there are two specializations blocks for adoptions and intake. These blocks are webinars and last 6 and 9 hours respectively.

Additionally, CFS incorporates the use of Service Area Learning Teams (SALT) to support the trainee through the learning experience. The SALT includes the trainee's supervisor and field training specialist. Observations and feedback garnered from the SALT helps to inform the trainers about the trainees' progress, skill acquisition, competency with assigned tasks, and identify additional training areas if needed.

CP&S New Worker Training has focus areas to guide their training and includes:

- Advocating for each child's safety, permanency, and well-being
- Respecting each child's family and culture
- Implementing family-centered practice principles into case management to ensure the inclusion of children and families in the decision-making processes that impact their lives
- Adhering to principles and procedures of Structured Decision Making (SDM) for making decisions that will support keeping children and families safe
- Committing to evidence-based and promising family-centered casework practices that utilize a least restrictive approach for children and families
- Enhancing each worker's knowledge, skills, and abilities that are needed to successfully carry out his/her job

CP&S New Worker Training includes these key features (Nebraska DHHS-DCFS Child Protection & Safety New Worker Training 2022):

- Membership in each trainee's own SALT that meets regularly and has the purpose of supporting the trainee through the learning experience
- Training that includes 73 units and follows the life of a CFS case with many concepts interwoven through multiple units
- Training model that uses online learning to teach content that will later be applied in the classroom or during field tasks
- Local office training to include distance learning (self-paced online learning & webinars) and field activities to include shadowing on real cases
- Instructor led training that focuses on the application of content using simulation in the classroom or courtroom, or N-Focus lab.
- To promote the transfer of learning from the classroom to the field, trainees complete field tasks and structured field observations by the FTSs
- A final demonstration and assessment of skills

Nebraska New Worker Training Survey

Child protection services across the United States understand that new worker training effectiveness is a challenge. Child protection workers are required to absorb a plethora of information related to child safety and risk, engagement skills, protective factors, family dynamics, federal requirements, state laws, risk assessments, behavioral health, substance abuse, and learning about services and interventions designed to mitigate some of the challenges families face.

Surveys are a great first step in benchmarking the impact that preservice training programs have on an organization. Specifically, a post-training survey provides feedback from trainees that have recently participated in the preservice training program to help inform the effectiveness and identify areas of improvement. Especially in the current virtual learning paradigm where employee engagement has become a more challenging element in preservice training, the post-training surveys can help improve the training for new child welfare workers.

Training surveys are completed, but the results did not provide the insight TSG was hoping to analyze to identify strengths, opportunities, and recommendations to improve the CFS new worker training.

Survey Results

TSG developed a survey targeted at four focus areas of the new worker training. The survey was conducted during the entire month of June 2023. The survey collected 237 completed responses from CFS workers across the state. While the process focused on participation more than sampling criteria, the respondents aligned well with the job position characteristics of the agency. The position characteristics include the following:

- Eight-three (83) percent of the respondents were CFS Specialists
- Nine (9) percent were CFS Supervisors
- Three (3) percent were Lead Workers

Respondents were also asked when they completed the new worker training:

- Twenty-four (24) percent completed training in 2023
- Forty-one (41) percent completed training during calendar years 2021 – 2022
- Eleven (11) percent completed training during calendar years 2019 – 2020
- Eight (8) percent completed training during calendar years 2015 – 2018
- Fifteen (15) percent completed training prior to 2015

After asking position type and tenure related questions, the survey asked the respondents questions related to four focus areas: training material and content, instructor, training, and overall effectiveness. The matrix below summarizes the responses to the survey.

Summary Survey Responses	
Question Area	Response
Training Material & Content	• 56 percent agreed or strongly agreed the material aligned with the actual job responsibilities • 33 percent agreed or strongly agreed the content prepared them for their jobs • 40 percent agreed or strongly agreed the content was sufficient for their specific position
Instructor	• 83 percent agreed or strongly agreed the instructor was engaging and supportive • 79 percent agreed or strongly agreed the instructor effectively presented the content • 75 percent rated the instructor as effective or highly effective
Training	• 78 percent agreed or strongly agreed the training was delivered at a comfortable pace and they had adequate time to complete • 46 percent were able to immediately apply what they learned in training • 47 percent reported the training was relevant to real situations encountered while performing the job • 71 percent indicated they learned something different in training then how it was performed in the field
Overall Effectiveness	• 40 percent agreed or strongly agreed training met their expectations • 54 percent agreed or strongly agreed they could relate training objectives to the learning achieved • 29 percent agreed or strongly agreed they felt competent and confident after training

The analysis of the New Worker Training survey responses identified several strong emerging themes. The responses identify a significant disconnect between the training content and real-time job applicability to expectations. It's not surprising and should be expected, child welfare pre-service training throws a lot at new workers, and it's not uncommon for new workers to feel overwhelmed as they begin their new career journey. Although the respondents were clear with some very high percentages, the training was not always throwing the right things at the new workers.

Less than half of the respondents agreed the material was sufficient for their specific position and just over half felt the content aligned with their actual job responsibilities. The respondents' understanding of the learning objectives and comprehension of the training material scored very high, but the respondents felt the curriculum did not prepare them for the daily demands of child welfare.

An overwhelming percentage of the respondents felt that the instructors answered questions, were engaging, had strong presentation skills, and rated the overall effectiveness of the trainers as very high. This was not surprising given the experience of the CCFL training staff and their long-term relationship with CFS.

The respondents expressed satisfaction with the pace of the training and the time to complete the training was acceptable to the trainees, but the training relevance and application to the job scored low. This was further amplified in the comments by Initial Assessment and On-going workers expressing the training was too focused on areas not within the scope of their responsibilities.

When the respondents addressed the overall effectiveness of the New Worker Training, it was clear the training did not meet the expectations of most of the trainees, and they did not feel competent or confident after training to do their job.

One respondent wrote, "The sheer amount of things and policies that we need to know were overwhelming." Another wrote, "We need more hands-on training with a mentor completing parts of a case." Additionally, one wrote "the role playing was a waste of time." Again, these comments are not totally unexpected, but adjustments could be made to improve the new workers' sense of preparedness as they finish the New Worker Training and move into the next phase of their career journey.

Overall, the New Worker Training Survey points to a committed training team, strong curricula, with a nationally recognized blended-learning model. However, the training design, alignment of the most prevalent skills required, and the modernization of the simulation training could improve New Worker Training and better prepare Nebraska's next generation of workers and leaders in child welfare.

Focus Group Summary

TSG met with a focus group of tenured supervisors from different parts of the state to discuss CFS new worker training. When asked what was working, all of the supervisors agreed the base training of child and family assessment, Structured Decision-Making, policies, and regulations was on point, but there was

acknowledgement it was a tremendous amount of information for new workers to absorb. Following up on what was working, the supervisors were quick to highlight the role and experience of the Field Training Specialist. The supervisors also agreed the experience and knowledge of the CCFL trainers was excellent. The supervisors also mentioned the online training as positive and shadowing in "real" cases as excellent modalities in the new worker training.

When asked what was not working, the supervisors agreed the training lacked the "how" to apply learning to actual case activities. Some examples provided included engagement skills and referrals for services to children and families. The supervisors were also in agreement that the existing new worker mentor program is not effective. Mentors are assigned their own cases and it's difficult to balance working with new staff. Additionally, mentors do not receive a stipend for the additional responsibilities, although they had in the past. Another challenge identified was the Desk Aid embedded in N-Focus.

When asked what was missing in the training, how to apply learning continued to be the primary issue. Supervisors would like to see more emphasis on engagement and dealing with and having difficult conversations with challenging clients. The how to apply the tools and policies learned in training is another area supervisors feel requires more focus. Supervisors also identified time management skills and selfcare as missing in training.

Supervisors were asked how to improve new worker training and three prevalent focus areas were highlighted; 1) new workers need more time in the field shadowing on real cases, and 2) more focus on the day-to-day activities of a child welfare worker, and 3) training concentration on a new workers assigned role.

Trends in Child Welfare New Worker Training

Many states have started to provide experiential learning as a complement to traditional classroom training for their child welfare workforce. Child welfare workers around the country are exposed to simulation training with mock home visit training and mock court room hearings. Nebraska jumped on this train early to incorporate a blended learning model into new worker training many years ago.

Research indicates that as little as 10 to15% of training content is actually transferred to practice in the workplace (Kontoghiorghes, 2004). Collins, Amodeo, and Clay (2007) evaluated numerous federally funded training projects to determine if training had the necessary impact on new workers. These authors recognized that classroom instruction models can be effective for transfer of certain learning tasks

but stated “they may be highly limited when applied to the complex nature of intervening with families with great challenges.”

Traditional child welfare training has historically combined instruction in practice and agency policies with examples, often shared from the trainer’s own experiences in the field. These shared experiences can be illustrative but may be counter-productive if policies and practices have changed over the years and/or the shared experience no longer represents best practice.

Classroom PowerPoints can highlight procedures, policies, and practices by reviewing the “why and what” but has limitations for the critically important “how” of assessing and engaging families. For new child welfare workers, the “how” is what builds confidence, competence, and develops the expertise required to engage families and assess the risk of child maltreatment.

Many researchers in the education field have advocated for experiential learning (Kolb, 2015; Kreber, 2001) and active learning for some time (Astin, 1993; Pascarella & Terenzini, 1991; Terenzini & Pascarella, 1998), but prior to 2014, there is little evidence that experiential learning beyond role play was used for child welfare professionals (Bogo, Shlonsky, Lee & Serbiski, 2014).

These gaps in knowledge and skills can be supplemented by on-the-job experiential training in most professions, with new employees shadowing other employees, or a preferred model using a dedicated mentor. Nebraska does use a field training specialist as part of the new worker training, but it ends or does not last long enough to develop solid practice skills. Nebraska has also used full-time mentors in the past, but now mentors are also case carrying workers and caseloads have been too high to allow for long periods of mentoring or not using mentors at all. These realities exponentially highlight the need for experiential training to provide opportunities for practice to take new workers out of the classroom and into situations that give them opportunities to apply new skills.

During the last several years, many child welfare agencies have adopted simulation training to strengthen worker confidence, build capacity, reinforce learning, and expand child welfare skill sets. The training simulates real-life situations and conditions to provide the most comprehensive experience for child welfare trainees. Simulation and role play training are considered types of experiential learning but have distinct differences. Role play scenarios are done in the classroom without specific rehearsal, staging, and props. Simulation training strives to create real-world situations, conditions, and scenarios to reflect an environment a worker may actually experience.

Virtual simulation training occurs in a digital environment using a computer or virtual reality headset. Utah has incorporated virtual simulation training by creating videos of home visits. Onsite simulation training takes place in a realistic environment designed to recreate real situations a child welfare worker may experience in the field. Florida has begun to incorporate the hiring of actors and sets with scripted scenes to recreate encounters a worker may experience.

There are four primary benefits for child welfare simulation training; (Capacity Building Center For States, 2020 Keeping it Real; How simulation training can support the child welfare workforce)

- Allows workers to practice their skills in an environment similar to the complex situations they will encounter in their practice
- Increases worker confidence when in the field
- Encourages trainers to break down skills into manageable subsets allowing skills to be built in a thoughtful way that increases the chance of success for participants
- Supports workers in transferring newly acquired skills to real-life situations

There is a plethora of research in child welfare highlighting the benefits and importance of experiential learning to prepare new child welfare professionals. Below are a sampling of examples:

Kourgiantakis, T., Bogo, M., Sewell, K.M. (2019) Practice Fridays: Using simulation to develop holistic competence. *Journal of Social Work Education,* 55(3), 551-564*. h*ttps://doi.org/10.1080/10437797.2018.1548989

Haight, W., Waubanascum, C., Glesener, D., Day, P., Bussey, B., & Nichols, K. (2019). The Center for Regional and Tribal Child Welfare Studies: Reducing disparities through indigenous social work education. *Children and Youth Services Review, 100*, 156-166. https://doi.org/10.1016/j.childyouth.2019.02.045

Lee, B., Ji, D., & O'Kane, M. (2021). Examining cross-cultural child welfare practice through simulation-based education. *Clinical Social Work Journal, 49*, 271-285. https://doi.org/10.1007/s10615-020-00783-8

Pecukonis, E., Greeno, E., Hodorowicz, M., Park, H., Ting, L., Moyers, T., Burry, C., Linsenmeyer, D., Strieder, F., Wade, K., & Wirt, C. (2016). Teaching motivational interviewing to child welfare social work students using live supervision and standardized clients: A randomized controlled trial. *Journal*

of the Society for Social Work and Research, 7(3), 479-505. https://www.journals.uchicago.edu/doi/pdf/10.1086/688064

Radey, M., Schelbe, L. & King, E.A. (2019). Field Training Experiences of Child Welfare Workers: Implications for Supervision and Field Education. *Clinical Social Work Journal, 47*, 134–145. https://doi.org/10.1007/s10615-018-0669-2

Goulet, B. P., Cross, T. P., Chiu, Y., & Evans, S. (2021). Moving from procedure to practice: a statewide child protection simulation training model. *Journal of Public Child Welfare, 15*(5), 597-616. https://doi.org/10.1080/15548732.2020.1777247

University of Utah College of Social Work. (2019) Changing the way child welfare workers learn. https://socialwork.utah.edu/publications/innovation-matters/2018/childwelfare-workers.php

States are also exploring the implementation of professional certification programs for their child welfare workforce. Certification would provide evidence that Nebraska's child welfare professionals have demonstrated competency in their field by successfully passing a rigorous evaluation. Certification demonstrates the workforce has the knowledge and skills to perform and practice high quality child welfare services.

Professional credentialing also strengthens the public's confidence in the skills and integrity of the certified professional. Research shows that certification programs benefit the public, the employer, and the certified employee. Additionally, the Child Welfare League of America published a study suggesting credentialing child welfare workers can promote competent care.

According to the National Certification Board for Child Welfare Professionals, the employer benefits include:

- Demonstrates agency commitment to superior service by qualified individuals
- Reduces turnover as certified professionals report greater job satisfaction
- Encourages on-going professional development
- Allows real-time verification of potential employee's qualifications and disciplinary history

The certified individual benefits include:

- Enhances confidence in ability to recognize and respond to risk indicators and use appropriate decision-making skills
- Provides portability – the credential belongs to the individual
- Increases sense of professional accomplishment and credibility
- Supports continued professional development through annual educational requirements
- Demonstrates commitment to ethical and professional conduct

Nebraska New Worker Training Strengths

- The long-term relationship with University of Nebraska adds significant credibility to the new worker training and adds consistency to the training model
- Center on Children, Families, and the Law (CCFL) has a combined 700+ years of child welfare experience; to include a training manager, curriculum designer, industrial psychologist, attorney, trainers, and field trainers
- National child welfare publications have recognized Nebraska for their training approach using a blended-learning model
- The use of a Field Training Specialist to introduce and reinforce practice techniques and approaches real-time in the field during the shadowing experiences
- The Service Area Learning Teams provide an additional layer of support and the monitoring progress for new trainees

Work Group Recommended Strategies for CFS New Worker Training (III.A)

The following strategies should be considered by DHHS in adopting new worker training for CFS staff:

- The curricula should be redesigned using the newly created and adopted Nebraska child welfare practice to shape and inform the construction of the new worker training
- Rebrand the training model to include worker wellness throughout the training to prepare the workforce for the demands of the profession and increase retention rates
- Re-imagine and develop a new “Core” training module that focuses on the foundational elements and knowledge all new workers should understand – the “Why” and “What” of the Nebraska child welfare system
- Re-imagine and develop specialty tracks (Intake, Initial Assessment, On-going, Adoption) to streamline and reduce the amount of time trainees spend in training and allow workers to focus on their selected stage of service

- Include testing and require a passing score after the “Core” and “Specialty” training blocks to measure knowledge acquisition, training effectiveness, and worker preparedness
- Re-examine the existing blend of experiential and simulation training to include more “Real” field practice aligned with the most prevalent skills and practices required to prepare a new worker
- Continue to build on the experiential platform by modernizing the simulation training and incorporate virtual reality to augment real-life scenarios a worker may experience
- Consider partnerships with local Community Colleges in the West and Northwestern parts of the state or find creative ways to deliver training in the remote parts of the state
- Create dedicated mentors to assign to all new workers for a period of at least six months
- Adopt an initial and ongoing professional certification process for the child welfare workforce
- Adhere to a manageable glidepath for the assignment of child welfare cases (families) to new workers

CFS Workforce/Caseload Review

Child welfare leaders have long recognized the value of organizational stability to achieve desired outcomes. The impact of instability and an inexperienced workforce has severe consequences in many fields, but exponentially more in child welfare. The need for well trained, experienced, and those committed to the mission of child protection are critical to achieving the best outcomes for the children and families served.

The workgroup sought to explore actionable factors most relevant to improving recruitment and retention of Nebraska’s child welfare workforce. The body of work to address the acute and systematic problems of Nebraska’s CFS workforce challenges used an analytical approach to identifying a set of actions that held a reasonable probability of improving outcomes with recruitment and retention. We used data collected during a series of community forums and focus groups conducted around the state during the Summer of 2023, national research and data, and incumbent surveys to isolate key factors and related recommendations.

Improving quality outcomes for children and families is directly aligned with an agency’s ability to build a high-quality, professional, and stable workforce with manageable caseloads. Child protective services (CPS) workers help children and families in complex environments that demand a skilled and professional workforce.

The work requires a specialized set of intellectual and behavioral skills with appropriate and effective training.

Child protective services workers provide a unique and essential service to support the children and families served by Nebraska's Children and Family Services Division (CFS). The role is a complex and challenging job that requires significant mental and emotional demands (Kothari et al., 2021; Annie E. Casey Foundation, 2003). As a result, the field has seen significant levels of turnover for more than three decades (Lipien et al., 2020).

High CFS turnover disrupts continuity and stability of service for the families they serve, but also creates instability in the workplace through increased workload and the depletion of skilled workers. Child welfare leaders know high attrition amongst the CPS workforce has a direct effect on the quality of services and a negative impact on service outcomes. Improving the recruitment and retention of skilled workers is of critical importance to ensure the continuity of quality services and maintaining reasonable stability in the workforce and workload.

Even after the Covid-19 Pandemic, the current labor market continues to present challenges to both private and public sector employers at all levels. The combination of the pandemic, changing perceptions of the workplace to include remote work options, shifting employer needs, and life priorities all perpetuate skill shortages in key categories and industries.

A plethora of research indicates that unmanageable workloads are a key contributing factor in child welfare turnover. High caseloads drive both high turnover and poor outcomes for children. This produces a Freudian effect leading to higher levels of turnover, lower job satisfaction, increased workloads, and poor quality of service delivery (Clark et al., 2011). In a 2008 report, the Child Welfare League of America suggested that,

> "*No issue has a greater effect on the child welfare system's capacity to serve at-risk and vulnerable children and families than a shortage of competent and stable workforce."*

The workgroup identified numerous comments and observations, most, if not all provide confirmation of issues and concerns previously identified in other national child welfare workforce research. The themes were repeated often in the community forum meetings and routinely identified as a key challenge across the entire state. The findings offered insight into the overlapping and complex root

cause factors that create issues with recruitment and retention. The most often repeated themes related to workforce challenges, included:

- High caseloads / workload
- Low compensation
- Lack of resources
- Work-life balance
- Multiple job demands

Caseload / Workload

Workload was highlighted in the community forums, focus groups, and surveys as a primary reason CFS staff leave. The findings are consistent with national studies suggesting one of the most prevalent reasons workers leave child welfare is workload.

Nebraska law 68-1207 requires the Department of Health and Human Services to maintain caseloads to carry out child welfare services which provide adequate, timely, and in-depth investigations and services to children and families. The law requires caseloads to range between twelve and seventeen cases based on the following criteria:

1) If children are placed in the home, the family shall count as one case regardless of how many children are placed in the home
2) If a child is placed out of the home, the child shall count as one case
3) If, within one family, one or more children are placed in the home and one or more children are placed out of the home, the children placed in the home shall count as one case and each child placed out of the home shall count as one case
4) A child is considered to be placed in the home if the child is placed with his or her biological or adoptive parent or a legal guardian and a child is considered to be placed out of the home if the child is placed in a foster family home, a residential child-caring agency, or any other setting which is not the child's planned permanent home.

Additionally, 68-1207 requires the department to include the workload factors that may differ due to geographic responsibilities, office location, and the travel required to provide a timely response in the investigation of abuse and neglect, the protection of children, and the provision of services to children and families in a uniform and consistent statewide manner.

Nebraska 68-1207 also requires the department to utilize the workload criteria established as of January 1, 2012, by the Child Welfare League of America (CWLA). 68-1207.1 requires the department to annually provide a report to the Legislature and Governor outlining the caseloads of child protective services, the factors considered in their establishment, and the fiscal resources necessary for their maintenance. The department's annual report shall also include changes in the standards of the CWLA or its successor. Several years ago, the CWLA discontinued publishing their caseload standards and began shifting their efforts to focus on the related workload.

The annual report to the Legislature and Governor outlining the caseloads of child protective services must include the following:

1) A comparison of caseloads established by the department with the workload standards recommended by national child welfare organizations along with the amount of fiscal resources necessary to maintain such caseloads in Nebraska
2) The number of child welfare case managers employed by the State of Nebraska and child welfare services workers, providing services directly to children and families,
3) Statistics on the average length of employment in such positions, statewide and by service area
4) The average caseload of child welfare case managers employed by the State of Nebraska
5) The outcomes of such cases, including the number of children reunited with their families, children adopted, children in guardianships, placement of children with relatives, and other permanent resolutions established, statewide and by service area
6) The average cost of training child welfare case managers employed by the State of Nebraska statewide and by service area

The Child Welfare League of America (CWLA) has long been the premier resource at setting caseload and workload standards since the 1980s. For decades, the benchmark caseload standards for child protective investigations (Nebraska refers to these as Initial Assessment (IA) workers) was no more than 12 active cases and 12-15 children for foster care workers (Nebraska refers to this workforce as Ongoing). Additional benchmarks for child welfare workers working with child welfare involved families varies by the number of families and the corresponding level of risk. See below CWLA previous caseload standards.

Previous CWLA Caseload Standards	
Worker Type	**Caseload Standard**
Workers making initial CPS assessments	No more than 12 active reports per month
Workers providing ongoing CPS support	No more than 17 active families, assumingthe rate of new families assigned is no more than one for every six open families
Working both making initial CPS assessments and providing ongoing CPS support	No more than 10 active ongoing families and no more than 4 active initial assessment
Worker providing Intensive Family-Centered Services	2-6 families
Worker providing Family-Centered Casework	No more than 12 families
Worker counseling with birth families, preparing and assessing adoptive applicants for infant placements and supporting these families following placement	20-25 families
Worker preparing children for adoption who are older or who have special needs	10-12 children
Worker assessing and preparing adoptive applicants for the placement of children whoare older or have special needs and providing support to these families following placement	12-15 families
Worker assessing and preparing adoptive applicants for inter-county adoption	30-35 families
Family foster care social worker	12-15 children, depending on the level of services required to meet the assessed needs of each child

The Nebraska Legislature requires the department to utilize the workload criteria of these standards established as of January 1, 2012, by the Child Welfare League of America. The law is ambiguous because it also describes caseloads of 12 – 17 children per worker based on defined case types that are not aligned with the criteria established by the CWLA.

Although the CWLA had previously recommended no more than 12 – 15 children per worker for foster care workers and a certain number of families served by a worker, depending on case type, Nebraska blends their workforce with Ongoing workers that serve foster care and children served in the home. The children and caseload data provided and maintained by CFS makes it challenging to calculate using the required Nebraska 68-1207 or the CWLA standards.

For example, after reviewing the most recent July 2023 CFS Caseload Status Report, that tracks monthly caseloads of CFS Specialists and CFS case manager positions, we were unable to determine how the above CWLA standards were applied. The report blends several of the CWLA caseload standards for children served in the home and out of the home and uses percentages of staff in compliance with the standards rather than actual caseload ratios. The report indicates that statewide IA workers

are 96.6 % in compliance with the CWLA standards and Ongoing workers are only 61.9% in compliance with the CWLA standards. Additionally, when both types of workers are combined, CFS reports they are 70% in compliance with the CWLA standards.

Additionally, the calculations are limited to staff with one or more assigned CFS cases. The report has 381 workers with one or more assigned cases. At the time the report was filed, there were 549 filled positions (625 CFS positions authorized including Hotline and Adult Protective Services). 525 of the CFS positions are assigned as CFS Specialists and lead workers (IA & On-going), although CFS does not assign a dedicated number of positions to the Initial Assessment and On-going job type. Additionally, a percentage of the CFS workforce do both IA and On-going job functions. This further complicates the task of calculating and projecting caseloads. The difference in filled positions and workers assigned cases is caused by the number of workers in training and a small percentage not assigned cases for other reasons, e.g., FMLA.

As comparison, TSG reviewed a larger sample of CFS data related to both IA and Ongoing workers using the number of intakes and children served over the last three years to show a caseload ratio. This method does not consider if there is more than one child in the home, therefore, the calculated and projected caseloads in the below chart could be slightly lower. We were able to identify an average of 14,814 cases that were accepted for investigation during this time period – see below.

Intakes						
				Accepted	Not Accepted	Total
Year	Substantiated/Court Pending	Alternative Response	Not Substantiated			
2020	1,776	1,528	10,051	13,355	21,046	34,401
2021	1,937	3,358	10,820	16,115	21,504	37,619
2022	1,749	4,338	8,885	14,972	25,542	40,514
			Avg	14,814		

Using this calculation, based on the number of filled IA positions as of July 2023, CFS would appear to meet the CWLA standard of 12 active cases per month for IA workers. However, please note that assigned cases are not the same as active. CFS is actually in a position to reallocate some of its IA workforce to On-going to balance the workload – see below chart.

	Initial Assessment Workers	2020 – 2022 Avg Monthly Intakes	Caseload
Filled Positions	141	1,234	8.75
Authorized Positions	120	1,234	10.28

For Ongoing workers, the average number of children served monthly from July 1, 2022, through June 1, 2023, was used to calculate the average number of children assigned to a CFS Ongoing worker per month – see below.

Monthly Children Served

Date	Residential	Kinship	Foster Care	Other	Total Out of Home	In Home	Alternative Response	Total Children Served
6/1/2023	315	1801	985	150	3251	1173	1485	5909
5/1/2023	318	1812	996	139	3265	1161	1543	5969
4/1/2023	313	1819	996	124	3252	1152	1515	5919
3/1/2023	303	1829	1030	128	3290	1078	1774	6142
2/1/2023	288	1857	985	137	3267	1128	1580	5975
1/1/2023	294	1828	985	122	3229	1178	1460	5867
12/1/2022	280	1805	1047	122	3254	1105	1527	5886
11/1/2022	256	1858	1068	128	3310	1105	1682	6097
10/1/2022	241	1842	1052	135	3270	1126	1546	5942
9/1/2022	233	1850	1051	132	3266	1213	1288	5767
8/1/2022	217	1840	1069	122	3248	1299	1446	5993
7/1/2022	206	1832	1099	126	3263	1256	1591	6110
							Avg	**5,964**

The number of filled and authorized Ongoing workers was used to calculate the average number of children assigned per month per worker. Using the modified CWLA standard, it appears that CFS does not meet the target with filled positions. It should be noted that the caseloads are exponentially higher for much of the workforce because a portion of the workforce is new with protected caseloads. However, as can be seen below, if CFS was able to fill more of their authorized positions, they could meet the caseload standards of 12 to 17.

	Ongoing Workers	2022 – 2023 Avg Monthly Children Served	Caseload
Filled Positions	273	5,964	21.8
Authorized Positions	405	5,964	14.73

The caseload standards reflect the maximum number of children or cases for which a worker should be responsible. Recently, the CWLA recognized that the number of

children or families was not sufficient, and that the actual workload associated with each child or family should also be considered.

The CWLA reported that most agencies tend to focus only on the caseload size standards, and not on the actual work required for each child or family. Therefore, the CWLA Program Specific Standards of Excellence recommends that a workload study be conducted to reflect a better benchmarking of what an actual caseload should be in relation to work being done, including the consideration of local context. A 2018 CWLA report did not offer a definitive solution to the challenges of measuring and interpreting child welfare caseload and workload, it actually reported the field is not there yet (2018 Collins-Camargo et al.,)

CWLA is currently updating its Program Specific Caseload/Workload Standards and moving away from the traditional focus on caseload standards by creating outcome-based workload standards. The CWLA is also developing a methodology for managing the new standards. The Nebraska Legislature's foresight many years ago to include workload factors such as geographic responsibilities, office location, and staff travel is aligned with the direction the CWLA wants to take child welfare workload standards. A complete workload analysis would also include, but not be limited to, case acuity, identifying all activities and tasks for each stage of service, court time, activity time studies, data entry, etc.

As noted earlier in the workgroup report, the CWLA reports that unmanageable caseloads/workloads impact a worker's ability to achieve results for the children and families they are assigned, but it is also a catalyst in worker turnover.

Therefore, child welfare agencies should strive to ensure that their staff has manageable workloads (not caseloads) to achieve positive outcomes for the children and families they serve. The recent CWLA National Blueprint for Excellence in Child Welfare recommends that child welfare agencies develop a system appropriate to its size and function for evaluating the effectiveness of its workforce and the efficacy of each person's workload.

Work Group Recommendation for CFS Caseload (III.B)

The workgroup recommends Nebraska adopt the CWLA approach and conduct a caseload / workload analysis to set new standards of monitoring and evaluating their child welfare workload.

Nebraska CFS Best of the Best Survey Results

TSG conducted a survey of tenured (three or more years of experience) Nebraska child welfare professionals. Forty-one staff with 3 or more years of experience responded to the survey. Half of the responses were received from the Eastern and Southeastern service areas, and the remaining responses from the Central, Western, and Northern service areas.

Eighty percent of respondents indicated that child welfare became their career goal after college or after their first job and a related question revealed that child welfare was not their ultimate career choice before or during college for seventy-five percent of the respondents.

Ninety percent of the best of the best had prior job experience and almost seventy percent had job experience in a related human services field.

Survey results also reinforced similar themes highlighted during the community forums around the state. When the best of the best survey participants were asked why their co-workers leave child welfare, the top three answers were: emotional exhaustion, high caseloads, and low compensation. The participants were asked to identify what they like least about the job and the top answers included high caseloads, stressful nature of the job, amount of paperwork, compensation, and lack of salary progression.

When asked if their co-workers were actively searching for a new job in the last 6 – 12 months, seventy percent responded yes. When the best of the best were asked if they were actively searching for a job, fifty-one percent responded yes.

When the best of the best were asked what they liked most about their job, the number one response with a ninety-one percent response, helping children and families. The best of the best were asked to identify their top retention strategies and the top two answers were manageable caseloads and improved compensation.

Similar surveys were conducted in Florida and Texas (2014 – 2021) and child welfare workers reported that workload, low compensation, and the lack of career progression were significant contributing factors to turnover (FCC 2021; Texas 2015, FCC, 2014). All three studies found more than 80% of respondents felt workload and compensation were key factors that led to turnover. Moreover, in 2021, when asked what they liked least about their job, case managers reported that compensation (54.13%) and lack of salary progression (67.7%) were the two top reasons for dissatisfaction. Similarly, when asked why their coworkers left their

position, the stressful nature of the work, work/life balance, and compensation were the top three reasons suggested for turnover.

CFS Leader Survey Results

Fifteen CFS leaders and supervisors were asked a series of questions to compare and validate the survey results of their staff across the state. Like their staff, seventy-four percent of CFS leaders did not consider child welfare as a career goal until after college or their first professional job. When asked if turnover and high caseloads were a problem, one hundred percent answered yes to both questions. When CFS leaders were asked what their staff like least about their job, the top answers were:

1) High caseloads
2) Stressful nature of the job
3) Compensation
4) Lack of salary progression

When asked why their staff leave child welfare, the top answers were:

1) Emotional exhaustion
2) High caseloads
3) Work/life balance
4) Compensation

As expected, the results of why staff leave child welfare align closely with what staff like least about their job. CFS leaders were asked to identify the top traits for an ideal child welfare worker, the top answers were:

1) Passion for helping children and families
2) Ability to handle stress
3) Personal resilience

CFS leaders were asked to identify strategies to retain high quality child welfare workers and reduce turnover, overwhelmingly, the top answers were:

1) Manageable caseloads
2) Improved compensation

One of the leaders' responses was a good summary of the results, "More child welfare workers - the amount of work expected is very high and we are constantly adding more to their plate. To do good work staff should be kept at the designated

case cap and really give them time to do good work - that only comes from lowered caseloads".

CFS Salary

The Nebraska child welfare worker salary reported by CFS reflects a worker that has completed new worker training, OJT, and promoted to the full CFS Specialist position is $51,064. Nebraska's starting CFS worker (trainee) salary is $43,546. The current average salary for a CFS Specialist is $54,458. Both the trainee and CFS Specialist received a ten percent increase during the summer of 2023. The recent increase makes Nebraska more competitive with other nearby states and only 6.46% behind the average salary of $57,978 of the following eight states we compared.

State	Education Requirements	Salary	Career Path / Title
Illinois	Bachelor's in social work or related human services field	$51,270 - $70,715	8 steps
Texas	Bachelor's – preference given to human services & social work	$45,800 - $58,500	Level I – Level V
Kansas	4-year degree in Social Work, Psychology, Sociology, Criminal Justice or related field	$49,000 - $51,000	Child Protection Specialist
Missouri	B.A. or B.S. Social Work, Psychology, Counseling and 1 year of related experience	$57,000 - $59,000	Foster Care Case Manager
Ohio (Toledo)	Bachelor's in human services related studies	$47,297 - $61,085	Child Welfare Worker I - III
Nevada	Bachelor's degree, Social Work required for Level III	$53,966 - $67,693	Social Worker I - III
Colorado	Bachelor's degree	$64,053	Child Welfare Case Worker
Iowa	Bachelor's in social services or related field	$50,731 - $76,502	Social Worker 3
	Avg Salary	**$57,978**	

When comparing the average salaries of Nebraska jobs with similar experience and education requirements, such as police officer, teacher, social worker, nurse, and probation officer; child welfare workers are paid slightly less than some of the related careers and aligned closely with some of the similar careers in the state. Without the recent increase, there would have been a noticeable salary gap between the jobs.

*Actual salary

According to Zippia.com (the Career Expert) website, Nebraska ranks as the 33rd best state for child welfare workers.

Work Group Recommendation for CFS Salary (III.C)

Going forward, the Workgroup recommends there be continued effort to ensure Nebraska's CFS case worker salaries continue to be competitive to similar positions in the state. Although Nebraska offers pay bands in their employee classifications, it is recommended this classification include delineated tiered salary progression opportunities for tenure and performance to retain child welfare staff.

Moreover, the same can be said for Juvenile Probation Officers who provide critical case management for youth in the state, including some that are also in foster care, and both of these front-line staff positions are a key ingredient to meeting the overall objectives of an integrated, transformed, and effective future child welfare model of practice.

Recruitment

Considering the important role of the CPS worker in the child welfare system, a successfully executed recruiting and selection strategy is paramount to serving Nebraska's families. While there are many organizational and personal variables that lead to a highly motivated and successful workforce (e.g., training, workload, compensation, supervision, etc.), a key foundation to further develop the Nebraska CFS workforce begins with selecting the right individual.

To complicate the recruiting conundrum, the amount of negative local and national media attention makes it difficult to attract qualified candidates to public child welfare. Nebraska CFS must improve the image of their workforce by increasing awareness of the profession by highlighting the excellent and sometimes lifesaving work done every day.

All levels of staff in child welfare acknowledge that CFS workers perform complex, challenging, and worthwhile work. However, community forum feedback and national research pointed to the following recruitment challenges:

- Awareness and understanding of job – most potential candidates lack awareness of the opportunities available in child welfare as well as possess a lack of comprehensive knowledge of the day-to-day demands of the job
- Continuous need – high levels of turnover require near continuous hiring of new case managers, thus reducing confidence and morale of current staff
- Weak branding – lack of a strong marketplace image for child welfare-related work. Employment branding focused on traditional sources of applicants and does not leverage social media and other non-traditional recruitment sources
- Strong labor market competition – changes in the level of competition in the labor market and opportunities for entry-level white-collar workers limit the ability of agencies to compete for child welfare workers
- Lack of candidate skills – the multitude of required skills necessitate careful evaluation of candidate's capabilities and a commitment to skill development

Selection

A TSG survey of tenured Nebraska child welfare workers revealed additional insight on pre-hire job experience and educational training. Specifically, the survey showed that 90% of child welfare workers with three or more years of experience had previous professional work experience, in many instances in areas other than child welfare. Additionally, the survey captured education background. The top college majors of child welfare workers were social work (22%), criminal justice (17%), psychology (15%), education (12%) and other (29%).

In the past, some states, including Florida and New Mexico, have advocated for specific degree requirements for child welfare professionals. However, numerous studies from both the child welfare and business management literature suggest that specific educational and work experience are weak predictors of turnover in most organizational contexts (Van Iddekinge et al., 2019; Perry, 2006; Nissly et al.,

2005; Rosenthal et al., 1998). New Mexico abandoned the Social Work degree requirement and Florida has recently allowed related experience to substitute for post-secondary education.

The Nebraska CFS selection process was not studied, but it is not uncommon to find varying practices for screening candidates across different geographical regions of a state agency. The on-going need to fill positions to alleviate higher caseloads results in agencies hiring quickly to prevent additional turnover. While agencies experience similar recruitment challenges, the combination of a lack of standardized and effective selection practices as well as the volume of turnover generates both a recruitment/selection and operational dilemma. Typically, child welfare agencies struggle with:

- The lack of consistent criteria and practices for selection
- The absence of a success profile (key traits and characteristics) for child welfare workers

The best of the best survey participants were asked to identify the top traits and characteristics that would make an ideal child welfare candidate and the top responses include:

- Ability to handle stress
- Passion for helping children and families
- Personal strength and resilience
- Good organizational skills
- Strong work ethic
- Previous work experience

The qualifications for Nebraska CFS Specialist require a bachelor's degree in social work, psychology, sociology, counseling, human development, mental health care, education, criminal justice, or other closely related degrees. The department prefers experience in child welfare, juvenile justice, case management experience, and/or internships with human services/child welfare agencies.

Recently, to assist in attracting candidates from a very tight labor market, one state in particular, Florida, expanded its candidate profile for individuals performing child welfare services to include related work experience to substitute for post-secondary education. Individuals with an associate degree from an accredited college or 60+ college credits from an accredited college or university and one of the following:

- Two years of professional work experience or,

- Two years of full-time social work or human services experience

Examples of professional work experience could be, although not limited to: Guardian Ad Litem or similar child advocate role, family support worker, teacher's assistant/aide, childcare provider/worker, therapeutic assistant, behavior health technician, home health aide, nurse (LPN or RN), Emergency Medical Services (EMS), or other professional jobs that require an assessment of factors that can contribute to trauma or protective capacities with children and families. Additionally, a high school diploma or GED equivalent and four + years of full-time social work or human services experience.

During each of our community forums, recruiting a more diverse and professional workforce capable of handling the future challenges of child welfare case management, especially in addressing many of the behavioral health, substance abuse and increased social care needs of families and children coming into the system, was a priority item continuously raised.

The Work Group believes that opening up this type of broader pathway for individuals dedicated to helping others could meet the Practice Model goal of increasing representation in a professional workforce and staffing. This could also include veterans, former law enforcement, and other professionals that have direct or related experience.

Retention

Retention is the outcome of multiple actions taken by an organization. Job requirements and environmental factors impact an organization's success with employee retention. The most common challenges for retention fall into three categories: type and level (degree of difficulty) of work, rewards (salary and benefits), and culture. Feedback and survey data collected points to a significant gap in employee expectations and the actual reality related to the type and level of work and inadequacy of rewards. The major retention challenges associated with the child welfare work performed include the following:

- Type of work – child welfare workers work includes several stressors, including conflictual interactions with multiple parties, thus necessitating a broad set of critical competencies.
- Level of work – current workloads, lack of automated tools, and the multi-faceted nature of the work creates a work environment that leads to higher turnover; and

- Value proposition – when considering continued employment, employees desire predictable as well as escalating rewards and opportunities for advancement.

As mentioned earlier, high CFS turnover disrupts continuity and stability of service for the families they serve, but it also creates instability in the workplace through increased workload and the depletion of skilled workers.

High employee turnover rates are prevalent in modern workplaces, creating challenges for leaders and human resource professionals. The national turnover situation only escalated following the COVID-19 pandemic. During the 2021" Great Resignation" the number of quits hit a historic high of 4.5 million people by November.

Nebraska CFS had an annual worker turnover rate of 42.8 for calendar year 2022, with the additional challenge of not being able to fill their allocated Specialist positions. The annual turnover rate was calculated by dividing the number of employees who left during 2022 by the average number of employees and multiplying that number by 100. For calendar year 2022 there were 214 CFS case manager separations and the average number of case managers was 500 (214/500*100 = 42.8%). Generally, annual employee turnover in the United States averages 18% (Lumina 2023).

The department is trending in a good direction for calendar year 2023. Using separations for the first six months of the year and projecting a total number of separations signals turnover is on the decline. TSG is projecting 164 separations and the average number of staff at 520 for the year, for an annual turnover rate of 31.5% (164/520*100 = 31.5%). The turnover rate could continue to trend in the right direction as the department continues to hire vacant positions.

In January 2022, CFS received a 33% increase in the number of CFS Specialists (150) to reduce caseloads and workload. During the first quarter of 2022, CFS did an exceptional job of filling positions and reducing the vacancy rate from 30% to 13%. CFS has made recent progress for July and August of 2023 and reduced the vacancy rate to 9%, but for the last 18 months, vacancies have remained at approximately 14% or 80 unfilled positions each month. (See chart below)

CFS Trainees & Specialists					
Month	Year	Filled Positions	Vacant Positions	Total Authorized Positions	% Vacant
DEC	2021	400	53	453	12%
JAN	2022	405	183	588	31%
FEB	2022	444	147	591	25%
MAR	2022	489	102	591	17%
APR	2022	517	74	591	13%
MAY	2022	496	93	589	16%
JUN	2022	495	96	591	16%
JUL	2022	503	89	592	15%
AUG	2022	512	79	591	13%
SEP	2022	517	74	591	13%
OCT	2022	513	78	591	13%
NOV	2022	507	83	590	14%
DEC	2022	500	90	590	15%
JAN	2023	509	81	590	14%
FEB	2023	510	80	590	14%
MAR	2023	510	80	590	14%
APR	2023	515	74	589	13%
MAY	2023	513	76	589	13%
JUN	2023	522	78	600	13%
JUL	2023	549	52	601	9%
AUG	2023	546	56	602	9%
SEP	2023	537	63	600	11%

Lower turnover rates are meaningless if a significant number of positions remain unfilled. A 30% turnover rate would be more manageable with the additional 80 positions filled, vs. a 20% turnover rate and the 80 positions unfilled. The unfilled vacancies exasperate the caseload/workload issue identified by CFS staff and leaders as a challenge to employee retention.

Workgroup Recommendations for More Effective Recruitment, Selection, and Retention (III.D)

Recruitment (III.D.1)

- Develop a strategic marketing and recruitment plan that contains a complete profile of the ideal candidate, a more creative and targeted analysis of the

best places to source for talent (considering the majority of tenured workers has other professional jobs before child welfare), and positive branding and messaging to promote positive occupational awareness about the position
- A mandatory and rigorous, realistic job preview process that is moved forward in the hiring process and completed before an application is submitted that will improve the understanding of the role, increase the quality of the applicant pool and create incoming job expectations
- Continue to monitor compensation so as to align with similar careers and job demands in Nebraska
- Focus on early career education of child welfare opportunities with high school and college students
- Develop and deploy a community awareness campaign to increase understanding and desirability of child welfare as a career
- Develop a digital-based employment branding plan to increase the size and quality of candidate pools
- Create recruitment partnerships with educational organizations to offer job shadowing and internship opportunities

Selection (III.D.2)

- Strengthen and standardize the hiring process to improve applicant quality and timeliness of hire
- Implement screening procedures based on relevant occupational factors and competencies
- Expand candidate profiles for individuals performing child welfare work to allow non-degreed individuals with specified backgrounds and experience

Retention (III.D.3)

- Job Design - Create paraprofessional support positions below the case manager to improve efficiency and effectiveness
- Promotional Track - Align compensation with career demands and offer opportunities for salary progression
- Workload - Implement a scalable staffing model (anticipating and planning for turnover) to improve workload management and conduct a workload analysis as described earlier in the report
- Improve Workplace Culture - It has a direct effect on people factors such as employee engagement and motivation, productivity, quality, and retention

Key Takeaways

- Historical data and current trends predict child welfare will continue to have higher than average attrition rates and implementing a scalable staffing model to improve workload management is paramount. The emphasis should be on anticipating turnover and keeping positions filled. Nebraska CFS needs to emphasize filling the vacant positions to reduce caseload and workload
- Compensation is a critical element for recruiting and retention success in more challenging careers and positions. The lack of a strong compensation strategy and salary progression signals to potential applicants limited opportunities and the unpredictability of rewards
- Develop and deploy a community awareness campaign to increase understanding and desirability of a Nebraska CFS career to include digital-based marketing
- The job design should include dedicated paraprofessional support positions below the case manager to improve efficiencies and effectiveness
- The Work Group is not recommending any new staff positions as part of the LB 1173 Child Welfare Transformation. We believe that CFS needs to prioritize filling existing vacant positions and conduct a workload analysis to modernize a set of standards for monitoring and evaluating their child welfare workload

IV. Maximize the Value of Existing Medicaid and Create Additional Opportunities and Innovation to Meet Gaps in Service

Managed Care Organizations as Valuable Intersectoral Partners

There is an untapped resource when states overlook opportunities to engage Medicaid Managed Care Organizations (MCOs) as valuable intersectoral partners for child welfare systems and community collaborative strategies. The engagement of an MCO can and should go beyond the payor source because MCOs have healthcare insight on their members that can further maximize the benefit and value of state and federal engagement strategies, such as LB 1173 and the Family First Preservation Services Act (FFPSA). Medicaid is an integral piece of the community pathways network because many families that come through the child welfare system are Medicaid beneficiaries, and states can leverage MCOs to identify at-risk families and support preservation. For example, The MCO must conduct outreach to all Medicaid members upon enrollment into their health plan to identify the

Member's immediate healthcare needs. MCOs will help schedule and coordinate healthcare appointments, help members better understand their health conditions, and serve as healthcare experts when navigating the Medicaid system. The MCOs will offer comprehensive case management services and treatment plan support by licensed and clinical professionals to Members with high-acuity healthcare needs. MCOs will also initiate referrals to community organizations to help members with social determinants of health.

MCOs know what Medicaid services their Members access through claims submissions, as Medicaid providers must submit a claim to receive payment for services rendered. MCOs can track claims data to identify members who are high utilizers of Medicaid services, those with high acuity medical conditions and behavioral health diagnoses, and those identified as high cost because of treatment expenses incurred to support the Member. Particularly, claims insight for pharmacy utilization, psychiatric facility visits, inpatient admissions and readmissions, emergency medical department visits, intensive in-home services, and mobile crisis responses can be helpful in identifying at-risk families. MCO data insights can also lead state discussions and influence decisions for FFPSA evidence-based program (EBP) planning since many of the FFPSA EBPs are Medicaid allowable and Medicaid is under federal law the payer of first resort. Medicaid data can also support the development of blended and braided funding strategies for FFPSA which we outline further in our Finance Model and assist the state with capacity building by utilizing its provider network and relaxing provider requirements to expand access to services.

Medicaid Managed Care Organizations Need to Be Held Accountable in the New Child Welfare System (IV.A)

MCOs are critical players in state Medicaid programs because they help improve individuals' access and quality of care, increase budget predictability, and constrain Medicaid spending by receiving a set capitation payment per member per month for comprehensive acute care and sometimes long-term services and support. Capitation models allow health plans to receive fixed payments upfront for the anticipated utilization of covered services by members to cover the administrative costs and allow for profit. States will utilize varying systems within their contracts with MCOs to modify risk, incentivize performance, and ensure payments are not too low or too high. However, MCOs can gain higher enrollment of members and increase monthly capitation payments made to their health plan by exerting flexibility in provider payment rates and offering value-added services (additional benefits) beyond the state requirement.

As states pay and hold MCOs accountable for improving the access and quality of care to Medicaid beneficiaries, DHHS should consistently require MCOs to become active participants to assist CFS staff, Juvenile Probation, courts, community collaboratives and stakeholders in helping the child welfare community with navigating healthcare issues and resolving barriers within Medicaid. It is common practice for child welfare professionals and community-based organizations to absorb the responsibility to lead and drive healthcare efforts despite the state already having a paid healthcare contractor and expert available within Medicaid. It can be overwhelming and confusing for CFS case workers and caregivers to navigate through a Medicaid health plan, or three, such as in Nebraska, beyond keeping children safe, protected, and thriving in foster care.

It was evident through feedback at the community forums that the community is unaware of the Medicaid benefits and resources available to children at risk of foster care entry or in foster care. While the Work Group did not perform a detailed analysis to uncover and identify the barriers or lack of healthcare accountability, participants consistently conveyed an apparent disconnect between CFS, the child welfare community and the three Medicaid health plans. Stakeholders and Tribal communities do not hear from MCOs. They do not know who their MCO case manager is. They do not know if their child has enrolled in case management. There is no consistent engagement between the MCO plan representatives and the child welfare community to validate multidisciplinary support or communication for a child's healthcare.

Creating a multidisciplinary approach to support children at risk of entry into foster care or in foster care and those who care for them provides immediate opportunity and benefit. Recognizing the MCOs as the health plan experts and requiring them to share their data and expertise with CFS caseworkers, family providers, including Child Welfare placement providers will result in big wins to enhance care coordination and access to services, improve health care outcomes, and create a path for developing electronic medical records. As a start, requiring MCOs to designate staff or dedicated liaisons to support CFS children will instantaneously:

- **Increase the transparency of the child's medical and behavioral needs**
    - At the time of removal, families undergoing an investigation for child abuse and neglect are not always forthcoming with healthcare information for their children. When removed from their care, parents do not always provide CFS caseworkers with their child's medications or durable medical equipment (DME). Even though most children who enter foster care have Medicaid coverage, CFS does not have an established

rapport with the MCOs to have support of caseworkers as CFS brings children into the state foster care system. This systemic gap often leads CFS case workers to investigate and troubleshoot to identify what medications the child was on to avoid an abrupt disruption to medication regimens. We have heard from CFS staff how caseworkers will call in favors to secure medical equipment on an emergency basis to secure placement and often do not have the extra bandwidth to seek information about which medical professionals the child would see to support continuity of care.

These realities can be overwhelming and go beyond the expertise of a CFS caseworker and Tribal CFS Departments. If CFS could begin capturing what Medicaid MCO the family has at the time of an investigation, the investigator could then coordinate with the MCO liaison to gather intel on the child/ren medications, DME, health care diagnosis, and provider network established. This process could begin the child's medical record and become a standard investigation practice to ensure CFS understands the child's immediate health care needs to support continuity of care as the child enters foster care. Should the child not enter foster care, this information would still be valuable to CFS for future abuse/neglect concerns reported. The information would be a great resource to review and compare the child's condition between investigations. Implementing this best practice would provide an immediate health care expert to CFS and Tribal CFS Departments in navigating health care barriers upon removal and further promote transparency into the true nature of the child's health care condition when making placement decisions, conducting permanency planning, and informing the Court of the child's medical and behavioral health progress.

- **Promote consistent information distribution amongst authorized consenters.**
    - All children placed in foster care are high priority and high profile. The family underwent a process where CFS determined the child/ren were victims of abuse or neglect or were at further risk of harm where they could not remain with their caregivers. As a ward of the state, a child placed in foster care has many professionals advocating for them and being accountable for their well-being. This practice requires documentation to validate the efforts and actions taken on each party's behalf, often including treatment planning. Plans of care, service plans, and treatment plans are often created for the same child by various

professionals such as CFS caseworkers, Tribal community agencies, placement providers, the Medicaid health plan, Medicaid providers like primary care physicians/therapists/home visiting providers, community-based organizations, their educational provider, the orders of the Court, etc. If no multidisciplinary approach exists or there is no intentional effort to align practices, these various care plans can be duplicative, siloed, conflicting, and confusing. Utilizing the MCO to become the expert go-to source and lead of all healthcare-related information for the treatment planning process promotes consistent data for the child to work towards their treatment goals. It also helps define roles of accountability and minimizes the administrative burden to authorized consenters who must research what medications the child is on, what healthcare professionals they see, what Medicaid services they accessed or have not begun, and concerns remain unaddressed.

- **Cultivate opportunities for health plans to offer technological solutions that are child welfare friendly.**
  - Child welfare professionals must investigate health care information for the children they serve and are accountable to ensure children are getting the care needed in a timely manner. CFS must incorporate a child's health care information into court reports, treatment plans, placement decisions, and case audits. CFS caseworkers need validation that the child is consistently getting the required treatment. CFS also want to know that the child is getting better while under CFS care. As child welfare professionals are not well versed in claims and healthcare protocols, what resources do contract MCOs have to offer insight into a member's well-being? Can MCOs share medical information with the child welfare communities so the data can provide initiative-taking measures to stabilize placements rather than keep this insight as an internal resource? How can MCOs support CFS caseworkers, Tribal CFS, and placement providers with multiple children under their care as the healthcare expert?
  - As noted, Medicaid MCOs receive a monthly capitation rate upfront for their members' anticipated utilization of covered services regardless of the reality of services accessed. MCOs must be engaged, utilized, and accountable for participating actively with CFS and stakeholders supporting children and families, including those in Tribal communities. As the healthcare expert, if engaged with notification, MCOs can report healthcare data of their members placed in foster care, members identified as needing support through community collaboratives, and even families who may become at-risk. Through claims data, MCOs can

create dashboards identifying EPSDT exams completed, psychotropic medication utilization, inpatient admissions to medical and psychiatric facilities, length of stay for inpatient admissions, the number of days children stay in the hospital beyond medical necessity, data insights for maternal health members, mobile crisis responses initiated, etc. These data outcomes can identify the referral source and the household setting of the Member to differentiate if the child/family is involved with the CPS system, if the member is from a Tribal community, if the referral escalated through a community collaborative or the abuse/neglect hotline. The process to begin this type of reporting may be manual at the onset of this practice. Still, it will take consistent conversations, open communication, willingness to collaborate, and a path for accountability to determine the best approach for future automation.

- **Competitive advantage for increased enrollment with an MCO.**
  - Deploying a multidisciplinary approach allows for contract accountability to MCOs. It will require them to actively lead and report on their care coordination/management efforts, resulting in healthy competition amongst the three MCOs. By openly publishing population outcomes, the community can get insight as to which MCO is the leading health plan to improve the well-being of its members. As Medicaid beneficiaries can choose which health plan they enroll in, the designated authorized party can determine which health plan best suits their health care needs, increasing the MCO's volume of capitation payments. It will be imperative for Medicaid to have a defined path to hold these MCO contractors accountable for their members' care coordination, management, and healthcare outcomes.

Children who enter the state foster care system should have the same, if not better, access to Medicaid services and health plan support because now the state is their legal conservator. Luckily, Nebraska ranked in the Top 10 in a state-to-state comparison of overall child well-being within the Annie E. Case Foundation (AECF) Kids Count Data Book for 2023[8].

AECF is a national foundation recognized for its commitment to enhancing the lives of children and youth. AECF strengthens families, builds stronger communities, and ensures access to opportunities by advancing research, offering tangible solutions for improvement, and sharing outcomes for investing strategies based on reliable evidence. AECF assesses state trends in child well-being each year and publishes the

[8] aecf-2023kidscountdatabook-2023.pdf

Kids Count Data Book report. The Data Book tracks how children are progressing in every state and nationally through sixteen key indicators of child well-being across four domains: (1) Economic Well-Being, (2) Education, (3) Health, and (4) Family and Community. Composite scores get combined and converted into state rankings to identify overall child well-being nationwide.

In the AECF Kids Count Data Book for 2023, a state-to-state comparison of overall child well-being identified Nebraska as eighth in the nation. Nebraska ranked the best number 1 in the country within Economic Well-Being. For the three other domains, Nebraska ranked as follows:

AECF Domain	2023 National Ranking	2022 National Ranking
Overall Well-Being	8th	8th
Economic Well-Being	1st	1st
Education	12th	14th
Health	15th	16th
Family and Community	20th	20th

As CFS becomes the "parent" of a child who enters foster care, and there are a few thousand children under CFS care, CFS as the parent has an invested interest in ensuring any contractor receiving funds to manage the large volume of their children's health care needs remains actively engaged to support as needed. Enhancing communication engagement and establishing a multidisciplinary approach with all three MCOs will further increase Nebraska's rankings to strengthen families and build stronger communities.

Preventative Care Collaboration: Medicaid Managed Care Organizations Should Collaborate with Pediatricians (IV.B)

Preventative and routine care are essential practices within the healthcare industry. These practices can reduce the risk of disease, disability, and even death. These also help minimize health care costs through the prevention of health problems from occurring and can find and treat concerns before becoming serious. Children need regular well-child and dental visits to monitor development and identify health problems early for the onset of treatment. Timely Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) exams are vitally important for children entering the foster care system because the exams validate and document the child's health condition and need for treatment by a medical professional after entering the care of CFS. This insight must be included in the child's medical record to drive treatment planning and access to specialty services while under the supervision of CFS.

MCOs must have network adequacy that meets the needs of their membership population, which includes an adequate network of pediatricians. As a contracted provider with an MCO, Pediatricians must undergo training by the health plan to understand contract requirements in serving their members. Requirements can include the notification of early onset health care conditions, reporting concerns about social determinants of health, and offering clinical expertise for treatment planning of members enrolled in case management programs. With a multidisciplinary approach focus, MCOs can utilize and potentially incentivize their pediatric network to provide MCO notification when prevention issues arise for immediate intervention. For example, suppose a pediatrician identifies early childhood development concerns during an office visit. In that case, the pediatrician could escalate their concern to the MCO through a secure email, designated health plan representative, or fax capability to ensure the MCO coordinates with the Office of Early Childhood, Nebraska's Early Development Network (EDN), and Community Collaboratives as appropriate. As the first five years of a child's life are the most critical for development, impacting their health, well-being, and the overall trajectory of their lives, interagency collaboration must exist and have an established protocol for expedited coordination of care concerns, which the MCO can lead. Deploying this type of accountability and partnership can also decrease calls to the abuse/neglect hotline. Pediatricians will have a path to engage the MCOs on the early onset of concerns. As the MCOs engage the appropriate parties, the designated case managers of those agencies can meet with the family to offer community-based services voluntarily to address the immediate concerns and preserve the family unit.

Expand Efforts to Educate Communities About Medicaid Managed Care Organization Services to Children and Families Statewide (IV.C)

To effectively deploy a statewide intersectoral collaboration, it will take an intentional effort for communities to understand the available benefits and resources. There must be a recognized value of a health plan partnership to support CFS caseworkers, foster parents, kinship families, placement providers, community collaboratives, and community-based organizations. The MCOs should be more assertive in marketing strategies to educate the community on the types of support the health plan can deliver, respectfully operating within the marketing guidelines of Medicaid. As a start, MCOs can create or modify new provider and member orientations that explain the Medicaid benefits and enhanced services they offer to Medicaid members. Specifically, these orientations should identify the designated staff or health plan liaisons and the established protocol for connecting with them so that CFS caseworkers, community collaborative staff, and community-based organizations that support at-risk families can utilize them. In outlining our future

Prevention vision with a community pathway, we identified the MCOs as key partners for pathway navigation. This will mean they will need more than indirect connection to the pathway vendor in order to be available to and effectively assist families.

In the future, DHHS should require each MCO to create a training calendar that identifies how their education and awareness strategies will be delivered throughout the state, including Tribal communities. It should include the approval of presentation material, the dates training will occur, the targeted audience invited, the method by which invitations to attend the training will occur, geographic locations covered, and the presentation delivery technique. In addition to a general orientation on the explanation of Medicaid benefits, MCOs should offer healthcare training to support their membership and improve their healthcare outcomes, such as: What types of telephonic outreach does the MCO complete for their members? What kind of care coordination does the health plan do, and what does the Member benefit from enrolling for case management services? What kind of support can the health plan offer caregivers and case workers needing to admit a child into a psychiatric hospital? What training or support can the health plan offer when children are discharged from a hospital? What type of support can the health plan provide for children who enter foster care without their medications or if the child changed placements and the medicines do not come with them to their subsequent placement? What should occur when there is a concern about the medication a child is taking? What happens if there is a medical or behavioral health emergency after hours? Is there a nurse or clinician available?

Equally, children in foster care with diabetes or seizures cannot find placement easily because caregivers may get intimidated to care for these types of health conditions without specialized training. Children with these diagnoses may stay in medical hospitals beyond medical necessity or in-state caseworkers' care in state offices or hotels until placement is secured. When this occurs, it jeopardizes the child's health if no trained individual is available to care for them with these conditions. Licensed caregivers with this type of medical experience capable of caring for these children often remain at total capacity, providing placement for more medically complex children. There is also a demonstrated need for health plans to support better medically complex children discharged from hospitals and transitioned to caregivers who may not be as experienced in caring for these issues. While the state may have a family willing to care for a child and eager to learn how to support these healthcare needs, onsite training at the medical facility may be required before a discharge can occur. When training cannot be scheduled timely, placements get delayed for the child, and many staff hours are exhausted at CFS and

with caregivers to coordinate this type of care, resulting in administrative redundancy, duplication of efforts, and placement delays.

MCOs know health care. MCO staff understand their health plan's network landscape. They are the experts in their industry to provide equitable healthcare access to all members despite their culture, Tribal association, linguistic, and healthcare needs. The MCOs have clinical and non-clinical staff, a 24-hour nurse advice line, and a 24/7 mental health and substance use crisis line to support their members throughout their Medicaid coverage. MCOs receive payment to manage their members' care and improve outcomes. DHHS must align these MCO contract requirements with the efforts of CFS staff to keep children safe and help them thrive while these children are under CFS conservatorship. Defining interagency roles and expertise accountability allows the state to maximize the use of its staff resources for a more significant impact.

Medicaid State Plan Amendments Should Be Considered to Reduce Barriers and/or Cover Additional Services as Part of a New Child Welfare System (IV.D)

Medicaid state plans vary in the types of populations they serve, the provider network they allow, and the benefits they offer because states have the authority to determine what to include in their managed care solution as long as it meets federal rule requirements. MCOs also have the flexibility to decide certain aspects of their operations, such as provider payment rates and what additional benefits to offer their members beyond those required by the state for increased enrollment.

There has always been a shortage of mental health providers within behavioral health, especially in pediatrics. While the need to expand provider access is nationwide, it is particularly evident in Tribal communities and rural areas.[9] The shortage of providers includes child therapists, social workers, psychologists, and licensed professional counselors. By 2030, the demand for behavioral health workers will increase by 13% for mental health counselors, 15% for addiction counselors, 9% for marriage & family therapists, 12% for social workers, and 5% for psychologists.[10]

The shortage of mental health professionals and the increase in the need for mental health support have prompted states to partner with public health, developmental disabilities and behavioral health entities, and other licensing agencies to identify areas of opportunity where standards can be relaxed to maximize workforce

[9] The Youth Mental Health Crisis Worsens amid a Shortage of Professional Help Providers - Scientific American

[10] Behavioral Health Workforce Projections | Bureau of Health Workforce (hrsa.gov)

capacity. Many states are incorporating trainee programs to expand their non-licensed staff capacity. For example, North Carolina is offering Family Center Treatment (FCT) as an alternative or "in lieu of" service with staffing requirements modified, allowing non-licensed staff to be credentialed as qualified professionals if they are fully certified in FCT within 12 months and can show competence in the required components of certification. Supervision is still required by FCT Supervisors who are associates or fully licensed behavioral clinicians practicing within the scope of their license. FCT is one of the initial FFPSA Evidence-Based Programs that DHHS rolled out to the communities, and we heard how effective the service is in Nebraska, especially in the Western part of the state. However, we also heard that the licensing standards have made it difficult to continue this intervention program in Western Nebraska.

Legislators can play an essential role in supporting the state's health workforce policies to meet the behavioral health needs of the state in addition to rural and underserved communities. For example, Oregon, through House Bill 4071 and House Bill 2949, increased the recruitment and retention of behavioral health providers who are people of color, Tribal members, or residents of rural areas of Oregon that can provide culturally responsive care for diverse communities by directing the Oregon Health Authority to create a Behavioral Health Workforce Initiative. The initiative was intended to develop a diverse behavioral workforce in licensed and non-licensed occupations through scholarships, loan repayment, retention, and peer workforce development. It also allocated funding for grants to license behavioral health providers to provide supervised clinical expertise to associates or other individuals so they may obtain a license to practice. [11]

It is also becoming more common for state Medicaid agencies to utilize non-licensed workers such as counselors, peers, and other qualified staff to accommodate the increasing need for SUD treatment and recovery services for Medicaid beneficiaries. For example:

- Louisiana allows counselors in training to provide screening, evaluation, assessment services, counseling, and crisis intervention services under the supervision of a licensed mental provider to be reimbursed.
- Washington State allows chemical dependency professional trainees to be reimbursed if they can provide screening, evaluation, assessment services,

[11] Oregon Health Authority: The Behavioral Health Workforce Initiative: Behavioral Health Services : State of Oregon

counseling, case management, and care coordination under the supervision of a certified individual who has completed some college. [12]

- Maryland allows alcohol and drug trainees to practice clinical drug and alcohol counseling without a license or certificate through telehealth while under supervision and meeting specific experiential or course study requirements.[13]
- Minnesota expanded the mental health practitioner requirement by including individuals completing a practicum or internship as part of their undergraduate or graduate-level social work, psychology, or counseling programs. This change allows a mental health agency to bill for the work provided by people doing a practicum or internship, with the intern being paid for their work.[14]

As MCOs must demonstrate network capacity, they should utilize their best practices from other state contracts to offer workforce shortage solutions that have demonstrated outcomes. Strategies for consideration include telehealth options or mobile clinics to provide comprehensive care and promote patients to access treatment with selected high-performing, high-quality, trauma-informed providers who serve as the preferred hub for services. As Nebraska evaluates how it can leverage opportunities to support workforce shortages, it should consider the National Academy for State Health Policy state strategies[15] of:

- Prioritize behavioral health recruitment and retention of the healthcare workforce. Utilize Medicaid data to identify workforce gaps and opportunities for development by capturing provider licensure and certification information to understand behavioral health workforce needs better.
- Apply the state Workforce Innovation Opportunity Act[16] plan, which allows policymakers to incorporate interagency diversity initiatives and programs promoting workforce development.
- Create a more culturally inclusive workplace. Recognize and respond to the lived experiences of Black and Indigenous People of Color (BIPOC) communities through meaningful engagement, outreach, and planning to consider building diversity and equity initiatives.

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[12] 50-State Scan: How Medicaid Agencies Leverage their Non-Licensed Substance Use Disorder Workforce - NASHP

[13] Legislation - HB1287 (maryland.gov)

[14] HoW66_PFjk6vuGtwo9aNug.pdf (mn.gov)

[15] State Strategies to Increase Diversity in the Behavioral Health Workforce - NASHP

[16] Workforce Innovation & Opportunity Act (WIOA) - Texas Workforce Commission

- Engage and align all pertinent agencies under centralized state leadership to connect and maximize resources and minimize duplication in support of diversity and equity initiatives.
- Explore and leverage all funding opportunities available to invest and maximize a diverse workforce with recent federal initiatives and potential legal settlements in using non-workforce specific dollars to address behavioral health workforce needs.
- Leverage new and emerging funding opportunities to invest in a diverse workforce. Recent funding options through federal initiatives and potential legal settlements offer states a unique opportunity to consider using non-workforce-specific dollars to address behavioral health workforce needs.

In addition, specific attention in Nebraska, should be given to the following ideas gathered through the LB1173 community forums:

- Review and adjust the MCO menu of covered mental health services for children and youth, including the Community Treatment Aide Definition recommended by the Nebraska Commission and Justice Committee for Nebraska Commission.
- Expand the Medicaid definition for Multisystemic Therapy (MST) to include a bachelor's level practitioner, supported by national MST EBP requirements.
- Align the Medicaid rate for Functional Family Therapy (FFT) with the current MST rate to support providers launching services in Nebraska. In addition, consider the bachelor's level inclusion for FFT to expand resources.
- Include all eligible Medicaid Probation Youth or Legislative language that requires Medicaid to include all Medicaid-eligible youth (including probation) in the plan and waiver for the new service Therapeutic Family Care system of care rollout.

Consider Medicaid Provisions Where Evidence Can Be Demonstrated on Financial Budget Neutrality (IV.E)

States have various opportunities to pursue Medicaid provisions that will enhance access to behavioral health services for vulnerable populations like children placed in foster care. With an intersectoral approach, interagency leaders must ensure that implementing a new program design will meet Medicaid requirements and the needs of the populations being served. State strategies to consider include:[17]

[17] Medicaid Waiver Authorities – Casey Family Programs

- **Massachusetts**: Deployed a Medicaid State Plan Amendment that allows targeted case management (TCM) for Wraparound Intensive Care Coordination to assist children with behavioral health needs, including intensive in-home services, family support, and therapeutic mentoring. The Medicaid Rehabilitation Services Option is also utilized to help children and youth with disabilities, including those with serious behavioral health needs, to live in community-based settings.
- **Michigan**: Utilized a Home and Community-Based Waiver to support youth with severe emotional disturbances who meet the criteria for risk for psychiatric hospitalization without intensive community-based services in child protection. Services are delivered within a system of care framework, and child protection funds are transferred to the behavioral health authority to maximize the Medicaid match. This strategy allows increased dollars for more intensive home- and community-based services for those with "substantial impairment" on the Child and Adolescent Functional Assessment Scale.
- **New York**: Combined several waivers into one to address services for children with serious emotional disturbance, developmental disability, or who are medically fragile, and provide for services, such as accessibility modifications, crisis response, care coordination, and respite, among others.
- **Arizona**: Through an 1115 Research and Demonstration Project Waiver, Arizona uses a single Medicaid physical and dental health plan for foster care. Behavioral health services are provided through a managed care system overseen by the Arizona Department of Health Services and Division of Behavioral Health Services featuring:

    - Risk-adjusted rates
    - Using child welfare funds to draw down additional Medicaid match
    - Specific child welfare-focused Medicaid practice guidelines and protocols
    - Co-location of behavioral health and child welfare staff
    - Respite and family peer support
    - 72-hour behavioral health screens following a child's entry into care
    - Focus on appropriate psychotropic medication use
    - Specialty providers, and
    - Utilization tracking for child welfare involved children and youth.
- **Massachusetts**: Provides a capitated managed care system with an 1115 waiver that is described as a physical health and behavioral health integrated care system for minors, including those in child protection:

    - Mandatory behavioral health screening (part of EPSDT)
    - A continuum of HCBS services
    - Peer support; and
    - Mobile crisis with longer-term crisis team involvement.
- **North Carolina:** Offers approved Behavioral Health "In Lieu Of Services" through a specialized Foster Care Plan such as:
    - Behavioral Health Urgent Care
    - Institution for Mental Disease (IMD) for acute psychiatric care
    - Behavioral Health Crisis Risk Assessment and Intervention (BH-CAI)
    - Rapid Care Services
    - Family Family-centered treatment[18] is an alternative model to Intensive In-Home Services and Residential Treatment Levels II and III. Established with comprehensive, evidence-based treatment components, the FCT program addresses the causes of family system breakdowns and promotes positive changes to sustain family functioning improvements after treatment completion. FCT therapists are available 24/7.[19]

In Lieu of Services may also be explored to provide housing support for Nebraskans. Our research revealed that states require MCOs to support housing initiatives to improve their members' health through Medicaid contract requirements.[20]

Consideration Should be Given for a Future Specialized Foster Care Medicaid Managed Care Organization Program as Part of Child Welfare Practice Transformation (IV.F)

A number of states have developed focused Medicaid MCO specialty foster care plans for foster children and youth that have promising results in enhancing care coordination for this vulnerable population. Some of the programs we highlight as follows:

- **The OhioRISE (Resilience through Integrated Systems and Excellence) Program** aims to shift the Ohio care system and keep families together by creating new access to in-home and community-based services for children with the most complex behavioral health challenges.
    - Through a 1915(c) Medicaid Waiver, Ohio works to improve cross-system outcomes for its enrollees with intensive care coordination and new and

[18] PowerPoint Presentation (ncdhhs.gov)
[19] SUPPLEMENTAL SERVICE DESCRIPTION (vayahealth.com)
[20] Addressing Housing Insecurity via Medicaid Managed Care - Manatt, Phelps & Phillips, LLP

enhanced behavioral health services. It addresses gaps in the health care system by developing a network of care management entities (CME) and working with Ohio's behavioral health providers to offer new, intensive, coordinated services for children and families statewide.

- The Ohio Department of Medicaid oversees and coordinates quality Monitoring and accountability. They also manage Aetna Better Health, the single statewide specialized care plan, using a shared governance structure with other Ohio Departments and agencies.
- Aetna contracts with the Care Management Entities (CMEs) and service providers to offer a full continuum of care. They perform utilization of management operations, quality improvement, network development, and provider reimbursement.
- The Care Management Entities (CMEs) serve as the locus of accountability for members with complex challenges and offer two tiers of care management: intensive and moderate.
- The Managed Care Organizations are responsible for assuring access to the Child and Adolescent Needs and Strengths (CANS) assessment to determine when a child needs the enhanced services of the OhioRISE plan. Until then, MCOs will cover existing Medicaid behavioral health services, Mobile Response and Stabilization Services, administrative care coordination, utilization management, and quality improvement efforts. If a member enrolls in OhioRISE, the MCO will provide all non-behavioral health care to youth, including physical health, dental, etc. Assist with referrals, transitions of care, and basic care coordination. The providers provide behavioral health services, intensive in-home treatment, inpatient, mobile response, and stabilization services.

- **Washington State Wraparound with Intensive Services (WISe)** provides comprehensive behavioral health services and support to Medicaid-eligible individuals up to 21 years of age with complex behavioral health needs and their families. Core elements include Engagement, Assessing, and Teaming, Service planning and implementation, Monitoring and adapting, and the Implementation of WISe based on interagency coordination with measured outcomes to reduce the impact of mental health symptoms on youth and families, increase resilience, and promote recovery; Keep the child safe, at home, and making progress in school; Help youth to avoid delinquency; and Promote youth development, and maximize their potential to grow into healthy and independent adults. The funding is 100% Medicaid and delivered through a statewide managed care model. There is improvement in keeping families together as Crisis intervention, and crisis prevention services are available to Medicaid-eligible DCYF-engaged families before a

child is removed from the home. However, the child would need to be enrolled in CHIP, the family already enrolled in traditional or expansion Medicaid, and Assessment standards and medical necessity criteria must also be met.

- **Virginia and Georgia**: Taking note from these two states, it is becoming the new innovative practice for state Medicaid programs to issue procurements to establish a contract with a certain number of qualified Medicaid MCOs that will provide Medicaid managed care services to the state Medicaid population and the state will plan to contract with one (1) of the selected MCOs for the provision of Benefits and Services for the state's Medicaid children, youth, and young adults in Foster Care, Adoption Assistance and select youth involved with the Department of Juvenile Justice. Both Virginia and Georgia recently released RFPs with such a focused system, and a review of the RFP shows a much more required intensive MCO provider, network, and care coordination effort on children and youth removed to foster care.

As part of the future Child Welfare Transformation, Nebraska should look to these state models in developing a more specialized and accountable focus of its Medicaid MCO program for children in foster care, the Juvenile Justice system, and children who have been adopted out of the child welfare system.

Create Solutions Where Intersectoral Partners Can Share Critical Member Data (IV.G)

There remains an opportunity within DHHS to create a future system or practice where the Division of Medicaid and Long-Term Care, working with MCOs, could share critical Medicaid member data with CFS. We were provided with examples where Medicaid data provided to a CFS worker could have been effective in helping reduce crisis or assist the CFS case worker. For example, we heard about a number of adoption disruptions that have occurred where it may have been prevented if CFS was made aware of a number of repeated medical or behavioral health episodes and was able to intervene with some additional intervention strategies, provided there was appropriate consent. We were told by CFS staff that they are never notified of any medical or behavioral health episodes, including hospitalization even though the DHHS Medicaid claim system and MCOs have data on claims that were paid for the child or youth that was adopted, since many continue to stay on Medicaid during the adoption. Sharing of data, with appropriate consent from adoptive parents early on could be used in a proactive way to help this family and child. There are many other examples we heard from CFS field staff where a case manager would clearly benefit by being alerted to or knowing in more real time any medical or behavioral health episode where a claim was paid to a provider or

hospital on behalf of a child that was a Ward of the State. Again, all of this data is available and should be shared with the CFS case workers in the field. Additionally, such data would be valuable to staff trying to expedite permanency planning so a child or youth can be reunified. Since both divisions are part of DHHS, we do think that identifying solutions of interoperability and sharing of data should be a top priority.

Moreover, as efforts of sharing critical child member data become intentional, Nebraska should review the efforts of the Children's Partnership, which launched a 5-year pilot initiative to promote electronic care coordination for children in foster care. The pilot's goals were to support the exchange of critical care-related information amongst multidisciplinary teams and to provide youth with the resources to empower self-management of their medical records and health. In 2016, a lesson-learned publication shared guidance for future efforts to promote the importance of critical health information being shared within an electronic record initiative[21]: Through their review, they identified five lessons for success:

- Build upon robust and committed leadership.
- Know your target audiences and involve them in the design, implementation, and improvement process.
- Cultivate trust in the tool and the process.
- Design to demonstrate value.
- Understand the evolving landscape.

They recommend six critical elements to ensure foster care electronic record initiatives achieve their fullest potential:

1. Gain further insight into how best to engage consumers through electronic records.
2. Initiatives should increase and improve communication across the care team.
3. User-centered design and testing must be more rigorous.
4. Evaluation and ongoing, iterative improvement should be strengthened.
5. Privacy challenges are real but not insurmountable.
6. Federal and state support is needed.

This effort could be expanded to Nebraska's current 1184 multi-disciplinary team process where multiple teams, including investigative, treatment, and specialized

[21] Foster-Youth-and-Parents-E-Records-Lessons-Learned_2016.pdf (childrenspartnership.org)

service providers, are brought together through facilitation to improve the handling of child abuse and neglect cases.

Areas of Opportunity (IV.H)

The foster care landscape has become more complex. Nationwide, children entering the system with higher acuity health care needs and state departments must align to address placement capacity issues together. Children requiring more intensive services require caregivers and placement providers to become better equipped to meet these challenges or children having more placement disruptions. It also increases psychiatric inpatient stays, reoccurring admissions, the potential of children remaining in hospitals past medical necessity, and the possibility of hospitals not getting paid for those extended days. The outcome of this pattern is not positive. For the child, prolonged hospitalizations cause them to deteriorate emotionally and behaviorally. They miss critical developmental milestones and fall drastically behind in school on top of all the other layers of trauma. For the state, healthcare costs increase, and it poses a risk to CFS to now house children at child protective offices, hotels, and other unlicensed settings.

State child welfare systems struggle to access and coordinate health care for the children they serve. They benefit from a health plan partnership to take on accountability to ensure health care services are readily accessible and to confirm that services delivered are quality regardless of their living setting. Nebraska must examine what type of managed care solution and partnership most benefits their child welfare system, community collaboratives, and Family First Preservation approach. Nebraska has an opportunity to enhance current MCOs' roles and heighten their accountability to engage and support CFS throughout all stages of services. It is incredibly critical for interagency partners supporting family preservation and child welfare issues to band together to improve healthcare equity throughout the child welfare continuum. Efforts should begin with preventing abuse and neglect to preserve families through the experience of a call made to the abuse/neglect hotline. There is an opportunity to escalate cases closed at intake by implementing a community pathway model. For those that move through investigation and enter foster care, an MCO should be accountable for leading all health care navigation through permanency of family reunification, adoption, and transition out of care.

MCOs can also unify with community stakeholders to impact change through innovative pilot programs that lead to policy changes, such as supporting long-term permanency efforts with biological families, adoptive parents, and youth transitioning out of care. They can help families access and monitor healthcare

services beyond permanency to ensure long-term success once child welfare cases close, but families remain covered by Medicaid. There is also an opportunity for MCOs to support child welfare systems in their state's family preservation efforts under the implementation of FFPSA. Focusing on the family should be a state priority when serving the child. Helping biological families access treatment, connecting them with community resources, and overcoming healthcare barriers will help expedite family permanency for children.

To immediately deploy a statewide intersectoral collaboration, Nebraska should require and hold MCOs accountable to lead all healthcare coordination for CFS and community collaborative cases. It is critical to identify and engage MCOs as key intersectoral partners to explore solutions for systemic gaps beyond requirements in their healthcare contracts to provide equitable and holistic care to all Medicaid families, especially children in foster care because they are wards of the state. Intersectoral healthcare outcomes should also align with the goals of the physical and behavioral health system[22] and include specific insights into child welfare, Tribal communities, and community collaboration. Monitoring outcomes should be consistent and shared publicly to demonstrate state oversight of the MCO and MCO accountability.

To begin, MCOs can ensure healthcare services are accessible and consistently utilized and remove existing barriers to promote family preservation. For example:

1. DHHS can establish the MCO as a key intersectoral partner with healthcare accountability supporting CFS leadership, community collaboratives, and community-based care organizations serving at-risk communities by:
    a. Providing crisis support to county child welfare investigators for pre/post removal support of community and health care resources.
    b. Taking the lead in coordinating immediate health care needs for CFS caseworkers, Community Collaborative Meetings, and cases where calls to the abuse/neglect hotline were closed and not assigned for investigation. Nebraska can take note of the state of Connecticut, which contracts with an outside Care Management Entity to work with families and local providers in providing services to families referred by the state through the abuse/neglect hotline but do not present immediate safety concerns.
2. Offering MCO designated staff/liaisons to serve as the Medicaid expert and resource to:

[22] Contract Year 2022–2023 External Quality Review Technical Report for Heritage Health Program (ne.gov)

a. Resolve healthcare barriers.
b. Improve access to health care services.
c. Case manage children in foster care.
d. Initiate referrals to community-based resources
e. Monitor utilization of ongoing services for short-term and long-term success, focusing on family preservation.
f. Share data on the member's well-being.
   Nebraska can take note of the practices of Washington, DC, which supports families with substantiated abuse and neglect reports but currently have low or moderate risk and those families with high levels of risk. Still, there is no substantiated finding with case management models using motivational intervention to connect families with specific services based on their needs.

V. Enhance the Accessibility of Behavioral Health Services for Children, Youth, and Families Engaged with the Child Welfare System

The Annie E. Casey Foundation defines core elements of a state's Child Welfare Practice model to include "evidence-based case management, targeted services to address risk and protective factors and evidence-based treatment models." [23] The 2022 edition of the AECF's "Kids Count Data Book"[24] finds that:

The accessibility of evidence based Mental Health and Substance Use Disorder services for the children/youth and families engaged with state child welfare agencies is critical for enhancing child/family wellbeing and their importance cannot be overestimated. Recent data highlighted by the Children's Bureau of the Administration of Children, Youth and Families (ACYF)[25] points out that:

- Mental and behavioral health is the largest unmet health need for these children and teens.
- Up to 80 percent of children in foster care have significant mental health issues, compared with approximately 18 to 22 percent of the general population.
- Native American/Alaskan Native people report experiencing serious psychological distress 2.5 times more often than the general population over a month's time. (Native and Indigenous Communities and Mental Health)

[23] https://www.aecf.org/resources/putting-family-first#findings-and-stats
[24] https://assets.aecf.org/m/resourcedoc/aecf-2022kidscountdatabook-2022.pdf
[25] https://www.childwelfare.gov/fostercaremonth/awareness/facts/#:~:text=Mental%20and%20behavioral%20health%20is,percent%20of%20the%20general%20population.

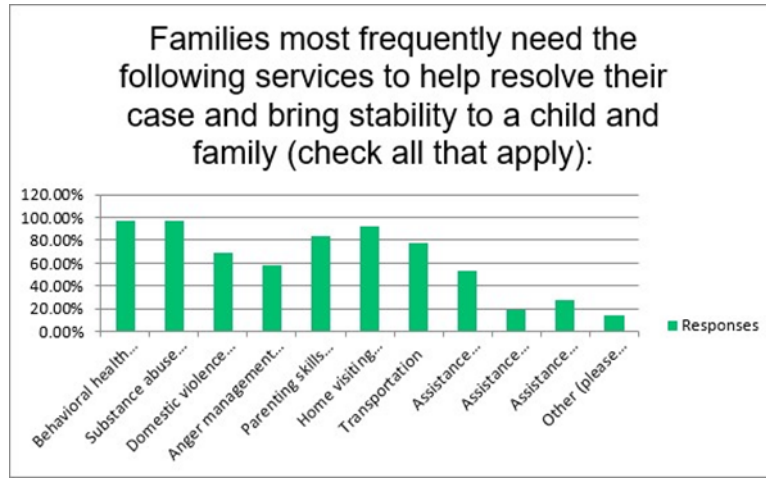
- Only one-in-three African Americans who need mental health care receives it. (Mental Health Disparities: African Americans)
- Nearly 90 percent of Latinx/Hispanic people over the age of 12 with a substance use disorder did not receive treatment. (Latinx/Hispanic Communities and Mental Health)
- Language barriers contribute to the difficulty in finding health care and other services. Overall, 32.6 percent of Asian Americans do not speak English fluently. (Asian American / Pacific Islander Communities and Mental Health)
- Because of the complex traumas faced by children and youth in foster care, foster care alumni experienced posttraumatic stress disorder at a rate nearly five times higher than the general adult population.
- Youth in foster care are prescribed psychotropic medications at a much higher rate (ranging from 13 to 52 percent) than youth in the general population (4 percent).

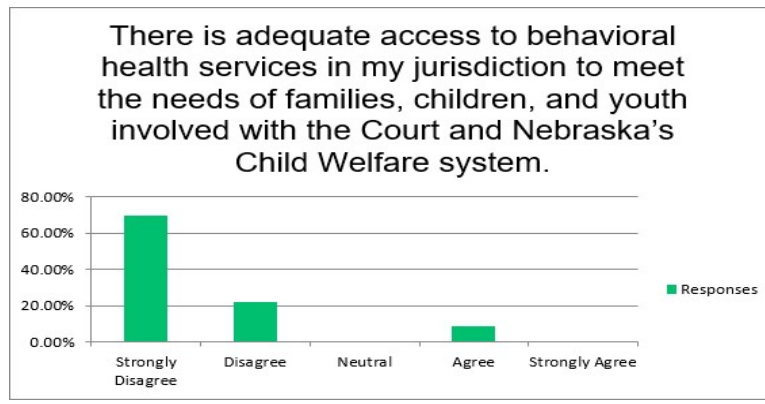
"Mental health is just as important as physical health. And as with other components of child well-being and success, the foundation for good mental health is laid during early childhood. Cognitive abilities, language proficiency and social skills develop alongside mental health."

Community Feedback: Behavioral Health Services for Children, Youth, and Families Engaged with Nebraska CFS

The Work Group approved project plan included meetings with the Tribal Nations, community members, judges, county attorneys, law enforcement, CFS case workers and supervisors, foster parents, youth with lived experience, parents currently engaged with CFS, advocacy organizations, prevention mission driven organizations, and the academic community. During the project multiple public meetings were conducted in Omaha, Lincoln, Columbus, Kearney, North Platte, and Scottsbluff. Well over 600 Nebraskans dedicated to and concerned about the state's Child Welfare system and related services participated.

One of the most prevalent concerns across the state we heard from the community was the lack of timely, accessible, and trauma informed. behavioral health services (mental health and substance use disorder) for children, youth, and parents/caregivers engaged with the CFS system. As an example, a survey of 36 of the state's county attorneys indicated that behavioral health services is the "most frequently" needed service to assist families and stabilize children/youth and that access to the current system was "inadequate" in meeting these needs within their jurisdictions.





Additionally, in a meeting we held with county sheriffs in the state, we heard that law enforcement is "seeing more and more Mental Health issues than we ever have in children of young ages." Moreover, "sheriffs are struggling to find behavioral health resources and where to send these youth."

The following "Voice of the Community" statements from across the state provides a representative sample of the concerns of Nebraskans regarding Behavioral Health Services and the Child Welfare system we heard across the state.

- "Placement challenges for children and youth with high trauma, behavioral health needs, aggressive, assaultive, and sexualized; Providers are unwilling to take these kids even where homes are available." (3/23)
- " Mental health resources and funding for them are significant areas of need – "We are seeing more and more Mental Health

issues than we ever have in children of young ages; "Sheriffs struggling to find behavioral health resources/where to send these youth." (3/23)

- "Behavioral health providers won't take Medicaid because rates are too low." (3/23)
- "Crisis management and services is not just a challenge on the Reservation but across the state." (3/23)
- "Need for mobile crisis services; need for Multi-Disciplinary Teams at the beginning of the process of engaging families." (4/23)
- "Substance Use Disorder (SUD) treatment initiation needs to be expedited/aligned with removal/reunification court orders." (4/23)
- "Families need crisis navigation assistance in their language to access Regional Behavioral health services." (4/23)
- "Cycle of behavioral health crises in youth: children need behavioral health services–no access-problem behaviors-crisis-child ends up in residential placement." (6/23)
- "Behavioral health wait lists for services are very long, up to six months, leaving parents and foster parents feeling very alone; Sometimes it takes multiple calls for Managed Care Organizations to find providers that will accept patients and even more difficult for certain conditions. This shortage of care makes it difficult to be proactive. The farther away from Lincoln and Omaha you get, the farther you get from help." (6/23)
- "Lack of mental health and substance abuse services (especially in rural areas)." (6/23)
- "The regional behavioral health system is an integral partner of CFS, and they need to be included in any future participation with a Community Pathway." (6/23)
- **"**When a youth needs residential treatment services MCOs won't move the residential services paperwork or provide transportation in the rural areas. They say they pay for treatment, but other payers have to pay other non-RX costs and there are no other payers." (7/23)
- " Need for more Mental Health services." (7/23)
- "Professional Partner program cannot serve CFS kids because it was deemed that this service was duplication of CFS case manager work. The Regional Behavioral Health Authorities could provide Professional Partnership (Fidelity Wrap Around) services for these kids with braided funding. " (8/23)
- "Regional Behavioral Health Authority services would be more available for low income families if the department's

financial guidelines were reviewed and increased to current economic conditions so that more people could be served, and the Cliff Effect would not hinder individuals and families seeking needed mental health services. The Eligibility worksheet should be revised. The number of families who are ineligible for the Professional Partner Program continues to increase every year. Also, the max cap for expenses do not reflect the current markets or inflation." (8/23)

- "Paperwork required of parents/guardians is not completed for many children and youth that need mental health treatment. Student Counseling referrals in 90% of referrals made to one of the two Region 3 behavioral health services contract providers in Buffalo County is often not completed, thus, many youths are not being connected to behavioral health services and are on waiting lists." (8/23)
- "Continue to find that, by and large, CFS workers are not communicating with Medicaid to ensure that there is the type of care coordination that should exist for children with really high needs, who are on Medicaid and the MCO is being paid on a monthly basis to offer care coordination. This lack of effective engagement, especially as it relates to care coordination for children with high needs, is a continuation of the need for better coordination within DHHS/Medicaid/CFS and the MCOs." (8/23)
- "Opportunity for increased coordination and communication between MCOs and CFS case workers based on MCO requirements to identify CFS-eligible children/youth as a High Risk Population with an assigned MCO case manager." (8/23)
- "There is a need to find safe places and services for crisis stabilization for children and youth who do not meet inpatient criteria but cannot go home for short periods of time." (8/23)
- "During the privatization era across the state there were units for wraparound but once this stopped in most of the state this was lost along with residential capacity." (9/23)
- "Medicaid has never ("refused") supported High Fidelity Wrap Around as a service." (9/23)
- "Cycle of behavioral health crises in youth: children need specialized behavioral health services–access is an issue-crisis occurs and a child ends up in residential placement. Law enforcement with behavioral health provider model works well to break that cycle; mobile response is a great idea, but

needs to be responsive, especially in rural areas." (9/23)
- "Many developmentally disabled children are only in the CFS system to access services – there is a gap between the ages on 19 – 21 when they become waiver eligible." (9/23)
- "Medicaid uses ASAM clinical criteria in managed care but not in a comprehensive manner matching service needs to benefit." (9/23)
- "Substance abuse services for youth are limited – no residential services other than PRTFs." (9/23)
- "The MCOs are limited based on provider capacity and availability after hours even if the plan is meeting 'network adequacy'". (9/23)
- "There is a need for a wide campaign for provider capacity expansion across the state connected with the University of Nebraska's Workforce Development Project – which has helped to increase the behavioral health work force in Nebraska, but many of these providers are not signing up as Medicaid providers." (9/23)
- "DHHS needs to look at licensing authority for behavioral health assessment and service qualifications to expand capacity to get adults, children and youth more timely service than the current state of the system." (9/23)

Consider Existing and Effective State Models for Medicaid Behavioral Health/Substance Use Disorder/Serious Emotional Disturbance Waivers in Future Child Welfare Transformation (V.A)

Background

All states are challenged on the best methods to deliver Behavioral Health (Mental Health/Substance Use Disorder (SUD)) services to their high risk/high need adult and infant, child, youth Medicaid eligible populations and their families. States have responded to this challenge with a variety of Medicaid waiver authority models that reflect the uniqueness of their state's health care system and economics as well as the political will to innovate, plan, implement, and accept accountability. Over time the Centers for Medicare & Medicaid Services (CMS) has developed new policy supporting innovations at the state level including managed care models, fee for service models (FFS), and derivative models of covered populations, benefits design, and payment methods.

In November 2018, CMS issued a "State Medicaid Directors" letter[26] that outlines "existing and new opportunities for states to design innovative service delivery systems for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED). The letter includes a new opportunity for states to receive authority to pay for short-term residential treatment services in an institution for mental disease (IMD) for these patients" thereby integrating IMD exclusions with community-based delivery systems – a critical advance for state flexibility at that time. In order for states to receive greater flexibility in the design of their SMI/SED/SUD strategies and benefits they must agree "good quality of care in IMDs, improve connections to community-based care following stays in acute care settings, ensure a continuum of care is available to address more chronic, on-going mental health care needs of beneficiaries with SMI or SED, provide a full array of crisis stabilization services, and engage beneficiaries with SMI or SED in treatment as soon as possible." State 1115 waiver designs must address: 1) earlier identification and engagement in treatment (including improved data-sharing between schools, hospitals, primary care, criminal justice, and specialized mental health providers to improve communications); 2) integration of mental health care and primary care that can help ensure that individuals with SMI or SED are identified earlier and connected with the appropriate treatment sooner; 3) improved access to services for patients across the continuum of care including crisis stabilization services and support to help transition from acute care back into their communities; 4) better care coordination and transitions to community-based care; and, 5) increased access to evidence-based services that address social risk factors including services designed to help individuals with SMI or SED maintain a job or stay in school[27]. Waivers approved under the expanded spending authorities must be budget neutral.

New Hampshire Fidelity Early Childhood Wraparound Program (works in coordination with the NH SUD/SMI/SED waiver through a Systems of Care Model)

- **NH Wraparound Model:**
  - The FAST Forward Early Childhood Wraparound program serves the mental and behavioral health needs of at-risk young children (ages 0-5) and their caregivers by providing enhanced care coordination through the state's two contracted Care Management Entities (CME) chosen through an RFP process. The CMEs provide a modified version of the evidence-based practice of NH Wraparound, which provides support to families in figuring out what their strengths and needs are and

[26] https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd18011.pdf
[27] Ibid

connecting the family with appropriate supports in their communities. Established by state statute.[28]

- **Payment Model:** State General and Department of Education funds/Contract Billing
- **Eligible Population:**
  - Children aged 0-5, includes children in Foster Care and their families
  - Dual Eligibility Criteria: 1) Children who may already have a mental health diagnosis or who have a mental health or behavioral concern; 2) Caregivers who are dealing with their own mental health needs, have current/past substance use, are in recovery, have had a history of their own adverse experiences in childhood, have other systems involved with the family such as the state child welfare agency, and/or there are concerns for abuse/neglect; all of which are impacting their child's needs.

- **Early Childhood Wraparound and related FAST Forward services:** All services are based on child/caregiver needs. Along with care coordination there may be referrals such as:
  - Child-Parent Psychotherapy, an evidence based practice, or other mental health services.
  - Home visiting programs, parent education programs
  - Family Centered Early Supports and Services
  - Other services as needed.
  - Case coordination with managed care

- **New Hampshire Substance Use Disorder Serious Mental Illness Serious Emotional Disturbance Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver[29]**

  - **Purpose:** 1. Reduce utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI/SED while awaiting mental health treatment in specialized settings; 2. Reduce preventable readmissions to acute care hospitals and residential settings; 3. Improve availability of crisis stabilization services, including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and

[28] Bill Text: NH SB14 | 2019 | Regular Session | Amended | LegiScan

[29] https://www.medicaid.gov/sites/default/files/2023-04/nh-sud-treatment-recovery-demnstrtin-aprvl-ca2-04142023.pdf

residential treatment settings throughout the state; 4. Improve access to community-based services to address the chronic mental health care needs of beneficiaries with SMI/SED, including through increased integration of primary and behavioral health care; and 5. Improve care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities. Includes Corrections related reentry services.

- **Eligible Populations: Enrolled** Adults: 21-64 (capitation payment); Youth under 21 (FFS payment authority)
- **Model of Waiver Administration:** Administered through two state Care Management Entities outside of state Medicaid managed Care Organizations
- **Payment Model**: Capitation/FFS/state and Medicaid federal share
- **Clinical Assessment Method for Services Eligibility:**
  - State child welfare agency nurse assessments: under 21/Child Welfare engaged
  - CANS/CAT Assessment
  - American Society of Addiction Medicine (ASAM) Levels of Care Assessment Model

- **New Hampshire SUD/SMI/SED 1115 Waiver Eligible Populations and Continuum of Services**

Benefit	Population	Medicaid Authority	Expenditure Authority
Outpatient Services	SMI/SED and/or SUD	State Plan	N/A
Intensive Outpatient Services	SMI/SED and/or SUD	State Plan	N/A
Inpatient Services	SMI/SED and/or SUD	State Plan (Individual covered services)	Services provided to individuals residing in IMDs
Residential Treatment Services	SMI/SED and/or SUD	State Plan (Individual covered services)	Services provided to individuals in IMDs
Medically Supervised Withdrawal Management	SUD	State Plan	Services provided to individuals in IMDs
Medication Assisted Treatment – MAT	SUD	State Plan (Individual covered services)	Services provided to individuals in IMDs
Screening, Brief Intervention, and Referral to Treatment (SBIRT)	SUD	State Plan	N/A
Partial Hospitalization	SUD/SMI and/or SUD	State Plan	N/A

Benefit	Population	Medicaid Authority	Expenditure Authority
Recovery Support Services	SUD	State Plan	Services provided to individuals in IMDs

Kansas Serious Emotional Disturbance Waiver (SED): 1915 (C)/1115[30]

- **Purpose:** The Serious Emotional Disturbance (SED) waiver provides children with some mental health conditions, special intensive support to help them remain in their homes and communities. The term "serious emotional disturbance" refers to a diagnosed mental health condition that substantially disrupts a child's ability to function socially, academically, and/or emotionally. Parents and children are actively involved in planning for all services. Enrollment is through KS Community Mental Health Centers. This waiver operates within an 1115 waiver for managed care.
- **Payment Model**: Capitation and FFS
- **Eligible Population:** Individuals with serious emotional disturbance ages 4-18 years who meet a hospital level of care and financially eligible for Medicaid.
- **Assessment Method for Services Eligibility:**
  - Be age 4-18 years old
  - Have a diagnosed mental health condition which substantially disrupts the ability to function socially, academically, and/or emotionally
  - Be at risk of inpatient psychiatric treatment
  - Meet Child And Adolescent Functional Assessment Scale (CAFAS) assessment and Child Behavior Checklist (CBCL) threshold for eligibility
- **Waiver Services:**
  - Attendant care
  - Independent living/skills building
  - Short-term respite care
  - Parent support and training
  - Professional resource family care
  - Wraparound facilitation services individuals with serious emotional disturbance ages 4-18 years who meet a hospital level of care
- **Organization of the Models Functions[31]:** entity either supervises the function or establishes or approves the delegated function:

[30] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/KS0320.zip
[31] Ibid, p. 20

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	✓	✓	✓	✓
Waiver enrollment managed against approved limits	✓	✓		
Waiver expenditures managed against approved levels	✓	✓		
Level of care evaluation	✓	✓	✓	✓
Review of Participant service plans	✓	✓	✓	
Prior authorization of waiver services			✓	
Utilization management	✓	✓	✓	
Qualified provider enrollment	✓		✓	
Execution of Medicaid provider agreements	✓	✓	✓	
Establishment of a statewide rate methodology	✓	✓	✓	
Rules, policies, procedures, and information governing the waiver program	✓	✓	✓	✓
Quality assurance and quality improvement activities	✓	✓	✓	✓

Alaska Substance Abuse Disorder Treatment and Behavioral Health Program 1115 Waiver Model[32]

- **Model of Waiver Administration: Administrative Service Organization (ASO) model designed to:**
  - Increase regional access to appropriate BH services
  - Standardized assessment and treatment planning for all eligible populations
  - Improve health outcomes for all publicly funded beneficiaries of BH services (i.e., Medicaid and non-Medicaid State and federal grant funded BH programs); and
  - More efficiently and effectively manage the cost of BH service delivery in Alaska.
- **Payment Model**: capitated payments to ASO; FFS to providers
- **Eligible Populations:**

[32] https://health.alaska.gov/dbh/Documents/1115/1115_Waiver_RenewalApplication.pdf

- Group 1: Children, adolescents, and their parents or caretakers with or at risk of mental health disorders and SUDs
- Group 2: Transitional age youth and adults with acute mental health needs
- Group 3: Adults, adolescents, and children with SUDs

- **ASO Clinical Assessment Method for Services Eligibility:**
  - Level of Care Utilization System (LOCUS): Versions 20: American Association of Community Psychiatrists
  - ASAM Levels of Care Assessment Model: American Society of Addiction Medicine
  - Applied Behavior Analysis (ABA) Clinical Criteria assessment

Alaska SUD/BH 1115 Waiver Continuum of Services

- **Covered SUD Program Services:** Early Intervention- Services*; Outpatient Services*; Medication-Assisted Treatment (MAT)*; Opioid Treatment Services (OTS) for persons experiencing an Opioid Use Disorder (OUD); Intensive Outpatient Services; Ambulatory Withdrawal Management; Partial Hospitalization Program (PHP); Residential Treatment; Clinically Managed Residential Withdrawal Management; Medically Monitored Intensive Inpatient Services; Medically Monitored Inpatient Withdrawal Management; Medically Managed Intensive Inpatient Withdrawal Management. (*Services authorized under the State Plan).
- **Covered Behavioral Health Services:** Community Recovery Support Services (CRSS); Home-based Family Treatment; Intensive Case Management Services (ICM); Partial Hospitalization Program Services (PHP); Intensive Outpatient Services (IOP); Children's Residential Treatment (CRT); Therapeutic Treatment Homes; Assertive Community Treatment Services (ACT); Adult Mental Health Residential Services (AMHR); Peer-based Crisis Services; Mobile Outreach & Crisis Response Services (MOCR); 23-Hour Crisis Observation & Stabilization Services (COS); Crisis Residential/Stabilization Services.

Florida Department of Children and Families Mobile Response Teams and Community Action Teams[33]

- Mobile Response Teams (MRT) provide 24/7 emergency behavioral health care to anyone having a severe emotional or behavioral health crisis in their home, school, or wherever they are. MRT services are available statewide,

[33] www.myflfamilies.com/

managed through the state's seven Regional Behavioral Health Managing Entities at 50 sites covering the state.

- Designed to reduce trauma, prevent unnecessary psychiatric hospitalizations and criminal justice involvement through de-escalation, appropriate crisis intervention, and connecting people to resources in their communities
- Program Eligibility: have an emotional disturbance; or are experiencing a mental health or emotional crisis; or experiencing escalating emotional or behavioral health reactions and symptoms that impact their ability to function typically within their family, living situation, or community environment; or are served by the child welfare system and are at high risk of placement instability.
- MRT teams include: a Licensed Mental Health Professional; Certified Peer Recovery Specialist; access to an On-Call Psychiatrist or Psychiatric Nurse Practitioner; and Support Staff.
- MRTs provide in-person and telehealth services that provide on-demand crisis interventions in any setting in which a behavioral health crisis occurs. Services offered include Screenings and Assessments; Crisis De-escalation and Stabilization Services;
- Crisis Counseling: Development of Safety or Crisis Plans; Psychoeducation; and Care Coordination (connects systems including behavioral health, primary care/Medicaid, peer and natural supports, housing, education, vocation, and the justice systems.
- **Community Action Teams (CAT)** help children and young adults with behavioral health concerns to recover at home safely. These teams also assist families in building and maintaining a support system within their community. CAT is a safe and effective alternative to out-of-home treatment or residential care for children with serious behavioral health conditions. Sixty teams across the state provide CAT services.
    - Eligibility: Children and young adults with serious behavioral health conditions.
    - Youth with complex needs that contribute to family disruption or increase the risk of family separation such as: Multiple behavioral health hospitalizations; Involvement with the Department of Juvenile Justice or law enforcement; School challenges like poor academic performance or suspensions; and Repeated failures at lower levels of care.
    - Youth younger than 11 years old may be able to receive services if they have more than one of the needs described above.
    - Treatment models: **Traditional CAT Teams** serve children and young adults with a behavioral health condition and at risk of out of home placement. **Family First Prevention Services Act (FFPSA) Teams** serve

families where the child(ren), parent(s), or caregiver(s) have a behavioral health condition that contributes to risk of family separation or child out-of-placement. **Family Support Teams (FST)** serve families where frequent use of emergency psychiatric services contributes to family separation or child out-of-home placement.

- Services: Care Coordination; Case Management; Crisis Intervention; Therapy; Mental Health and Substance Use Treatment; Psychoeducation; Respite Care; and Transportation Assistance.

Recommendations for Future Child Welfare Transformation (V.B)

The following recommendations for future child welfare transformation aligned with LB 1173 practice model to enhance Nebraska's children's mental health and substance use disorder system of care

Consider Aligning Behavioral Health (Mental Health and Substance Use Disorder) Services Definitions Across All Departments (V.B.1)

DHHS should consider aligning Behavioral Health (Mental Health and Substance Use Disorder) services definitions across all Departments providing these services with Medicaid definitions as the foundation across DHHS.

- Clarify the "care coordination" definition across all DHHS divisions and programs touching CFS children in care and at risk and reach a decision on specific purpose of the service, operational responsibilities to provide care coordination for transitions and provider search, programmatic/clinical use, commonalities, variances, eligible populations, and funding source.
- Clarify the "case management" definition across all DHHS divisions and programs touching CFS children in care and at risk: see below under RBHAs.

Consider Assessing all Existing State Plan Amendment and Waiver Services Definitions and Credentialing Requirements (V.B.2)

Nebraska Medicaid should consider assessing all of its existing SPA and Waiver services definitions and credentialing requirements and comparing them to Evidence Based Practices reviewed and listed by sanctioning entities such as SAMHSA, California Evidence-Based Clearinghouse for Child Welfare, Oregon Health Authority approved practices, Tribal Programs, and SBIRT tools, or the Pacific Northwest Evidence-Based Practice Center (Oregon Health & Science University funded by AHRQ) and update accordingly. In addition, current credentialing requirements should be compared to states that have recently adjusted key BH provider requirements to expand workforce capacity in a safe manner.

Consider Developing and Implementing a Comprehensive Behavioral Health, Institutions for Mental Diseases Exclusion, Substance Use Disorder, and Serious Emotional Disturbance 1115 Waiver (V.B.3)

DHHS/Medicaid should consider developing and implementing a comprehensive Behavioral Health, IMD Exclusion, Substance Use Disorder, and Serious Emotional Disturbance 1115 Waiver based on a standardized assessment of acuity levels and carved out from the existing managed care program.

- The covered population would be all eligible infants, children, youth, and adults who upon standardized assessment are determined to have a high level of acuity/severity/persistence. Services definitions should be evidence based to the maximum extent possible and include mobile crisis services, inpatient, residential, day programs, outpatient, fidelity Wrap Around services, evidence-based Prevention services, and SDOH/In Lieu of Services.

- The delivery system for this waiver could be anchored in the strengths of Nebraska's Certified Community Behavioral Health Clinics/CCBHCs, Federally Qualified Health Centers/FQHCs, and the Regional Behavioral Health Authorities (RBHA). The operational model would include a standardized scope of work, Evidence Based Practices, an agreed upon standardized assessment instrument that determines acuity levels and service needs, a standardized treatment planning method, and a direct relationship with or provider of fidelity Wrap Around services. Bi-directional care coordination between these entities and the Managed Care Organizations would be embedded in a Memorandum of Agreement.

Consider a Waiver Administrative Platform of an Administrative Services Organization (V.B.4)

Nebraska Medicaid could consider a waiver administrative platform of an Administrative Services Organization (similar to Alaska). The ASO model could provide the state with more direct oversight of and accountability for the behavioral health delivery system for high acuity/high cost infants, children, youth, and adults.

- An augmented Fee For Service rate for specified services coupled with a single provider revenue cycle (compared to multiple MCOs) could provide an

incentive for more credentialed private sector providers[34] to become Medicaid providers.

- Nebraska Medicaid could also consider embedding this waiver within the existing managed care contract model (similar to KS) thereby inheriting the existing strengths and challenges of that system. This approach would also be expedient and rely on the existing MCO capacities for care coordination of high acuity/high costs individuals which, based on community comments across the state, would have to substantially improve.

Expand Opportunities for the Regional Behavioral Health Authority System to be a vital partner of the future child welfare transformation (V.B.5)

Expand Opportunities for the RBHA System to be a vital partner of the future child welfare transformation through the new system of care for children and families struggling with Behavioral Health and Substance Abuse Disorder and Serious Emotional Disturbance issues.

We have had the opportunity to meet with individuals from the RBHAs in the community, have been presented with details about the value the system could bring to children and families in Nebraska through our Workgroup meetings, and we have also met with Nebraska Division of Behavioral Health staff and reviewed detailed program and cost information. Through all our interactions and review, we believe that there are untapped resources and value that the RBHA system could bring in the future to many children, youth and families that are at risk of child welfare involvement.

- The statewide RBHAs are established by Nebraska Revised Statute 71-801-818 and are responsible for the development and coordination of adult and children's publicly funded behavioral health services within their region primarily funded by SAMHSA Block Grant funds, state, funds, local funds, private insurance, and self-pay.
- The population RBHAs serve is any child or adult with a behavioral health need who is not a Medicaid beneficiary. Financial access to services is based on state determined Income Guidelines, private insurance coverage, or self-pay.

[34] The Marly Doyle Behavioral Health Center of the University of Nebraska (established by LB 608) reports that there was an increase of 32% of psychiatric prescribers and 39% of psychologists and mental health therapists between 2010 and 2020. https://nebraska.edu/nuforne/marley-doyle

While there is variation across the RBHAs (some directly deliver services or contract them out to private providers willing to work with them) they all deliver the Professional Partnership Program. This program is designed to assist families with a child experiencing Severe Emotional Disturbance through a fidelity Wrap Around model and is needs/strengths based.

Thus, the Work Group sees significant untapped potential for the RBHA system to be a pivotal part of the future LB 1173 child welfare system transformation, and identifies the following opportunities for Nebraska to consider moving forward:

Consider the Professional Partnerships program as the Statewide HUB (V.B.6)

Consider the Professional Partnerships program as the statewide HUB (or a participant HUB with the CCBHCs and FQHCs based on regional variations) for fidelity Wrap Around within the recommendation for a Medicaid BH/IMD/SUD/SED 1115 waiver. Note that currently the RBHA Professional Partnership Program serves approximately 1,000 children on an annual basis at a cost of approximately $6 million of non-Medicaid funds (SAMHSA, state funds) across the state.[35] Further note that the need for a DHHS wide definition of BH/SUD/SED case management services mentioned previously is supported by the current understanding that children and youth in Foster Care, who could benefit from Professional Partnership services, are not eligible because CFS case workers are assumed to provide Fidelity Wrap Around services as part of their case management duties, however, while Juvenile Justice Cross Over youth, we are told, are eligible and receiving these services.[36]

RBHAs are well positioned in their communities/region to provide or partner with Mobile Crisis teams based on Paramedic/EMT participation such as the models we learned about in the Kearney and Omaha regions sponsored by Lutheran Family Services.

Consider Developing a Method that Balances Currently Appropriated Regional Behavioral Health Authority System Funding with New and Revised Financial Income Guidelines that are More Flexible (V.B.7)

Between FY 2019 and FY 2023 DBH provided a total of $435,435 million in SAMHSA Block Grant and state general fund dollars for RBHA services with a total of $351,591 million expended during this time period. Several RBHA directors we spoke with

[35] Source: DBH Spreadsheet: 8/29/23

[36] This understanding comes from several community meetings including caseworkers. We could not find any statute or rule supporting the omission of CFS “wards” of the state from the Professional Partnership program.

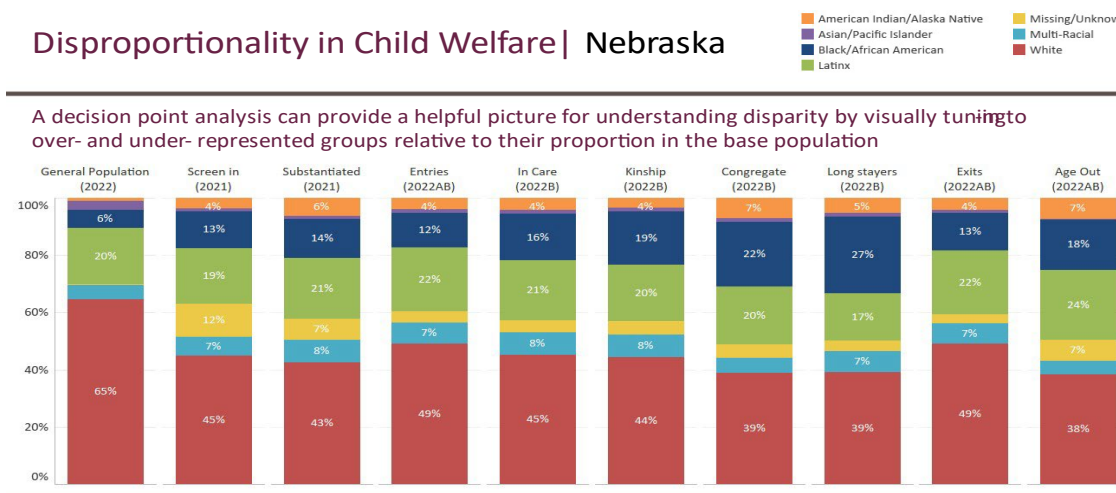
indicated the current state Financial Income Guidelines for RBHA services eligibility was often too high for struggling families whose income was just above current guidelines, falling within the "Cliff Effect."[37] We recommend that DHHS/DBH consider developing a method that balances currently appropriated RBHA funding with new and revised Financial Income Guidelines that are more flexible in managing over or under budget expenditures throughout the Fiscal Year. These additional dollars represent funding that currently exists in the system that can be used by leveraging existing dollars.

VI. Additional Child Welfare Practice Recommendations

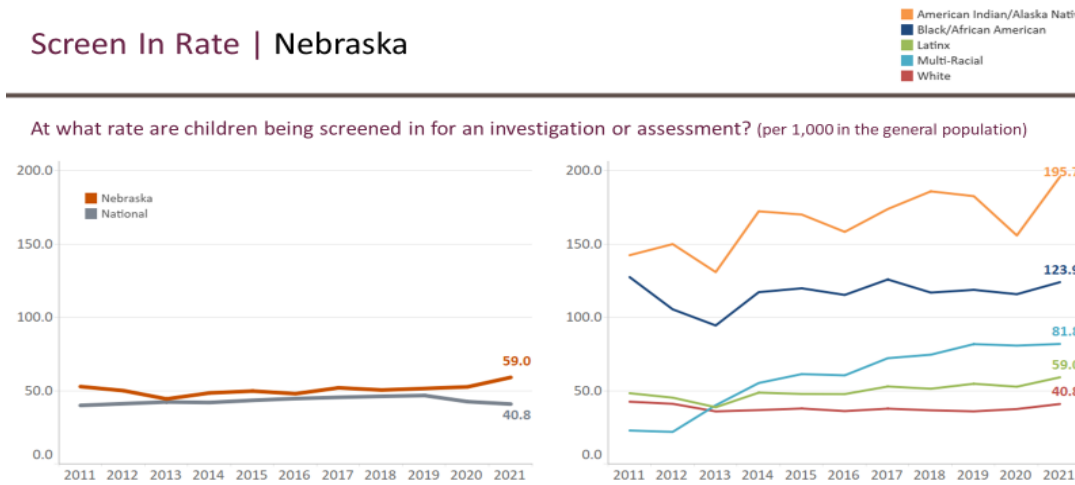
The following recommendations are aligned with the LB 1173 Child Welfare Practice Model.

Increase Efforts to Address Disproportionality (VI.A)

The disproportionate representation of African Americans and Native Americans in Nebraska's child welfare system was documented in a May 1173 Work Group session during a presentation from Casey Family Services. (based in part on data from Nebraska's AFCAR). This presentation identified that as overall percentages of the population, there is a significantly higher per capita representation of these families in the child welfare system which is represented below.



[37] "The cliff effect refers to the sudden and often unexpected decrease in public benefits that can occur with a small increase in earning." National Council of State Legislators: https://www.ncsl.org/human-services/introduction-to-benefits-cliffs-and-public-assistance-programs



Many of these families also experience higher levels of poverty, lower education achievement, higher unemployment rates and higher rates of incarceration.

Concerns about these kinds of statistics were also expressed consistently at the community forums and in individual meetings. Issues were also raised about the system's inability to provide culturally appropriate preventive and post-engagement services to families of color and how that may impact their disproportionate representation in the child welfare system. It was reported that among Latino populations, not only is there a dearth of culturally appropriate supports and services-there were also large gaps in service regarding translation/interpretation services. We also heard about the need to address the dialectic variations of Spanish that are spoken among Nebraska's diverse Latino population. The absence of appropriate interpretation/translation services, especially at legal hearings, may increase the risk of more punitive child welfare actions as families struggle to understand the complexities of the court system without interpretation/translation support.

We also learned that while the availability of translation/interpretation support is a challenge statewide, it is more acute in rural areas. Moreover, state supported translation/interpretation assistance for other English as a Second Language (ESL) populations is severely limited. According to Acutrans, the top foreign languages spoken in Nebraska, include Chinese, Vietnamese, Arabic, Amharic, Tagalog, in addition to many Tribal tongues.

Compounding the ESL issues were reports from stakeholders that the deployment of culturally competent services/support throughout the child welfare system is

inconsistent. The National Center for Cultural Competence at Georgetown University, defines cultural competence best practices for organizations as follows:

Cultural competence requires that organizations:

- Have a defined set of values and principles, and demonstrate behaviors, attitudes, policies, and structures that enable them to work effectively cross-culturally.
- Have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge, and (5) adapt to diversity and the cultural contexts of communities they serve.
- Incorporate the above in all aspects of policymaking, administration, practice and service delivery, systematically involve consumers, families and communities.
- Recognize that cultural competence is a developmental process that evolves over an extended period. Both individuals and organizations are at various levels of awareness, knowledge, and skills along the cultural competence continuum.

The feedback received from stakeholders and sovereign nations across the state suggests that there needs to be an enhanced focus going forward in transformation on recognizing the unique cultural needs for disproportionately represented Nebraskans throughout the child welfare system. Many believe that further development of more culturally sensitive prevention and community development support can strengthen families'/communities' capacity to nurture children safely and successfully at home.

Adoption of statewide culturally competent services in child welfare can entail a number of practices including increasing the utilization of organically grown community organizations as valued community partners. This can lend more credibility to initiatives to enhance cultural competence in the child welfare system. Working with trusted grassroots organizations such as Midland's Latino Community Development can also bolster trust and support at risk communities. These organizations can provide locally developed solutions to locally defined issues.

Disproportionate rates for children of color in out-of-home care remains a critical issue to be examined and addressed, regardless of which agency or agencies are involved.

Continue to Expand Authentic Engagement of Those with Lived Experience (VI.B)

The increased deployment of LivedEx as peer support can bolster state led child welfare initiatives. LivedEx peers can also provide support for families struggling to navigate the complexities of the child welfare system and provide guidance on referrals for local community services and neighborhood resources.

The value of the collective voices of those with LivedEx has been profound as we have collected empirical data across Nebraska. These very unique experiences speak to both the challenges *and* the hope for the child welfare system. Many urged the transition of the child welfare system as a punitive engagement to a family support mindset. They repeatedly called for the system transformation to adopt a less punitive approach to supporting families in need.

Moreover, the inclusion of these LivedEx *experts* and families at the state's system/administrative levels to inform policies and practices will also support better experiences and outcomes for families and communities. Their input should be reflected in all critical aspects of the transformed system. This bold step will require meaningful sharing of *power* between state/agency level professionals and family/community stakeholders. Simply put, to improve child and family experiences and create a more efficient and effective system, their direct input must be considered highly valued and integral to transformation. As we heard from several stakeholders-they want the recognition that this initiative reflects the statement, 'nothing about us, without us!'

The community collaboratives framework, via NCFF, has provided solid support to myriad community based organizations-contributing to an integrated infrastructure that emphasizes alignment of multiple resources to strengthen families. We observed considerable cross-functional engagement amongst the local community collaboratives-which foster a 'no wrong door' approach to providing preventive services to minimize child welfare reporting and subsequent actions. To maximize the impact of this approach, a full family risk assessment can be completed no matter which organization was initially sought out by the family/community referral source. These full risk assessments can expedite the delivery of critical services/supports and mitigate potential child welfare system reporting. NCFF also exemplifies the practices of LivedEx inclusion in this work, as their workforce includes a significant number of these valuable community representatives.

Practices for youth aging out of foster care is another significant opportunity for LivedEx input to improve outcomes. According to feedback from stakeholders within

the child welfare system and from those providing wrap around services, Nebraska's strategies for supporting youth aging out of foster care would benefit from a more intersectoral focus. Many LivedEx participants reported having experienced inconsistent support to prepare them for transitioning out of foster care. Some reported it as akin to poor hospital discharge planning-there was little support for sustainability in the community post discharge. As a result, many Nebraska young adults fall prey to the circumstances listed above-dropouts, homelessness, incarceration, etc. Building a more robust aging out model may also reduce generational child welfare participation, a concern raised by many stakeholders.

The socioeconomic impact on families and communities can be significant when aging out youth are not primed to be contributors in the community. As noted in the Annie E. Casey report, Future Savings The Economic Potential of Successful Transitions From Foster Care to Adulthood[38] with the right resources applied to foster care youth transitions:

- Education: 5,290 more young people would graduate from high school each year, leading to $2.17 billion in economic gains through increased lifetime income.
- Early Parenting: 2,866 fewer young women would experience early parenthood by the age of 19, resulting in avoided societal and taxpayer costs of $295 million for the first 15 years of the child's life.
- Homelessness: 4,370 fewer young people would experience homelessness, which would save $9.6 million in spending on beds, per night across homeless episodes, needed to provide temporary shelter.
- Incarceration: 4,870 fewer young people would experience the juvenile justice system, resulting in $1.6 billion less spent on the cost of per-day detention, cost of crime to society and victim and recidivism rate.

Engaging those with LivedEx to support the redesign of success-oriented transition programming could significantly improve outcomes for the affected youth. Leveraging community-based organizations and school based support systems authentically working with such youth strengthens their long term viability as community contributors.

Continue to Engage Tribal Nations During LB 1173 Transformation (VI.C)

The Casey Family Programs presentation during the May 2023 Work Group meeting provided detailed data about Nebraska's higher rates of disporportionality in child

[38] https://assets.aecf.org/m/resourcedoc/aecf-futuresavings-2019.pdf

welfare-especially for Tribal families. Tribal families experience higher screen-in rates for investigations and enter care more frequently than other non-Tribal famialies. In addition to disproportionate representation in the child welfare system, Tribal families continue to grapple with historical and intergenerational trauma, disconnection from culture and loss of cultural identity, poverty, high unemployment and, a lack of access to adequate resources.

According to the 2021 Kids Count in Nebraska Report by Voices for Children, Native American children continued to comprise only one percent of Nebraska's population but represented nearly four percent of children in the state's child welfare system.[39] Data published by the National Indian Child Welfare Association in 2021 ranks Nebraska as the fifth highest child welfare disproportionality rate out of the top 15 states in the Nation.[40]

Addressing Tribal communities in child welfare entails consideration of factors that are unique to these communities. First among them is Tribal sovereignty, protected and guaranteed by myriad federal/state legislation including but not limited to:

- Indian Reorganization Act, 1934
- Indian Civil Rights Act, 1978
- Indian Child Welfare Act, 1973
- Indian Tribal Justice Act, 1993
- Nebraska Indian Child Welfare Act, rev. 2015

Tribal nations are authorized to engage in self-government which includes oversight of child/family welfare infrastructures. State child welfare systems must accede to these federal laws in the systemic design and administration of child and family welfare programming. Ideally, state child welfare systems are aligned with Tribal systems for improved child/family safety, coordination of additional support/services and reduction in adverse outcomes. A primary premise of the Indian Child Welfare Act (ICWA) calls for prioritization of culturally appropriate placements for Tribal children who are removed from their homes. However, according to NICWA, currently there are no licensed foster homes classified as Tribal foster homes in Nebraska.

During the course of the LB 1173 system evaluations, we convened a number of key meetings with Tribal stakeholders, including a Winnebago reservation-based

[39] https://kidscountnebraska.com/child-welfare-2022/

[40] https://www.nicwa.org/wp-content/uploads/2021/12/NICWA_11_2021-Disproportionality-Fact-Sheet.pdf

session, to gain better insight into sovereign nation child welfare administration and to represent the Work Group's desire to support a more intersectional approach to addressing Tribal disproportionality. We have gathered sage and practical insight from meetings with organizations like, The Nebraska Indian Child Welfare Coalition, the Nebraska Urban Indian Health Coalition (NEIHC), and from several one-to-one interviews.

One issue that was repeatedly echoed throughout these meetings was the need to recognize that Tribal nations' cultures are not homogenous. Each has a distinct history/culture-akin to the differences between Japanese, Portuguese and German cultures. These nuances color Tribal governmental infrastructure design and their approaches to child welfare. The state child welfare system transformation must factor in these unique considerations in planning for broader Tribal understanding, support and engagement.

Distrust of the state system among Tribal Nations is another significant factor-as is the case for many of the disproportionately represented populations. This distrust may be primary borne out of the perception that the state system has limited recognition and responsiveness to the Tribal culture and rights. Several of the goals of the NICWC include, '…reconnect Native children with their families, communities, cultures and heritage; promote education about Native American cultures…advocate for the ICWA to be respected.' This group has worked successfully with coalition partners across the state to achieve these objectives and reported an improvement in state/Tribal connectivity. They strongly recommend imbedding culturally sensitive training across CFS, courts, healthcare, etc.

We also learned that routine communication between state government entities and Tribal governments is lacking. This impacts the efficacy of Tribal agencies' service to their communities. For example, termination of Medicaid coverage occurs with very little communication with Tribal agencies that may have been able to provide intervention to mitigate loss of coverage. Tribal representatives also reported concerns with the onerous nature of the Medicaid eligibility process for Tribal families. In some cases, Tribal agency staff are not well versed in the complexities of the Medicaid program impacting their capacity to support families. There's an opportunity for cross training between Tribal/state agencies to improve access to Medicaid services, including utilization of Medicaid covered preventive services that enhance family stability. Additionally, better coordination and standardized application of Medicaid services between Indian Health Centers (IHC) and other clinical entities providing Medicaid covered services can reduce barriers to access to care. Training and technical assistance for state and Tribal agencies

regarding unique Medicaid program coverages/exclusions for Native Americans- including their participation in Medicaid MCOs would augment navigation support provided to families. In many instances, limited Tribal funds-designated for other purposes- can be diverted to cover family services that are eligible for Medicaid reimbursement.

Stakeholders also reported that all Tribal child welfare systems are not created equally. While some function very efficiently, others struggle to keep up with growing demands and delivery of high-quality services. These disparities can lead to longer wait times for assistance, increasing the risk for child welfare intervention. For many Tribal communities there is a single Tribal Court Judge or Prosecutor, which means dockets are backed up. Concerns were raised about some Tribal courts' availability of funding for public defenders to represent families/children. The Nebraska child welfare transformation should address development of more intersectional engagement between state and Tribal child welfare agencies- including leveraging funding to create equity among Tribal child welfare systems.

Feedback from Tribal related conversations also indicated that there is often a lack of synthesis between Tribal and state child welfare statutes, regulations, and policies. Without considering the impact on Tribal communities, development of some state policies/practices have negatively impacted Tribal children/families. Organizations like NICWC are committed to constant policy monitoring to advocate for reforms that are reflective of implications for Tribal nations. Tribal stakeholder representation in any transformation efforts going forward will be critical to ensuring the transformation process reflects the best interests of all clients- particularly Tribal nations.

Within this report, enhancing community pathways as a coordinated option to avoid child welfare engagement is shared as a recommended strategy. We acknowledge that today, Tribal Nations are part of the Bring Up Nebraska Community Collaborative system. These community pathways can be beneficial to Tribal families/children if they are designed to reflect the diverse culture/needs of Tribal communities. The design of community pathways programming that is culturally appropriate for high-risk communities is essential to successful support for all child welfare clients.

The Crossover Youth Practice Model is Effective and Aligned with the LB 1173 Child Welfare Practice Model and Should Continue To Be Implemented in every Region Statewide (VI.D)

Over the last year, we have had the occasion to meet with many front line CFS and Juvenile Probation Officers at their Regional Offices as well as leadership from both agencies. Based on all of our discussions, it is clear that both agencies have so much to offer cross over children and youth and embody a clear and unified vision to enhance the well-being of every youth in care. There will be a need to continue this spirit of collaboration with an enhanced focus on adherence to the Crossover Youth Practice Model (CYPM), in alignment with the transformative LB 1173 Child Welfare Practice Model. The CYPM has been in existence in Nebraska for a few years not and we have found that this model, when practiced with fidelity, is a best practice collaboration between the Administrative Office of the Courts and Probation (AOCP) and Department of Health and Human Services – Division of Children and Family Services (DCFS) and will lead to more effective outcomes for these Crossover youth. The CYPM is created as a guide for agreed on expectations and daily work procedures to improve outcomes for these dual system involved youth. It also can be a vehicle to provide clarity on the different roles and responsibilities between a juvenile probation officer in Nebraska and a CFS case manager, which was a theme we heard in our meetings that, at times, is needing clarification for not just for both agency staff, but for courts and other stakeholders.

The CYPM enables effective early identification of a dual system youth, contact and effective and continuous communication between staff of each agency, supported by established, consistent supervisory staff collaboration. Pursuant to the CYPM, every regional/local CFS and AOCP Probation District creates a "Local Process" document to note how the following key process steps will be accomplished in their area:

- Supervisory Collaborative Support: Regular staffing of emergency and temporary placements, such as detention, crisis intervention, respite, and shelter. Monthly supervisory meetings to review operations, connect any needed staffing, discuss services and approvals of recommendations for case disposition.
- Identification of Youth: Every youth entering system checked to identify if they are a dual-system youth. This would include both emergency and non-emergency situations.
- Aligned Assessment and Planning: Once a youth is identified, immediate contact between Probation Officer and CFS case worker to prepare for

detention/removal and court hearings in emergency situations. In Non-emergency situations contact between two agency workers made timely, usually within 5 business days and a plan for formal exchange of case information in a timely manner after notification. Schedule assessments and interviews and continue to coordinate on the schedule and work.

- Coordinated Case Management: Timely ongoing communication between both agencies, ongoing team meetings, consistent documentation, attending all court hearings and use of a Crossover Collaboration Report to represent collaboration to the court.

We believe that this is an effective model and that it should continue as it is already aligned with some of the key LB 1173 themes, as well as the recommended Practice Model. In the future, we would strongly recommend that the Judicial Branch and DHHS consider including Alternative Response cases in the dually involved definition, and also ensure that there is proper training for new hires about the Model and its importance.

Consider Implementing Douglas County Youth Impact! Initiative Statewide for Cross Over Youth (VI.E)

In 2007 Casey Family Programs and the Center for Juvenile Justice Reform at the Georgetown University Public Policy Institute (CJJR) began partnering to develop the Crossover Youth Practice Model (CYPM) that describes the specific practices that need to be in place within a jurisdiction in order to reduce the number of youths who crossover between the child welfare and juvenile justice systems. In February 2012, Douglas County, Nebraska agreed to become a CYPM site and on November 1, 2012, the CYPM was officially implemented in Douglas County. In 2014 this initiative was re-branded Youth Impact! to reflect the intentional youth focus of the initiative.

The Douglas County Youth Impact! Initiative is a voluntary coordinated effort of public and private agencies that have come together to address the unique issues presented by children and youth who are known to both the child welfare and juvenile justice systems. In this best practice model, Douglas County, through leadership of Judge Chad Brown, is utilizing the 1184 Crossover Team created by statute to bring members together for coordinated case planning.

The 1992 Nebraska Legislature created the teams in LB 1184, and it is from the bill number that they received their popular name. Every county in Nebraska is required to create and maintain 1184 Teams in order to monitor and coordinate investigations when abuse or neglect has been reported. The teams also coordinate and monitor treatment for families where child abuse or neglect has been found.

The teams operate pursuant to protocols that provide for coordinated joint law enforcement and Health and Human Services investigation of cases; ensure law enforcement participation; reduce the risk of harm to child abuse and neglect victims; ensure that children are in safe surroundings; share information among professionals; and manage the team's activities.[41]

The Douglas County Youth Impact! Initiative is using the 1184 process, formalized by a Memoranda of Understanding (MOU), coordinated through the Child Advocacy Center, that binds the partners together, including parent and youth. Following are the outcomes and goals included in the MOU.

Outcomes:

- Reduce recidivism.
- Reduce youth from crossing over.
- Reduce the number of youth in out of home placements.
- Reduce use of detention.
- Reduce disproportionate minority contact.

Goals:

- Promote increased cooperation, coordination, and integration at the administrative and service delivery levels for the benefit of children and families.
- Achieve and institutionalize greater multi-system coordination and integration to achieve the intended outcomes (stated above) set out for the Youth Impact! for Douglas County children, youth and families.
- Strengthen the family voice and choice by engaging parents and youth throughout the Youth Impact! process.
- Maintain the interests of community safety while recognizing the need to support the safety, permanency, and well-being of children and youth.

These outcomes and goals, along with leveraging the existing 1184 Team consisting of intersectoral partners, is directly synergistic to the efforts of LB1173. We recommend considering implementing the Douglas County Youth Impact! Initiative statewide through leveraging the intersectoral partnerships of the existing statewide 1184 Teams and the Nebraska Community Collaboratives to provide crossover youths with much needed support and successful outcomes.

[41] https://ccfl.unl.edu/our-work/projects/resource-center-child-abuse-and-neglect-teams-rccant

All child welfare system stakeholders should continue to collaborate and work on LB 42 to redefine the definition of Neglect (VI.F)

One of the most common themes we heard during the community forums and in many of our stakeholder meetings was that poverty does not equate to neglect and should not be the reason for removing a child from his or her parents. Families should be supported where children are safe, rather than reported when there is no risk to safety but a need for services and support for families in their communities. Our LB 1173 Child Welfare Practice Model embraces the practice of helping these struggling families as its first priority:

- When safely possible, children should be raised in their family - families should be viewed as the solution and not the problem.
- We will design and deliver supports early to build on family strengths.
- We will prioritize supporting the family unit by identifying the most prevalent issues with matching intensity and focused solutions.

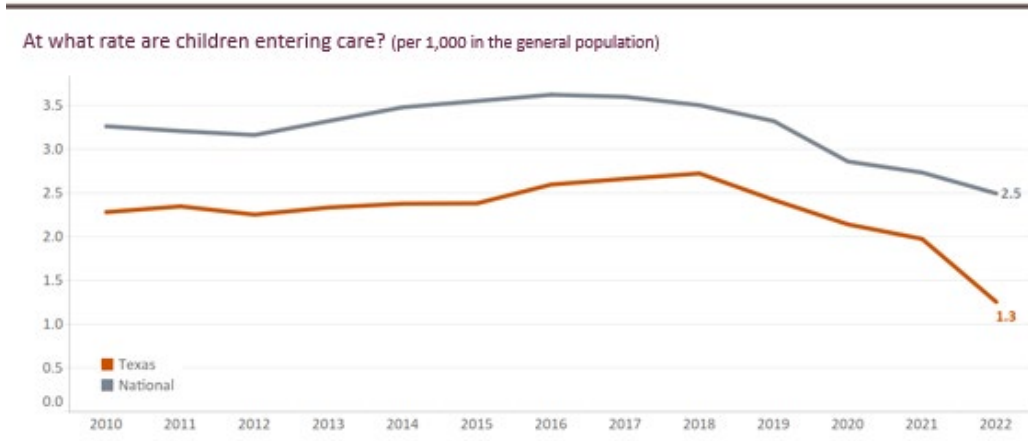
Nebraska LB42 seeks to redefine Neglect and provides definition for independent activities. It has broad support from a variety of diverse stakeholders to include Nebraska Children and Families Foundation, Nebraska Appleseed, Let Grow, and Home School Legal Defense Association, Voices for Children in Nebraska, Americans for Prosperity, Nebraska Christian Home Educators Association, and the ACLU. As of this writing, LB42 was referred to the Judiciary Committee where it still sits after a hearing in February[42].

While LB42 is silent on the topic of poverty and economic disadvantage ***Senator Hansen stated in his testimony to the Judiciary Committee that "Oftentimes, what should be identified as poverty is often labeled as child neglect by those on the outside looking in, hardship does not equal harm."[43]***. Neglect has an overly broad definition that leaves room for families struggling to meet their basic needs to be unnecessarily involved in the child welfare system due to economic circumstances which could be ameliorated by connecting the family to services. We recommend including language as Texas did recently regarding the fact that economic disadvantage does not constitute clear and convincing evidence sufficient for a court to remove a child[44].

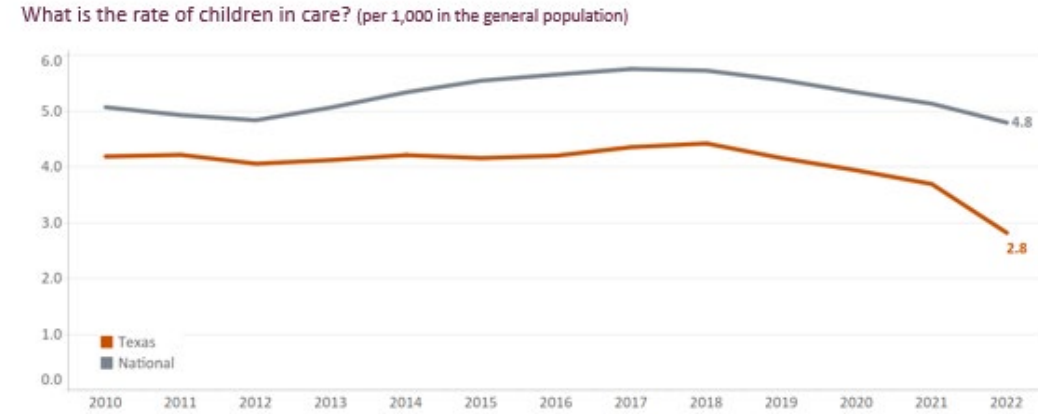
[42] https://nebraskalegislature.gov/bills/view_bill.php?DocumentID=49881
[43] Page 2 https://www.nebraskalegislature.gov/FloorDocs/108/PDF/Transcripts/Judiciary/2023-02-22.pdf
[44] https://capitol.texas.gov/tlodocs/87R/billtext/pdf/HB00567F.pdf#navpanes=0

In HB567, the State of Texas redefined Neglect and eliminated non-emergency removals which went into effect in September of 2021 and has led to positive changes in reducing removals. The following graphs provided by Casey Family Services show the longitudinal decline in Texas foster care entries and children in care. Comparing 2018 to 2022, removals dropped by 53%.

Entry Rate | Texas



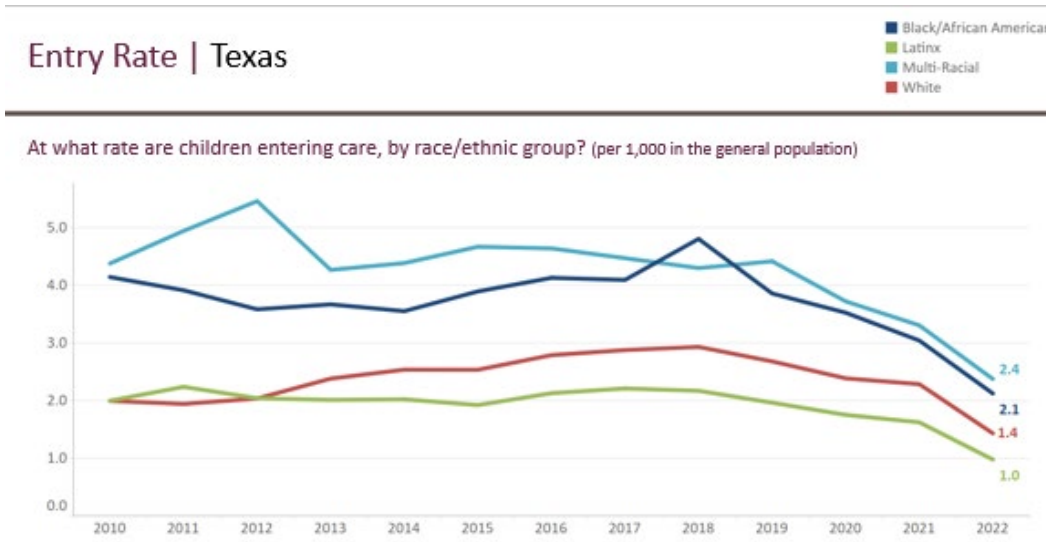
In Care Rate | Texas



[45]

[45] Lower rate is considered better. Point in Time 09/30/2022

The data also indicates all population cohorts benefited from the reduction in removals. No cohort was left behind and the rate of decline is fairly consistent across population cohorts. The following graphs provided by Casey Family Services illustrate the removals by race/ethnicity.



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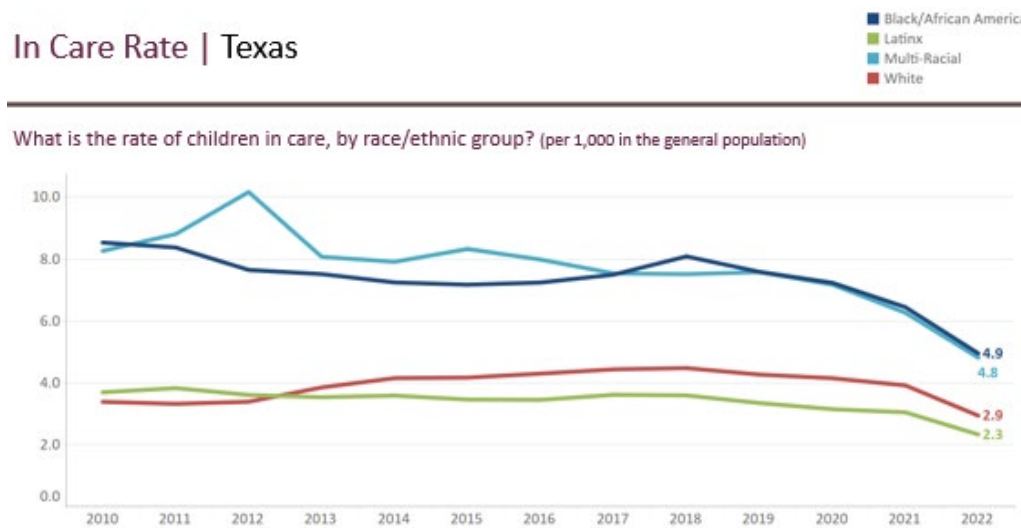


We recommend all stakeholders, and intersectoral partners continue to work on the LB42 legislation and try to achieve common ground on redefining Neglect or work together to achieve the goal of reducing unnecessary system involvement where

[46] Asian/Pacific Islander and American Indian/Alaska Native not displayed due to < 100 children of those races in care.

family supports would be an appropriate intervention. Furthermore, as stated above, we recommend amending the language of LB42 to include that economic disadvantage does not constitute clear and convincing evidence sufficient for a court to remove a child from its family. Additionally, we believe that defining independent activities, as LB42 currently does, should expect to support a decline in unnecessary removals as well as serve to preserve and strengthen families. See Appendix C for comparison of both bills.

Enhance Collaboration, Communication and Partnership with County Attorneys (VI.G)

County Attorneys in Nebraska are key intersectoral child welfare partners and their input on system improvements is invaluable. Their main focus is to ensure the safety and protection of any child or youth that has been abused and neglected under state law. They are also key in moving a case through the process in a timely manner, which is so critical in reducing trauma from placements and involvement with the foster care system.

We were encouraged during our meetings and discussions with several county attorneys across the state with their willingness to provide input on the LB 1173 process and future child welfare Transformation. County Attorneys we met see their role as a partner in the child welfare system and appreciate that lens as opposed to being viewed as an advisor when collaborating on cases.

We also appreciate their openness to embrace, as part of the new practice model, the focus on front end prevention without system involvement. In our discussions they recognize the validity of the prevention focused community pathway to strengthen families by meeting them where they are in their communities with appropriate interventions. However, they want to be assured that safety is the first priority, and the resources are provided on the front end to assist these families, which would include greater access to mental health and substance abuse services.

In all of our discussions, it was clear that where there are true and authentic partnerships, with great collaboration early on in any case, between a county attorney a CFS case worker, and/or a juvenile probation officer, the process worked in a much more effective manner. Where there was not good collaboration between the county attorney and the case workers, usually the result was not as positive. Thus, consistent with the Practice Model, we recommend that case workers involved in the Child Welfare system in Nebraska enhance collaboration, communication, and authentic engagement with county attorneys by way of real and meaningful partnerships.

Our emphasis here is not only based on our interviews, but on the results of a survey we conducted where 36 County Attorneys around the state participated and answered twenty-one questions and also provided detailed comments on system improvements. – See results of survey at Appendix D. These county attorneys offered great insight into a number of areas that should warrant attention during Transformation and are also addressed in the LB 1173 Practice Model and in a number of our engagement strategies and recommendations. The results of the survey can be summarized as follows:

CFS case worker Court Preparation

The results show majority of county attorneys believe that CFS caseworkers are able to meet their requests for information in preparing petitions for removal, but there is strong disagreement that CFS caseworkers are prepared for court and, even with proper training most did not agree that they are well suited to make final decisions on whether a child can safely be left in a home with a safety plan in place.

CASA and GAL Participation

County attorneys strongly value the input, involvement and recommendations of GALs and CASA and believe overwhelmingly that they both serve to facilitate or expedite permanency efforts in a case.

Petition for Removal

Largely county attorneys feel that petitions for removal contain sufficient information regarding reasonable efforts and exigent circumstances.

Birth and Family involvement

County attorneys believe that families are involved in decision making and court hearings. Conversely, they feel foster parents are not.

Service Access and Coordination

County attorneys overwhelmingly believe there is inadequate access to mental health and substance abuse services to meet the needs of families, children and youth. They have also identified behavioral health services, substance abuse services, parenting sill development, home visiting services, and transportation as significant areas of need to bring stability to a child and family. Additionally, the majority of county attorneys do not believe that DHHS does an excellent job in linking and coordinating all departments and services needed for families.

The vast majority of County Attorneys also do not believe that CFS caseworkers should be given more discretion over the decision to remove children or in making decisions for the family.

Training and Understanding

County Attorneys believe they have had sufficient training to understand childhood trauma and in understanding their role in helping a child reach permanency, but the majority do agree that they need more training related to understanding the child welfare system and its decision tools. Collaboration and Permanency County Attorneys overwhelmingly believe there is not enough collaboration with DHHS attorneys, and that cases do not reach permanency in a timely manner.

Enhancing collaboration, communication, and partnership with the County Attorneys is an area ripe with opportunity under our recommendations and the implementation of the Practice Model. Going forward, we would recommend that DHHS meet regularly with County Attorneys to provide regular reports regarding the status of cases in their jurisdictions, including those that are non-court or Alternative Response. These reports should include at minimum the number as well as the status of engagement with families under these categories. The data can be used to collaborate and engage with the County Attorneys to help the families before becoming court involved. Additionally, another way of showing collaboration is where DHHS provides updates on these types of cases at the 1184 team meetings where transparency with intersectoral partners serves to strengthen those relationships and improve outcomes for families.

Concrete and Economic Supports As Part of New LB 1173 Child Welfare Transformation (VI.H)

We have heard during many of our community forums and discussions with stakeholders, including CFS staff in the field, about the need for essential concrete and economic supports for families that are struggling in order to bring stability to the family unit. This could be funds to pay for short term housing or rental assistance, or for essential child care so a parent can work, or transportation to and from a job site, especially in rural areas of the state, including Western Nebraska. We have also heard stories about case workers not being able to access some basic concrete support for a parent that could allow for a child to return home. In addition, we heard from a number of stakeholders that in foster care cases permanency planning is sometimes delayed because a parent does not have stable housing or access to quality child care. (As referenced by Foster Care Review Office in its June 2023 Quarterly Report: “eviction and other forms of housing instability

have been tied to increased risk for child welfare involvement, out-of-home placement, and longer lengths of time in care (Bai et al., 2022; Bassuk et al., 1997; Berg & Brannstrom, 2018; Marcal et al., 2022; Tang et al., 2022)).

We were also encouraged to hear how some of the Community Collaboratives have raised funding from the community to provide flex funding for up to $500 dollars per family to allow for payments for emergency rental assistance or needed child care, and the Collaboratives also have been laser focused on the issue of access to quality child care in their communities for quite some time.

In the child welfare system, short term concrete and economic supports can make the difference between being reported to the abuse and neglect hotline or staying out of the system all together. They can also be the difference in having your child return home after a removal to foster care, as we heard a number of times from CFS staff. However, in the new child welfare transformation, such supports need to be made available to the case workers and to the community to provide assistance, with flexibility and accountability. This will lead to more positive outcomes, especially in the permanency planning and reunification area to also reduce the length of stay in foster care, which is an area that this Work Group feels needs priority attention System Transformation going forward.

Several recent studies have demonstrated the effectiveness of concrete and economic supports in reducing overall child welfare expenditures significantly. (more detail about these studies is provided in the Finance Framework attached to this Report). Additionally, both childhood exposure to housing instability and involvement in child welfare is associated with short- and long-term detrimental outcomes for children such as increased risk for juvenile justice system involvement (Almquist & Walker, 2022), mental and physical health concerns (Bomsta & Sullivan, 2018; Marcal et al., 2022), and housing and socio-economic struggles in adulthood (Bassuk et al., 1997; Jasinski et al., 2005). In its June 2023 Quarterly Report, the Nebraska Foster Care Review Office identified that it was working in collaboration with the University of Nebraska at Omaha/Creighton, as the University is conducting a study to explore the connections between eviction and out-of-home foster care in Nebraska. It will be important for the Legislature to review the findings of this evaluation when making its policy decisions related to LB 1173 Child Welfare Transformation.

Enhance Family Peer Support (VI.I)

Another key theme we heard at all our community forums is how valuable and effective family peer support engagements can be for families involved in the

Nebraska child welfare system. Many do not know what their rights are, the certain aspects of an investigation and the court process if there is a petition for removal filed. We have heard from key Intersectoral partners, including judges, that if families are provided with peer support early on in the process it has resulted in much better outcomes for all parties involved.

Additionally, the utilization of Family/Peer Support Programs is highly touted as an effective tool to empower families engaged in the child welfare systems. These programs have been proven to enhance the experiences of and outcomes for families engaged in child welfare system-especially those who have experienced child removal. The value of families working with people with LivedEx to provide trusted, nonjudgmental, personalized support, counsel, and navigation assistance for the complexities of the child welfare system cannot be understated. LivedEx peers' personalized experiences aid families in reunification efforts, referrals/resource utilization, diminishing trauma, etc. Peer support mentors are also invaluable in mitigating many of the disparities driven challenges for families.

Ideally, these mentors are trained representatives from families' communities-with common cultural/linguistic and child welfare LivedEx. Community based peer mentors are more accessible, trusted, and empathetic. Peer mentors can also be valuable allies for CFS staff through their personal connections to families.

A study of the Iowa Parent Partner Program found that involvement with the program reduced re-entry rates within 12 months by more than 40% and significantly increased the likelihood of reunification. Additionally, an evaluation of Kentucky's Sobriety Treatment and Recovery Teams (KY START), a program that pairs child protective services workers trained in family engagement with family peer support mentors (employees in long-term recovery) using a system-of-care and team decision-making approach with families, treatment providers and the courts, found that:

- Children in START are 50 percent less likely to enter out-of-home placements than children from a matched comparison group.
- At case closure, more than 75 percent of children served by START remained with or were reunified with their parent(s).

Additionally, from an economic perspective, investments in peer support interventions make fiscal sense. The same KY START evaluation, for example, found that for every $1 spent on START, $2.22 is saved on out-of-home placement costs. Thus, this evaluation clearly aligns with the common theme throughout this report

which is the significant value of preventive services and early interventions from the family/child, community, and taxpayer perspectives.

We further learned more details about the Nebraska Family Peer Support Programming in a unique forum that featured dialogue with individuals from three of Nebraska's Family Peer Support organizations. They reported very positive results with the families with whom they've been engaged. They also raised concerns about how systemic/financial challenges impede broader efforts to successfully support families/children. Some comment concerns noted include:

- There is inconsistent utilization of family peer programming across the CFS system. Some offices welcome the support and provide opportunities for early engagement to maximize outcomes. Others rarely make referrals or do not provide timely referrals/communication-leaving families at risk. Early intervention is the foundation of family peer support efficacy and a strong deterrent to child removal.
- More training on the value of family peer support programming could increase CFS referrals. Additionally, standardizing successful practices from engaged CFS offices could contribute to more engagement efficacy.
- More concentrated efforts to connect English as a Second Language (ESL) and other immigrant communities with family peer supports can help reduce the cultural and linguistic barriers they face. The state should invest in recruiting peer mentor trainees from these communities.
- Many participants reported concerns about the billing/payment process. Errant paperwork, delays in finalizing contracts, etc., have resulted in ineligible billing/rejected payments. More training and standardized practices would help minimize these errors.
- Several stakeholders commented that there is often an adversarial reaction from some CFS offices as they work to advocate for family rights in the system. Family/Peer mentors can provide useful support to both CFS workers and families.
- There is a scarcity of state certified family/peer support organizations in Nebraska. Several participants suggested that addressing the cost and cumbersome work involved in the certification process might encourage broader organizational participation.
- Nebraska workforce challenges-create capacity challenges for established and emerging organizations. They recommended state sponsored recruitment and training programming. Emphasis on recruitment /training of LivedEx.

As part of the future LB 1173 child welfare Transformation, the Work Group believes that enhancing Nebraska's family peer support services and capacity can improve state performance outcomes, strengthening family/children stability and provide much needed 'extenders' to be part of a multi-disciplinary team needed to provide additional support to the CFS workers. Per studies quoted here and around the nation, family peer support services support families/children by offering relevant LivedEx experiences that can help reduce shame and isolation and assist with navigation through myriad state systems.

One additional area that was raised in the community forums that we believe should be part of the consideration of providing enhanced family peer support in the future is around the area of engaged families with special needs children and early identification, assessment and supports. Some of these families involved in the child welfare system may be reluctant to engage in any further 'state' intervention-creating further risk. This is an area where specially trained/experienced peers can provide focused guidance and advocacy to ensure that these children receive Early Development Network services/supports.

Consider Expansion of Lancaster Family Treatment Drug Court Model (VI.J)

"Family treatment Courts (FTCs) have proven to support positive outcomes for families affected by parental substance use disorder, including improved recovery for adults, safety for children, and timely permanency for families."[47] In these special courts, judges, attorneys, child protection service workers, and treatment personnel unite with the goal of providing safe, nurturing, and permanent homes for children, while simultaneously providing parents with the necessary support and services to encourage abstinence from drugs and alcohol. These multidisciplinary teams allow collaborative, evidence-based efforts to be delivered efficiently to shorten the time a family spends in the court system. These Family Treatment Courts aim to combine court procedures, substance use treatment, employment, transportation, safe and affordable housing, and mental health treatment with the help of their network of agencies and partners.

In Nebraska, the Family Treatment Court model is being deployed in Lancaster County as the Family Treatment Drug Court FTDC. This model has been in existence since 2014 with cases assigned to the docket of Lancaster Judge Roger Heideman. The main components of this court are identification and selection of families; monthly team meetings; emergency team meetings; 90-day review hearings; specialized, trauma-informed substance use treatment and parenting services; and

[47] https://www.casey.org/ftc-brief-two/

timely implementation of intervention measures. In the FTDC, court orders often include chemical testing, behavioral health treatment, and participation in monthly Family Team Meetings with case managers, attorneys, service providers, support persons, and Judge Heideman. A similar model is also being used by Judge Elise White on parental domestic violence cases involving the child welfare agency.

Both of these courts are a partnership with CFS as they are focused on abuse/neglect cases. There is also a current MOU that includes the Administrative Office of the Courts, Juvenile Probation which allows for data sharing, plus there is a hired Coordinator that reports to both courts. See feature article Family Treatment Courts in Nebraska by Adam Jorgensen Adam Jorgensen, the State Problem-Solving Court Director of the Programs & Field Services Division in the Nebraska Administrative Office of the Courts and Probation. The Nebraska Lawyer 28 July/August 2020.

For these models to work, Judicial leadership is critical to the effective planning and operation where the judge works collectively with several stakeholders and agencies to establish clear roles and shared mission and vision. As part of the development of our LB 1173 Child Welfare Practice Model, The Work Group met with both Judge Heideman and Judge White for the purposes of exploring this and other models further with the judges and we are extremely grateful for their time and also for their valuable efforts in developing such best practice models in Nebraska.

In fact, there have been measured outcomes from Judge Heideman's court including enhancing timely permanency. In fact, a 2020 evaluation by the University of Nebraska-Lincoln, Center on Children, Families, and the Law (CCFL) supported a number of positive outcomes that show how such a focused, collaborative team based, early intervention strategy could bring to any court in Nebraska, as well as reunifying children with families in a safe and stable environment. (2016 to 2020 evaluation by the Nebraska Resource Project for Vulnerable Young Children, University of Nebraska – Lincoln, Center on Children, Families, & the Law showed, in comparison to a controlled group that did not participate in the Family Treatment Drug Court, higher rates of parent participation, cases reaching important milestones faster, more cases closing through reunification, more families completing substance abuse treatment and cases reaching permanency faster[48].

We have also reviewed outcomes of a the FTDCs models nationally and we are of the opinion that such a multidisciplinary process with positive outcomes should not

[48] https://nebraskababies.com/sites/default/files/2022-09/nrpvyc-lancaster-ftdc-findings.pdf

only be exclusive to Family Treatment Courts or other specialty courts, but, in fact, similar MDT strategies should be implemented in any child and family well-being system and in any family court in Nebraska. This type of Intersectoral system collaboration between the courts, county attorneys, CFS and numerous other stakeholders, including treatment and service providers, can lead to positive results for families in any area of the state. Thus, as part of LB 1173 Implementation, the three branches should consider making these strategies consistent statewide for other complex child welfare cases where permanency and timely and safe exits from foster care are the goal.

Consider Improvements to the N-Focus system Functionality to Guide Future Case Worker Decision and Support (VI.K)

We have heard from DHHS leadership and from CFS workers in the field throughout the LB 1173 process about the lack of accurate and real time reporting that comes from the N-Focus system. In the child welfare transformation, there will need to be decisions made about how the state will improve data system functionality to facilitate accurate and real-time reporting of key performance indicators and support data driven decision making for case workers based on the facts contained within data. The Work Group believes it is important to have a more intricate knowledge of the N-Focus data model and system workflows in order to assess future system upgrades and integrations. It will be important here to explore all options related to leveraging existing N-Focus functionality and inventory usable artifacts in order to drive a fiscally responsible future upgrade solution to improve upon transactional integrity.

In moving forward, key decisions will need to be made on improvements to the entire N-Focus data management system, including its usability and functionality for case workers that achieve the following goals:

Decision Supports

A system that analyzes large amounts of client data in real-time and proactively pushes *critical* information to workers that includes worst case scenarios and best possible options.

Interoperability with other programs

A system that interoperates with other human service programs areas including health, education, courts, Medicaid, and ancillary systems used by staff.

Data Exchanges

A system that allows sending and receiving of batch or transactional data backed by quality and interface standards.

Single source of truth

A system that aggregates data from across the agency as well as other human service programs and that no reporting requirements rely on siloed data. This centralized client perspective will also ensure a master client index, linking client information between other source records.

Zero duplicate data management

No data management concludes with source data that resides outside the single source of truth; that information contained in the single source of truth does not have to be re-entered in any other system module; that all reports required by the agency represent the same data outputs and that there are no discrepancies across reports.

Front-line tools including mobility

A system where front-line staff benefit from real-time interactions, bi-directional informational flows, about their case load (including but not limited to risk indicators, action items, late action items, court information, education information, foster parent information, etc.). The system must provide the ability to submit information directly to the single source of truth from the field and not require intermediate steps for the information to reach its final destination.

Operationalized data for daily use

Unlike reporting that will support scorecards and performance outcomes, the point here is that data will be readied and used daily to drive conversation, used for decision making, provides real-time interactions, and that the purpose of the data is always well-known.

Other considerations:

- Business processes and alignment w/ technology and associated automation
- Eliminate all use of paper and spreadsheets to track business level data
- Eliminator or integrate ancillary systems (outside of SACWIS/CCWIS)

- Programming interfaces and data sharing between partners and contributing agencies
- Electronic signatures
- Mobile apps
- Mobility integration with backend systems (SACWIS/CCWIS) and interfaces to support them
- Complete Master data management strategy and operational compliance
- Support for web services, API's
- bi-directional data sharing
- Single audit pane and 360-degree views
- Data quality improvements aligned with a data quality plan
- Data sharing agreements for external partners and covered entities
- Productivity tools for front line (not just mobile, but front-line use activity lists, caseload-based dashboards, etc.)
- Foster parent participation using technology
- Comprehensive Electronic Document libraries
- Master document index
- Master client index
- GIS services
- Alerting, notification (automation, what, who, when)
- System performance, bottlenecks, why, when
- IT continuity and communications plan
- System capacity

Consider Changes to Drug Testing Policy that Promotes Safety and Accountability (VI.L)

In 2017 Nebraska DCFS drug testing policy allowed CFS workers to conduct drug testing as one tool to determine if a parent is using substances and to facilitate decision making with families affected by substance use disorders to ensure the safety of children in the home. Under this policy DCFS was required to pay for the testing. In 2018 this policy was changed and the CFS workers no longer had drug testing as a tool. Instead, the CFS worker must make a referral to a provider for the assessment. Under the current (2018) policy the provider must arrange payment with the parent vis-à-vis insurance or some other arrangement. We learned that neither county attorneys nor courts were included in any meaningful collaboration when this policy was changed.

As a result of the policy change, the assessment of parent(s) or caregiver(s) for a substance use disorder must wait for an evaluation to be scheduled or for a CFS

worker to request a court order. This leads to delays and burdens an already overburdened system along with negative outcomes for families and children.

In 2022, DCFS worked on a proposed change in the policy which would give the drug testing tool back the CFS worker. It is important to note that in the proposed Standard Operating Procedure the following was noted in bold:

"**A drug test alone, whether positive or negative and whether a drug test has been taken or not, will not be used alone to determine the safety of children**."[49]

This process for this proposed policy change did allow some consultation with the courts in its development. It would allow for the CFS worker to use a substance use screening tool identified as the Tobacco, Alcohol, Prescription medications, and other Substance (TAPS) Tool as part of the safety assessment.

The Nebraska Family Treatment Drug Court (FTDC) in Lancaster County uses a standardized drug testing protocol to monitor participants' use of illicit and licit substances throughout their FTDC participation. The FTDC ensures that participants are tested randomly a minimum of two times per week (whether by the FTDC or its partners), which is usually frequent enough to detect any substance use quickly and reliably. The FTDC's drug testing protocol specifies the frequency, scheduling, randomization procedures, observation, duration, and breadth of testing. The protocol also outlines processes for confirmation, notification, and dissemination of test results. One evaluation of an FTDC reported a 50% decrease in positive tests when the program increased its random, observed testing to twice weekly

Having a drug testing tool is recognized as a best practice nationally. According to the National Center on Substance Abuse and Child Welfare:

"The most effective way to identify a substance use disorder or determine if a child is at risk for maltreatment or neglect is to use a combination of screening and assessment tools, including safety and risk assessments: clinical instruments, random drug testing, self-reports, and observations of behavioral indicators. Assuming there are no other safety concerns, a positive drug test or a series of positive drug tests should not be used as the sole factor in the removal of a child from the home or to determine parental visitation."[50]

[49] DHHS T-102.SOP Template, V. 1.0

[50] https://ncsacw.acf.hhs.gov/topics/drug-testing/

We recommend DCFS implement the proposed policy change contemplated in 2022 and provide CFS workers with the tools necessary to make an assessment of a parent or caregiver where there is a reported substance use allegation to ensure the safety of children in the home.

It should be noted that the LB 1173 Practice Model provides for the authentic engagement of County Attorneys, Courts, and other partners such as GAL, families with lived experience to engage and collaborate in future policy changes which will strengthen the system and keep children safe in their homes. See Appendix E for a comparison matrix of the Nebraska DCFS 2017, 2018 and 2022 proposed policy regarding drug testing.

Future Performance Measures to Consider In Evaluating Success of LB 1173 Child Welfare Practice and Finance Model (VI.M)

Collecting and analyzing data to evaluate child welfare programs and services facilitates the ability of leaders to make informed policy and practice decisions. In turn, these decisions lead to improved outcomes for children and families.

Thus, as mentioned, the Three Branches should continue to meet regularly and assess outcomes of the new LB 1173 Practice and Finance Models. In doing so, it will be critical to identify and focus on specific system-wide measures that can be tracked and directly relate to program objectives, goals, and service efficacy. As part of transformation, the legislature should identify key system-wide performance measures that all intersectoral partners, including the Three Branch leadership, can consider for ongoing monitoring of the impact of future child welfare system transformation and the achievement of positive outcomes of safety, permanency, and child well-being. Some, but not all, of the key measures directly connected to the success of the LB 1173 Practice and Finance Model recommended strategies to consider could include:

- Rate of Children Entering Foster Care
- Length of Stay of Children Exiting Foster Care
- Percentage of Children and Youth in Care Greater than 24 months
- Percentage of Children Adopted after Termination of Parental Rights
- Number of children served by Community Response Pathway
- Percentage of Expenditures tied to Source of Funds (Fed, State, Foundation, Private)
- Access to and Utilization of Behavioral Health and Substance Abuse Services
- Racial Equity Service Indicators

Appendix A - List of Community Sessions and Surveys

Community Sessions:

- Project Kickoff/Workgroup Stakeholder Engagement – Omaha
- LB 1173 Reimagine Well-Being Listening Session – Lincoln
- LB 1173 Community Forum – Columbus
- LB 1173 Community Forum –Kearney
- LB 1173 Community Forum –Omaha (2)
- LB 1173 Community Forum –Scottsbluff
- LB 1173 Community Forum –North Platte
- LB 1173 Community Forum –Lincoln

Surveys

- CFS New Worker Training Survey
- CFS Best of the Best Survey
- CFS Leader Survey
- Nebraska County Attorney Survey

Appendix B – Full-Service Community Schools 2021 – 2022 Evaluation Report

Full-Service Community Schools

2021 - 2022 Evaluation Report | August 2022

Together, Better Initiative

A partnership of **Nebraska Department of Education** and the **Nebraska Children and Families Foundation**

Full-Service Community Schools

2021 - 2022 Evaluation Report

The Full-Service Community Schools pilot was launched in fall 2021 in four Nebraska communities: Fremont, Grand Island, Schuyler, and South Sioux City. All four Full-Service Community School sites began the implementation in September 2021. NDE and NCFF provided strategic support to build a learning cohort across the four locations, define a shared understanding of Community Schools, identify the measurable results they'll be working toward, understand the current conditions for each of the sites/communities, and develop key strategies to accelerate the work. Each of the four sites has created plans and started the implementation of strategies that will accelerate

- Student Learning and Development;
- Family and Community Engagement, and;
- Partnership Development.

This evaluation report aggregates data collected at all four pilot sites and serves as a starting point for further development of a comprehensive evaluation plan that can inform these communities and stakeholders across the state about the impacts of the Full-Service Community Schools initiative.

Report prepared by Teresa Wanser-Ernst, Ph.D., Cultural Competence Center LLC.
Funding for this report was paid for by Nebraska Children and Families Foundation.

Table of Contents

Executive Summary

The Full-Service Community Schools (FSCS) strategy supports the planning, implementation, and operation of services to provide comprehensive academic, social, and health services for students, students' families, and community members. The goal is to improve educational outcomes for students.

The Nebraska Department of Education (NDE) and the Nebraska Children and Families Foundation (NCFF) developed the *Better, Together Initiative* to pilot the Full-Service Community School strategy in Nebraska. Four communities were identified to participate in the pilot. The communities began the implementation of the Full-Service Community School strategy in the fall of 2021. The public schools in the communities of Fremont, Grand Island, Schuyler, and South Sioux City agreed to partner in this pilot project.

The following were accomplished during the 2021-2022 school year:

- School leaders and staff were trained on the FSCS model
- School Community Coordinators (SCCs) were hired at each FSCS
- NDE and NCFF built relationships with staff at the four FSCSs
- SCCs began identifying student and family needs
- SCCs connected with community partners to plan and implement services to meet the identified needs
- Parents and the communities developed an emerging awareness of the FSCS strategy potential

The next steps for further implementation of the FSCS strategy include:

- Developing an FSCS evaluation plan that includes stakeholder involvement. The evaluation plan should provide the necessary data collection and data management tools to ease that burden on FSCS staff.
- Facilitating the intentional communication to parents/caregivers who are unaware or reluctant participants of these services
- Developing School and Community Advisory Committees who are tasked with developing and implementing plans to address the community's needs
- Expanding the network, reach, and impact of the FSCS strategy

The Full-Service Community School Approach

According to the Department of Education, Office of Elementary & Secondary Education[1], Full-Service Community Schools are defined as a strategy that

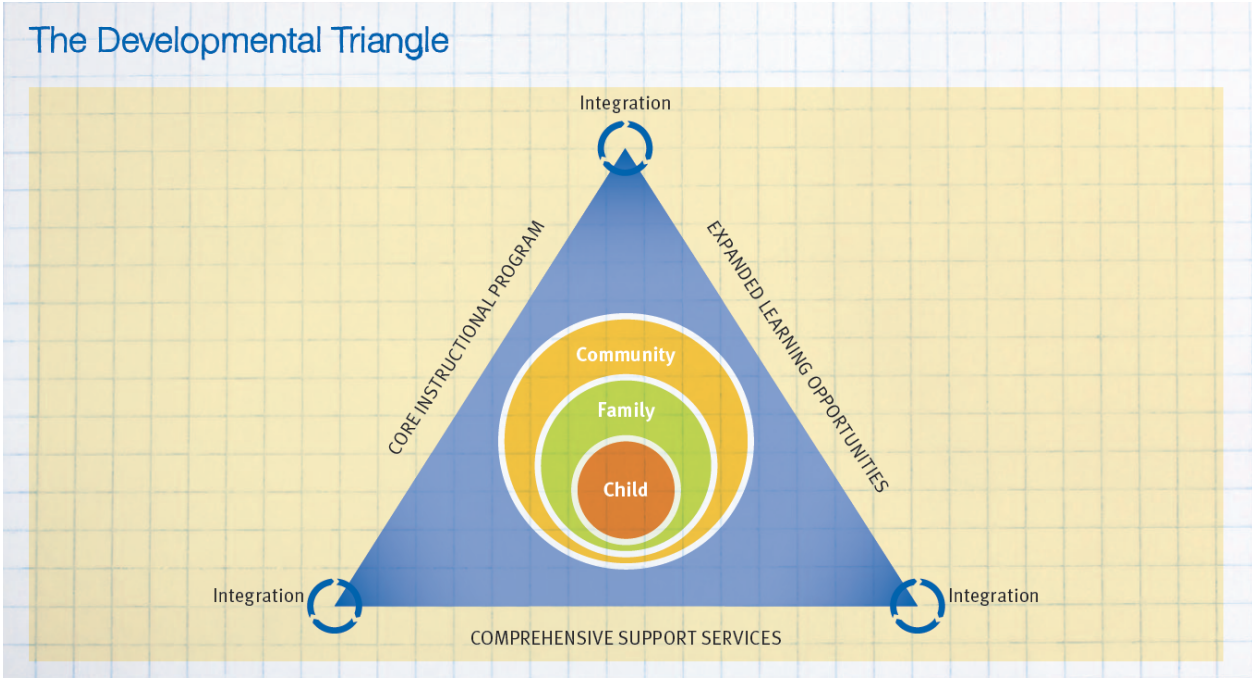
> "... provides support for the planning, implementation, and operation of full-service community schools that improve the coordination, integration, accessibility, and effectiveness of services for children and families, particularly for children attending high-poverty schools, including high-poverty rural schools. FSCSs provide comprehensive academic, social, and health services for students, students' family members, and community members that will result in improved educational outcomes for children.
>
> These services may include:
>
> - high-quality early learning programs and services;
> - accelerated learning aligned with academic supports and other enrichment activities, providing students with a comprehensive academic program;
> - family engagement, including parental involvement, parent leadership, family literacy, and parent education programs;
> - mentoring and other youth development programs;
> - community service and service learning opportunities;
> - programs that provide assistance to students who have been chronically absent, truant, suspended, or expelled;
> - job training and career counseling services;
> - nutrition services and physical activities;
> - primary health and dental care;
> - activities that improve access to and use of social service programs and programs that promote family financial stability; mental health services; and
> - adult education, including instruction of adults in English as a second language."

The National Center for Community Schools (NCCS) was established by Children's Aid in 1994 to answer the nationwide call to build schools that surround students with support.[2] In the nearly 30 years since NCCS has been developing and studying the impacts of community schools, they have developed a firm theoretical grounding of the community schools strategy. This strategy, coupled with strong empirical evidence,

[1] Retrieved from https://oese.ed.gov/offices/office-of-discretionary-grants-support-services/school-choice-improvement-programs/full-service-community-schools-program-fscs/
[2] See https://www.nccs.org/

indicates that in the presence of a “whole child” approach to education, all children can succeed and thrive.[3]

NCCS has created several resources to guide new communities in the development of highly effective full-service community schools. *Building Community Schools: A Guide for Action* describes and outlines the stages and capacities for effective community school development. The Developmental Triangle modeled below, places children at the center, surrounded by families and communities. Fundamentally, students’ academic success, health, and well-being are the focus of every full-service community school. In this model, the legs of the triangle represent the interconnected support systems.



The *Core Instructional Program* is designed to help all students meet high academic standards. *Expanded Learning Opportunities* enrich the learning environment for students and their families. A *comprehensive range of physical and mental health support services* promote students’ well-being and remove barriers to learning. The corners of the triangle represent the critical integration of services where community schools ensure coherence in service integration. No entity acting alone can improve educational outcomes for all students. Partners in the full-service community school (FSCS) strategy must develop a set of shared goals and a system to accomplish those goals. They also share leadership and accountability for results.

[3] The Children’s Aid Society & National Center for Community Schools. (2011). *Building Community Schools: A guide for action.*

Partnerships in the areas of health, social services, academics for children and adults, sports, recreation, and culture transform schools into vital hubs, benefiting students, their families, and the surrounding community. Key components of the FSCS approach include

- a focus on school, family, and community engagement;
- expanded learning opportunities for children and adults;
- comprehensive partnerships;
- site coordination;
- wellness, and;
- sustainability.

Compared to traditional schools, community schools offer a wide range of programs for students, families, and the community.

Nebraska Community Schools

Many Nebraska communities already have key components of a Full-Service Community School (FSCS) in place. The 21st Century Community Learning Center Program is one such example, providing core support for the coordination of school-based services, out-of-school learning, and family engagement activities. Additionally, several localities throughout the state have established Community Well-Being (CWB) Collaboratives with the assistance of the Nebraska Children and Families Foundation. The CWB Collaboratives provide a proven structure for leveraging and aligning a variety of resources from diverse partners, with intentional inclusion of student and family voices as well as shared leadership between the collaborative and the school. By building on those examples and existing partnerships, the FSCS approach creates a great opportunity for a coordinated, collaborative community platform through which the needs of all children and families are more effectively and efficiently met.[4]

Better, Together Initiative: A Full-Service Community Schools Pilot

To assist schools, children, and families in Nebraska, the Nebraska Department of Education (NDE), in partnership with Nebraska Children and Families Foundation

[4] Nebraska Department of Education & Nebraska Children and Families Foundation. *The Full-Service Community School (FSCS) Approach.*

(NCFF), leveraged the influx of pandemic related funding to form the *Together, Better Initiative*, which is a series of strategic investments in authentic, evidence-based, and reimagined learning supports and family and community engagement. NDE and NCFF are collaborating to address these critical needs for students, families, and communities with five strategies. One of the strategies included creating the Full-Service Community Schools (FSCS) Pilot Project. This effort was launched in fall 2021 in four communities: Fremont, Grand Island, Schuyler, and South Sioux City. All four Full-Service Community School sites began the implementation in September 2021. NDE and NCFF provided strategic support to build a learning cohort across the four locations, define a shared understanding of Community Schools, identify the measurable results they'll be working toward, understand the current conditions for each of the sites/communities, and develop key strategies to accelerate the work. Each of the four sites has created plans and started the implementation of strategies that will accelerate

- Student Learning and Development;
- Family and Community Engagement, and;
- Partnership Development.

The initial success parameters for each of the sites are being reinforced through the *Together, Better Initiative* partnership between NDE and NCFF. The collective team members meet regularly for planning and update sessions and meet with each of the sites to provide implementation support. This team will continue to work with the sites to design and implement the formal evaluation, and to help sites quickly adapt to emerging needs in their communities as the pandemic persists.[5]

Nebraska's FSCS Communities

The four pilot programs include Fremont Middle School in Fremont, Early Childhood Education at O'Connor Learning Center in Grand Island, Schuyler Elementary School in Schuyler, and Dakota City Elementary School in South Sioux City. Each program hired a full-time school-based School Community Coordinator (SCC). The person in this position is charged with building partnerships with students, families, and the community and works under the vision and direction of the community collaborative leadership, school principal, and site-based FSCS team. Site-based FSCS teams are composed of the SCC, school principal, representatives from partnering agencies, and may also include a parent or other stakeholders. Partnerships will apply the core components of a community school and other relevant frameworks, identify the needs present in the school by addressing academic, social-emotional, health, basic needs, and other key priority areas. All of this is coordinated within the context of community and school partnerships that support the whole child and their family.

[5] See NDE/NCFF FSCS one-sheeter_Feb2022

The program information presented on the following pages were collected from site visits, focus groups, the NDE Education Profiles,[6] and local data. School Community Coordinators provided the data that were collected at the site (e.g., surveys and needs assessments).

Fremont, Fremont Middle School

Data from the NDE Education Profile

Paraphrased school description

Fremont Middle School serves approximately 600 7th and 8th graders each school year. Each student and staff member are provided a Chromebook that supports cross-curricular academics. Students are taught in approximately six teams, averaging 100 students per team and three teams per grade level. Two-thirds of a student's day is spent in math, science, social studies, and English. Students also have opportunities to engage in physical education, computer coding, business/computer apps, family and consumer science, art, industrial technology, and fine arts. Fremont Middle School implements a Multi-Tiered System of Support (MTSS) to help students achieve social, emotional, and academic success.

2020-2021 Data for Fremont Middle School

- 43 Teachers
- 661 students, grades 7-8
- 8% English Language Learners
- 61% Participating in the Free or Reduced-Price Lunch Program, 15% higher than the state average
- 16% Gifted

Program Goal

One of the key issues recognized by this site team is related to the barrier of reliable transportation so families can be connected to the school. This site will be working to address transportation issues for family and community engagement events to ensure all families can attend.

FSCS Outcomes from Year 1

Staff from the Fremont Family Coalition reported the following achievements from the past school year and goals for the coming school year.

[6] See https://nep.education.ne.gov/ for each Nebraska public school's profile.

Achievements include

- A School Community Coordinator was hired
- Experiential field trips for middle school students throughout the summer
- Vision Mobile from Children's Hospital in Omaha provided vision screenings for 12 students with four of those students receiving eyeglasses
- Engaging the middle school principal in FSCS goal setting and program planning
- Connecting resources for families and teachers with students who are struggling with behavior issues in school
- Applying a community-based database system
- Building relationships across systems with 10 active partnerships currently in place
- Developing a resource room within the middle school that has basic-needs items for students and parents/caregivers to access
- Using language interpretation devices that an interpreter can speak into and parents/caregivers can hear the interpretation of a speaker's message through earphone device. Parents were very appreciative of this.

Plans for the coming year include

- Connecting school social workers to the community-based database to ensure referrals to services are consistent and tracked appropriately
- Developing and holding parent/family engagement events, such as basic literacy, inclusive communities, life skills, and parent/child interactive experiences
- Further development of the partnership with the school principal, staff, and faculty, including professional development and relationship building opportunities
- Identifying resources for sustainability

Grand Island, Early Childhood Education at O'Connor Learning Center

Data from the NDE Education Profile

Paraphrased school description

The Early Learning Center (ELC) serves children ages three to four in an inclusive, half-day preschool setting. Preschool students and families are served by 10 certified teachers, 20 paraeducators, and a support team. Educators strive for every child to have access to meaningful experiences in a play-based, language-rich environment to empower the whole child through family and

community relationships. Educators are empowered to be instructional leaders, personalize learning pathways for each student, design decisions using data, and partner with the community. Students are prepared to make positive contributions to society and thrive in an ever-changing world.

2020-2021 Data for O'Connor Learning Center, Grand Island Public Schools

- 13 Teachers
- 263 students, preschool students ages 3-4
- 95% Participating in the Free or Reduced Lunch Program, 49% higher than the state average

Program Goal

A key goal for this site was to address the need for childcare for early learning students when they were not in the program. As a result, this site established a partnership with local YWCA to provide on-site childcare for out-of-school time. Additionally, this collaboration team is exploring the idea of "success planning" for each early learner to ensure each student has a successful transition to elementary school.

FSCS Outcomes from Year 1

Staff from the Grand Island CommUNITY Schools reported the following achievements from the past school year and goals for the coming school year.

Achievements include

- A Family and Community Engagement Coordinator was hired
- Identified goals for parent engagement
- Developed a parent/guardian volunteer program
- Held the first Community Café in January of 2022 with the goal to share collective knowledge and wisdom for a better future together
- Held Parent Advisory meetings to collect ideas for the CommUNITY school, plan family nights, develop a newsletter, create goals for the school, and discuss questions and concerns
- Developed 24 community partnerships
- Developed a food pantry

Plans for the coming year include

- Further develop Parent Engagement through shared responsibility and power, creating a welcoming environment in the school, facilitation of respectful interactions, practicing two-way communication
- Further develop the parent/guardian volunteer program
- Identifying resources for sustainability

Schuyler, Schuyler Elementary School

Data from the NDE Education Profile

Paraphrased school description

Schuyler Elementary School serves approximately 800 students in grades Kindergarten through 5th grade and is composed of an ethnically diverse student body. Most students (~80%) are Latino/a, from countries in Central and South America. Special emphasis placed on English Language Learners, Title I students, and students receiving Special Education services. The school improvement goal focuses on interventions to improve reading skills for all students. Schuyler Public Schools opened this building for the first time in the 2009-2010 school year as a Kindergarten through 3rd grade school. Recent construction has expanded to house students in grades Kindergarten through 5th grade. Schuyler Elementary School is a Title 1 School-wide school.

2020-2021 Data for Schuyler

- 54 Teachers
- 669 students, grades 7-8
- 61% English Language Learners
- 66% Participating in the Free or Reduced Lunch Program, 20% higher than the state average
- 4% Gifted

Program Goal

This site has been engaged in the ongoing development of cross-sector site team to address the needs that were identified by families. One of those needs is related to adult and family literacy, and as such, the Site Coordinator is developing a partnership with the Family Literacy Program to provide programming for adults of children attending the Schuyler Elementary School.

FSCS Outcomes from Year 1

Staff from Schuyler Elementary School reported the following achievements from the past school year and goals for the coming school year.

Achievements include

- Family Literacy program to support parents' understanding of their child's academic experiences to help them feel more confident in supporting their child's learning at home
- Partnering with local mental health providers to inform them about the impacts of the COVID-19 pandemic effects on children and their parents/caregivers

- Provided free vision screenings to 33 1st and 2nd grade students
- Securing funding for the TeamMates mentoring program to purchase academic activities and t-shirts for participants
- Development and scaling of a mobile food pantry that distributed 225 sets of food
- Began discussions on how to best support students struggling with behavior challenges in school
- Development of a Community Site Team, composed of members from across the community

Plans for the coming year include

- Supports to address chronic absenteeism
- Access to criminal justice concerns
- Before school learning programming
- Weekend learning programming
- Computer skills
- Mental health services
- Summer learning programming
- Access to the arts
- Early childhood education programs
- Family and student resource center
- Family education & support networks
- Community partners & non-profit organization and businesses

South Sioux City, Dakota City Elementary School

Data from the NDE Education Profile

Paraphrased school description

Dakota City Elementary is dedicated to maintaining a safe, productive, and positive learning environment encouraging all students to be lifelong learners while promoting a partnership with families, staff, and the community. Dakota City Elementary houses students in grades Kindergarten through 5th with a population of about 225 students who engage in rigorous academic experiences aligned to the Nebraska State Standards. School staff collaborates weekly to focus on student learning, student growth, and planning supports for all students to be successful. Educator teams intervene using the MTSS model and work collaboratively to ensure all students are getting what they need. In addition to school day offerings, Dakota City also has a Beyond School Bells program for afterschool services throughout the school year. The PTA meets regularly to plan a variety of activities for students, staff, and families.

2020-2021 school year data

- 19 Teachers
- 202 students, grades 7-8
- 33% English Language Learners
- 72% Participating in the Free or Reduced Lunch Program, 26% higher than the state average
- 2% Gifted

Program Goal

This site has continued development of a cross-sector site team to address the needs that were identified by families. Similar to the needs identified at the site in Schuyler, one need shared by families related to family literacy supports. The Site Coordinator is also cultivating a partnership with the Family Literacy Program to provide programming for families with children enrolled in elementary school.

FSCS Outcomes from Year 1

Staff from Dakota City Elementary School reported the following achievements from the past school year and goals for the coming school year.

Achievements include

- Development of 7 partnerships
- Held a 6-week class on mental health
- Held a 6-week class on technology
- Held a Love & Logic class
- Provided free summer meals
- Held School & Home Partnership adult meet-up to openly discuss community, education, parenting, and home life
- Monthly meetings were held with Heartland Counseling

Plans for the coming year include

- Development of afterschool academic supports
- Implementation of social-emotional wellbeing curriculum
- Field trips to build world knowledge
- Develop clarification of role for school community coordinator
- Build relationships with school and district administrators
- Develop college and career opportunities for students
- Discussion for supporting families with health and preventive care needs

Aggregated FSCS Outcomes from Year 1

Each Full-Service Community School focuses the development of their work around four main goal areas. These include

- integrated student and family supports;
- expanded and enriched learning time and opportunities;
- active family and community engagement, and;
- collaborative leadership practices.

Site-based teams develop project plans each year that identify the program goals and the services that will be put into place to meet those goals. The annual plans are shared with their communities, NDE, and NCFF. The annual plans help guide how resources are most effectively coordinated and which services will best serve the needs of students, families, and the community. The goals and services identified in the annual plan can be used by the site-based teams to identify the benchmarks for evaluating the impact of services provided.

Site visits and focus groups were held in each community during the spring of 2022. To facilitate this data collection, a framework was created by the Better, Together leadership team and key stakeholders from each FSCS community (see Appendix F). Indicators were selected from the Community School Standards developed by the Coalition for Community Schools and the Institute for Educational Leadership.[7] Selected indicators were identified specifically for these newly developed FSCS programs. Upon the request of evaluators from NCFF, site-based teams identified school leadership, parents, and students who were willing to participate in focus groups. The hour-long focus groups were segregated by key stakeholder group (school leadership, parents, students). There were at least two participants in each group. Focus groups were held for all key stakeholder groups except in one community where no parents arrived for the focus group.

An aggregated summary of the focus group findings and site observations can be found in Appendix F. Highlights of the strengths and recommendations for next steps from the aggregated report will be listed below.

[7] Retrieved from https://www.communityschools.org/resource/community-schools-standards/

Strengths

Family Engagement

1. Family Literacy programs have occurred in at least two of the sites. This has been a success for the participants who feel well-informed about their children's education and educational needs.
2. Sites are meeting the needs of the parents/caregivers and community they serve through food pantries, medical services (vision, dental, mental health), etc.
3. The locations (schools) of these sites have quickly become the "hub" for full-service community school services. This is an asset of the FSCS model and is already realized in these communities.
4. The sites have some form of parent/caregiver group that engages with some decision-making.
5. Parents/caregivers are becoming more engaged in the schools their children attend.

Partnership Health and Development

1. Each FSCS has hired a full-time School Community Coordinator (SCC). This person's primary role is to facilitate partnerships between the school, families, and community. The SCC identifies the needs of families and the community and develops plans and resources to meet those needs. This added resource for the FSCSs has had a tremendously positive impact on these school communities. Each site has shared the various benefits from this person's role in meeting the needs of the community, which are reflected throughout the strengths identified in this report.
2. Discussions to sustain the SCC position have already started within each of the FSCSs, including discussions about local, state, and national funding streams.
3. Many families are involved and feel more connected with FSCS supports in place.
4. Conversations on how to build community awareness of FSCSs is already occurring.

Student Learning and Development

1. Sites began identifying community needs and those results were reviewed and used as the starting point for providing services.

2. School Improvement Teams are beginning to involve the SCC in developing School Improvement Plans (SIPs). The integration of FSCS practices is beginning to be evident in SIPs.
3. Schools are well-adept at developing IEPs for qualifying students as well as implementing the MTSS process to support students as needed.
4. Educators and school staff have received professional development on supporting families with trauma, human trafficking, mental health needs, and social-emotional learning.
5. Schools are aware of community resources and the SCC works with the school counselor(s) and social worker(s) to access those resources to meet the needs of students and their families.

Recommendations for Next Steps

Family Engagement

1. All parents/caregivers need to be made aware of services and opportunities offered. Communication between school and home can be a challenge. Multiple methods of communicating information need to be used.
2. Verbal translation services need to be available for parents/guardians at Full-Service Community Schools as well as translated written materials for all newsletters, notes, and other information going home from school. The student should not be primary translator between school and parent/caregiver.
3. All parents/caregivers need to have the opportunity, and be encouraged, to complete annual surveys, needs assessments, etc. This ensures that all voices are contributing to the improvement and identification of services for the FSCS. Multiple methods (e.g., phone calls, paper-pencil, electronic/e-mail) and opportunities for providing feedback need to be offered to parents/caregivers.
4. More opportunities to develop skills to support student learning need to be offered to all parents/caregivers, which may require targeted outreach to families that live a distance from the school or who are reluctant participators in at-school functions.
5. Teachers may need professional development on how to engage and empower families, especially those whose cultures may differ from their own.

Partnership Health and Development

1. An adequate needs assessment needs to be developed. The needs assessment should identify who is and is not receiving services and what needs are present

for all stakeholders in the community. A strong model should be developed by NDE and NCFF leaders that can be tailored to each community's needs.
2. MOUs need to reflect responsibilities of each entity, provide clearly defined roles for each partner, and be signed annually.
3. Site-based School and Community Advisory Committees should be established with actionable goals that will address the community's needs.
4. Community Cafés should be held regularly (e.g., every quarter or semester), with outreach to community organizations invited to participate with the purpose of identifying needs and connecting resources.
5. Community directories of resources should be developed and widely disseminated using a variety of methods to increase awareness and access.

Student Learning and Development

1. FSCSs may need guidance from NDE and NCFF for the development of surveys that can inform and improve services and resources provided at each site.
2. Training on the use of data for identifying student needs and providing appropriate supports would be beneficial for key staff and groups (e.g., School and Community Advisory Committee).
3. Involve the SCC in MTSS meetings and IEP meetings as non-academic supports are considered for students.
4. Professional development should be provided for school staff, SCC, and community partners to participate together to establish common language/frameworks and build relationships.
5. School staff, SCC, and community partners would benefit from professional development on culturally affirming practices, building awareness of community resources that would meet families' needs, responding to evidence of child abuse, neglect, or domestic violence, and social-emotional learning.

Appendix A - Better, Together Initiative

Shared Priorities, Goals, and Guiding Principles:

- Nebraska Will Have the Most Robust Community Well-Being Model in the US
- Connected Systems of Supports for Children and Families
- Children and Families Can Thrive with Support
- Intentional Family Engagement Promotes Sustainability
- Robust Community Well Being Will Impact Economic Growth
- Partnership Will Yield Greater Impact and Extend the Reach of Services
- Success and Well-Being for Children, Families, and Community

In order to...

- Address learning and opportunity disparities
- Deepen investments in primary prevention
- Enhance efficiency for basic needs supports
- Ensure all can live "The Good Life"
- Rebuild connectedness and trust in institutions
- Reduce impact of poverty on life outcomes for youth
- Support pandemic recovery

Key Strategies:

- Afterschool and Summer School
- Community Schools
- Early Learning
- Family Engagement
- Provide High-Quality Learning
- Rural Community Focus
- Whole Child Approach

Existing WorkStreams to Leverage and Expand:

- Beyond School Bells
- 21st Century Learning Centers
- Communities 4 Kids
- Community Response
- Connected Youth Initiative
- Rooted in Relationships
- Postsecondary Readiness
- Sixpence
- Statewide Family Engagement Center

Desired Results:

For Our Youth

- Academic Growth and Learning
- Connected to Advocates & Navigators
- Developed 21st Century Skills
- Enhanced Equitable Access to Needed Services
- Expanded Opportunities and Experiences
- Post-secondary Readiness
- Successful School Transitions

For Our State

- Inspire Future Partnerships with State Agencies
- Integrated Resources to Further Reach
- Maximized Services Without Duplication
- Productive School - Community Partnerships
- Robust Learning and Continuous Improvement
- Rural Vitality and Sustainability
- Supported Schools
- Thriving Families and Communities

Appendix B - Fremont Impact Report

AUGUST 2022

FULL SERVICE COMMUNITY SCHOOLS

FREMONT IMPACT REPORT

COMMUNITY PARTNERS:

- Aspire
- Children's Hospital Vision Mobile
- Salvation Army/ Summer Lunch Program
- Nebraska Extension
- FPS Migrant Education Program
- Capstone Behavioral Health
- Life house/ entity that manages McKinney Vento grant
- FPS social workers
- YMCA
- Inclusive Communities

ACHIEVEMENTS:

This summer we achieved much in terms of youth and community engagement:

- Work with Aspire and providing students with experiences and field trips throughout the summer
- We scheduled a visit from the Vision Mobile (from Children's Hospital, Omaha) and had 12 students' vision checked. 4 received eyeglasses.
- This summer we have been very intentional in building our relationships with the school system. We have parent/family engagement activity ideas we are exploring.
- Having new administration at the middle school has been super exciting, the principal has been very engaged and includes FSSC and ED in decision making regarding plans for this school year.
- Examples of plans for this school year include sponsoring and assisting with back-to-school bash, FSSC was added to the tier teams and received training this summer to connect resources for families that have students struggling with behavior in school, supplying resources to encourage and motivate staff and students. FSSC will introduce herself at the back-to-school event to the parents and students. Andrea along with the school social workers will utilize Clarity our community-based database to ensure that information and referrals are consistent and tracked appropriately. Along with this we have a standing meeting with school social workers this school year to review cases that school and community partners share through CR.
- Last school year was spent mostly building relationships. Since I came into my position at the end of last year, it took me a few months to understand what this role could look like that best fits the needs of our community. Andrea felt that she had little guidance from prior director. I am so excited for this year! We are going to knock it out of the park.

COMMUNITY-SCHOOL FUNDS HAVE BEEN USED FOR:

- Back-to-school efforts
- Training for faculty
- Parent engagement activities, such as basic literacy, inclusive communities, life skills and parent/child interactive
- Teacher and student incentive items
- Huge success! Interpretation devices, one device is for an interpreter to simultaneously interpret for the speaker and the Spanish speaking persons have an earphone device that allows them to hear presentation in their language. Parents were so appreciative!

STUDENT INFORMATION:

7th Grade: 394 students

Free/reduced lunch: 253
Special Education: 92
English Language Learners: 61

8th Grade: 380 students

Free/reduced lunch: 207
Special Education: 72
English Language Learners: 46

ONGOING ACTIVITIES:

- Vision Mobile @ summer school programming – 12 families participated and 4 received glasses
- Summer Lunch/school programming
- Urban Tiger - resource room within the middle school that has basic need items for students and parents to access
- Parent engagement planning - We have 4 engagement activities planned at this time but working on a basic literacy program for parents that would be a series of classes.
- MEP family engagement activity - 12 families participated and 4 received glasses
- The attendance numbers from the summer programming were consistently around 240. Previous summers programming for kids over 5th grade was nonexistent.
- Andrea - through her outreach - had a consistent group of 12 students that attended. The youth that were targeted were unconnected youth.
- There are 64 MEP families and 13 were in attendance. The focus was to connect families to the school and FSS.

CHALLENGES:

- We knew from the start that our public school system would be a challenge. Unlike other schools in our state, they have a long history of keeping others out. Their first contract for having others do work within the school was this one. It has been a major shift of mindset for the Administrators. We as the entity coming into the school system must carefully balance how we approach our working relationship. In other words, they need to see the value of FSS concept. We have invited administrators and social worker to attend FSS conference coming later this year. The vice principal and social worker have agreed to attend with Andrea. We are very excited about this! I do believe that in our school system it would be valuable to have a longer grant period. We are just getting started and grant will be over this year. The first year for new programming is usually relationship building and the implementation process. None the less we will do our very best to take full advantage of this opportunity for this year. Through our work my hope is for our school and community want to have funding conversations because they see the value.
- Scheduling
- Transportation for parents

nebraskachildren AND FAMILIES FOUNDATION

NEBRASKA DEPARTMENT OF EDUCATION

Appendix C - Grand Island, O'Connor Learning Center CommUNITY School

Nebraska Department of Education

Full Service Community Schools: Grand Island

Individual Impact

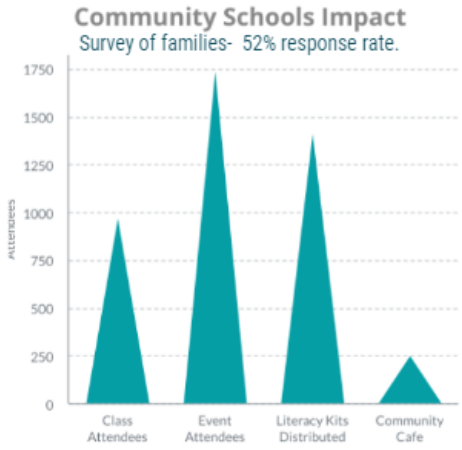
" You guys have so many great resources, made our children feel loved and cared for and made it a great experience for our family."

$10,000
Community Cafe Grant

$2,000
GIPS Foundation: Food and Hygiene Party

$1,000
Last Day of Schoo Celebration and Fa Family Night at the Pumpkin Patch)

Impact



"One of our primary goals during our first year of Community Schools work was to help our families feel welcomed and engaged."

99% of respondents felt satisfied or very satisfied with the programs and services offered at school.

74% of respondents reported that they attended at least one opportunity at school (class, event, etc.).

99% of respondents felt comfortable or very comfortable in the school.

24 Community Partners

- Central Community College
- Early Development Network
- Clearwater Counseling
- Multicultural Coalition
- Grand Island Public Library
- Legal Aid

25 Activities completed

- Food Pantry
- Healthy Lifestyles Series
- Math In Real Life/Family Bowling Night
- Stress Less Strategies
- UNL Extension Nutrition Class
- YWCA Employment & Training Program
- Zumba Class
- Parent Orientation Community Fair
- Health Fair
- COVID vaccinations

Appendix D - Schuyler Elementary School

Nebraska Department of Education

Full Service Community Schools: Schuyler

Activities

- Ongoing comprehensive vision exams
- Extending vision exams to older students and families
- Off comprehensive vision exams annually

Impact

Vision Clinic

- **5** students referred for additional eye care
- **10** volunteers from the community
- **33** 1st & 2nd grader students received eye vision exams
- **4** vision techs
- **33** students served, they all needed glasses

Community Partners

Nebraska Foundation for Children's Vision

Steps to Program Success

- Gaining trust from parents in receiving vision services
- Educating parents on the importance of vision care
- Educating parents on the importance of follow up visions after initial vision exam

Appendix E - South Sioux City, Dakota City Elementary School

Nebraska Department of Education

Full Service Community Schools: Dakota City

About Dakota City

Dakota City Elementary is a two section K-5 elementary school. The student population is approximately 100. About 51% of the students at Dakota City are minority students

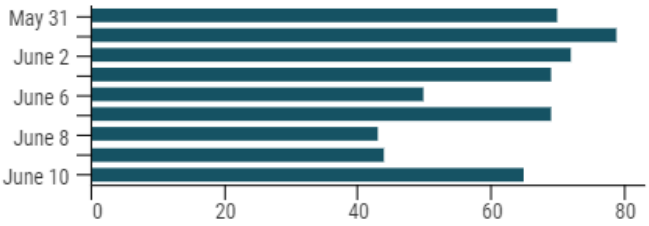
First year summer meals were offered at Dakota City Elementary

Monthly meetings with Heartland Counseling

Monthly classes with NE Extension

Impact

Number of free lunches served



Monthly family classes to expand learning with Ne Extension- Sewing, photography, cooking, etc.

10% of families attended empowered parents meetings

21 adults participated in adult education

Summer meals served for the first time in Dakota City

Family outings to "new places"

Development of a Family Resource Center at School

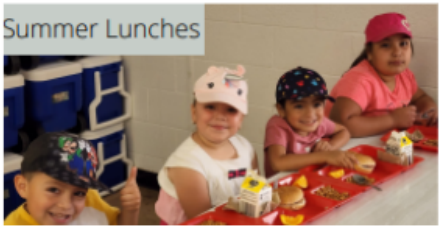
Increased PTA involvement

First time families volunteering in their community

Community Partners

- Dakota City Public Library
- NE Extension in Dakota County
- Heartland Counseling
- Northeast Community College
- LaunchPad Children's Museum
- Sioux City Art Center
- Norm Waitt Sr. YMCA

Events



- Mental Health Workshop - 6 week class
- Technology Classes - 6 week class
- Love & Logic class
- Free Summer Meals
- School & Home Partnership adult meet-up to openly discuss community, education, parenting, home life

Appendix C – Matrix of Neglect Definitions

Nebraska LB42 Change provisions relating to child abuse and neglect under the Child Protection and Family Safety Act and the Nebraska Juvenile Code	**Texas HB567** Relating to the procedures and grounds for terminating the parent-child relationship, for taking possession of a child, and for certain hearings in a suit affecting the parent-child relationship involving the Department of Family and Protective Services.
Source: https://nebraskalegislature.gov/bills/view_bill.php?DocumentID=49881 Introduced 1/5/2023 Referred to Judiciary Committee 1/9/23 Judiciary Hearing 2/22/23 – last action on bill	https://capitol.texas.gov/tlodocs/87R/billtext/pdf/HB00567F.pdf#navpanes=0 – Enrolled Version https://capitol.texas.gov/BillLookup/History.aspx?LegSess=87R&Bill=HB567 – Full History Filed w/out Governor's signature 5/15/2021 – Effective 9/1/21
A BILL FOR AN ACT relating to children and families; to amend sections 43-247 and 43-292, Reissue Revised Statutes of Nebraska, and sections 28-101, 28-707, 28-710, and 43-2,129, Revised Statutes Cumulative Supplement, 2022; to define and redefine terms; to change provisions relating to what constitutes child abuse and neglect under the Child Protection and Family Safety Act and the Nebraska Juvenile Code; to change grounds for juvenile court jurisdiction and termination of parental rights; to harmonize provisions; and to repeal the original sections.	AN ACT relating to the procedures and grounds for terminating the parent-child relationship, for taking possession of a child, and for certain hearings in a suit affecting the parent-child relationship involving the Department of Family and Protective Services.

Nebraska LB42 Change provisions relating to child abuse and neglect under the Child Protection and Family Safety Act and the Nebraska Juvenile Code	**Texas HB567** Relating to the procedures and grounds for terminating the parent-child relationship, for taking possession of a child, and for certain hearings in a suit affecting the parent-child relationship involving the Department of Family and Protective Services.
28-707 (1) Subject to section 4 of this act, a ~~A~~ person commits child abuse if he or she knowingly, intentionally, or negligently causes or permits a minor child to be: (a) Placed in a situation that endangers the minor child's ~~his or her~~ life or physical or mental health under circumstances such that the danger is sufficiently obvious that no reasonable person would cause or permit the minor child to be placed in such situation; 28-710 (2) (b) Child abuse or neglect means, subject to section 4 of this act, knowingly, intentionally, or negligently causing or permitting a minor child to be: (i) Placed in a situation that endangers the minor child's ~~his or her~~ life or physical or mental health under circumstances such that the danger is sufficiently obvious that no reasonable person would cause or permit the minor child to be placed in such situation;… (b) (iv) Left unattended in a motor vehicle if such minor child is six years of age or younger in conditions likely to cause serious harm that have not been mitigated by reasonable precautionary measures; Sec. 4 (1) Permitting a minor child, who is of sufficient maturity, physical condition, and mental abilities to	SECTION 3. Section 161.001(c), Family Code, is amended to read as follows: (c) Evidence of one or more of the following does not constitute clear and convincing evidence sufficient for a court to ~~[A court may not]~~ make a finding under Subsection (b) and order termination of the parent-child relationship [~~based on evidence that the parent~~]: (1) the parent homeschooled the child; (2) the parent is economically disadvantaged; (3) the parent has been charged with a nonviolent misdemeanor offense other than: (A) an offense under Title 5, Penal Code; (B) an offense under Title 6, Penal Code; or (C) an offense that involves family violence, as defined by Section 71.004 of this code; (4) the parent provided or administered low-THC cannabis to a child for whom the low-THC cannabis was prescribed under Chapter 169, Occupations Code; [or] (5) the parent declined immunization for the child for reasons of conscience, including a religious belief; or (6) the parent allowed the child to engage in independent activities that are appropriate and typical for the child 's level of maturity, physical condition, developmental abilities, or culture.

Nebraska LB42 Change provisions relating to child abuse and neglect under the Child Protection and Family Safety Act and the Nebraska Juvenile Code	**Texas HB567** Relating to the procedures and grounds for terminating the parent-child relationship, for taking possession of a child, and for certain hearings in a suit affecting the parent-child relationship involving the Department of Family and Protective Services.
avoid a substantial risk of physical harm, to engage in independent activities, either alone or with other children, shall not be considered child abuse under section 28-707 or child abuse or neglect under section 28-710. (2) For purposes of this section, independent activities include, but are not limited to: (a) Traveling, including, but not limited to, by walking, running, or bicycling, to and from school or nearby commercial or recreational facilities; (b) Playing outdoors; (c) Remaining unattended in a motor vehicle, unless it is in conditions likely to cause serious harm that have not been mitigated by reasonable precautionary measures; or (d) Remaining at home unattended for a reasonable amount of time, provided the person has made provisions for any reasonably foreseeable emergencies that may arise. 43-247 (3) (a) Subject to section 6 of this act: (i) Who ~~who~~ is homeless or destitute, or without proper support 3 through no fault of his or her parent, guardian, or custodian; (ii) Who ~~who~~ is abandoned by his or her parent, guardian, or custodian;	SECTION 4. Section 161.101, Family Code, is amended to read as follows: (b) petition or motion filed by the Department of Family and Protective Services in a suit for termination of the parent-child relationship is subject to Chapter 10, Civil Practice and Remedies Code, and Rule 13, Texas Rules of Civil Procedure. SECTION 5. Section 261.001(4), Family Code, is amended to read as follows: (4)"Neglect" means an act or failure to act by a person responsible for a child 's care, custody, or welfare evidencing the person 's blatant disregard for the consequences of the act or failure to act that results in harm to the child or that creates an immediate danger to the child 's physical health or safety and: (A) includes: (i) the leaving of a child in a situation where the child would be exposed to an immediate danger [~~a substantial risk~~] of physical or mental harm, without arranging for necessary care for the child, and the demonstration of an intent not to return by a parent, guardian, or managing or possessory conservator of the child; (ii) the following acts or omissions by a person: (a) placing a child in or failing to remove a child from a situation that a reasonable person would realize requires judgment or actions beyond the child 's level of maturity, physical condition, or mental abilities and that results in

Nebraska LB42 Change provisions relating to child abuse and neglect under the Child Protection and Family Safety Act and the Nebraska Juvenile Code	**Texas HB567** Relating to the procedures and grounds for terminating the parent-child relationship, for taking possession of a child, and for certain hearings in a suit affecting the parent-child relationship involving the Department of Family and Protective Services.
~~who lacks proper parental care by reason of the fault or habits of his or her parent, guardian, or custodian;~~ (iii) Whose ~~whose~~ parent, guardian, or custodian, through willful, reckless, or grossly negligent conduct, neglects or refuses to provide the minimum ~~proper or~~ necessary subsistence, education, or other care necessary for the health, safety ~~morals~~, or well-being of such juvenile; (iv) Whose ~~whose~~ parent, guardian, or custodian is unable to provide or neglects or refuses to provide special care made necessary by the mental condition of the juvenile; (v) Who ~~who~~ is in a situation, including labor trafficking of a minor or sex trafficking of a minor, as defined in section 28-830, which is ~~or engages in an occupation, including prostitution~~, dangerous to ~~life or limb or injurious to~~ the health, safety, or well-being ~~or morals~~ of such juvenile; or (vi) Who ~~who~~, beginning July 1, 2017, has committed an act or engaged in behavior described in subdivision (1), (2), (3)(b), or (4) of	bodily injury or an immediate danger [~~a substantial risk~~] of [immediate] harm to the child; (b) failing to seek, obtain, or follow through with medical care for a child, with the failure resulting in or presenting an immediate danger [~~a substantial risk~~] of death, disfigurement, or bodily injury or with the failure resulting in an observable and material impairment to the growth, development, or functioning of the child; (d) placing a child in or failing to remove the child from a situation in which the child would be exposed to an immediate danger [~~a substantial risk~~] of sexual conduct harmful to the child; … (e)…(b) does not include: … (ii) allowing the child to engage in independent activities that are appropriate and typical for the child 's level of maturity, physical condition, developmental abilities, or culture [~~Subparagraph (ii)~~]. SECTION 6. Section 262.116(a), Family Code, is amended to read as follows: … (6) allowed the child to engage in independent activities that are appropriate and typical for the child 's level of maturity, physical condition, developmental abilities, or culture; or (7) tested positive for marihuana, unless the department has evidence that the parent 's use of marihuana has caused

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this section and who was under eleven years of age at the time of such act or behavior; (b)(i) Who ~~who~~, until July 1, 2017, by reason of being wayward or habitually disobedient, is uncontrolled by his or her parent, guardian, or custodian; who deports himself or herself so as to injure or endanger seriously the morals or health of himself, herself, or others; or who is habitually truant from home or school; or (ii) Who ~~who~~, beginning July 1, 2017, is eleven years of age or older and, by reason of being wayward or habitually disobedient, is uncontrolled by his or her parent, guardian, or custodian; who deports himself or herself so as to injure or endanger seriously ~~the morals~~ or health, safety, or well-being of himself, herself, or others; or who is habitually truant from home or school; or (c) Who ~~who~~ is mentally ill and dangerous as defined in section 71-908; Sec. 6. (1) The fact that a person permits a juvenile, who is of sufficient maturity, physical condition, and mental	significant impairment to the child 's physical or mental health or emotional development SECTION 7. Section 262.201, Family Code, is amended by amending Subsections (e), (g), (h), and (n) and adding Subsections (g-1) and (q) to read as follows: … (g) In a suit filed under Section 262.101 or 262.105, at the conclusion of the full adversary hearing, the court shall order the return of the child to the parent, managing conservator, possessory conservator, guardian, caretaker, or custodian entitled to possession from whom the child is removed unless the court finds sufficient evidence to satisfy a person of ordinary prudence and caution that: … (g-1) In a suit filed under Section 262.101 or 262.105, if the court does not order the return of the child under Subsection (g) and finds that another parent, managing conservator, possessory conservator, guardian, caretaker, or custodian entitled to possession did not cause the immediate danger to the physical health or safety of the child or was not the perpetrator of the neglect or abuse alleged in the suit, the court shall order possession of the child by that person unless the court finds sufficient evidence to satisfy a person of ordinary prudence and caution that, specific to each person entitled to possession: (1)the person cannot be located after the exercise of due diligence by the Department of Family and Protective

Nebraska LB42 Change provisions relating to child abuse and neglect under the Child Protection and Family Safety Act and the Nebraska Juvenile Code	**Texas HB567** Relating to the procedures and grounds for terminating the parent-child relationship, for taking possession of a child, and for certain hearings in a suit affecting the parent-child relationship involving the Department of Family and Protective Services.
abilities to avoid a substantial risk of physical harm, to engage in independent activities, either alone or with other children, shall not be a basis for the juvenile court to exercise jurisdiction under subdivision (3)(a) of section 43-247 or to terminate parental rights under section 43-292. (2) For purposes of this section, independent activities include, but are not limited to: (a) Traveling, including, but not limited to, by walking, running, or bicycling, to and from school or nearby commercial or recreational facilities; (b) Playing outdoors; (c) Remaining unattended in a motor vehicle, unless it is in conditions likely to cause serious harm that have not been mitigated by reasonable precautionary measures; or (d) Remaining at home unattended for a reasonable amount of time, provided the person has made provisions for any reasonably foreseeable emergencies that may arise. 43-292 Subject to section 6 of this act, the ~~The~~ court may terminate all parental rights… (3) The parents, being financially able, have willfully neglected to provide the juvenile with the necessary subsistence, education, or other care necessary for	Services, or the person is unable or unwilling to take possession of the child; or (2) reasonable efforts have been made to enable the person 's possession of the child, but possession by that person presents a continuing danger to the physical health or safety of the child caused by an act or failure to act of the person, including a danger that the child would be a victim of trafficking under Section 20A.02 or 20A.03, Penal Code. (h) In a suit filed under Section 262.101 or 262.105, if the court finds sufficient evidence to make the applicable finding under Subsection (g) or (g-1) [~~satisfy a person of ordinary prudence and caution that there is a continuing danger to the physical health or safety of the child and for the child to remain in the home is contrary to the welfare of the child~~], the court shall issue an appropriate temporary order under Chapter 105. --- (n) If the [~~The~~] court does not order possession of [~~shall place~~] a child by a [~~removed from the child 's custodial parent with the child 's noncustodial~~] parent, managing conservator, possessory conservator, guardian, caretaker, or custodian entitled to possession under Subsection (g) or (g-1), the court shall place the child [~~or~~] with a relative of the child [~~if placement with the noncustodial parent is inappropriate,~~] unless the court finds that the placement with [~~the noncustodial parent or~~] a relative is not in the best interest of the child.

Nebraska LB42 Change provisions relating to child abuse and neglect under the Child Protection and Family Safety Act and the Nebraska Juvenile Code	**Texas HB567** Relating to the procedures and grounds for terminating the parent-child relationship, for taking possession of a child, and for certain hearings in a suit affecting the parent-child relationship involving the Department of Family and Protective Services.
his or her health, safety ~~morals~~, or welfare or have neglected to pay for such subsistence, education, or other care when legal custody of the juvenile is lodged with others and such payment ordered by the court; (4) The parents are unfit by reason of debauchery, habitual use of intoxicating liquor or narcotic drugs, or repeated lewd and lascivious behavior, which conduct is found by the court to be seriously detrimental to the health, safety ~~morals~~, or well-being of the juvenile; 43-2,129 Sections 43-245 to 43-2,129 and section 6 of this act shall be known and may be cited as the Nebraska Juvenile Code.	(q) On receipt of a written request for possession of the child from a parent, managing conservator, possessory conservator, guardian, caretaker, or custodian entitled to possession of the child who was not located before the adversary hearing, the Department of Family and Protective Services shall notify the court and request a hearing to determine whether the parent, managing conservator, possessory conservator, guardian, caretaker, or custodian is entitled to possession of the child under Subsection (g-1). SECTION 8. Section 263.002, Family Code, is amended by amending Subsection (c) and adding Subsection (d) to read as follows: (c) At each permanency hearing before the final order, the court shall review the placement of each child in the temporary managing conservatorship of the department who has not been returned to the child 's home. At the end of the hearing, the court shall order the department to return the child to the child 's parent or parents unless the court finds, with respect to each parent, that: (1) there is a continuing danger to the physical health or safety of the child; and (2) returning the child to the child 's parent or parents [~~The court shall make a finding on whether returning the child to the child 's home is safe and appropriate, whether the return~~

Nebraska LB42 Change provisions relating to child abuse and neglect under the Child Protection and Family Safety Act and the Nebraska Juvenile Code	**Texas HB567** Relating to the procedures and grounds for terminating the parent-child relationship, for taking possession of a child, and for certain hearings in a suit affecting the parent-child relationship involving the Department of Family and Protective Services.
	~~is in the best interest of the child, and whether it~~] is contrary to the welfare of the child [~~for the child to return home~~]. (d) This section does not prohibit the court from rendering an order under Section 263.403. SECTION 9. Section 263.401, Family Code, is amended by adding Subsection (b-3) to read as follows: (b-3) A court shall find under Subsection (b) that extraordinary circumstances necessitate the child remaining in the temporary managing conservatorship of the department if: (1) a parent of a child has made a good faith effort to successfully complete the service plan but needs additional time; and (2) on completion of the service plan the court intends to order the child returned to the parent. SECTION 10 Subchapter E, Chapter 263, Family Code, is amended by adding Section 263.4011 to read as follows: Sec. 263.4011. RENDERING FINAL ORDER; EXTENSION. (a) On timely commencement of the trial on the merits under Section 263.401, the court shall render a final order not later than the 90th day after the date the trial commences. (b)The 90-day period for rendering a final order under Subsection (a) is not tolled for any recess during the trial. (c) The court may extend the 90-day period under Subsection (a) for the period the court determines necessary if, after a hearing, the court finds good cause for the extension. If the

Nebraska LB42 Change provisions relating to child abuse and neglect under the Child Protection and Family Safety Act and the Nebraska Juvenile Code	**Texas HB567** Relating to the procedures and grounds for terminating the parent-child relationship, for taking possession of a child, and for certain hearings in a suit affecting the parent-child relationship involving the Department of Family and Protective Services.
	court grants a good cause extension under this subsection, the court shall render a written order specifying: (1) the grounds on which the extension is granted; and (2) the length of the extension. (d) A party may file a mandamus proceeding if the court fails to render a final order within the time required by this section. SECTION 11. Section 263.403 (a-1), Family Code, is amended to read as follows: (a-1) Unless the court has granted an extension under Section 263.401(b), the department or the parent may request the court to retain jurisdiction for an additional six months as necessary for a parent to complete the remaining requirements under [~~in~~] a service plan [~~and specified~~] in a transition monitored return under Subsection (a)(2)(B) [~~the temporary order that are mandatory for the child 's return~~]. SECTION 12. Section 264.203, Family Code, is amended to read as follows: Sec. 264.203. REQUIRED PARTICIPATION. (a) The department may file a suit requesting [~~Except as provided by Subsection (d),~~] the court to render a temporary [~~on request of the department may~~] order requiring the parent, managing conservator, guardian, or other member of the [~~subject~~] child 's household to:

Nebraska LB42 Change provisions relating to child abuse and neglect under the Child Protection and Family Safety Act and the Nebraska Juvenile Code	**Texas HB567** Relating to the procedures and grounds for terminating the parent-child relationship, for taking possession of a child, and for certain hearings in a suit affecting the parent-child relationship involving the Department of Family and Protective Services.
	(1) participate in the services for which the department makes a referral or services the department provides or purchases for: (A) alleviating the effects of the abuse or neglect that has occurred; [~~or~~] (B) reducing a continuing danger to the physical health or safety of the child caused by an act or failure to act of the parent, managing conservator, guardian, or other member of the child's household [~~the reasonable likelihood that the child may be abused or neglected in the immediate or foreseeable future~~]; or (C) reducing a substantial risk of abuse or neglect caused by an act or failure to act of the parent, managing conservator, guardian, or member of the child 's household; and (2) permit the child and any siblings of the child to receive the services. (b) A suit requesting an order under this section may be filed in a court with jurisdiction to hear the suit in the county in which the child is located [~~The department may request the court to order the parent, managing conservator, guardian, or other member of the child 's household to participate in the services whether the child resides in the home or has been removed from the home~~]. (c) Except as otherwise provided by this subchapter, the suit is governed by the Texas Rules of Civil Procedure applicable

Nebraska LB42 Change provisions relating to child abuse and neglect under the Child Protection and Family Safety Act and the Nebraska Juvenile Code	**Texas HB567** Relating to the procedures and grounds for terminating the parent-child relationship, for taking possession of a child, and for certain hearings in a suit affecting the parent-child relationship involving the Department of Family and Protective Services.
	to the filing of an original lawsuit [~~If the person ordered to participate in the services fails to follow the court 's order, the court may impose appropriate sanctions in order to protect the health and safety of the child, including the removal of the child as specified by Chapter 262~~]. (d) The petition shall be supported by a sworn affidavit by a person based on personal knowledge and stating facts sufficient to support a finding that: (1) the child has been a victim of abuse or neglect or is at substantial risk of abuse or neglect; and (2) there is a continuing danger to the physical health or safety of the child caused by an act or failure to act of the parent, managing conservator, guardian, or other member of the child 's household unless that person participates in services requested by the department [~~If the court does not order the person to participate, the court in writing shall specify the reasons for not ordering participation~~]. (e) In a suit filed under this section, the court may render a temporary restraining order as provided by Section 105.001. (f) The court shall hold a hearing on the petition not later than the 14th day after the date the petition is filed unless the court finds good cause for extending that date for not more than 14 days. (g) The court shall appoint an attorney ad litem to represent the interests of the child immediately after the filing but

Nebraska LB42 Change provisions relating to child abuse and neglect under the Child Protection and Family Safety Act and the Nebraska Juvenile Code	**Texas HB567** Relating to the procedures and grounds for terminating the parent-child relationship, for taking possession of a child, and for certain hearings in a suit affecting the parent-child relationship involving the Department of Family and Protective Services.
	before the hearing to ensure adequate representation of the child. The attorney ad litem for the child shall have the powers and duties of an attorney ad litem for a child under Chapter 107. (h) The court shall appoint an attorney ad litem to represent the interests of a parent for whom participation in services is being requested immediately after the filing but before the hearing to ensure adequate representation of the parent. The attorney ad litem for the parent shall have the powers and duties of an attorney ad litem for a parent under Section 107.0131. (i) Before commencement of the hearing, the court shall inform each parent of: (1) the parent ’s right to be represented by an attorney; and (2) for a parent who is indigent and appears in opposition to the motion, the parent ’s right to a court-appointed attorney. (j) If a parent claims indigence, the court shall require the parent to complete and file with the court an affidavit of indigence. The court may consider additional evidence to determine whether the parent is indigent, including evidence relating to the parent ’s income, source of income, assets, property ownership, benefits paid in accordance with a federal, state, or local public assistance program,

Nebraska LB42 Change provisions relating to child abuse and neglect under the Child Protection and Family Safety Act and the Nebraska Juvenile Code	**Texas HB567** Relating to the procedures and grounds for terminating the parent-child relationship, for taking possession of a child, and for certain hearings in a suit affecting the parent-child relationship involving the Department of Family and Protective Services.
	outstanding obligations, and necessary expenses and the number and ages of the parent ’s dependents. If the court determines the parent is indigent, the attorney ad litem appointed to represent the interests of the parent may continue the representation. If the court determines the parent is not indigent, the court shall discharge the attorney ad litem from the appointment after the hearing and shall order the parent to pay the cost of the attorney ad litem ’s representation. (k) The court may, for good cause shown, postpone any subsequent proceedings for not more than seven days after the date of the attorney ad litem ’s discharge to allow the parent to hire an attorney or to provide the parent ’s attorney time to prepare for the subsequent proceeding. (l) An order may be rendered under this section only after notice and hearing. (m) At the conclusion of the hearing, the court shall deny the petition unless the court finds sufficient evidence to satisfy a person of ordinary prudence and caution that: (1) abuse or neglect has occurred or there is a substantial risk of abuse or neglect or continuing danger to the physical health or safety of the child caused by an act or failure to act of the parent, managing conservator, guardian, or other member of the child ’s household; and

Nebraska LB42 Change provisions relating to child abuse and neglect under the Child Protection and Family Safety Act and the Nebraska Juvenile Code	**Texas HB567** Relating to the procedures and grounds for terminating the parent-child relationship, for taking possession of a child, and for certain hearings in a suit affecting the parent-child relationship involving the Department of Family and Protective Services.
	(2) services are necessary to ensure the physical health or safety of the child. (n) If the court renders an order granting the petition, the court shall: (1) state its findings in the order; (2) make appropriate temporary orders under Chapter 105 necessary to ensure the safety of the child; and (3) order the participation in specific services narrowly tailored to address the findings made by the court under Subsection (m). (o) If the court finds that a parent, managing conservator, guardian, or other member of the child 's household did not cause the continuing danger to the physical health or safety of the child or the substantial risk of abuse or neglect, or was not the perpetrator of the abuse or neglect alleged, the court may not require that person to participate in services ordered under Subsection (n). (p) Not later than the 90th day after the date the court renders an order under this section, the court shall hold a hearing to review the status of each person required to participate in the services and the child and the services provided, purchased, or referred. The court shall set subsequent review hearings every 90 days to review the continued need for the order.

Nebraska LB42 Change provisions relating to child abuse and neglect under the Child Protection and Family Safety Act and the Nebraska Juvenile Code	**Texas HB567** Relating to the procedures and grounds for terminating the parent-child relationship, for taking possession of a child, and for certain hearings in a suit affecting the parent-child relationship involving the Department of Family and Protective Services.
	(q) An order rendered under this section expires on the 180th day after the date the order is signed unless the court extends the order as provided by Subsection (r) or (s). (r) The court may extend an order rendered under this section on a showing by the department of a continuing need for the order, after notice and hearing. Except as provided by Subsection (s), the court may extend the order only one time for not more than 180 days. (s) The court may extend an order rendered under this section for not more than an additional 180 days only if: (1) the court finds that: (A) the extension is necessary to allow the person required to participate in services under the plan of service time to complete those services; (B) the department made a good faith effort to timely provide the services to the person; (C) the person made a good faith effort to complete the services; and (D) the completion of the services is necessary to ensure the physical health and safety of the child; and (2) the extension is requested by the person or the person ’s attorney.

Nebraska LB42 Change provisions relating to child abuse and neglect under the Child Protection and Family Safety Act and the Nebraska Juvenile Code	**Texas HB567** Relating to the procedures and grounds for terminating the parent-child relationship, for taking possession of a child, and for certain hearings in a suit affecting the parent-child relationship involving the Department of Family and Protective Services.
	(t) At any time, a person affected by the order may request the court to terminate the order. The court shall terminate the order on finding the order is no longer needed. SECTION 13. The following provisions of the Family Code are repealed: (1) Section 262.113; (2) Section 262.1131; and (3) Sections 262.201(b) and (j)

Appendix D County Attorney Survey Results

LB 1173 Survey of County Attorneys

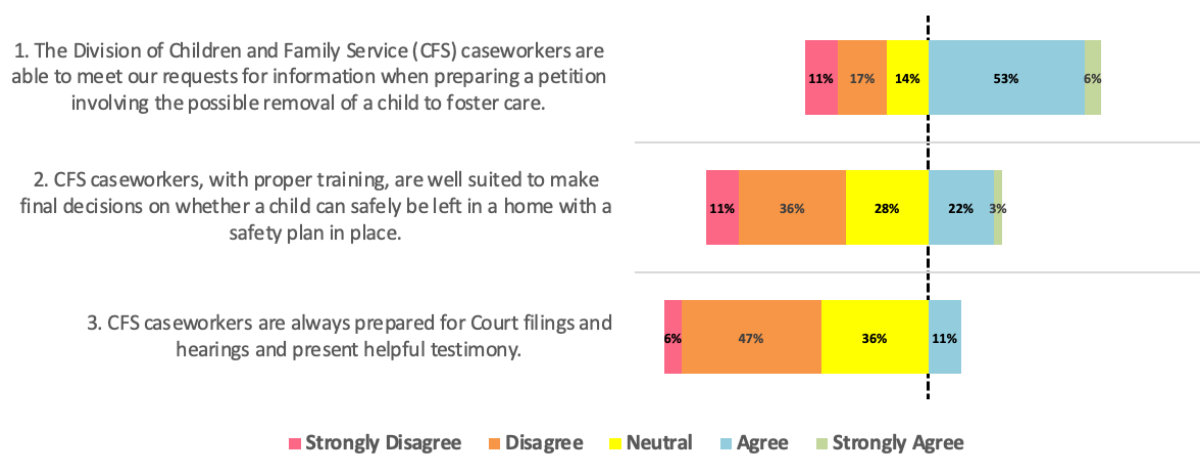
June to August 2023

Between the months of June through August 2023, Nebraska County Attorneys were surveyed as part of the LB 1173 process to re-imagine child welfare in Nebraska and design a new and transformative Child Welfare Practice Model. The survey's questions focused on issues involving CFS casework and court preparation, CASA and GAL case involvement, the process related to petitions for removal, services and coordination, foster parent participation, CFS decision making and discretion, training and understanding and permanency and collaboration.

The survey was forwarded by The Stephen Group to county attorneys statewide and there were 36 responses. We would like to specifically recognize and thank Lancaster County Attorneys Christopher Turner and Christopher Reid for their assistance in helping with the distribution of this survey.

The survey results are as follows:

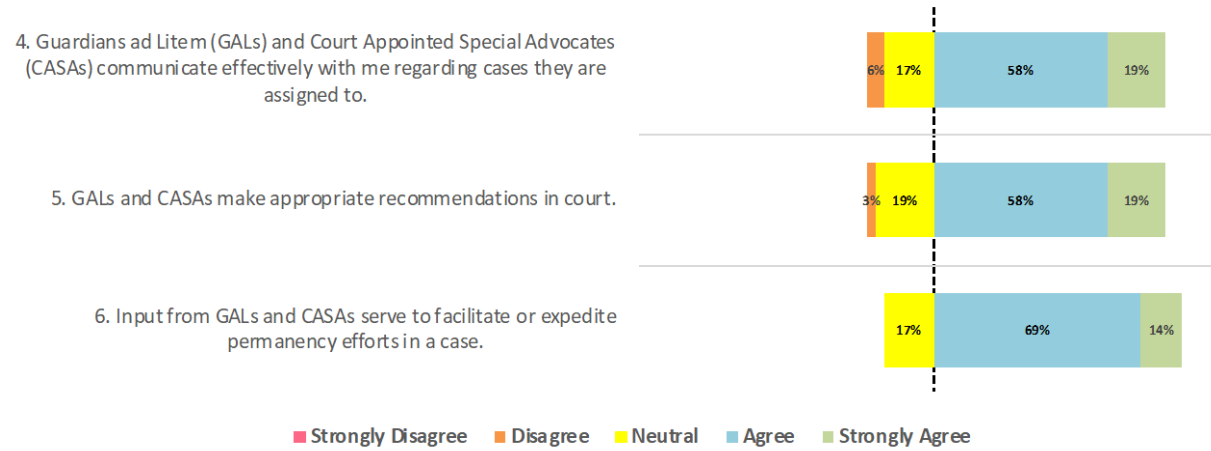
CFS Casework and Court Preparation



The results show majority of county attorneys believe that CFS caseworkers are able to meet their requests for information in preparing petitions for removal, but there is strong disagreement that CFS caseworkers are prepared for court and, even with

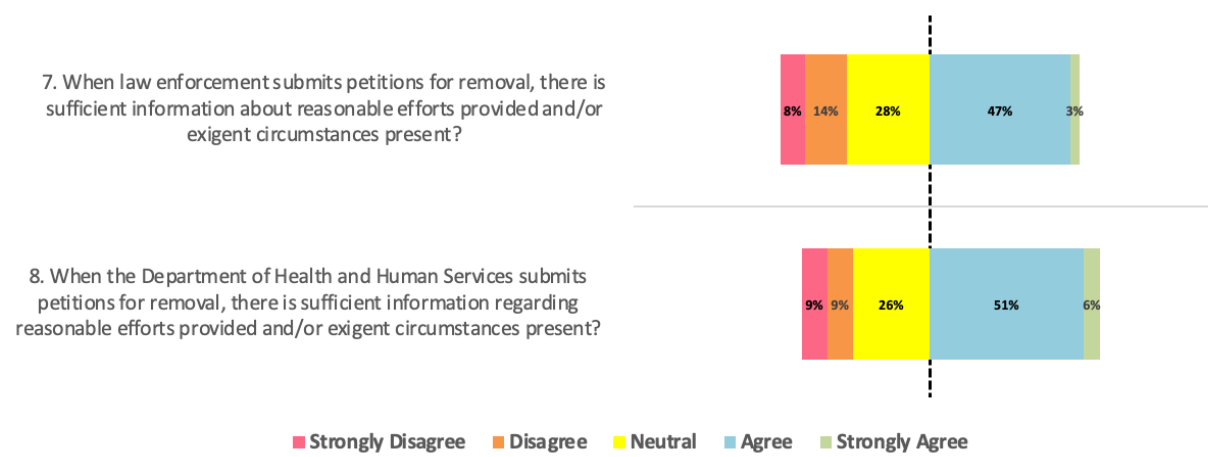
proper training are well suited to make final decisions on whether a child can safely be left in a home with a safety plan in place.

Court Appointed Special Advocates and Guardians ad Litem Court Involvement



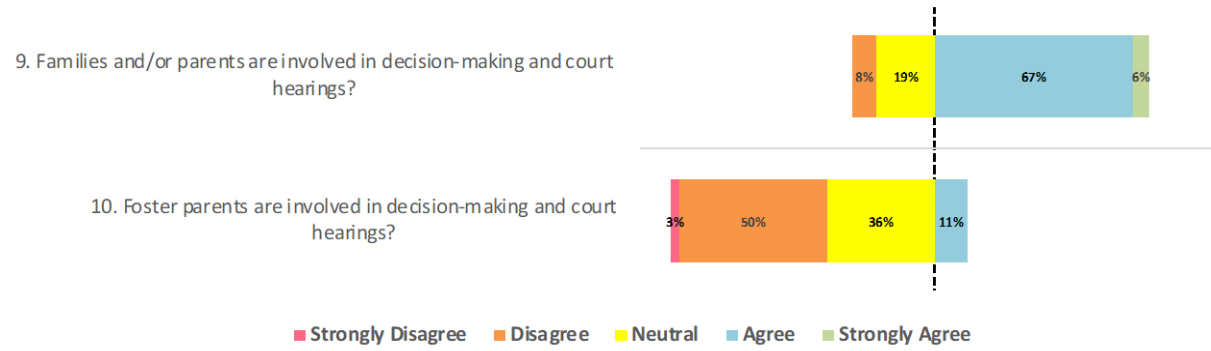
County attorneys strongly value the input, involvement and recommendations of GALs and CASA and believe overwhelmingly that they both serve to facilitate or expedite permanency efforts in a case.

Petitions for Removal



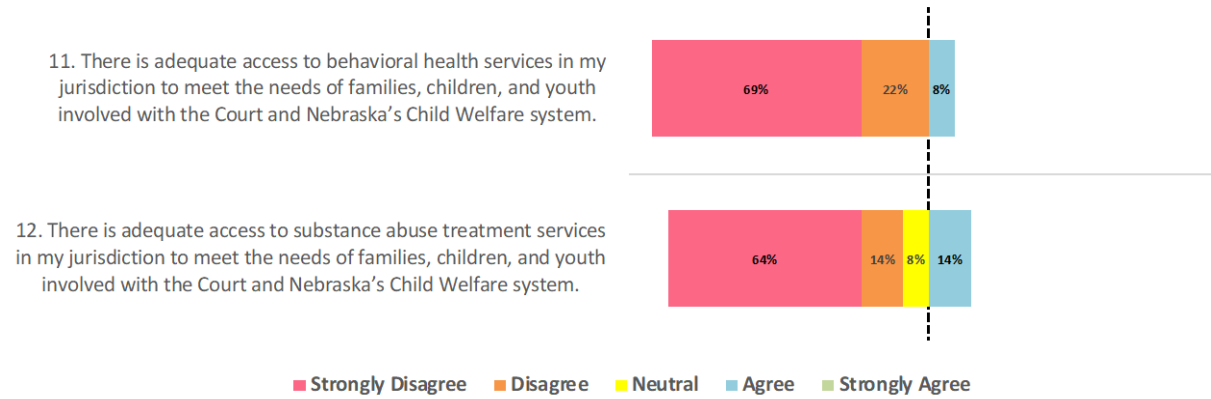
Largely county attorneys feel that petitions for removal contain sufficient information regarding reasonable efforts and exigent circumstances.

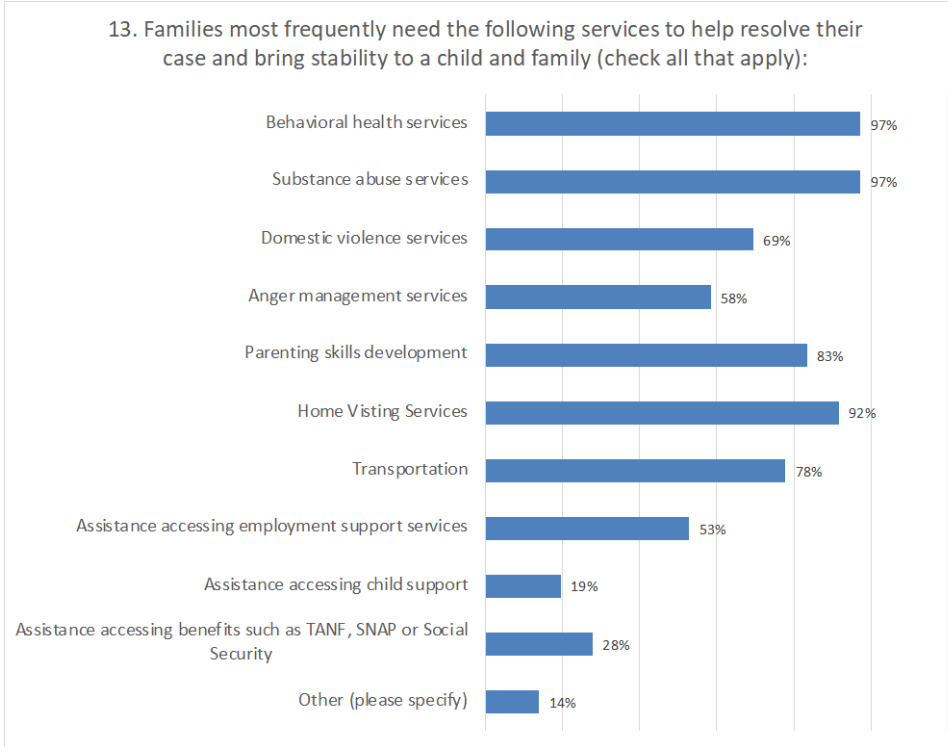
Birth and Foster Family Involvement in Court Hearings



County attorneys believe that families are involved in decision making and court hearings. Conversely, they feel foster parents are not.

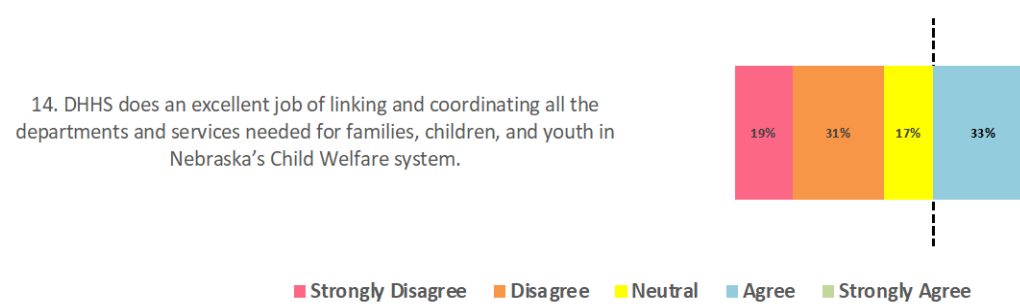
Service Access and Coordination





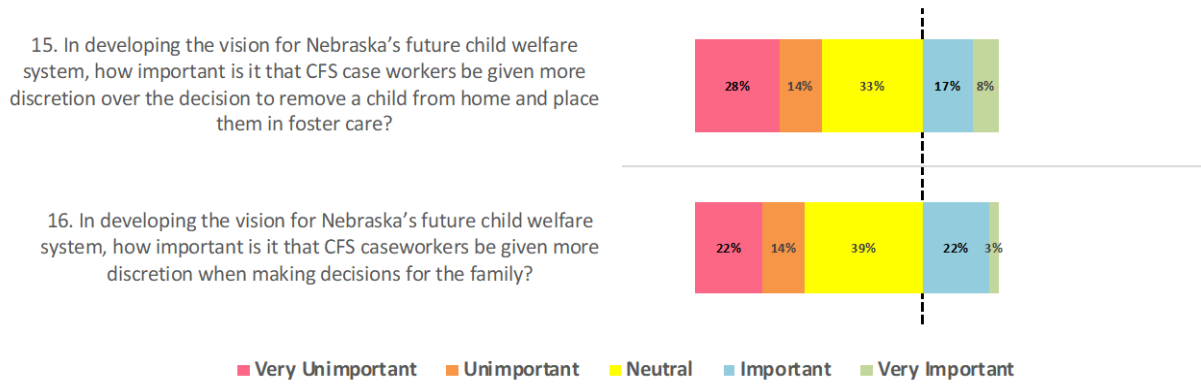
Other Responses:

1. Drug and alcohol testing
2. Drug testing to ensure sobriety and/or aid parents in getting the level of counseling that is appropriate.
3. Housing
4. Professional mental health evaluation, such as parenting assessment and/or psych evaluations



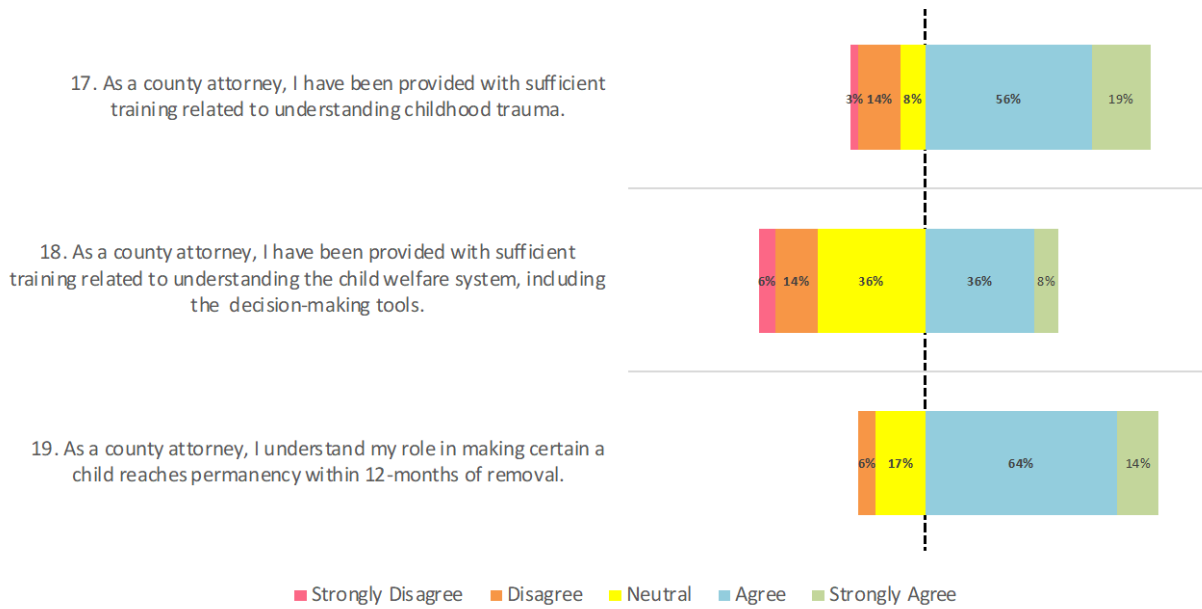
County attorneys overwhelmingly believe there is inadequate access to mental health and substance abuse services to meet the needs of families, children and youth. They have also identified behavioral health services, substance abuse services, parenting sill development, home visiting services, and transportation as significant areas of need to bring stability to a child and family. Additionally, the majority of county attorneys do not believe that DHHS does an excellent job in linking and coordinating all departments and services needed for families.

CFS Decision Making and Discretion



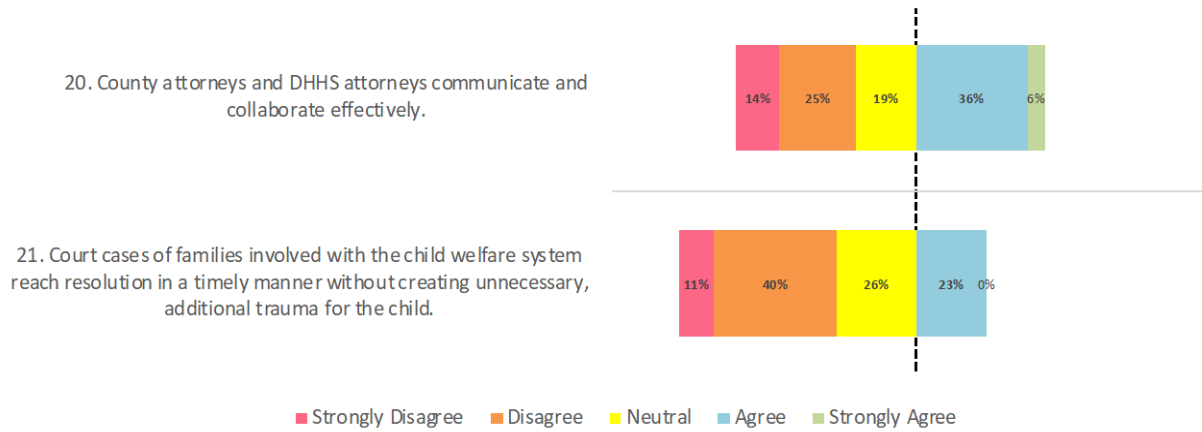
The vast majority of County Attorneys do not believe that CFS caseworkers should be given more discretion over the decision to remove children or in making decisions for the family.

Attorney Training and Understanding



County Attorneys believe they have had sufficient training to understand childhood trauma and in understanding their role in helping a child reach permanency, but the majority do agree that they need more training related to understanding the child welfare system and its decision tools.

Collaboration and Permanency



County Attorneys overwhelmingly believe there is not enough collaboration with DHHS attorneys, and that cases do not reach permanency in a timely manner.

Comments and Clarifications

Please clarify any of your prior responses or offer any additional comments you think are relevant:

1.	#1. DHHS does not recommend removal from home on a new filing/initial removal. They used to, but it is my understanding they do not write affidavits per DHHS policy and need supervisor or admin approval in order to do so. #2. The key being "with proper training". #4. I consistently and regularly get more information from the CASA and/or GAL before getting it from the DHHS worker, if I even get the information from the DHHS worker at all. Oftentimes, as county attorney I am the LAST person to get information. #8. It is DHHS policy to NOT submit petitions for removal. I have seen it done in cases with a newborn whose sibling is already a ward of the state, but that is rare. I have received more affidavits in support of removal from health care professionals than I have received from DHHS. #14. In my experience, communication is poor between DHHS and other agencies (especially probation). Both agencies always want to say it's the other agency's responsibility. #15. Discretion or authority? Currently DHHS workers have no authority to removal a child from the home and place in foster care (this is assuming a "first" removal, not removing a child who is already a ward of the state from the parental home on an emergency basis). DHHS discourages law enforcement from exercising their statutory authority to remove children from the home, so granting them any statutory authority likely wouldn't result in additional removals. #16. The way this question is worded makes it difficult to answer. DHHS implements services and pays for them when it wants to (i.e., according to their policy), but requires court orders to provide other services (drug testing). I don't think the answer is granting DHHS more discretion because I think the discretion will ultimately be interpreted as a reason to further restrict and narrow the services it feels like offering or implementing. #20. My county doesn't have a DHHS attorney present at all hearings, which I don't believe is necessary anyway. However, the times DHHS attorneys have become involved, they communicate well even if our positions on certain issues differ. #21 When children are available for adoption/guardianship, it takes DHHS too long to prepare the adoption/guardianship packets. Additional comments: Communication from DHHS workers needs significant improvement.
2.	I wish they would make better use of calendar invites that include zoom links for family team meetings, as opposed to having to search through tons of emails to locate. Also, the CAO corrects the assigned attorney on cases and DHHS continues to subsequently send reports to the wrong attorney. This results sometimes in reports not being received by the correct attorney ahead of hearings. It also mean sometimes the report does not reach the attorney in time for the hearing.
3.	I think the questions about GALS and CASAS should have been split. I find GALS very helpful and very good at communicating. CASAS are not always as helpful, generally if I have issues with CASA it is because the specific worker lacks and understanding of the law (such as parental preference, minimal parenting standards etc). Caseworker preparation and testifying is very dependent on the individual worker. Some workers are always prepared and provide good testimony. Others are rarely prepared and thus rarely provide helpful testimony.

4.	I have had the pleasure of working with amazing CFSS, and some that are less than stellar. I think more training on the impact of trauma and lack of permanency on children is needed for the County Attorneys, and ESPECIALLY for judges. I also think it is critical that we provide better training on exception hearings and effective/efficient ways to use them, and more training with ICWA/NICWIC. I have sought further education in juvenile law that has been critical for me to do a good job as county attorney in rural/Greater Nebraska, but that does not necessarily overcome other structural barriers, which include lack of services in the areas or the barriers to reunification caused by distance to access services.
5.	As a county attorney, I did not receive appropriate juvenile justice/child welfare training until well after my first few years of practice. Even then, I had to seek out additional training, and the trainings provided by the NECAA were lacking in appropriate procedural as well as trauma informed advocacy material.
6.	We are struggling with DHHS in Western Nebraska. I believe a lot of the issues are related to caseworkers being understaffed and overworked and lack of services in the area, but the decision making I've seen out of DHHS lately has been extremely concerning.
7.	The DHHS hotline has, for over a year, screened several VERY concerning cases as "does not meet" or "information only"--one of the biggest challenges we face is the hotline not screening properly. Also, we struggle with families who have voluntary cases, but then ghost DHHS and DHHS closes (per their protocols) and then not having eyes on family, but DHHS is unable to provide legal documentation or recommend removal/filing.
8.	It all depends on the caseworker. Some are very competent and efficient. Some are not. Caseworkers are often hampered in their efforts by decisions or policies made by higher-ups.
9.	When the State closed the Regional Centers and touted community based services as the new panacea they should have helped cultivate those services. Instead, they just walked away leaving communities to try to put a patchwork of services together. While Lincoln and Omaha may be able to access services Western Nebraska can not. Without community based services no one in the Child Welfare system can do their jobs. There is not enough counselors to help addicts and mentally ill people in the communities. The DHHS and Legislature need to work with colleges throughout the State to cultivate more mental health professionals to aid people. They need to cultivate new and better crisis facilities throughout the State. They need to cultivate new and better long-term mental health facilities.
10.	I did struggle to answer many of the questions. Some of my "neutral" responses were because it just depended on several factors. For example, I did not understand what was meant by giving HHS workers more discretion. Frequently their discretion is hampered by their own policies, and sometimes is hampered by me filing things because I disagree. So I would support some policy HHS policy changes that would give them more true discretion, but I am not going to support changes that give them "discretion" by limiting my ability to file when I disagree with HHS policy. Other times I put "Neutral" because "sometimes" and "it depends on the officer/CFS" weren't options. Some officers explain exigent circumstances, some don't. Most CFS are fairly competent, but some are not.
11.	DHHS often approaches removal situations from a financial perspective and it seems that they are concerned more with saving money than they are with child safety. I believe more discretion to CFS will only make the problems worse. We need more services in rural Nebraska.
12.	I have an excellent working relationship with the DHHS supervisors and caseworkers and my jurisdiction is small enough that I know each caseworker by name and they feel comfortable reaching out to me with issues/questions. We also have monthly meetings to discuss open/active cases and DHHS is involved in our

	monthly LB1184 meetings. If I didn't have this relationship with the workers/supervisors I don't think my answers would have been as positive as I know there are issues in other jurisdictions.
13.	If a CFS has the appropriate training, I agree that discretion is important. I also think that the "tools" sometimes cover the issues in the family and that reunification is not always the answer or keeping the kids at home is not always the best option. Overall, my CFS workers in my area prepare for Court and are ready to give responses. The majority of the workers will keep me in the loop of information that is important in the cases. I struggle with the ones that are the exception. I do have a handful of workers that do not prepare, do not seem to understand they are to advocate for kids over parents, and focus too much on family voice and choice when it may be to the detriment of the child's well-being. Very recently, services have begun to disappear and are not as readily available in our area for mental health and substance abuse. There is a long wait-list for these services at times and there is a wait-list for visit workers, in-home family services and overall support services for families. We have a few providers to do psychological evaluations and parenting assessments and one is basically retired so getting access to these evaluations has been much more difficult in the last year or so.
14.	I answered neutral to Number 19. I certainly understand the County Attorney's role to help a child reach permanency after an extended time in foster care, however, my reading of 19 is that it is an incorrect statement of Nebraska's law. The law does not require permanency after 12 months of foster care or any specific set time. Instead, parental rights can be terminated after 15 months of foster care, or if other circumstances that are harmful to the child exist, and it is in the child's best interests to terminate. I am well aware of my role and obligation to argue for permanency to the court after 15 months of foster care when it appears that termination of parental rights is in the child's best interest. However, I do not have an obligation to make "certain" that a child has permanency within 12 months of foster care as there is no basis in the law for that claim.
15.	All of my answers depend on who the caseworker and/or GAL are. If I have a good worker and a good GAL, the cases move appropriately and the communication is good. When I have a bad worker or GAL the cases require my attention beyond a prosecutor's role in order to move the case forward. I am concerned about the number of cases that are voluntary or AR that are never discussed with the prosecutor. We have workers that are not familiar with these families or the services in the area, yet they are making decisions on these families with no input from anyone in the community. If I didn't constantly monitor intakes and follow up with DHHS, numerous children and families who need assistance would fall through the cracks. I am also increasingly concerned about the legal advice provided to these workers. Our local DHHS attorney has no courtroom experience and no juvenile law experience. Her involvement causes roadblocks in cases that do not need to be there and she holds up cases with unrealistic expectations.
16.	Our current system regularly prioritizes the welfare and rights of parents above the welfare and rights of children.
17.	I answered the questions involving CFS workers being "given more discretion over the decision to remove a child" with the belief that this really means DHHS Admin making policy re: removal vs. allowing law-enforcement/co atty/judges. I believe that would lead to greater numbers of children remaining in imminent risk of abuse. If the questions really means that the CFS working with the family actually has discretion (without DHHS Admin policy telling them to never consider removal) utilizing their training, education, and experience - then I would support .
18.	Communication of information with all parties is the key and timely availability of services.
19.	Over the years, DHHS has implemented policies based on cost reduction, rather than policies which focus on the risk of harm to the child. Risk of harm is often treated as whether or not the child is at immediate

	risk of physical harm, but routinely ignores the evidence that persistent, long-term neglect is and can just as damaging as immediate physical abuse toward a child. Many of the people involved in these decision making processes have never lived through the circumstances, neglect, and related issues that many children have to endure. The policies in place which seek to divert referrals for review are not rooted in the best interest of the children, but instead are rooted in the best interest of DHHS' pocketbook.
20.	There is an increasing breakdown in relations and communications between DHHS and the county attorney's office. At times it appears as if DHHS intentionally withholds information from the county attorney.
21.	In my service area there are one or two good caseworkers. The rest have no idea what services are offered in my community. They also have no ability to make decisions or advocate for kids and families. Everything has to be run by a supervisor who does not know what is going on. My county continually gets bumped to another service area and we have on call workers who refuse to come out because it is too far. The workers are rude and act like their job is an inconvenience. Getting any information out of all but a couple workers is next to impossible. Many times they block law enforcement from portions of their investigation and I have no one to write an affidavit to remove. They do everything possible to keep cases out of court so they have no oversight. I am not informed when a voluntary or AR case is open or closed. They refuse to provide information on AR cases at the 1184 meetings so my community members think those kids are falling off the radar. The last 1184 meeting a worker told a foster mother what was discussed at the meeting causing her to threaten to sue an agency. That agency now does not want to participate in the 1184 meetings causing a huge gap of information. The workers who are good are getting burned out because the bad workers can do nothing and get away with it while the good workers get in trouble for things that aren't their fault. Every time I turn around there are new DHHS policies that they refuse to explain and there is no way to look them up to find out if they even exit. The DHHS attorneys back the department no matter what without even looking into the information. The attorney in my area doesn't even show up to court for hearings and we have numerous issues with her that go unaddressed. We do not have CASAs but our GALs are generally well trained and do a good job. There is one or two that have issues but the judges know who to appoint to avoid issues.

Appendix E - Comparison Matrix of the Nebraska DCFS 2017, 2018 and 2022 Proposed Policy Regarding Drug Testing

Prior Protocol #17-2016	Current Protocol Update #3-2018	Proposed Pilot (11/2022)
1. The CFS Specialist will utilize the results of the Structured Decision Making (SDM) Assessments, reports from Law Enforcement and the UNCOPE tool to determine if: • There are any individuals within the family who may need further evaluation regarding the individual's substance use; or • Information exists that demonstrates that an individual is abusing substances. An evaluation of the individual's substance use may be necessary to determine the extent of the use and any treatment recommendations. • The CFS Specialist must identify a clear purpose for using drug testing **Determining Whom to Test:** Given the limitations of drug testing, the CFS Specialist should base decisions on which individuals to test using information from the safety	1. During the Initial Assessment or Ongoing case management, when it is determined that substance use is a contributing factor related to a SDM@ Safety Threat or contributing factor to the SDM@ Risk Assessment or SDM @Risk Reassessment level of high or very high risk, the CFS Specialist will refer the parent(s) or caregiver(s) for a substance use disorder evaluation. a. The CFS Specialist or designee will assist the parent or caregiver to arrange for an evaluation. b. The CFS Specialist will work with the parent or caregiver to follow any recommendations provided from the evaluation. c. When drug testing is recommended as part of substance abuse treatment, drug testing should be arranged by the treatment provider	1. A report concerning abuse or neglect due to substance use allegations of a parent/caregiver has been reported to and received by Nebraska's Child Abuse and Neglect hotline. The report has been accepted by the hotline for an initial assessment. • The Safety Assessment will be completed. During the Safety Assessment, the substance use screening tool (TAPS) will be offered to the parent/caregiver to complete with the assistance of the CFSS. If the parent/caregiver declines the offer to complete the TAPS tool, proceed with the rest of the steps in this process. 2. As part of the Safety Assessment, CFSS will observe the parent/caregiver, children, and surroundings to look

Prior Protocol #17-2016	Current Protocol Update #3-2018	Proposed Pilot (11/2022)
assessment, risk or prevention assessment and family assessment. Other considerations may involve mothers of babies who were identified at birth as having been prenatally exposed to drugs. The CFS Specialist will also consider recommendations from the substance abuse evaluation or orders from the court. Drug testing is a service available for court and non-court involved cases. **Detection:** CFS Specialist completes initial screening. Confirmatory tests are used for further analysis of a sample, to confirm a positive or sometimes, negative result. **Probation:** When an individual is on Probation and the Office of Probation is conducting drug tests, the CFS Specialist must work with the parent to obtain a Release of Information or a court order for the results and documentation of any drug tests conducted by Probation. CFS should not authorize additional drug testing unless it is court ordered or the individual will not consent to the Release of Information. **Authorizing Drug Testing:**	and the individual. Medicaid, private insurance or the individual is responsible for the costs of any recommended drug testing. **Court Ordered Testing:** If the court orders drug testing, the CFS Specialist will comply, but will notify the CFS Supervisor and provide the CFS Supervisor with copies of the petition that brought the child into care; the court order; and the case plan and court report. a. The CFS Supervisor will review the information to determine if DHHS Legal staff need to be notified for possible reconsideration or appeal: i. In certain cases, i.e. 3(a) No Fault and 3(c) cases where substance use is not cited as a safety concern in the Petition, CFS attorneys may file a Motion to Reconsider and argue to the Court that drug testing should not be required.	for signs and symptoms of specific drug use, and how it affects parenting, as trained. CFSS will reference the CFS-approved mobile tools accessible in the field regarding signs and symptoms of specific substance use. 3. The CFSS will assess the appropriateness of offering a drug/alcohol test to the parent/caregiver **<u>after</u>** the CFSS has done the following during the Safety Assessment: • Had the parent/caregiver complete the TAPS tool (if they choose); • Observed for signs and symptoms of drug use; • Utilized CFS-approved tools for signs and symptoms of drug use; • Obtained collateral information (when appropriate); and, • Contacted a CFS Lead Worker for support or consultation. 4. If the CFSS assesses it is appropriate to offer a drug test, the CFSS will

Prior Protocol #17-2016	Current Protocol Update #3-2018	Proposed Pilot (11/2022)
The CFS Specialist will create a Service Referral that specifies the length and frequency of drug testing. The CFS Specialist will need to check with the DCFS Contracted Drug Testing providers to determine which provider(s) are able to provide the type and frequency of testing needed. Drug testing will not be conducted with parent(s) who admit to use unless there is additional information in which the use of substances other than what is disclosed is suspected that would impact the safety of the child. DCFS contract providers of drug tests will report the following to the CFS Specialist by the end of the next business day, in writing, unless otherwise directed in the service referral. **Addressing Results of Drug Tests:** The CFS Specialist will report all drug test results (positive & negative), self-disclosures, refusals and no shows to the court. Unless there is a court order authorizing the release of the results to other parties, the results of the drug test will be shared with the	b. If an Order for drug testing is under Appeal or Reconsideration, the original Court Order for drug testing remains valid and must be honored until the Court rules on the Appeal or the motion to reconsider. c. When the Court orders drug testing to be completed on a parent or caregiver and it is not a part of the substance abuse treatment recommendations and CFS is ordered to pay then the CFS Specialist will submit an authorization for drug testing. **Authorizing Court Ordered Drug Testing:** The CFS Specialist or designee will create a Service Referral specifying the length and frequency and the specific drug(s) for which the testing is ordered and will provide the parent or caregiver a list of the contracted providers for the service and the parent may select the provider. **Addressing Results of Drug Tests:** The results of all drug tests including those performed by treatment providers, probation, self-disclosures,	contact their CFS Supervisor or the on-call CFS Supervisor (CFSSS), discuss the situation, and the CFSSS will make the final determination regarding a drug test being offered to the parent/caregiver. CFS Administration will be available for a consult if needed by the CFSSS. • If the CFSSS does not agree with offering a drug test, the CFSS will continue the SDM assessment process, as trained, to determine safety. • With CFSSS verbal approval, the CFSS will offer the parent/caregiver a drug/alcohol test. Testing allows CFS to assess and identify red flags to determine the possible need for a substance use evaluation or subsequent treatment. • If the parent agrees to take the drug test, CFSS will contact the identified drug testing contracted

Prior Protocol #17-2016	Current Protocol Update #3-2018	Proposed Pilot (11/2022)
court, the county attorney and the attorney for the parent who was tested.	refusals and 'no shows', will be reported to the Court, the county attorney, the attorney for the parent or caregiver and any other party for whom there is a Court Order authorizing the release of the results. These results will be shared in the court report unless otherwise indicated by the court order.	provider. A test will be done, and preliminary results received. • If the parent/caregiver disagrees with completing a drug/alcohol test, the CFSS will document this and follow the SDM assessment process, as trained, to determine safety. • Note: If the parent/caregiver already completes substance use testing for Adult Probation, work with the parent/caregiver to coordinate testing through this entity, if possible, within the time frames needed by CFS, so duplicate testing is not done. Releases of information signed by the parent/caregiver will likely be required by the entity. • If a safety plan is developed with the family network, identified CFS-approved

Prior Protocol #17-2016	Current Protocol Update #3-2018	Proposed Pilot (11/2022)
		educational material will be provided to the family network identified as a support, to understand and recognize signs, symptoms, and behaviors of substance use. • Depending on the results of the TAPS tool and how that corresponds to the TAPS recommendations, complete a service referral for a substance use evaluation. ***SOP doesn't address who receives the results of testing***

Nebraska Intersectoral Stakeholders

We believe that the lives of children & families can be enhanced by building strong partnerships for child & family well-being transformation that invests resources in effective & innovative ways

SDOH
Faith-Based Organizations
Early Childhood Development
Regional BH System
Community Action Teams
Peer Support
Family
Tribes
Community Collaboratives
Home Visitation
Public Health
MIECHV
DHHS Economic Assistance
NE Legislature
DHHS Developmental Disabilities/ Medicaid
Courts
Public Safety
Community Providers (EBPs)
Juvenile Probation
NDE
After School Programs
Youth Development
Managed Care Organizations
DHHS CFS
Dept. of Labor
WIOA
DHHS Childcare
Early Learning

Engagement Strategies

Child Welfare Practice Model Framework

Prevention

Workforce

Family Engagement

Core Values

Intake & Assessment (Safety First)

Teaming

Guiding Principles

Services to Children and Families

Well-Being

Strategic Priorities

Out of Home Placements

Permanency

Transitions for Older Youth

Finance Recommendations

RE-IMAGINED WELL-BEING

1. Safety
2. Community prevention
3. Reduced maltreatment & recidivism
4. Reduced family separation
5. Child & family well-being
6. Accessibility
7. Improved system experience
8. Community representation

LB 1173 INTERSECTORAL THEORY OF CHANGE

Mission

Engaging communities to support families so they thrive, & children are safe.

Vision

Every child in Nebraska has what they need to thrive in a safe, stable, & permanent home, sustained by nurturing relationships & strong family & community connections.

We will strengthen families in their communities by safely reducing the need for intervention & system involvement by aligning resources more effectively.

Measures of Success

- Rate of Children Entering Foster Care
- Average Length of Stay for Children in Foster Care
- # of Children Served by Community Response Pathway
- Percentage of Expenditures Tied to Source of Funds (Federal, State, Foundation, Private)
- Well-Being (% of Children Receiving Physical, Developmental & Mental Health Screenings within 30 Days of Entry into Care)
- Percentage of Children & Youth in Care Greater Than 24 Months
- Percentage of Children Adopted After Termination of Parental Rights
- Access to/Utilization of Behavioral Health & Substance Abuse Services (% of Medicaid-Enrolled Children in Care Receiving These Services)
- Racial Equity Indicators (Reduction in Disproportionality of BIPOC Families with Child Welfare System Involvement)