



**Nebraska’s Five-Year Title IV-E Prevention
Program Plan
2025- 2029
State Plan**



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ACRONYMS & TERMS

ACF	Administration for Children and Families
CARE	Connect-Achieve-Reflect-Empower
CEBC	California Evidence Based Clearinghouse
CFS	Division of Children and Family Services
CFSS	Child and Family Services Specialists
CIP	Court Improvement Project
CQI	Continuous Quality Improvement
CWLA	Child Welfare League of America
DBH	Division of Behavioral Health
DHHS	Department of Health and Human Services
DPH	Division of Public Health
EBP	Evidence-Based Program
FCT	Family Centered Treatment
FCTF	Family Centered Treatment Foundation
Federal Clearinghouse	Title IV-E Prevention Services Clearinghouse
FFPSA	Family First Prevention Services Act
FIS/MIS	Fatherhood Is Sacred/Motherhood Is Sacred
HFA	Healthy Families America
HomVEE	Home Visiting Evidence of Effectiveness
Hotline	Child Abuse and Neglect Hotline
HRSA	Health Resources and Services Administration
IA	Initial Assessment
ICWA	Indian Child Welfare Act
LIA	Local Implementing Agency
MI	Motivational Interviewing
MLTC	Division of Medicaid and Long-Term Care
NFPP	Nebraska Family First Prevention Advisory Committee
N-FOCUS	Nebraska Family Online Client User System
N-MIECHV	Nebraska-Maternal Infant Early Childhood Visiting Program
NWT	New Worker Training
OEA	Office of Economic Assistance
PAT	Parents As Teachers
Plan	Title IV-E Prevention Program Plan
POSC	Plans of Safe Care
PP	Prevention Plan
RRR	Restoring Resilience Response

SACWIS	State Automated Child Welfare Information System
SOP	Safety Organized Practice
SWI	Standard Work Instruction
TANF	Temporary Assistance for Needy Families

INTRODUCTION

The Nebraska Department of Health and Human Services' (DHHS) overarching mission is to "Help people live better lives." Since becoming an early adopter of the Family First Prevention Services Act (FFPSA) in October 2019, the vision of the Division of Children and Family Services (CFS) has become more robust in its effort to transform the well-being of Nebraska children and families and intends to build on the efficiency of already existing prevention infrastructures and expand prevention outside of child welfare.

In 2026, Nebraska joined the federal initiative, "A Home for Every Child", reinforcing the State's commitment to ensuring every child has a safe, stable and permanent home.

Nebraska will align its below priorities within "A Home for Every Child" with FFPSA:

- **Support at home first** – prevent unnecessary entry into foster care by strengthening prevention supports and services for families.
- **Relative/kin first placement when needed** - prioritize placement with relatives or kin to maintain family connections and stability.
- **Safe permanency, without delay** – reach safe, timely permanency for children when out of home care is necessary.

SERVICE DESCRIPTION AND OVERSIGHT

Since implementing the Family First Prevention Services Act (FFPSA) in 2019, Nebraska has continued to identify needs within child welfare to determine essential services, gaps in geographic locations, and populations that touch the child welfare system.

In 2025-2029, the FFPSA expansion and full-state implementation will continue. This includes adding evidence-based programs (EBPs) to underserved areas of the state, and expansion of the Kinship Navigator program. The Division of Children and Family Services (CFS) will implement and expand prevention services that will meet the needs of system involved and non-system involved families, that are representative of Nebraska's population. This will continue to be done in partnership with the collaborators, additional stakeholders as identified through the process, and with other initiatives in Nebraska, to build and expand capacity of prevention services within child welfare and communities.

Services

Nebraska provides and/or intends to provide the following services for a child and the caregiver(s) of the child, when it is directly related to the safety, permanency and/or well-being of the child to prevent their entry into foster care.

Mental Health, Substance Abuse Prevention and Treatment Services and In-Home Parent Skill Based Programs

- Familias Unidas
- Family Centered Treatment
- Motivational Interviewing

Mental Health and In-Home Parenting Skills Based Programs

- Family Check Up
- Fatherhood Is Sacred/Motherhood Is Sacred

In-Home Parenting Skills Based Programs

- Family Spirit
- Healthy Families America
- Parents As Teachers

Outcomes

Each EBP selected for Nebraska’s Plan has goals with the expectation of improved, specific outcomes for children and families (see below table). CFS believes that FFPSA, along with other current CFS and statewide initiatives focused on reducing entry into child welfare and foster care and improving outcomes for youth and families, will continue to be a catalyst for sustained positive impact for Nebraska children and families. Nebraska’s expectation is that each of the evidence-based practices proposed, when administered to model fidelity, regardless of the prevention pathway, will target the specific needs of the children and families being served and meet the individualized outcomes listed on the Federal Clearinghouse.

CFS will also collaborate with Tribes, service providers and the purveyor of the specific EBP to verify if the outcomes being reported, align with the intended outcomes of the program as indicated on the next page.

EBP and Rating	Goals	Outcomes
Familias Unidas: <i>Well-Supported</i>	<ol style="list-style-type: none"> 1. Empower parents by increasing their support network 2. Teach parents about protective and risk factors 3. Improve parenting skills 4. Enhance parent-adolescent communication 5. Facilitate parental involvement and investment in adolescent's lives 6. Prevent child maltreatment 	<ol style="list-style-type: none"> 1. Child behavioral and emotional functioning 2. Child substance use and sexual risk behaviors 3. Positive parenting practices 4. Positive family functioning
Family Centered Treatment: <i>Supported</i>	<ol style="list-style-type: none"> 1. Reduce maltreatment 2. Improve caretaking and coping skills 3. Enhance family resiliency 4. Develop healthy nurturing relationships 5. Increase children's well-being through family value changes 	<ol style="list-style-type: none"> 1. Family stability 2. Increased family functioning in the critical areas contributing to increased risk of family dissolution 3. Increased effective coping 4. Reduced harmful or hurtful behaviors 5. Reduction in delinquent behavior
Family Check Up: <i>Well-Supported</i>	<ol style="list-style-type: none"> 1. Improve parenting skills 2. Improve family management practices 3. Improve a range of emotional, behavioral and academic child outcomes 	<ol style="list-style-type: none"> 1. Child Well Being: behavioral and emotional functioning 2. Adult Well Being: positive parenting practice
Family Spirit (Tribal): <i>Promising</i>	<ol style="list-style-type: none"> 1. Promote positive behavioral and emotional outcomes among mothers and children. 2. Develop positive parenting practices, strengthen mother's coping skills 3. Learn how to avoid coercive parenting behaviors and substance use 	<ol style="list-style-type: none"> 1. Child wellbeing: behavioral and emotional functioning 2. Adult wellbeing: parent/caregiver mental or emotional health 3. Adult wellbeing: parent/caregiver substance use
Fatherhood Is Sacred/Motherhood Is Sacred (Tribal): <i>Does Not Currently Meet Criteria</i>	<ol style="list-style-type: none"> 1. Strengthen families through responsible parenting. 2. Connect with their Native American Heritage as they become actively involved in the lives of their families. 	<ol style="list-style-type: none"> 1. Adult Well Being: positive parenting practice 2. Positive family functioning
Healthy Families America-Child Welfare Protocol: <i>Well-Supported</i>	<ol style="list-style-type: none"> 1. Improve birth outcomes. 2. Cultivate and strengthen nurturing parent-child relationships. 3. Promote healthy childhood growth and development 4. Enhance family functioning by reducing risk and building protective factors 5. Prevent child maltreatment 	<ol style="list-style-type: none"> 1. Child development and school readiness 2. Child health 3. Family economic self-sufficiency 4. Linkages and referrals 5. Maternal health 6. Positive parenting practices 7. Reductions in child maltreatment 8. Reductions in juvenile delinquency, family violence and crime

<p>Motivational Interviewing: <i>Well-Supported</i></p>	<ol style="list-style-type: none"> 1. Promote and enhance internal behavior change 2. Reinforce motivation 3. Improve physiological, psychological and lifestyle outcomes 	<ol style="list-style-type: none"> 1. Adult Well Being: parent/caregiver substance use 2. Child safety 3. Strengthened behavioral changes to help client achieve their goals
<p>Parents As Teachers: <i>Well-Supported</i></p>	<ol style="list-style-type: none"> 1. Increase parent knowledge of early childhood development 2. Improve parenting practices 3. Promote early detection of developmental delays and health issues 4. Prevent child maltreatment 5. Increase school readiness and success 	<ol style="list-style-type: none"> 1. Child safety 2. Child Well Being: social functioning 3. Child Well Being: cognitive functions and abilities

To help bolster Nebraska’s plan to improve outcomes for youth and families, CFS continues to use Safety Organized Practice (SOP®), a collaborative practice approach that emphasizes the importance of teamwork in child welfare. SOP® aims to build and strengthen partnerships with the child welfare agency and within a family by involving their informal support networks of friends and family members. A central belief of SOP® is that all families have strengths.

The EBPs that Nebraska is choosing to expand and/or implement as part of the 2025 Plan along with SOP® all carry the tenants of ensuring for one’s safety and well-being. With the use of SOP® combined with an EBP, it is anticipated the work being done between CFS and the family will be through a trauma-informed practice, a shared focus to guide those involved in the case, enhancing one’s physical and mental safety, solution-focused outcomes, and collaboration.

Implementation of Evidence Based Programs

Nebraska currently provides and/or will implement the below EBPs to CFS involved families. These EBPs are provided by qualified providers and are not for more than a 12-month period, unless it is determined after 12-months, there is a continued need for the service or program. It is the intent of CFS to expand the provision of current and future EBPs not only within CFS, but to tribal children and families and children and families via community pathways, who are not involved with CFS, upon approval of this Plan.

Familias Unidas:

Familias Unidas is a family-centered intervention that addresses mental health, substance use, and in-home parenting skills amongst Hispanic youth ages 12-16 and their parent/caregiver. This program addresses substance use and risky sexual behavior of the adolescent and empowers parents by increasing their support network, education, communication enhancement, and parental involvement and skills. Familias Unidas is rated as well-supported on the Federal Clearinghouse.

Familias Unidas utilizes an eco-developmental model. To create better outcomes for adolescents, the program tries to strengthen the bonds between the different individuals and systems within the adolescent's life. Familias Unidas focuses on strengthening the caretaker's bond with the adolescent, the school, community, and the adolescent's peers. Familias Unidas supports parents in trying to navigate the differences.

Upon approval of Nebraska's Plan, CFS will post a Request for Information (RFI), to solicit interest in provision of Familias Unidas. Dependent on responses, it will then be determined if CFS will enter into a Contract with at least one interested party. Prioritization to location of delivery of the EBP will be dependent on the propensity of Hispanic communities involved with child welfare across Nebraska.

Book/Manual: Per the Federal Clearinghouse, the book/manual/available documentation for Familias Unidas is:

- Estrada, Y., Pantin, H. M., Prado, G., Tapia, M. I., & Velazquez, M. R. (2020). *UM-Familias Unidas Program: For the families of Hispanic adolescents: Intervention manual*. University of Miami.

Family Centered Treatment (FCT)

FCT is rated as a "supported" model of intensive treatment services for youth and families, using psychotherapy designed to reduce maltreatment, improve caretaking and coping skills, enhance family resiliency, develop healthy and nurturing relationships, and increase children's well-being through family value changes. FCT is designed to find simple, practical, and common-sense solutions for families faced with disruption or dissolution of their family. This can be due to external and/or internal stressors, circumstances, or forced removal of their children from the home due to the youth's delinquent behavior or parent's harmful behaviors.

Since implementation of FCT, successful outcomes have been demonstrated and Nebraska intends to expand-capacity to serve more families. The flexibility of the FCT model while adhering to fidelity and consistent outcomes makes FCT a great fit for Nebraska's frontier/rural areas where sustainability of programs has increased challenges.

In 2024, Nebraska expanded its availability of FCT to cover approximately 95% of its counties, by adding 4 additional FCT providers. Nebraska monitors the provider capacity consistently to determine the need for additional FCT providers. Additionally, Nebraska has a "prevention track" that is a voluntary continuum of FCT provision after the child welfare case is closed, so long as the initial "Joining Phase" of FCT is completed by the family.

Book/Manual: Per the Federal Clearinghouse, there are two manuals that provide overviews of the foundation and research support for the program, the program model, and guidance on the implementation and administration of FCT. They are:

- Painter WE, Smith MM. (2004). *Wheels of Change—Family Centered Specialists Handbook and Training Manual*. Richmond, VA: Institute for Family Centered Services.

- Wood TJ, (2014) Family Centered Treatment® Design and Implementation Guide. Revised 2018, Charlotte, NC: Family Centered Treatment Foundation Inc.

Family Check Up

Family Check Up is an In-Home Parent Skill-Based and Mental Health program. This well-supported model provides strengths-based intervention focusing on the improvement of parenting skills and family management practices for families who have children ages 2-18.

Nebraska currently provides Family Check Up across the state as a post-adoption/guardianship service; this also serves those whose adoption or guardianship arrangement is at risk of disruption or dissolution that could result in a foster care placement. In Nebraska, Family Check Up is part of a larger program through the Nebraska Children’s Home Society called Families Forever; this program is provided through age 21.

Book/Manual: Per the Federal Clearinghouse, the book/manual/available documentation for Family Check Up is:

- Dishion, T. J., Gill, A. M., Shaw, D. S., Risso-Weaver, J., Veltman, M., Wilson, M. N., Mauricio, A. M., & Stormshak, B. (2019). *Family check-up in early childhood: An intervention manual* (2nd ed.) [Unpublished intervention manual]. Child and Family Center, University of Oregon.

Healthy Families America (HFA)

The Federal Clearinghouse rated HFA as a well-supported EBP for FFPSA. Through collaboration with DPH, HFA continues to be provided in Nebraska. CFS utilizes the HFA Child Welfare Protocol, which expands the referral age of the child to 24 months old for those involved in a child welfare case. HFA continues to be provided through 13 LIAs across Nebraska. CFS will continue collaborating with DPH to leverage funding sources and to build the capacity of HFA through FFPSA.

Additionally, Nebraska continues to utilize a “prevention track” that is a voluntary continuum of HFA provision after the child welfare case is closed.

Book/Manual: Per the Federal Clearinghouse, HFA manuals are made available as a part of the training sessions. More information about training and access to manuals can be found through the HFA website. HFA utilizes a copyrighted product of “Prevent Child Abuse America” and is made available to HFA sites upon accreditation:

- Healthy Families America 8th Edition (2022) *Best Practice Standards*. Prevent Child Abuse America.

Parents as Teachers (PAT)

Per the Federal Clearinghouse, PAT is rated as a well-supported service. This home visiting model works with expectant and new parents on their skills to promote positive child development and prevent child maltreatment. The Federal Clearinghouse reports that PAT aims to increase parent knowledge of early childhood development, improve parenting practices, promote early

detection of developmental delays and health issues, prevent child abuse, and neglect, and increase school readiness and success. The target population for PAT are expectant and new parents, which can begin prenatally and up until the child reaches kindergarten.

There is a high need for in-home parenting services in Nebraska, as identified through the Needs Assessments. PAT is currently provided through Nebraska Children’s Home Society and Lutheran Family and is available state-wide.

Additionally, Nebraska has a “prevention track” that is a voluntary continuum of PAT provision after the child welfare case is closed.

Book/Manual: Depending on the ages of children in the families served, the *Foundational Curriculum* is available to support families prenatal to age 3 and the *Foundational 2 Curriculum* is available to support families with children age 3 through kindergarten. The manuals may be used separately, concurrently, or sequentially.

- Parents as Teachers National Center, Inc. (2016). *Foundational curriculum*.
- Parents as Teachers National Center, Inc. (2014). *Foundational 2 curriculum: 3 years through kindergarten*.

Motivational Interviewing (MI)

CFS will keep MI in its Plan, but utilize MI differently than what was approved in Nebraska’s 2019-2024 Plan. CFS intends to use MI as the linkage to Central Navigation and Coaching within the community collaboratives through its Community Prevention infrastructure, by having the Coaches utilize the MI tool when working with families.

Book/Manual: Per the Federal Clearinghouse, the book/manual/available documentation for Motivational Interviewing is:

- Miller, W. R., & Rollnick, S. (2012). *Motivational Interviewing: Helping people change* (3rd ed.). Guilford Press. This provides an overview of the foundations and research support for the program, the program model, and guidance on the administration of MI.

Implementation of Tribal Evidence Based Programs

CFS continues to work with the Tribes to identify the unique needs and strategies for leveraging prevention services. The Tribes have expressed the need for increased parenting support. Tribal CFS staff noted that access to culturally appropriate services is limited and that efforts should be made to include Native American practitioners in the conversations about FFPSA-supported evidence-based practices. Tribal CFS staff also shared that the “Motherhood and Fatherhood is Sacred” models of parenting classes are currently used, and they would be interested in utilizing other programs such as “Family Spirit”.

Other than Fatherhood Is Sacred/Motherhood Is Sacred and Family Spirit, all services and programs have been and/or will be made available to CFS involved families and tribal child welfare involved families, due to Tribal IV-Agreements being updated to expand CFS' service delivery to include tribal child welfare involved families. Upon approval of this Plan, all services will be available to tribal families, regardless of child welfare involvement.

Family Spirit:

A provider within the Winnebago Tribe advised CFS in 2024 they were looking at implementing home visiting programs and considering Family Spirit; they confirmed selection of Family Spirit in 2025 and requested assistance from DHHS to attend the required training for Family Spirit and become a Family Spirit Affiliate, as defined within the Federal Clearinghouse, where it is rated as promising. However, due to time constraints, the training was not completed. CFS will continue to engage with the provider to determine applicability of the Family Spirit program and plan implement. Should it be determined that Family Spirit will be implemented within the Tribe, CFS will request their final determination of the practice criteria that is adapted to the culture and context of their tribal community as it falls within the tribal flexibility parameters as described in ACF Program Instruction 24-10¹. Once received, CFS will submit an amendment to ACF with that information.

Book/Manual: Per the Federal Clearinghouse, Family Spirit utilizes the Family Spirit[®] Implementation Guide. This guide is implemented in combination with lesson plans. These lesson plans are:

- *Family Spirit Program: Implementation guide.* (2019). Johns Hopkins Center for American Indian Health.
- *Family Spirit Program: Lesson plans.* (2019). Johns Hopkins Center for American Indian Health.

Fatherhood Is Sacred/Motherhood Is Sacred (FIS/MIS)

FIS/MIS is a curriculum that was created and designed by the Native American Families Association for Native fathers and mothers wanting to improve family relationships, prepare them to become responsible parents, reduce recidivism and substance use and improve safety for Native children, by empowering and uplifting fathers and mothers. This program teaches core principles to help strengthen them as parents. Native people believe in the sanctity of many things; animals, mountains, burial grounds, etc., but the most sacred is the role as a father and the role as a mother. FIS/MIS is uniquely designed with culturally relevant material to teach parents the vital impact of being responsibly involved in each child's life. This curriculum is delivered over the course of 12 weeks, in person via group sessions for Native American fathers and mothers.

FIS/MIS is being added to the Plan as it has already been implemented in Nebraska by the Winnebago Tribe through the Preserving Native Families program and falls within the tribal

¹ <https://www.acf.hhs.gov/sites/default/files/documents/cb/pi-24-10.pdf>

flexibility parameters as described in ACF Program Instruction 24-10². It is also part of the CFS child welfare contracted Family Support services through the Native Futures program in western Nebraska.

The Winnebago Tribe receives referrals through court ordered parenting classes and/or voluntarily. They keep track of attendance, progress and provide recommendations to the Court when required. Native Futures provides FIS/MIS within family support services, when requested by CFS staff on Indian Child Welfare Act (ICWA) cases in the Western Service Area, with the intent of moving eastward with the program. ACF is currently seeking clarification of allowability on ICWA cases under the guidance provided regarding Tribal programs and practices within PI 24-10. CFS has identified the target population for this service to be Tribal child welfare involved families and CFS families with tribal enrollment and/or “reason to know” under the Indian Child Welfare Act federal law.

Book/Manual: Per the Federal Clearinghouse, FIS/MIS does not meet criteria as an EBP. Due to the tribal flexibility allowed through ACF Program Instruction 24-10, and its current availability in Nebraska, FIS/MIS is being added to the subsequent Plan. The book/manual/available documentation for FIS/MIS is:

- Pooley, A. M. (2022). *Fatherhood Is Sacred® and Motherhood Is Sacred® manual*. Native American Fatherhood & Families Association. Pooley, A. M. (2020). *Fatherhood Is Sacred® and Motherhood Is Sacred® for Youth manual*. Native American Fatherhood & Families Association.

Continous Monitoring of Fidelity and Outcome Determination

The Nebraska CFS Continuous Quality Improvement (CQI) team is responsible for CQI and fidelity monitoring of programs and services provided. Regularly scheduled meetings occur between CFS, internal partners, the provider(s) and the model purveyor when applicable. The purpose of these meetings is to review CQI and fidelity of the programs.

To adhere with model fidelity standards, Nebraska expects the outcomes of each proposed program to align with the outcomes identified by the model purveyor and by the Federal Clearinghouse with the intended goal to improve the livelihood of the children and families served within Nebraska, and to prevent entry into the child welfare system and/or the foster care system.

To monitor fidelity of implementation, CFS has verified the fidelity monitoring instruments as developed by each of the model purveyors. This involved CFS verifying with each purveyor, what the individual fidelity requirements are to implement the program, such as education, certification, training, and identification of the workbook/manual used. Prior to entering into a

² <https://www.acf.hhs.gov/sites/default/files/documents/cb/pi-24-10.pdf>

contract, CFS verifies with the model purveyor and contracted provider if they meet these requirements or are in process of meeting them.

Initial and ongoing fidelity with the model is contingent upon the agency having an initial and ongoing certification process, as required by the purveyor. If the provider is not able to meet these requirements, they will be unable to provide the program as an FFPSA service. Further fidelity monitoring instruments will be utilized by accessing data reports generated by CFS and by information obtained by Contract Monitoring Staff who assess contracted agency performance to ensure compliance with contractual language. This assessment is obtained through file reviews and reported on a central data site kept by CFS.

Additional strategies to assess for quality improvement include regular staffings with CFS to review referrals made by CFS to identify barriers in service provision, tracking referrals received, tracking families declining to receive the service and the reason for the service being declined, track families being served, and monitor consumer satisfaction and measure outcomes. This information is provided to CFS along with dates of service and outcomes of service, issues identified as the reason for the family involvement in the service, outcomes for families at end of service provision, average number of hours of service provision per family, and identification of services needed and not available and/or accessible to the child and/or family and the reasons why, such as gaps in services in the community. With the proposed addition of pathways outside of direct CFS involvement, the same staffings will occur due to the service being provided by a CFS contracted provider and the need to gather the aforementioned information.

The Nebraska CFS CQI & Fidelity process will draw upon internal teams, contracted providers, and model purveyors to report and review information documented into the updated referral module following the completion of a service authorization. Regardless of Pathway, the contracted providers will adhere to the reporting requirements of the evidence-based program they are providing and provide that information to CFS. Specific to the CFS internal system, the provider will be sent a "Post Authorization Questionnaire". The responses will be stored internally for CQI and Fidelity monitoring purposes. The below questions will be in the questionnaire:

- a. Practitioner/Service Provider Credentials – What is the highest level of education completed? If there was a change in practitioner/service provider during the course of services, please provide the credentials of the provider who served the child/family most frequently.
 - i. High School
 - ii. Bachelors
 - iii. Masters
 - iv. Doctorate
- b. How engaged was the client in their service?
 - i. Client never engaged in services
 - ii. Client engaged initially, but completed less than a quarter (25%) of expected services

- iii. Client completed about half (50%) of expected services
- iv. Client completed more than half of expected services, but did not fully complete service plan
- v. Client fully completed service plan

CFS has refined its referral platform to include a logic for communicating referrals created by CFS and CFS tribal staff and future referrals outside of child welfare, to providers based on geography and the ability to provide needed services; this will provide the ability for CFS to analyze gaps in services through a questionnaire sent to the CFS contracted provider upon their declination of a referral. The below response options reflect what will be asked of the provider:

1. Decline Request:
 - a. Child outside of target age range
 - b. Family needs were beyond the scope of our services
 - c. Family needs do not match the clinical eligibility criteria for the services
 - d. Family is already participating in the service
 - e. Family lives outside of our service area
 - f. Child does not live at home
 - g. Other (if this is selected, a text box is provided for the Provider to add additional information)
2. Unable to Fulfill Request
 - a. Waitlist
 - b. Limited capacity to serve
3. Other (if this is selected, a text box is provided for the Provider to add additional information)

To ensure that contracted providers are qualified to provide one of Nebraska's FFPSA services, CFS will ensure the provision of services adhere to the standards of being a promising, supported, or well-supported service.

Nebraska's CQI team provides quantitative analysis, qualitative reviews, and clear and concise feedback directly to program and staff statewide via established communication methods.

Assessing child and family outcomes is a critical component of the CQI process and is an area CFS will approach from multiple ways. Nebraska has modified the State Automated Child Welfare Information System (SACWIS) to include a PP, with begin and end dates, which enables CFS and CFS Tribal staff to specifically identify all families that meet the candidacy definition criteria as well as eligibility types, both prevention candidacy as well as pregnant and parenting. Accordingly, state and Tribal CFS has the ability to accurately identify all candidates for FFPSA services in its Nebraska Family Online Client User System (N-FOCUS).

Updates to SACWIS, the PP and the Tribal Title IV-E agreements allow for CFS to provide oversight and monitoring for both tribal and non-tribal children. CFS Tribal staff follow the same process of documenting a PP, which CFS can access. Modifications to the Title IV-E Tribal Agreements makes

the process of a Tribe referring to an EBP easier, by submitting the referral through the same referral platform as non tribal staff.

Upon approval of the proposed Pathways, the above CQI and fidelity monitorings processes will be utilized for FFPSA providers who are providing the EBP outside of child welfare. Additionally, the Warmline infrastructure will have continuous monitoring with a real-time dashboard to support ongoing quality improvement. This will include the following:

- Track follow up to confirm service connection via a closed loop referral system.
- Track families access to services and assess barriers if they did not.
- Ongoing performance monitoring, which includes:
 - o Call volumes
 - o Service categories
 - o Demographic tracking
 - o Referral rates and outcomes
 - o Child maltreatment rates and volume of CFS screened out calls diverted to the Warmline

Caller satisfaction through post call surveys.

Familias Unidas

Familias Unidas has not yet been implemented in Nebraska. A plan will be in place with the model purveyor and provider(s) regarding CQI and fidelity meetings, and cadence of the meetings.

When this EBP is implemented in Nebraska, it will be required that the provider adhere to the fidelity standards, such as conducting video recordings of family sessions for the model purveyor to observe that all content is covered by the facilitator, session completion, and how well the session was; the purveyor also reviews how well the facilitator engages the family. The fidelity adherence measures are recorded on a form the purveyor developed “in house.”

Family Centered Treatment

CQI and fidelity monitoring of FCT is conducted through the FCT Foundation (FCTF). Each FCT provider submits a monthly report to FCTF and CFS that reflects fidelity and model adherence. The providers input information into the FCTF Qualtrics data collection system that contains a live dashboard that can show CFS its FCT cases and outcomes in real time.

Family Check Up

CQI and fidelity monitoring for Family Check Up is conducted through an annual satisfaction survey provided to families by the contracted provider to monitor ongoing progress through the duration of the child’s adoption up to age 19 and measure outcomes. CFS meets with the provider each month to review outcome measures. These measures include:

- Track referrals received from phone inquiries.
- Track families declining to receive services and the reason for the service being declined.
- Track families being served.

According to the California Evidence Based Clearinghouse (CEBC³), the COACH fidelity tool is used to measure fidelity:

- Conceptually accurate in the model.
- Observant and responsive to family's context and needs.
- Active in structuring sessions to optimize effectiveness.
- Careful when teaching and providing corrective feedback.
- Hope and motivation.
- Client engagement.

Healthy Families America

CQI and fidelity monitoring of HFA is conducted through Nebraska MIECHV CQI. For HFA, CFS will meet the continuous monitoring requirements in partnership with the N-MIECHV Program. Based on the federal MIECHV Needs Assessment, N-MIECHV has strategically invested in planning, supporting professional development, and implementing HFA in Nebraska. This includes plans for CQI. The N-MIECHV CQI Plan is updated every year and approved by the Health Resources and Services Administration (HRSA). CFS will continue to partner with N-MIECHV to utilize the existing CQI structure for HFA and will tailor the process to meet the additional data analysis requirements of FFPSA.

CQI is an integral component of the N-MIECHV program. Local HFA sites are expected to participate in both state and program level CQI. The N-MIECHV Program Manager guides the sites through program level CQI. State level CQI is directly related to the federal performance measures; the N-MIECHV Team helps to guide local sites through this process with a community of practice approach. These levels of CQI include annual monitoring via fiscal desk reviews/audits and on-site programmatic monitoring; these two levels of CQI alternate each year.

Fiscal reviews/audits include source documents for a specified quarter that allows N-MIECHV to re-create their invoices. Questions are asked along the way and may include a meeting with the LIA fiscal team. Proper steps are taken to remedy anything identified as incorrect. On-site programmatic monitoring includes staff interviews, observation of a community partner meeting, observation of a reflective supervision session or a home visit, and a random file review.

To determine if desired outcomes are achieved for HFA, CFS will utilize the benchmark plan developed by N-MIECHV⁴. The federal MIECHV program requires that Nebraska data reflect positive change in a minimum of 4 out of the 6 benchmarks⁵ every 3 years as a determinant of funding.

Local HFA sites use a case management system to manage caseloads and track individual progress. The case management systems are the source of demographic and benchmark data

³ <https://www.cebc4cw.org/program/family-check-up/>

⁴ <https://dhhs.ne.gov/MCAH/NE%20Benchmark%20Plan%20Update%202019.pdf>

⁵ <https://dhhs.ne.gov/Pages/Data-and-Benchmarks.aspx>

that N-MIECHV collects and reports on families served. For FFPSA, the local HFA sites added an indicator to track referrals for FFPSA eligible candidates. Program Managers/Supervisors are responsible for monitoring accuracy and timeliness of the data entered by the home visitors; it is analyzed and reviewed by N-MIECHV staff, then reported back to the programs, HRSA, and the Nebraska State Legislature.

All sites use an approved case management system. N-MIECHV maintains a contract with the University of Kansas Centers for Public Partnerships and Research to provide data management, integration, analysis, and report functions in support of benchmark data collection and reporting through a software program specifically designed for the federal MIECHV program, called Data Application and Integration Solutions for the Early Years.

Motivational Interviewing

According to the Federal Clearinghouse and model purveyor, there is not a standard instrument, set of fidelity standards and outcome measures for MI. Those trained in MI are available to provide guidance to the contracted organizations in determining what instrument to use, fidelity standards and outcome measures.

Parents As Teachers

CQI and fidelity monitoring of PAT is conducted through a review of an annual Affiliate Performance Report that is stored on a PAT National approved database; this report is tied to the metrics that PAT requires for fidelity. PAT providers are required to meet specific CQI measures known as the “21 Essential Requirements.” Additionally, the PAT affiliate collects family feedback at least annually to understand the family’s experience with PAT. CFS meet with contracted PAT affiliates monthly to review and analyze this information as part of the CQI and fidelity review.

Tribal Continuous Monitoring of Fidelity and Outcome Determination

Family Spirit

Per PI 24-10, the tribe with an agreement with the Title IV-E state agency is not subject to the continuous quality improvement requirements of FFPSA.

Fatherhood Is Sacred/Motherhood Is Sacred

Per PI 24-10, the tribe with an agreement with the Title IV-E state agency is not subject to the continuous quality improvement requirements of FFPSA.

Refining and Improving Practices

CFS will continue to participate and/or set up scheduled CQI discussions with individual providers and model purveyors to support ongoing refining, improvement of practice and alignment with FFPSA and to determine if the EBP is reaching its target population and intended outcomes. This

monitoring of internal performance, and agency performance, will enhance and improve the outcomes experienced by the children and families receiving the FFPSA array of services.

Program Selection

Based on existing funding streams through Medicaid and Behavioral Health, Nebraska will no longer utilize “clinical only” programs at this time within its FFPSA prevention service array, but will continue to retain the following programs from its 2019 Plan through FFPSA for federal reimbursement:

- Family Centered Treatment (FCT)
- Healthy Families America (HFA)
- Parents As Teachers (PAT)
- Motivational Interviewing (MI)

Additional EBPs will be added to Nebraska’s 2025 Plan, that will seek federal reimbursement:

- Familias Unidas
- Family Check Up
- Family Spirit
- Fatherhood Is Sacred/Motherhood is Sacred

Program selection for this Plan has been a continuous process using data evaluation, process mapping, programmatic research, provider and staff surveys, focus groups, and a formal Gaps/Needs Analysis conducted by Chapin Hall between 2021-2023. The Gaps/Needs Analysis identified several areas within the State that indicated a need for home visiting programs, including those that address gaps in culturally specific services for Hispanic and Native American families.

To help inform the expansion of prevention and needed services, the Community Collaborative communities are required to complete a needs assessment, commonly known as Service Array, and develop a community plan through the Community Collaboratives. The Service Array is shared and used by the entire community collaborative to prioritize the use of braided funds to address gaps in prevention services across the area. The community then explores potential EBPs and practices that may result in improved outcomes for children, young people, and families. Community Plans must describe both needs and strengths in the community and how funding will be used to address identified needs.

A complex interplay of risk factors, including those associated with the parent or caregiver (e.g., depression, substance use, mental health issues), as well as contextual factors (e.g., social isolation, poverty, violence), may contribute to child abuse and neglect. Risk factors for victimization include child age and special needs (e.g., developmental and intellectual disabilities) that may increase caregiver burden. Additionally, socioeconomic factors, social determinants of health, housing access, and community-based support also contribute to a family potentially needing more support.

A key factor in the prevention of maltreatment is to identify community-based needs and geographic gaps to build capacity for prevention efforts in communities. CFS reviews the data trends around maltreatment to identify those at higher risk and opportunities to provide support earlier and before maltreatment or system entry is necessary. Factors that protect or buffer children from maltreatment are known as Protective Factors. Over the next five years, Nebraska will continue to focus on enhancing child and family Protective Factors to prevent maltreatment in partnership with communities. Research indicates that the cumulative burden of multiple risk factors is associated with the probability of poor outcomes, including developmental compromises and child abuse and neglect, while the cumulative buffer of multiple Protective Factors is associated with the probability of positive outcomes in children, families, and communities.

The *Bring Up Nebraska* community collaboratives target pre- and post-assessments with families on the Protective Factors scale. Additionally, many of the implemented and planned FFPSA EBPs focus on building protective capacity and early needs identification with families. Partnerships with sister DHHS divisions of DPH, DBH, and MLTC have provided opportunities to partner and blend funding to address gaps and programming that could not only increase protective factors but also focus on community-based prevention to intervene prior to maltreatment occurring. CFS also partners with families, youth and communities working through grassroots organizations close to the needs of their individual communities.

See Attachments Section, *Attachment III: State Assurance of Trauma-Informed Delivery* for Nebraska's assurance that each of the EBP services in the Plan meets the requirements of FFPSA related to trauma informed service-delivery.

Target Population

CFS has defined three pathways in which a child/family may receive one of the Plan's FFPSA services. These pathways are defined as:

Community Pathway:

In February 2026, the Nebraska Legislature passed LB668⁶, which will add language to Neb. Rev. Stat. 68-1212⁷. This added language provides a definition of a case going through the community pathway, This will go into effect in July 2026.

The Community Pathway s is a voluntary pathway for children and families who have an intake that doesn't meet the statutory definition of child abuse and/or neglect⁸ and/or has not touched the system but may be at imminent risk of maltreatment that could result in system entry.

⁶ <https://nebraskalegislature.gov/FloorDocs/109/PDF/Slip/LB668.pdf>

⁷ <https://nebraskalegislature.gov/laws/statutes.php?statute=68-1212>

⁸ <https://nebraskalegislature.gov/laws/statutes.php?statute=28-710>

Secondary Prevention Pathway:

Children/families with an accepted intake and/or an ongoing case and are at risk for formal out-of-home care that without at least one of the Title IV-E prevention services, could lead to formal out-of-home care.

Tertiary Prevention Pathway:

Children/families that have already been impacted by child maltreatment but have exited the child welfare system and continue to receive an FFPSA service without CPS involvement.

The intended pathway and target population is provided below, specific to each EBP within this Plan.

Familias Unidas Proposed Pathway with Target Population

Familias Unidas: addresses mental health, substance use, and in-home parenting skills amongst Hispanic youth ages 12-16 and their parent/caregiver.

Community Pathway-Hispanic families with a Candidate for Foster Care:

- A family referred to Familias Unidas after a call to the Warmline.
- A child residing in their home or informally with kin caregivers with support of approved Title IV-E prevention services to prevent the child's entry into child welfare and/or foster care.
- A child whose adoption or guardianship arrangement is at risk of a disruption or dissolution that would result in foster care placement.
- Youth who has had a touch point with Juvenile Justice (ex. diversion) and/or is under court-ordered supervision by Juvenile Probation and is living in the parental/caregiver home.

Secondary Prevention Pathway-Hispanic families with a Candidate for Foster Care

- A family with an Initial Assessment (IA) determined as Safe and can close and is referred to community resources. This includes both Traditional Response and Alternative Response involvement.
- Child(ren) assessed as unsafe and can remain in the home with an in-home safety plan.
- Child involved in an open child welfare court case and placed in home.
- Child who has reunified with their caregiver following a formal out-of-home placement.
- A child in an informal living arrangement with support of approved Title IV-E prevention services that is necessary to prevent the child's entry into foster care.
- Youth who has had a touch point with Juvenile Justice (ex. diversion) and/or is under court-ordered supervision by Juvenile Probation and is living in the parental/caregiver home.

Tertiary Prevention Pathway-Hispanic families with a Candidate for Foster Care

- Child/family who voluntarily continue to participate in Familias Unidas upon their CPS case closing.
- A child whose adoption or guardianship arrangement is at risk of a disruption or dissolution that would result in foster care placement. Youth who has had a touch point with Juvenile Justice (ex. diversion) and/or is under court-ordered supervision by Juvenile Probation and is living in the parental/caregiver home.

Family Centered Treatment Proposed Pathway with Target Population

Family Centered Treatment: families with youth who are at-risk for out of home placements, have trauma exposure, have histories of delinquent behavior or are working toward reunification. CFS also provides FCT to families who exit the child welfare system, but choose to voluntarily continue to participate in FCT, after they have successfully completed the first phase of FCT.

Community Pathway-Candidate for Foster Care

- A family referred to FCT after a call to the Warmline.
- A child residing in their home or informally with kin caregivers with support of approved Title IV-E prevention services to prevent the child's entry into child welfare
- Youth who has had a touch point with Juvenile Justice (ex. diversion) and/or is under court-ordered supervision by Juvenile Probation and is living in the parental/caregiver home.

Secondary Prevention Pathway-Candidate for Foster Care

- A family with an Initial Assessment (IA) determined as Safe and can close and is referred to community resources. This includes both Traditional Response and Alternative Response involvement.
- Child(ren) assessed as unsafe and can remain in the home with an in-home safety plan.
- Caregiver determined to have at least one diminished protective capacity.
- Child involved in an open child welfare court case and placed in home.
- Child who has reunified with their caregiver following a formal out-of-home placement.
- A child in an informal living arrangement with support of approved Title IV-E prevention services that is necessary to prevent the child's entry into foster care.
- Youth who has had a touch point with Juvenile Justice (ex. diversion) and/or is under court-ordered supervision by Juvenile Probation and is living in the parental/caregiver home.

Tertiary Prevention Pathway-Candidate for Foster Care

- Child/family who voluntarily continue to participate in FCT upon their CPS case closing.
- A child whose adoption or guardianship arrangement is at risk of a disruption or dissolution that would result in foster care placement.

- Youth who has had a touch point with Juvenile Justice (ex. diversion) and/or is under court-ordered supervision by Juvenile Probation and is living in the parental/caregiver home.

Family Check Up Proposed Pathway with Target Population

Family Check Up: families with children ages 2-18. In Nebraska it is for those families with children whose adoption or guardianship arrangement is at risk of disruption or dissolution that could result in a foster care placement.

Community and Tertiary Prevention Pathways-Candidate for Foster Care

- A child whose adoption or guardianship arrangement is at risk of a disruption or dissolution that would result in foster care placement.

Healthy Families America Proposed Pathway with Target Population

Healthy Families America (HFA): CFS utilizes the HFA Child Welfare Protocol, which expands the referral age of the child prenatal up to 24 months old for those involved in a child welfare case. CFS also provides HFA to families who exit the child welfare system, but choose to voluntarily continue to participate in HFA.

Community Pathway-Candidate for Foster Care

- A family referred to HFA after a call to the Warmline.
- A child residing in their home or informally with kin caregivers with support of approved Title IV-E prevention services to prevent the child's entry into child welfare and/or foster care.
- A family engaged in a Prenatal Plan of Safe Care.

Secondary Prevention Pathway- Candidate for Foster Care and/or Pregnant/Parenting Foster Youth

- A family with an Initial Assessment (IA) determined as Safe and can close and is referred to community resources. This includes both Traditional Response and Alternative Response involvement.
- Child(ren) assessed as unsafe and can remain in the home with an in-home safety plan.
- Child involved in an open child welfare court case and placed in home.
- Child who has reunified with their caregiver following a formal out-of-home placement.
- A child in an informal living arrangement with support of approved Title IV-E prevention services that is necessary to prevent the child's entry into foster care.
- An infant living in the parental/caregiver home, and caregiver with a screened in intake, who has a Plan of Safe Care.

Tertiary Prevention Pathway-Candidate for Foster Care and/or Pregnant/Parenting Foster Youth

- Child/family who voluntarily continue to participate in HFA upon their CPS case closing.

- A young adult who is pregnant and/or parenting, age 19-21, in the Bridge to Independence Program⁹ (extended foster care).

Motivational Interviewing Proposed Pathway with Target Population

Motivational Interviewing: used within a range of target populations and for a variety of problem areas; it works to promote behavioral change and improve overall well-being.

Community Pathway - Candidate for Foster Care

- A family referred to Central Navigation and Coaching within the Community Collaboratives, after a call to the Warmline.

Tertiary Prevention Pathway-Candidate for Foster Care

- A family referred to Central Navigation and Coaching within the Community Collaboratives, upon their CPS case closing.

Parents As Teachers Proposed Pathway with Target Population

Parents As Teachers: expectant and new parents, which can be prenatally and up until the child reaches kindergarten. CFS also provides PAT to families who exit the child welfare system, but choose to voluntarily continue to participate in PAT.

Community Pathway-Candidate for Foster Care

- A family referred to HFA after a call to the Warmline.
- A child residing in their home or informally with kin caregivers with support of approved Title IV-E prevention services to prevent the child's entry into child welfare and/or foster care.
- A family engaged in a Prenatal Plan of Safe Care.

Secondary Prevention Pathway- Candidate for Foster Care and/or Pregnant/Parenting Foster Youth

- A family with an Initial Assessment (IA) determined as Safe and can close and is referred to community resources. This includes both Traditional Response and Alternative Response involvement.
- Child(ren) assessed as unsafe and can remain in the home with an in-home safety plan.
- Child involved in an open child welfare court case and placed in home.
- Child who has reunified with their caregiver following a formal out-of-home placement.
- A child in an informal living arrangement with support of approved Title IV-E prevention services that is necessary to prevent the child's entry into foster care.
- An infant living in the parental/caregiver home, and caregiver with a screened in intake, who has a Plan of Safe Care.

⁹ <https://nebraskalegislature.gov/laws/statutes.php?statute=43-1311.03>

Tertiary Prevention Pathway-Candidate for Foster Care and/or Pregnant/Parenting Foster Youth

- Child/family who voluntarily continue to participate in HFA upon their CPS case closing.
- A young adult who is pregnant and/or parenting, age 19-21, in the Bridge to Independence Program¹⁰ (extended foster care).

Target Population and Prevention Pathway for Tribal Programs

To ensure tribal flexibility parameters as described in ACF Program Instruction 24-10, a provider with the Tribe must be the one to provide the EBP to the eligible child or parent/caregiver on behalf of the child when it is determined the child or parent/caregiver is enrolled in a Tribe, part of a Tribal Child Welfare case and/or when there is “reason to know” or confirmed Tribal eligibility within a CFS ICWA case.

Family Spirit: Proposed Pathway with Target Population

Family Spirit: for American Indian mothers ages 14-24 who enroll during the second trimester of pregnancy; additional family members can participate in the program with the mother.

Community Pathway-Candidate for Foster Care with Tribal Enrollment and EBP provided by the Tribe

- A family referred to Family Spirit after a call to the Warmline.
- A child residing in their home or informally with kin caregivers with support of approved Title IV-E prevention services provided by the Tribe to prevent the child's entry into child welfare
- A family engaged in a Prenatal Plan of Safe Care.

Secondary Prevention Pathway-Candidate for Foster Care and/or Pregnant/Parenting Foster Youth with Tribal Enrollment or at minimum “Reason to Know” through ICWA

- A family with an Initial Assessment (IA) determined as Safe and can close and is referred to Family Spirit provided by the Tribe. This includes both Traditional Response and Alternative Response involvement.
- Child(ren) assessed as unsafe and can remain in the home with an in-home safety plan.
- Child involved in an open Tribal child welfare court case and/or ICWA case and placed in home.
- Child who has reunified with their caregiver following a formal out-of-home placement.
- A child in an informal living arrangement with support of approved Tribal provided Title IV-E prevention services that is necessary to prevent the child's entry into foster care.

¹⁰ <https://nebraskalegislature.gov/laws/statutes.php?statute=43-1311.03>

Tertiary Prevention Pathway-Candidate for Foster Care with Tribal Enrollment

- Tribal child/family or ICWA determine child/family who voluntarily continue to participate in Family Spirit upon their CPS case closing.
- A young adult who is pregnant and/or parenting, age 19-21, in the Bridge to Independence Program¹¹ (extended foster care).

Fatherhood Is Sacred/Motherhood Is Sacred Proposed Pathway with Target Population

Fatherhood Is Sacred/Motherhood Is Sacred (FIS/MIS): for Native fathers and mothers wanting to improve family relationships, prepare them to become responsible parents, reduce recidivism and substance use and improve safety for Native children, by empowering and uplifting fathers and mothers.

Community Pathway-Candidate for Foster Care with Tribal Enrollment and EBP provided by the Tribe

- A family referred to Fatherhood Is Sacred/Motherhood Is Sacred after a call to the Warmline.
- A child residing in their home or informally with kin caregivers with support of approved Title IV-E prevention services provided by the Tribe to prevent the child's entry into child welfare
- A family engaged in a Prenatal Plan of Safe Care.
- A child whose adoption or guardianship arrangement is at risk of a disruption or dissolution that would result in foster care placement.
- Youth who has had a touch point with Juvenile Justice (ex. diversion) and/or is under court-ordered supervision by Juvenile Probation and is living in the parental/caregiver home.

Secondary Prevention Pathway-Candidate for Foster Care and/or Pregnant/Parenting Foster Youth with Tribal Enrollment or "Reason to Know" through ICWA

- A family with an Initial Assessment (IA) determined as Safe and can close and is referred to Fatherhood Is Sacred/Motherhood Is Sacred provided by the Tribe. This includes both Traditional Response and Alternative Response involvement.
- Child(ren) assessed as unsafe and can remain in the home with an in-home safety plan.
- Child involved in an open Tribal child welfare court case and/or at minimum "Reason to Know" ICWA case and placed in home.
- Child who has reunified with their caregiver following a formal out-of-home placement.
- A child in an informal living arrangement with support of approved Tribal provided Title IV-E prevention services that is necessary to prevent the child's entry into foster care.
- An infant living in the parental/caregiver home, and caregiver with a screened in intake, who has a Plan of Safe Care.

¹¹ <https://nebraskalegislature.gov/laws/statutes.php?statute=43-1311.03>

- Youth who has had a touch point with Juvenile Justice (ex. diversion) and/or is under court-ordered supervision by Juvenile Probation and is living in the parental/caregiver home.

Tertiary Prevention Pathway-Candidate for Foster Care with Tribal Enrollment

- Tribal child/family or ICWA determine child/family who voluntarily continue to participate in Fatherhood Is Sacred/Motherhood Is Sacred upon their CPS case closing.
- A young adult who is pregnant and/or parenting, age 19-21, in the Bridge to Independence Program¹² (extended foster care).
- A child whose adoption or guardianship arrangement is at risk of a disruption or dissolution that would result in foster care placement.
- Youth who has had a touch point with Juvenile Justice (ex. diversion) and/or is under court-ordered supervision by Juvenile Probation and is living in the parental/caregiver home.

How Programs Will Be Evaluated

CFS entered into an Evaluation Contract with the University of Nebraska Public Policy Center (UNL-PPC) in 2025 as detailed in the *Evaluation Strategy and Waiver Request* section of this Plan. One of the deliverables is to create and provide an evaluation tool that complies with FFPSA to support continued evaluation of programs by CFS, upon expiration of the Contract. This tool will include a guide to effective and optimal evaluation and evaluation planning. It will provide detail regarding evaluation design and plan as well as the implementation and applied use. The tool will be comprehensive of both process and outcome evaluation, highlighting actionable use of the evaluation results in program planning and improvement. The tool will be produced as a document and will be inclusive of all measures and forms. UNL-PPC will provide CFS with a narrated slide deck that will provide an overview of the tool and training on its use, which will also be used to train additional CFS staff for future use.

This is to be completed no later than December 31, 2027 and will be provided to ACF upon receipt, for review and approval.

EVALUATION STRATEGY AND WAIVER REQUEST

FCT will be evaluated through a well-designed and rigorous process, by UNL-PPC as detailed in *Attachment D: Family Centered Treatment Evaluation Plan*.

Consistent with federal legislation and subsequent HHS guidance, CFS is requesting a waiver for the following programs rated well-supported on the Title IV-E Prevention Services Clearinghouse (Federal Clearinghouse) and will follow established procedures to monitor, compile, assess, and

¹² <https://nebraskalegislature.gov/laws/statutes.php?statute=43-1311.03>

report fidelity and outcomes data as part of the ongoing effort to monitor the effectiveness of selected interventions. Refer to *Attachment II*, with the formal waiver requests.

- Familias Unidas
- Family Check Up
- Healthy Families America
- Motivational Interviewing
- Parents As Teachers

Evaluation of Tribal Programs

According to PI 24-10, the tribe under an agreement with the Title IV-E state agency is not subject to the evaluation requirements, nor is required to submit a request for an evaluation waiver, therefore an evaluation strategy and evaluation waivers will not be submitted for Fatherhood Is Sacred/Motherhood Is Sacred and Family Spirit.

Evidence of Effectiveness of Programs

Familias Unidas

The Federal Clearinghouse provides several studies that have been identified and reviewed for Familias Unidas.

Outcomes indicated that Familias Unidas reduces internalizing symptoms and helps improve internalizing symptoms by increasing family functioning. The increase in family functioning was found to attribute to the reduction in substance use, and unsafe sexual behaviors.

Within these studies, findings indicated favorable outcomes within child behavioral and emotional functioning, child substance use and sexual risk behaviors, positive parenting practices, and positive family functioning. Additional findings indicated a favorable outcome within child safety, child well-being: social functioning, and child well-being: cognitive functions and abilities.

Family Check Up

According to the Federal Clearinghouse, Family Check Up has shown areas of effectiveness in child well-being in the areas of: behavioral and emotional functioning, cognitive functions and abilities, and educational achievement and attainment. It also shows areas of effectiveness in adult well-being in the areas of: parent/caregiver mental or emotional health and positive parenting.

Per the review of Family Check Up by the Home Visiting Evidence of Effectiveness (HomVee), last updated in 2021, Family Check Up meets the criteria set forth by U.S. DHHS. Family Check Up was found to have favorable results in studies rated high or moderate in the following areas: child development and school readiness, maternal health, and positive parenting practices. Studies

have been conducted to prove the efficacy of Family Check Up. Studies and their outcomes can be found through the HomVEE site.

According to the Family Check Up site¹³, published research¹⁴ has shown that the program:

- Increases use of positive parenting
- Strengthens parent-child relationships
- Reduces family conflict
- Reduces child depression and anxiety
- Reduces parent depression
- Improves school readiness
- Reduces child problem behaviors
- Improves child emotional regulation
- Improves academic achievement
- Improves school attendance
- Decreases child and adolescent substance use through the young adult years

Healthy Families America

HomVEE¹⁵, a program administered by the United States Department of Health and Human Services (DHHS) The Administration for Children and Families (ACF), reviews the effectiveness for specific home-visiting models. Per this review of HFA, HFA meets the criteria set forth by U.S. DHHS. HFA was found to have favorable results in studies rated high or moderate in the following areas: child development and school readiness, child health, family economic self-sufficiency, linkages and referrals, maternal health, positive parenting practices, reductions in child maltreatment, and reductions in juvenile delinquency, family violence, and crime.

Over the past several years, HFA developed an optional child welfare protocol, which maintains the expected rigor and fidelity requirements providers have expected from HFA for almost 30 years. HFA sites that have received national office approval to utilize this adaptation are able to extend enrollment for families with a child up to 24 months of age referred by the child welfare system. All of the Nebraska sites implementing the HFA child welfare protocol have received national office approval.

HFA's best practice standard is to strive for serving at least 80% of families beginning prenatally or while in the newborn period because doing so optimizes the ability to achieve greater maternal and child health outcomes; but there is flexibility, so this standard is not absolute.

HFA's best practice standard requires home visiting services are offered for a minimum of three years and through age five, allowing children enrolled up to 24 months of age the full length of service.

¹³ <https://fcu.uoregon.edu/research>

¹⁴ <https://pubmed.ncbi.nlm.nih.gov/?term=%22family+check-up%22+FCU>

¹⁵ https://homvee.acf.hhs.gov/effectiveness?model=&hhs=All&sort_by=title&sort_order=ASC&page=1

HFA's evidence of effectiveness and the flexibility of enrollment makes HFA a great prevention choice for states and child welfare agencies seeking to strengthen families and reduce the number of children placed in foster care.

The HFA website¹⁶ displays specific research on how HFA prevents child abuse and neglect. HFA released a one-pager specific to FFPSA and highlights a few of the child welfare areas in which HFA was found to be effective in eight studies including: fewer substantiated child abuse/neglect reports, less neglect and abuse, reduced child welfare involvement, and preventing recurrence of child maltreatment by 1/3 among families with prior child welfare involvement.

Motivational Interviewing (MI)

According to the official MI website,¹⁷ there is a variety of research articles posted to reflect the effectiveness of MI. Per the CEBC, eight relevant published, peer-reviewed research articles are listed, which reviewed the use of MI in certain target populations and the outcomes of the intervention, up to four years post intervention. In review of each study, a majority reflected behavioral and motivational changes within the clients being provided with MI, in comparison with control groups or in random controlled trials.

The Federal Clearinghouse reports that of prioritized studies that were considered to be high or moderate, 16 favorable outcomes were identified. MI was found to have favorable results within adult well-being: parent/caregiver substance use.

Parents As Teachers

According to the PAT official website,¹⁸ over a dozen outcome studies have been completed on the PAT model. The overall results indicate that use of this model can assist in identifying a child's developmental delays and/or health problems early; children are ready and prepared to enter kindergarten; children achieve school success as they proceed through elementary school; parents own parenting knowledge and skills are improved; parents are more involved in their children's schooling; families are more inclined to promote children's language and literacy; and child abuse and neglect is prevented. Additionally, the program will assist families in applying for services, such as childcare subsidy, Medicaid, TANF, etc. Additional details and information can be found on the PAT website, listed above.

The Federal Clearinghouse provides several studies that have been identified and reviewed for PAT. Within these studies, findings indicated a favorable outcome within child safety, child well-being: social functioning, and child well-being: cognitive functions and abilities.

The effectiveness of these five EBPs has been demonstrated through multiple research studies and inclusion as EBPs in various clearinghouses. When considered together with the Federal Clearinghouse's Summary of Findings, Nebraska child welfare-involved families demographics

¹⁶ Healthy Families America: Preventing Child Abuse and Neglect; https://www.healthyfamiliesamerica.org/wp-content/uploads/2019/10/FFPSA_HFA_one-pager.pdf

¹⁷ <https://motivationalinterviewing.org/>

¹⁸ <https://parentsasteachers.org/>

and desired outcomes, Nebraska determined these programs effectiveness is compelling for Nebraska’s child welfare populations and families at risk of entering into the child welfare system.

MONITORING CHILD SAFETY AND ELIGIBILITY

Assessing Children and their Parents for Eligibility

Nebraska law and regulation sets forth requirements for assessing and monitoring child safety. This can be found in Neb. Rev. Statutes 28-712.01(3)¹⁹, Neb. Rev. Stat. 28-712(2)(a)²⁰ and Nebraska DHHS Rules and Regulations, Title 395, Chapter 6 and Chapter 9²¹

CFS and Tribal CFS continue to utilize SDM evidence-informed tools as a guide in determining eligibility for FFPSA services. EBP models also utilize their array of instruments and tools to help caseworkers in determining eligibility.

Per the Child Welfare Policy Manual, Section 8.6A²² Question 4, determinations for purposes of eligibility for the Title IV-E prevention program must be made by employees of the Title IV-E agency or the employees of another community-based agency that has entered into an agreement with the Title IV-E agency. CFS will continue to contract with tribal and non-tribal agencies to provide the Title IV-E prevention programs for children and families within all of the proposed Pathways and will continue to obtain information from the contracted providers to ensure compliance with the Title IV-E prevention program requirements, such as continued assessment of risk and eligibility of candidacy.

A family with a case that does not close after the IA receives an ongoing services case and assessment of eligibility will continue via the Secondary Pathway. A family with a case that closes after the IA may be offered access to services and community resources. If the family chooses to voluntarily participate in one of the EBPs, the family’s case will close and move from the Secondary Pathway to the Tertiary Pathway. Continued assessment of risk and FFPSA eligibility will continue through the contracted EBP provider and information shared with CFS who will verify continued eligibility and maintain the Prevention Plan, upon the family’s consent to release information.

Currently, during the IA, and/or ongoing services case, if a family is referred to home visiting programs, they have the opportunity to voluntarily continue participating in home visiting after their child welfare case closes successfully; this is called the “prevention track.” This ensures continuity of services, oversight of the family’s PP by CFS, and funding source through DHHS.

¹⁹ <https://nebraskalegislature.gov/laws/statutes.php?statute=28-712.01>

²⁰ <https://nebraskalegislature.gov/laws/statutes.php?statute=28-713>

²¹ <https://rules.nebraska.gov/rules?agencyId=37&titleId=181>

²² https://acf.hhs.gov/cwpm/public_html/programs/cb/laws_policies/laws/cwpm/policy_dsp.jsp?citID=631

DHHS acts as the “pass-through” for federal funding reimbursement and maintains the participant’s PP and determination of FFPSA eligibility. The use of home visiting providers’ evidence-based informed tools are utilized to help inform CFS of the child/family eligibility and assessment for risk. As FFPSA expands in Nebraska, it is the intent to add additional EBPs to the “prevention track” and to utilize the various tools and instruments used by the EBP providers to help CFS to determine FFPSA eligibility.

Nebraska is currently building capacity to support the infrastructure of a Warmline to support a Community Pathway, which will act as a centralized location for families to be referred to that are not involved in the child welfare system but may be in need of resources or services to mitigate a report to the Hotline and/or system entry and maintain the children and families safely within their communities. The Warmline will have a standardized intake process, using trauma informed approaches. This will include tools to assess urgency, match callers to services and review potential FFPSA eligibility determination and candidacy. When a family is referred to and accepts the services of an approved Title IV-E prevention service, the provider will utilize their evidence-informed tools to make recommendations of FFPSA eligibility to CFS; CFS will review the recommendation, make the final determination of eligibility and maintain oversight of the PPs, for all families, including Tribal families, as required by FFPSA.

Prevention Plan Oversight and Assessing Safety and Risk

Applicable to each Pathway listed below, risk and/or safety assessments must be completed during each 12 month period. If Nebraska determines the risk of the child entering foster care remains high despite the provision of the services, the State will reexamine the child’s prevention plan in consultation with the EBP provider during the 12-month period.

Community and Tribal Pathways

Through the revised candidacy definition and update to Neb. Rev.Stat. 68-1212 due to LB 668 being signed into law, the Tribal and Community Pathway contracted EBP providers will utilize their evidence-informed tools to periodically assess safety and risk for families referred to an FFPSA EBP via the Tribal and/or Community Pathway throughout the 12 month period in which the services/programs are provided on behalf of a child and provide a recommendation for FFPSA eligibility to the Title IV-E agency. The Contracted providers are also required to participate in training to understand when to contact the Child Abuse and Neglect Hotline (Hotline) if there is suspected child abuse and/or neglect. DHHS is currently creating a CFS Mandatory Reporter Training, which will be required of **all** FFPSA contracted providers, which will help providers to identify safety and risk.

Secondary and Tribal Pathway

CFS and Tribal CFS utilize evidence-based assessment tools for continuous safety and risk management. These tools mandate that CFS and Tribal CFS assess for safety when a report meets the definition of child maltreatment with set criteria. CFS and Tribal CFS makes the determination through use of the tools to identify if the threshold of safety/danger has been met and constitutes

a need for action to address the safety/danger concern. Additionally, CFS and Tribal CFS gathers information to have a comprehensive understanding of family circumstances to determine strengths and needs to manage risk. Additional safety and risk assessments are completed anytime there is a new allegation and/or any change of circumstance in accordance with the SDM tool. CFS and Tribal CFS will continue to assess FFPSA eligibility on families through the proposed Secondary Pathway, utilizing Structured Decision Making assessments, as applicable (*see Attachments E, F and G*).

Regular assessment allows the Child and Family Services Specialist (CFSS) and Tribal CFSS to identify needs of the family that should be prioritized in the family's case plan, will improve child safety, and will reduce risk of maltreatment by utilizing protective factors already existing in the family. CFS and Tribal CFS staff are required to meet with families and children face-to-face monthly. These visits should occur in the family home or home in which the child resides if they are placed out of the home.

Visits with children should be private face-to-face visits. These monthly visits provide information about the child's safety, permanency and well-being, and allow the child an opportunity to share information about what is working well, what are they worried about, and what needs to happen next.²³

CFS and Tribal staff have monthly face-to-face visits with all parents of all children involved in the case. These visits should occur in the family home at least every other month. During these visits, there should be discussion regarding child safety and risk factors, areas of strengths, family needs, and the effectiveness of services being provided to improve the family's safety. A parent is also provided an opportunity to express concerns or input regarding their case. CFS and Tribal staff will discuss the danger or harm statements identified by CFS and Tribal staff and the family. These statements focus on the areas of concern related to safety and risk. These statements clearly identify what the worry is about, what actions needed to mitigate the worry and how long the action needs to be demonstrated.

CFS contracts/intends to contract with providers to deliver the prevention services included in this Plan. The contracted providers are responsible for working with referred families to deliver the EBP to fidelity. For CFS and Tribal CFS involved families, CFS and Tribal CFS staff will complete the PP; CFS will maintain the PP. CFS and Tribal CFS staff will be responsible for monitoring safety and risk and documenting the corresponding safety and risk assessment for families that are actively working with CFS and Tribal CFS.

Tertiary and Tribal Pathways

EBP providers contracted with CFS and providing services to families no longer part of an active CFS or Tribal CFS case, will utilize their evidence-informed tools to assess safety and risk and provide a recommendation to CFS for continued FFPSA eligibility when the EBP has been working

²³ Academy for Professional Excellence; *Safety Organized Practice*; <https://theacademy.sdsu.edu/programs/cwds/sop/>

with the family for 12 months. CFS will be responsible for documenting this information through the Prevention Plan.

CONSULTATION AND COORDINATION

Consultation with Other Agencies to Foster a Continuum of Care

There continues to be a system shift regarding child welfare prevention with safety continuing to be the priority but also enhancing the focus on providing the right services at the right time to the right families; prevention; leveraging the experiences, expertise and insight of key individuals and organizations that are committed to creating a child and family well-being system that is oriented around the prevention of maltreatment; and promoting child and family well-being. This includes intentional engagement across all Department of Health and Human Services (DHHS) divisions and inclusion of communities, and stakeholders.

The Division of Children and Family Services (CFS) has continued to enhance its collaboration with partner divisions and departments, providers, communities, tribes, and others that contribute to the continuum of care and share in the vision of the well-being transformation for Nebraska's children and families, with a goal of removing silos in the communities and agencies.

CFS will implement and expand prevention services that will meet the needs of system-involved and non-system-involved families. This will continue to be done in partnership with the collaborators, additional stakeholders as identified through the process, and with other initiatives in Nebraska to build and expand the capacity of prevention services within child welfare and communities.

During the 2025-2029 period, CFS will engage stakeholders, families, and partners in the Family First Prevention Services Act (FFPSA) expansion planning through the external FFPSA Advisory Committee and internal FFPSA Steering Committee. Additionally, the *Bring Up Nebraska* initiative continues monthly partner meetings in various communities around the state to solicit feedback and engagement. The Statewide Wellbeing Plan²⁴ developed under the *Bring Up Nebraska* initiative includes various stakeholders, families, and community members.

Since the submission of Nebraska's most recent Child and Family Services Plan (CFSP) and Annual Progress and Services Report (APSR), the following information details additional consultation and collaboration.

Community Pathway

A majority of child welfare related services are provided after abuse and/or neglect is reported, and an investigation is initiated, rather than on "front end" primary prevention prior to child

²⁴ <https://statewideplan.bringupnebraska.org/>

welfare intervention. Often, there is a lack of collaboration among partners within primary prevention, further limiting family awareness and access to local services and resources.

Through research and feasibility determination of a Warmline, it is recognized that Nebraska offers a continuum of universal prevention services, targeted community-based services, child welfare services and prevention initiatives for children and families within child welfare and outside of child welfare, but not through a centralized hub. Referrals to community resources are contingent on knowledge of the resources/services; there is a limitation on thorough education of community resources due to there not being a centralized hub for families to contact to request resources/services in their local communities. The target population of the Warmline is individuals seeking information and support related to child and adult well-being, but whose concerns do not meet the legal definition of abuse or neglect.

Expansion of prevention services outside of an active child welfare case does not preclude DHHS from obtaining necessary information to monitor continued fidelity of the model and collecting required data that is to be reported to the Administration for Children and Families (ACF), as detailed in the Child Welfare Policy Manual, Section 8A, Question 2.²⁵ According to Section 8.6.B of the Child Welfare Policy Manual²⁶, the Title IV-E agency is not required to have an open child welfare case for an eligible child to receive an FFPSA service. With this flexibility, CFS intends to expand accessible services and programs to support families outside of formal CFS involvement while focusing on prevention; this will include enhancing all categories within the continuum of prevention and intentional efforts to address disparities and geographic access. DHHS is focused on preventing unnecessary child welfare entry by providing the right services at the right time to the right families.

To ensure successful implementation of the Community Pathway, Nebraska will utilize its vision as described in the *Introduction* of this Plan and the State's approved CFSP, to guide this work. Nebraska is envisioning a multi-year implementation for the full operation of a Community Pathway that addresses the risk factors identified under the *Community Pathway* in the next section.

Year 1 and 2:

- Procure a vendor to establish infrastructure and implement the Warmline.
- Continue to sustain and build capacity for home visiting programs.
- Continue to sustain and build capacity of Family Centered Treatment.
- Identify providers for Familias Unidas.
- Implement Family Spirit with at least one (1) Tribe.
- Implement Fatherhood Is Sacred/Motherhood is Sacred with at least one (1) Tribe.
- Advocate for state statute changes to allow for referrals to Title IV-E Prevention Services without child welfare involvement.

²⁵ https://acf.hhs.gov/cwpm/public_html/programs/cb/laws_policies/laws/cwpm/policy_dsp.jsp?citID=631

²⁶ <https://cwpm.acf.gov/citations/title-iv-e/title-iv-e-prevention-services-program/eligibility>

- Expansion of Kinship Navigator EBP to system involved families to prevent re-entry and build sustainability within broader family network
- Enhance Plans of Safe Care information at designated sites and consider expansion sites.
- Begin initial planning for implementation of Motivational Interviewing.
- Begin formal evaluation of Family Centered Treatment.

Year 3:

- Establish HIPAA compliant data sharing between the Warmline and CFS, for purposes of FFPSA Prevention Plans (PP), federal reporting and federal claims.
- Implement Familias Unidas.
- Establish additional Plans of Safe Care sites in Nebraska, that is data driven.
- Implement Motivational Interviewing.
- Continue engagement with Tribes regarding implementation of services.
- Review additional EBPs for possible inclusion in the State's FFPSA Plan.
- Evaluate continued sustainability of the Warmline.
- Evaluate continued sustainability of EBPs referenced in Years 1 and 2.

Year 4:

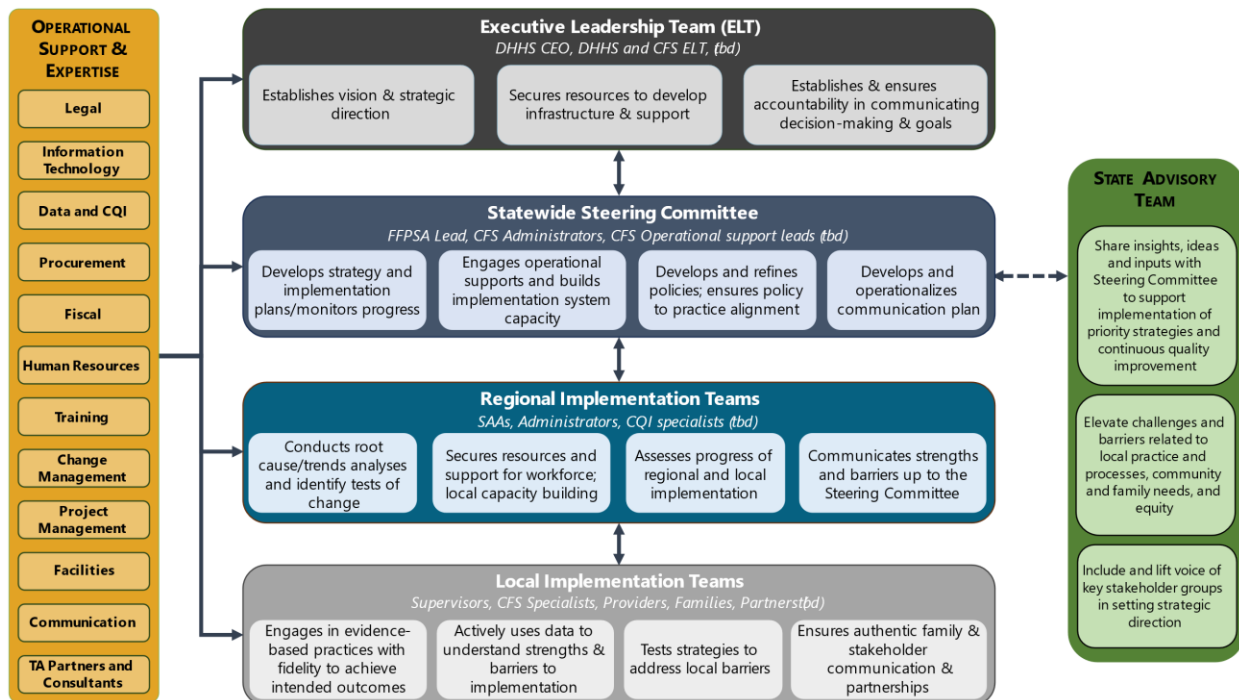
- Establish data sharing agreement with Juvenile Probation, to provide FFPSA services to probation only youth.

Year 5:

Establish processes to screen Hotline calls for economic instability and make appropriate referral.

FFPSA Governance Structure

Below is Nebraska's FFPSA Governance structure to align the prevention work at an executive level down to the regional level; it encompasses a variety of stakeholders and resources.



Nebraska Family First Prevention (Statewide) Advisory Committee

A subsidiary within the Governance Structure is the Statewide Advisory Committee. Nebraska has developed the Nebraska Family First Prevention (NFFP) Advisory Committee to help support infrastructure within communities to ensure families and children have what they need to remain safe, together, and thriving. The purpose of the NFFP Advisory Committee is to review the current Nebraska prevention and community-based support infrastructures and resources to identify gaps, needs, and where expanded capacity is needed. The NFFP Advisory Committee will provide input on statewide FFPSA and Community Pathway development, expansion, and sustainability.

The NFFP Advisory Committee focuses on two tracks: the IV-E agency FFPSA planning and the Community-Based Pathways and Warmlines. These two tracks cross over and interact with one another, requiring thought into the road maps for each and coordination.

Division of Public Health (DPH)

CFS will continue its collaboration with DPH's Nebraska-Maternal Infant Early Childhood Home Visiting (N-MIECHV) program²⁷, which oversees the Healthy Families America (HFA) program. Since the submission of the 2025 APSR, an additional HFA site was launched in southwestern

²⁷ <https://dhhs.ne.gov/Pages/Maternal-Infant-Early-Childhood-Home-Visiting.aspx>

Nebraska; this brings the total of Local Implementing Agencies (LIA's) to 14 across the State. It is anticipated this new LIA will enter into a contract with CFS within the next 12 months.

The Nebraska Legislature allocated DPH funding for an evidence-based universal nurse home visiting program for Medicaid-eligible families. "Families Connects" was selected because it maximized community reach with lean staffing requirements. Presently, "Families Connects" is provided through the Lincoln-Lancaster County Health Department, and DPH will use their "lessons learned" to implement the program in Douglas County. DPH will start training staff in January 2025 and will begin serving families when all staff are trained and service referral partnerships have been established. It should be noted that though "Families Connects" is an evidence-based program (EBP), it is not an FFPSA program.

CFS collaborates with DPH on Title V programs to support public health prevention and maternal child programming. They are also co-leads in the Prenatal Plans of Safe Care (POSC) project.

Division of Behavioral Health (DBH)

In partnership with the Division of Medicaid and Long-Term Care (MLTC) in 2025, DBH selected seven agencies to become Certified Community Behavioral Health Clinics (CCBHC). These clinics will offer Nebraskan's with a comprehensive approach to support physical and behavioral health services²⁸.

Division of Medicaid and Long-Term Care (MLTC)

CFS collaborates with MLTC on braided funding to support the provision of Family Centered Treatment (FCT). The FCT provider is able to file Medicaid claims for the treatment portion of FCT when FCT is provided by a state-licensed (including provisionally licensed) mental health practitioner. During 2025-2029, CFS and MLTC will identify strategies to implement code modifiers that would allow non-mental-health practitioners providing FCT to file Medicaid claims for the treatment portion of FCT.

Office of Economic Assistance (OEA)

Throughout 2022 and 2023, CFS collaborated with OEA to formulate recommendations for Nebraska's Temporary Assistance for Needy Families (TANF) Plan. This workgroup was created to assess low-income families' needs, provide a transparent TANF funding process, and evaluate the current TANF-funded program's performance effectiveness. In addition, the workgroup provides program funding recommendations to the director of CFS. These recommendations included program funding recommendations for prevention services.

The intention of Nebraska's shared collaboration is to seek approval to utilize TANF funding for the community collaborative work and the operations of the Warmline. Formal approval was submitted to TANF federal partners in October 2025.

²⁸ <https://dhhs.ne.gov/Pages/CCBHC.aspx>

In 2025, the Governor’s office announced that Nebraska was selected as one of five states to improve the TANF program²⁹. Though not a direct connection to FFPSA, this pilot focuses on a collaborative approach in line with other Divisions with the potential to indirectly support the work of Community Pathways.

Juvenile Justice

Nebraska is broadening its candidacy definition to include youth who may not be involved with child welfare but have had a “touch point” with Juvenile Justice (see the *Definition of Candidacy* section). CFS aims to improve cross-system practice, utilize strength-based family engagement, align resources, seek opportunities to divert youth from child welfare and/or juvenile justice involvement, and reduce out-of-home placements. This includes the utilization of Juvenile Probation providing mentors who assist youth who are involved with the juvenile justice system by providing assistance in navigating the system. The goal is to prevent the youth from having future involvement in the justice system.

Additionally, 2023, Nebraska legislated³⁰ a population of Probation youth to be eligible for the Bridge to Independence Program at age 19. This was implemented in 2025 and requires ongoing collaboration and partnership with Probation.

Tribal Consultation

CFS has three dedicated staff focused on ICWA and Tribal youth and families. These staff will continue collaborating with the Tribes to identify the unique needs and strategies for leveraging FFPSA-related services.

CFS continues to meet monthly with each of the Nebraska headquartered Tribes individually and quarterly with the four Tribes together. CFS anticipates that in the next five years, these quarterly joint meetings will include key stakeholders to help guide the collaborative work with Tribal citizens in Nebraska. Key stakeholders include the Oglala and Rosebud tribes from South Dakota, the Sac and Fox Nation, the Iowa Tribe of Nebraska, and Kansas from Kansas, as well as the Nebraska Indian Child Welfare Coalition and other organizations.

CFS anticipates increased capacity among the Tribal nations in Nebraska to meet needs for prevention, safety, and permanency through tribally created family well-being systems within our IV-E agreements. CFS has included Family Spirit and Fatherhood is Sacred/Motherhood is Sacred in Nebraska’s subsequent Plan. Additional information can be found in the *Service Description and Oversight* section. There have been ongoing discussions with the Tribes regarding the inclusion of culturally specific FFPSA services in the FFPSA Plan. Changes have been made in the Tribal State Agreements that allow the Tribes to utilize CFS’ service contracts, which includes FFPSA services. As a result, the Title IV-E agency will oversee the PPs and submit the federal claims for utilization of these services.

²⁹ <https://dhhs.ne.gov/Pages/Nebraska-One-of-Five-States-Selected-to-Participate-in-TANF-Fiscal-Responsibility-Act-Pilot.aspx>

³⁰ <https://nebraskalegislature.gov/laws/statutes.php?statute=43-4504>

Together for Indigenous Families is a five-year cooperative project between CFS, the Court Improvement Project (CIP), and the Winnebago, Omaha, and Ponca Tribes. Supported by a demonstration grant from ACF, Together for Indigenous Families will streamline communication between jurisdictions, enhance the experience of Indigenous families involved in child welfare, and help meet the political and cultural needs of children, families, and tribes. This project will also help build Tribal communities' capacity to prevent family entry into the child welfare system by developing culturally driven comprehensive community plans for prevention and supportive services.

Family First Prevention Service Coordination with Other IV-B Plan Services

Several of the programs in community prevention are funded through IV-B funded services, and align with the work of the Family First Prevention Services Act (FFPSA). It is the goal of Nebraska to centralize the community-based prevention designs to assist families in the community experiencing multiple crises to keep them from entering into and/or further into the child welfare system. Refer to Nebraska's 2025-2029 CFSP and most recent APSR for additional information.

CHILD WELFARE WORKFORCE SUPPORT

Workforce Support

Workforce support as required in the legislation and outlined in the pre-print will occur for any staff or provider that is overseeing a prevention plan.

Beginning in 2025, The Division of Children and Family Services (CFS) transitioned from contracting out workforce training and will provide training for the CFS workforce "in house." This training will continue to ensure CFS and CFS Tribal staff are competent, skilled, and professional when working within child welfare and understanding child welfare prevention.

CFS provides the Connect-Achieve-Reflect-Empower (CARE) Team as a monthly meeting for new CFS and CFS Tribal hires across the state while they participate in New Worker Training (NWT); in addition to these formal meetings, each CARE Team has a Webex space to share questions, concerns, and feedback and build connections. The Development and Resiliency Team facilitates the CARE Team in building employee resilience through connection and obtaining feedback on NWT and onboarding, with a general focus on well-being through mindfulness.

Part of the requirements of being an EBP is that the service must be trauma-informed. It is important that CFS and CFS Tribal staff receive trauma-informed training. All new staff who

attend CFS new worker training are provided with several different trauma-informed training. A listing and description of these trainings are in the *Workforce Training* section below.

Restoring Resiliency Response (RRR)

Additional support is provided to staff through the RRR. This is clinical support that offers a debriefing session following a traumatic event for CFS staff.

EBP Champions

As EBPs are implemented and/or expanded, EBP champions from each of the Service Areas are identified to help make the implementation/expansion successful. The champions provide input on the implementation/training plan development to ensure that their respective Service Area staff are knowledgeable about the EBP, what it is, what families are a good fit for referral, and the ongoing messaging and assistance with peer questions about the EBP. This will equip staff to be better informed about EBPs and to communicate with families about what is available.

Central Office

To provide additional support to the workforce and the EBP champions, CFS Central Office provides technical assistance, internal staff training, and written guidance and direction specific to FFPSA. This includes tip sheets, one-pagers, Standard Operating Procedures, Standard Work Instructions (SWI), referral decision making tools, EBP information, provider contact information, and maps of provider locations (see *Attachments A, B, C, H and I*). These documents are stored on an internal intranet site, specifically made for FFPSA, to make these documents easily accessible.

CHILD WELFARE WORKFORCE TRAINING

Workforce training as required in Neb. Rev. Stat. 68-1214³¹ and outlined in this section and the pre-print will occur for any staff or provider that is overseeing a prevention plan.

N-MIECHV conducts a quarterly model orientation on HFA for new home visitors. CFS staff can attend a session to learn more about HFA and its purpose. Additionally, LIAs meet with the local CFS offices through a cadence of meetings, to provide overviews of HFA, the referral process, and to provide technical assistance. N-MIECHV staff will continue to provide technical assistance and training as needed, annual refreshers on documentation and data, programmatic implementation, and model orientation for new staff.

CFS will provide new and current CFS and CFS Tribal caseworkers with training related to assessing a family's needs for prevention services and accessing identified trauma-informed and evidence-based services. CFS staff are and will continue to be trained in SOP[®] to enhance family engagement; CFS uses this framework to assist in gathering information. SOP[®] provides concepts

³¹ <https://nebraskalegislature.gov/laws/statutes.php?statute=68-1214>

and tools that help provide additional ways to engage and reach understanding with families. SOP® is a model designed to help child welfare staff use critical thinking and build good working relationships with families to improve child safety. Training is provided on an ongoing basis for specific trauma-informed and evidenced-based services as they become available to each community.

NWT provides an overview training of FFPSA. This training identifies the various provisions within the FFPSA law and how it directly impacts the work of the Child and Family Services Specialist (CFSS) and Tribal CFSS and their supervisors. The training includes information regarding the purpose and philosophy of FFPSA, details Candidates for Foster Care, the PP, information on how placements will be impacted by FFPSA, and step-by-step instructions for N-FOCUS changes that will occur because of the implementation of FFPSA.

New tribal workers receive training in prevention planning and the current workforce receives the same training resources as CFS staff regarding implementation of FFPSA.

Tribal Operations and CQI meetings also provide the opportunity for Tribal CFS staff to receive additional training on topics pertinent to their work.

As required through FFPSA, the EBPs must be trauma informed. To help CFS staff better understand what this means, a variety of trauma-related trainings are provided:

Training: Trauma Within Family Systems

Topic Area: Types of trauma in children, adolescents, and adults; typical trauma reactions in children, the five core principles of trauma-informed care; and the impact of trauma on the mind, body, and behavior.

Description: Trainees learn the important concepts and practices related to trauma and trauma-informed care.

Training: Secondary Trauma

Topic Area: Understanding, recognizing, and responding to the effects of secondary trauma and protective strategies for self and others.

Description: Trainees learn about secondary trauma and its impact on workers.

Training: Trauma Review and Application

Topic Area: Core principles of trauma-informed care, awareness of impacts on traumatic stress, and what therapeutic services should be utilized for trauma.

Description: Trainees review the important concepts and practices related to trauma and trauma-informed care in preparation for application in the classroom.

Becoming Trauma Capable

Topic Area: Understanding the CFSS’s role in decreasing the impact of increased distress within the family system; Adverse Childhood Experiences (ACEs); resiliency; how trauma can affect safety, permanency, and well-being; core principles of trauma-informed care and how to respond effectively to traumatic reactions; what therapeutic services should be utilized for trauma; and referring to evidence-based, trauma-focused treatment services.

Description: Trainees continue to explore and understand the important concepts and practices related to trauma and trauma-informed care.

During NWT, new staff are provided with a “Case Management Desk Aide” to help guide them in decision making, when they begin to formally manage cases. This Aide contains a variety of documents that provide guidance and procedure regarding case management, including case management processes for FFPSA.

When Nebraska receives approval from ACF on its subsequent Plan, training information regarding Candidates for Foster Care and Target Populations will be revised. Upon effectuation of LB668, an overview will be integrated into the FFPSA NWT for staff to understand what the Community Pathway is, its purpose and how it impacts child welfare.

During the establishment of the Warmline, there will be collaboration between the vendor and the CFS Hotline to define a referral process with appropriate confidentiality measures and alignment with FFPSA approved services. There will also be communications and education provided to community members, tribal nations, and other key partners, fostering buy-in of the Warmline, its goals and purpose and to ensure partnerships and public trust is maintained after its implementation.

The Warmline vendor will have an initial and ongoing training plan for its staff. This will include training on confidentiality requirements, mandated reporting and legal protections related to family engagement and service delivery, overview of relevant services available across Nebraska, engagement skills and supportive communication techniques, Motivational Interviewing, trauma informed care principles and guidance on when and how to refer a family to the CFS Hotline.

The Warmline will provide professionals with tools and knowledge on how to effectively engage families, offer support, and explain the Warmline’s role.

PREVENTION CASELOADS

For FFPSA eligible cases on the Community and Tribal and Tertiary and Tribal Pathways, the caseload size will be in adherence or best practice caseload standards of the specific EBP model being provided.

EBP	EBP Caseload Standard
Familias Unidas	1 Facilitator: 12 families
Family Centered Treatment	1 Practitioner: 5 families
Family Check-Up	1 Home Visitor: No requirements on caseload size
Family Spirit (Tribal)	1 Home Visitor: 25 families
Fatherhood Is Sacred/Motherhood is Sacred (Tribal)	Discretion of the Facilitator
Healthy Families America-Child Welfare Protocol	<i>First and Second Year as a Home Visitor</i> 1 Home Visitor: 10-12 families <i>Three Years+ as a Home Visitor</i> 1 Home Visitor: 15-20 families
Motivational Interviewing	Not applicable
Parents As Teachers	1 Home Visitor: 20 families

Caseload sizes for the Division of Children and Family Services (CFS) and CFS Tribal staff with eligible FFPSA families will align with current caseload standards. The Nebraska Department of Health and Human Services (DHHS) maintains strict case load standards for all CPS workers. CFS regularly oversees and monitors caseload standards through ongoing CQI practices. The table below contains operational definitions utilized for caseloads in accordance with Neb. Rev. Statute 68-1207³². The current caseload ratio for all CPS workers is as follows:

CFS Caseload Type	CFS Caseload Standard
Initial Assessment Cases	1:12 families – urban 1:10 families – rural
Mixed – Initial Assessment Cases & On-Going Cases	1:4 families for Initial Assessment 1:7 children out-of-home 1:3 non-court-involved families <i>Total: 1:14</i>
Alternative Response (AR) Cases	1:12 families – urban 1:10 families - rural
On-Going – Court-Involved, In-Home Cases	1:17 families
On-Going – Court-Involved, Out-of-Home Cases	1:16 children
On-Going – Court-Involved, Blended In-Home & Out-of-Home	1:10 Out-of-Home wards 1:7 In-Home families <i>Total: 1:17</i>

³² <https://nebraskalegislature.gov/laws/statutes.php?statute=68-1207>

ASSURANCE ON PREVENTION PROGRAM REPORTING

See Attachments Section for *Attachment I: State Title IV-E Prevention Program Reporting Assurance*.

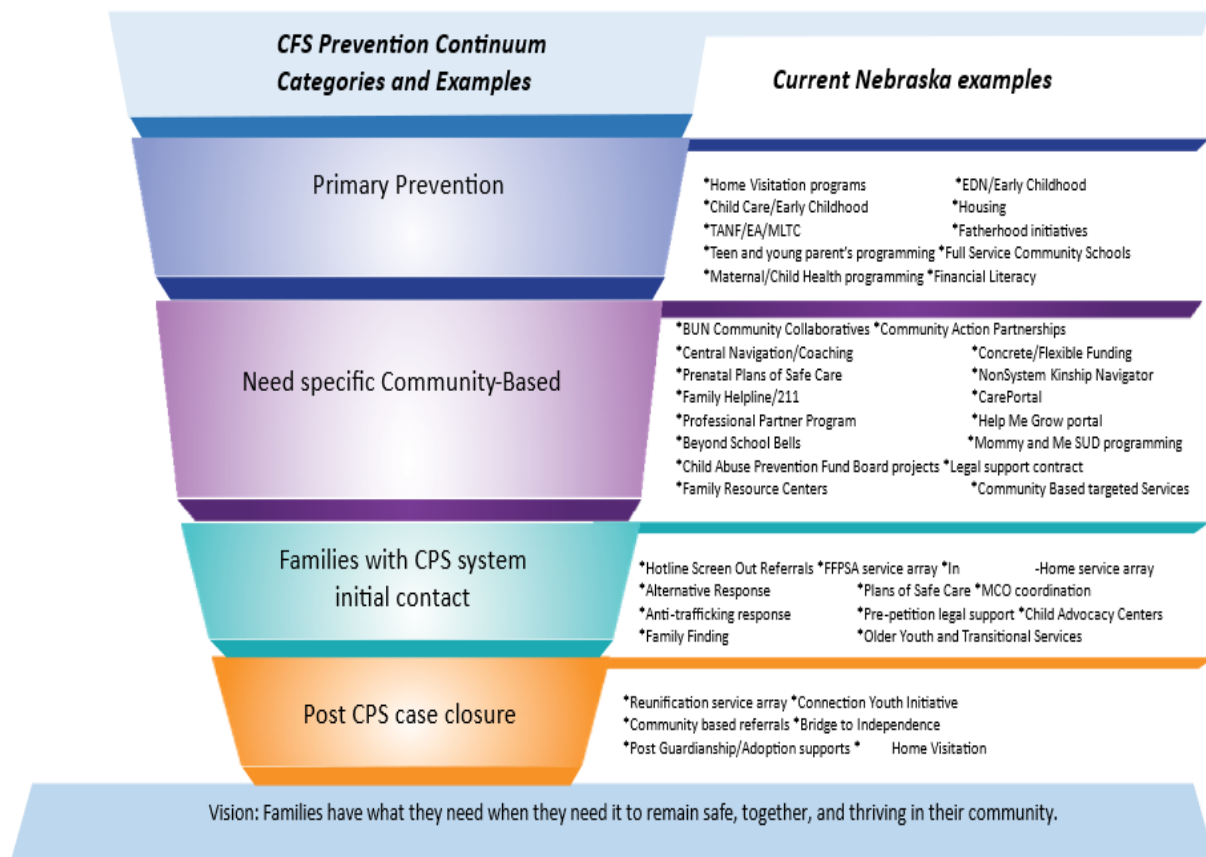
CHILD AND FAMILY ELIGIBILITY FOR THE TITLE IV-E PREVENTION PROGRAM

Since 2019, Nebraska's candidacy has focused on secondary prevention (children and families who are involved with child welfare). CFS's planning over the next five years includes the addition of community and tertiary pathways without a child welfare case being opened and/or re-opened.

There is an identified gap of service knowledge, community referral processes and poverty being a contributing factor in many neglect cases; as a result, a report is often made to the Child Abuse and Neglect Hotline (Hotline). The Community Pathways have yet to be fully incorporated into Nebraska's structures. Therefore, including expansive target population definitions in Nebraska's Plan supports the development and integration of a more comprehensive system as a part of multi-phased planning, crossing all levels of prevention, and increasing cost efficiency through braided funding to support provision of prevention services. In recognition of the prevalence of poverty within neglect cases, Nebraska is also being intentional about identifying families facing economic instability. According to the Child Welfare League of America (CWLA), it is a social determinant of health that can impact the health and well-being of children, youth, and families;³³ instability reflects the lack of reliable access to resources to meet basic needs, such as food, shelter, and clothing.

To support Nebraska's vision and strategies, Nebraska is revising its FFPSA candidacy definition to better align with the Public Health Model of Prevention within the Child Welfare Information Gateway Framework and expand into community-based prevention. As a result of this framework, CFS has further defined its prevention continuum, as seen in the visual below. This image is intended to visually display that Nebraska's intent is to serve more families and children in the primary and community based prevention than in system entry and to provide examples of programming at each resource point.

³³ <https://www.childwelfare.gov/topics/social-determinants-health/economic-stability/?top=307>



In late 2025, CFS executed a Contract with United Way of the Midlands to establish the Warmline. The Warmline will support the Community Pathway and serve as a conduit to families in accessing services and resources, including housing, transportation, childcare, legal assistance, FFPSA services etc. This Pathway will serve as a strategy to proactively mitigate circumstances within a family that may have resulted in unintended consequences or outcomes, such as a report to the Hotline.

The Nebraska Family First Prevention Advisory Committee (NFPP) within the FFPSA Governance Structure, referenced in the *Consultation and Coordination* section of this Plan, will partner with United Way of the Midlands to engage providers who will receive referrals from the Warmline to gather information and input to assist providers in understanding how the Warmline will function. Additionally, this group will identify strategies to clarify how families who were referred to the Hotline and not screened in can access the Community Pathway.

Nebraska's Definition of Candidacy

To be eligible for an FFPSA service, the child (tribal or non-tribal) must be a "candidate for foster care" or be a "pregnant/parenting foster youth". This definition aligns with the federal definition in section 475(13) of the Act: "...a child who is identified in a prevention plan under section 471(e)(4)(A) as being at imminent risk of entering foster care (without regard to whether the child would be eligible for foster care maintenance payments under section 472 or is or would be eligible for adoption assistance or kinship guardianship assistance payments under section 473) but who can remain safely in the child's home or in a kinship placement as long as services or programs specified in section 471(e)(1) that are necessary to prevent the entry of the child into foster care are provided. The term includes a child whose adoption or guardianship arrangement is at risk of a disruption or dissolution that would result in a foster care placement."

|

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FFPSA Administrator
jamie.kramer@nebraska.gov

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What is Family Centered Treatment?

Family Centered Treatment (FCT) is an evidence based, trauma informed family preservation model that provides home based treatment. FCT is designed to find simple, practical, and common-sense solutions for families that are faced with disruption or dissolution. This can be due to internal/external stressors, delinquent behavior of a youth, or a parent's harmful behaviors. FCT has a foundational belief that the recipients of service are great people with internal strengths and resources. Individual family goals are developed through those strengths, rather than deficits.

Program Goals

- Enable family stability through preservation or development of family placement.
- Enable necessary changes in critical areas of family functioning that are underlying causes for the risk of family dissolution.
- Reduce harmful behaviors that affect family functioning.
- Develop an emotional and functioning balance in the family so that the family system can cope effectively with any individual member's unresolvable challenges.
- Enable changes in client behavior to include family system involvement so changes are not dependent upon the therapist.
- Enable discovery and effective use of intrinsic strengths necessary for sustaining the changes made and enabling stability.

Phases of Service

- **Joining & Assessment** Gain family trust and identify strengths & areas of family need.
- **Restructuring** Identify maladaptive patterns and practice new skills.
- **Valuing Changes** See change as necessary over compliance.
- **Generalization** Skill adoption and predict future challenges.

How it Works

- With the whole family, in the family home, when it's convenient for the family.
- Session schedules involve clinician during most troublesome and difficult times.
- Provides 24/7 on call crisis support for the family with their known clinical staff.
- Opportunities for the family to practice functioning differently (not just talk therapy).
- Minimum of 2 multiple hour sessions per week (Exception with first and last month)
- Treatment is driven by family need and progress, average length of treatment is 6 months.

Target Population/Referring

- Families who have an identified safety threat, high risk factors, and/or children at risk for out of home placement.
- Youth who are transitioning home from a higher level of care.
- Youth who have been placed out of home, have a permanency plan of reunification and are transitioning home.
- FCT is voluntary and cannot be court ordered.

www.familycenteredtreatment.org

The Five Pillars of Family Centered Treatment

- Treat Families with Dignity and Respect
- Honor the Function of Behavior
- Treatment that is Relevant and Useful
- Internalization over Compliance
- Power of Giving & Restoring Self-Worth



Engagement

We must connect before we can correct

- 94% of families receive more than 5 contacts within first 30 days.
- Nearly 80% of families receive >20 sessions

The FCT Guarantees: Operationalizing the Pillars of FCT

1. I promise that I will care and respect your family enough to give you direct and honest feedback.
2. Likewise, I will ask you for direct and honest feedback.
3. When I make a mistake, I will acknowledge it, take responsibility for it and make it right.
4. You are the expert on your family.
5. I promise to ask your permission first to do any activity with your child.
6. I promise to include you in any contacts that I have with other agencies involved with your family.

FCT Foundation 2024

What is Healthy Families America?

Healthy Families America (HFA) is a voluntary, evidenced based, trauma informed, home-visiting program for new and expectant parents. HFA promotes child well-being and prevents abuse and neglect of children in communities through family focused and empathic support provided in the home.

Components of HFA

- Family goal planning
- Prenatal support
- Maternal and infant/child screenings
- Service planning
- Family events

Goals/Outcomes

- Improve birth outcomes
- Promote positive parenting practices
- Cultivate and strengthen nurturing parent-child relationships
- Improve child safety and prevent maltreatment
- Promote healthy child development
- Improve school readiness

Service Delivery

- HFA can be provided prenatally through age 5.
- Tiered services are provided and intensity of service is based on family progress;
- Home visits typically start out weekly and occur for one hour.
- Visits occur in the home but can occur in a community setting if needed.
- Highly trained home visitors are equipped with curriculum and other tools to help provide education and support to families.

Target Population

- Families can enroll prenatally through 24 months of birth (22 months or less for Lincoln Lancaster County Health Department).
- HFA is designed to serve families of children who have increased risk for maltreatment or other adverse childhood experiences.
- Each HFA site may determine certain characteristics that it targets such as low-income, single parent households, families who have experienced substance use, mental health needs, and/or domestic violence.

****HFA and Early Development Network (EDN) services are not the same and families may participate in both if they choose to.***

What is Parents as Teachers?

Parents as Teachers (PAT) is a voluntary, evidenced based, trauma informed home-visiting parent education model that teaches new and expectant parents skills intended to promote positive child development and prevent child maltreatment. PAT is designed so that it can assist diverse families with diverse needs.

Components of PAT Model

- Personal home visits
- Supportive group connection events
- Community resource networks
- Child health and developmental screenings

Goals/Outcomes

- Increase parent knowledge of early childhood development and positive parenting practices.
- Provide early detection of developmental delays and health issues.
- Strengthen community capacity and connectedness.
- Prevent child abuse and neglect.
- Increase children's school readiness and success.
- Improve maternal and child health.

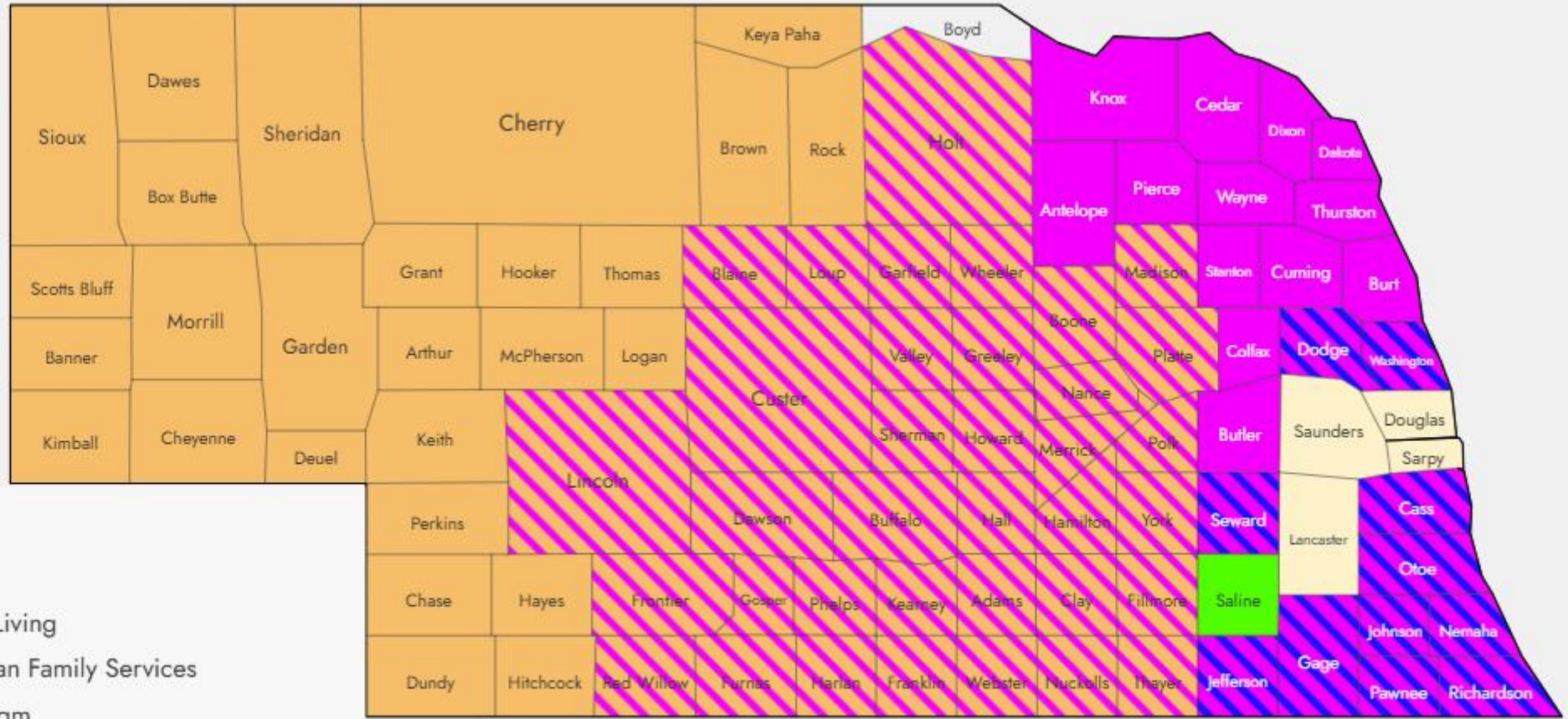
Service Delivery

- Families can receive PAT prenatally until their child starts Kindergarten.
- Highly trained parent educators meet with families for one hour at a time weekly, biweekly, or monthly based on need.
- PAT occurs in the families home, but can also occur in community settings if needed.
- Parent educators are equipped with PAT curriculum and other tools to help educate and support families.

Target Population

- New and expectant parents: Prenatal-Kindergarten.
- PAT model is designed to be used in any community with any family.
- PAT programs target families in possible high risk environments: teen pregnancy/parents, low income, parental low educational attainment, history of substance abuse in family, and chronic health conditions

**PAT and Early Development Network (EDN) services are not the same and families may participate in both if they choose to.*

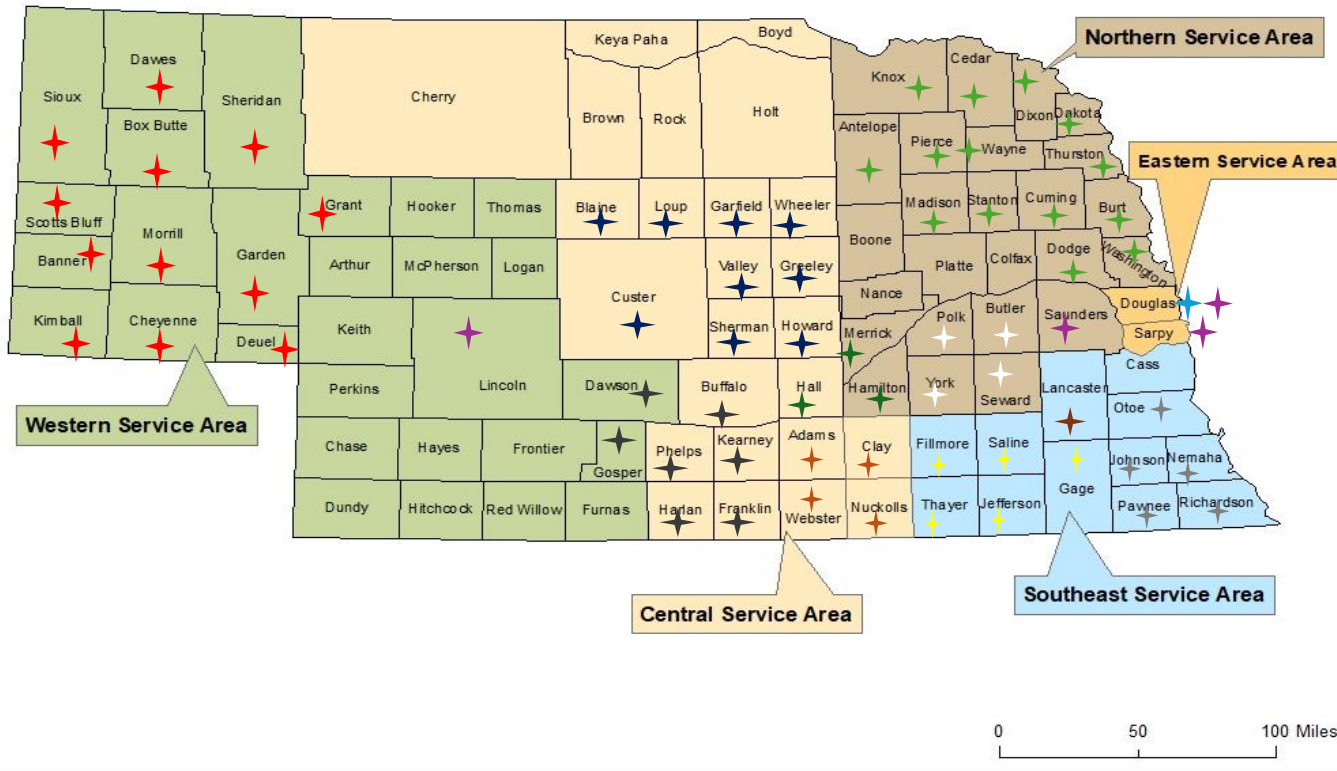


- Better Living
- Snowy Peak
- ▨ Snowy Peak and Better Living
- ▨ Better Living and Lutheran Family Services
- ▨ Better Living and Paradigm
- Better Living, Paradigm and Lutheran Family Services
- Better Living, Paradigm and Snowy Peak

Family Centered Treatment Provider Map

January 23, 2026

Division of Children and Family Service Areas



★ PPHD	★ PHS
★ LLCHD	★ LBPHD
★ NCHS	★ CDHD
★ SEDHD	★ SHDHD
★ VNA	★ TRPHD
★ NENCAP	★ FCHD

Panhandle Public Health District
 Box Butte, Morrill, Scotts Bluff,
 Banner, Kimball, Cheyenne, Garden,
 Deuel, Sioux, Dawes, and Sheridan
 counties
 Program Manager: Dezarae Brandt
 (308)765-5249
dbrandt@pphd.ne.gov

Lincoln-Lancaster County Health Department
 Lancaster County
 Program Manager: Kodi Bonesteel
 (402)441-6297
kbonesteel@lincoln.ne.gov

Nebraska Children’s Home Society
Douglas/Sarpy Counties: Angelica Hernandez
 (402)676-1932
ahernandez@nchs.org
Saunders County: Candace Johnson
 (402)451-0787
cjohnson@nchs.org
Lincoln County: Jamie Dollins
 (308)380-6556
jdollins@nchs.org

Southeast District Health Department
 Otoe, Johnson, Nemaha, Pawnee,
 Richardson counties
 Program Manager: Megan Piper
 (402)414-7197
megan@sedhd.org

Visiting Nurse Association Douglas County
 Program Manager: Jennifer Durand
 (402)930-4000
jdurand@vnatoday.org

Northeast Community Action Partnership
 Dakota, Thurston, Knox, Cedar, Dixon,
 Antelope, Pierce, Wayne, Madison, Stanton,
 Cuming, Burt, Dodge, Washington counties
 Program Coordinator: Jennifer Keller
jkeller@nencap.org

Public Health Solutions
 Jefferson, Gage, Fillmore, Saline, Thayer
 counties
 Program Manager: Angela Johnson
 (402)223-0067
ajohnson@phsneb.org

Loup Basin Public Health Department
 Garfield, Blaine, Custer, Greeley, Howard,
 Loup, Sherman, Valley, Wheeler counties
 Program Manager: Emily Smith
 (308)346-5795
smith@lbphd.ne.gov

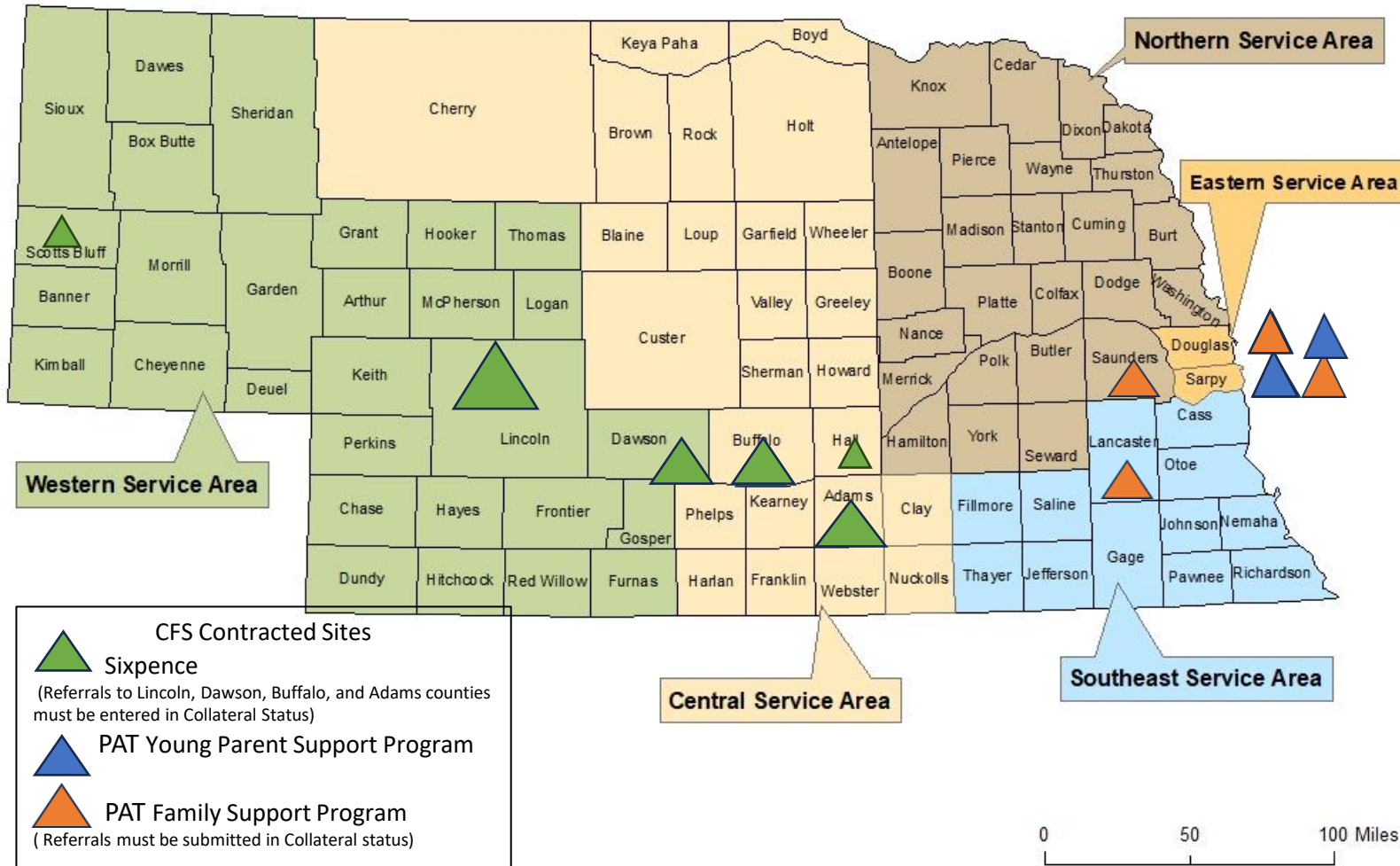
Central District Health Department
 Hall, Merrick, Hamilton counties
 Program Coordinator: Cindy Valez
 (308)385-5175
cvaldez@cdhd.ne.gov

South Heartland District Health Department
 Adams, Clay, Webster, Nuckolls counties
 Program Coordinator: Brooke Wolfe
 (402)462-6211
brooke.wolfe@shdhd.ne.gov

Two Rivers Public Health Department
 Dawson, Gosper, Buffalo, Kearney, Phelps,
 Franklin, Harlan counties
 Program Manager: Kate Mulligan
 (308)669-7154
kmulligan@trphd.ne.gov

Four Corners Health Department
 York, Seward, Polk, Butler counties
 Program Manager: Sharen Staff
 (402)362-2621
sharens@fourcorners.ne.gov

Division of Children and Family Service Areas



<p>Adams County: Hastings Public Schools Sara Horstmann 1515 W 8th Street Hastings, NE (402) 984-0593 sara.horstmann@hpstigers.org</p>	<p>Lincoln County: North Platte Public Schools Brandy Buscher 301 W F Street North Platte, NE (308) 530-0503 bbuscher@nppsd.org</p>
<p>Buffalo County: Kearney Public Schools Megan Schmidt 1511 5th Avenue Kearney, NE (308) 698-8046 megschmidt@kearneycats.com</p>	<p>Scottsbluff County: Scottsbluff Public Schools Mary Durbin 2617 College Park Scottsbluff, NE (308)631-9757 mdurbin@sbps.net</p>
<p>Dawson County: Lexington Public Schools Tracy Naylor 1501 Plum Creek PKWY Lexington, NE (308) 324-1841 tracy.naylor@lexschools.org</p>	<p>Douglas/Sarpy Counties: Young Parent Support Program (Parent must be 25 and younger) Nebraska Children's Home Society Dianna Jones 4939 South 118th Street Omaha, NE (402) 451-0787 djones@nchs.org</p>
<p>Hall County: Head Start Angelica Flores 310 N Piper Street Grand Island, NE (402)308-385-5115 aflores@hshn.org</p>	<p>Douglas, Sarpy, Lancaster and Saunders Counties: PAT Family Support Program Lutheran Family Services Susan Pawloski 7929 West Center Road Omaha, NE (402)342-7038 susan.pawloski@onelfs.org</p>

Title:	DHHS CFS Protection & Safety SWI for Prevention Plan		
DCS Number:	# given by Compliance Officer	Supersedes:	List previous version or "new"
Version		Effective Date:	April 22, 2024
Written by:	Jamie Kramer DHHS Administrator I	Approved by:	Camas Holder Community prevention Administrator
		Approved by:	_____ Add additional Approvers as needed

1.0 Policy

1.1 Every DHHS SWI must reference a specific, approved policy, which may be referenced in the appropriate SOP for this task.

2.0 Objective

2.1 To provide guidance to Protection and Safety Staff in the process of Prevention Plans.

3.0 Scope

3.1 The purpose of this SWI is to ensure the consistent application of DHHS procedures to achieve safety, permanency, and well-being for Nebraska’s children, young adults, and families by centering families as the experts in their own lives.

4.0 References

4.1 Attachments

- Attachment 1 – List of Abbreviations and Definitions
- Attachment 2 – How to Create a Prevention Plan
- Attachment 3 – Primary Prevention Assistance Code
- Attachment 4 – FFPSA Tip Sheet
- Attachment 5 – FFPSA Flow Chart

4.2 Policies

- Case Planning and Concurrent Planning SOP

4.3 Templates

4.4 Applicable Statutes and Regulations

5.0 Roles and Responsibilities

5.1 Child and Family Services Specialist (CFSS), Independence Coordinators (IC) are responsible for the steps outlined in this SOP. Other Protection & Safety staff are responsible for supporting these efforts.

6.0 Procedure

Determining a Candidate for Foster Care

- 6.1 A child should be determined to be a Candidate for Foster Care when the following circumstances are met:
 - 6.1.1 When an intake is accepted by the Abuse/Neglect Hotline for a family and assigned to a CFSS, Initial Assessment requirements and procedures will remain the same as outlined in the Initial Assessment SOP.
 - 6.1.2 Once a Structured Decision Making (SDM) Safety Assessment has been completed, if a child has been found “safe” or “conditionally safe” in their family home and evidence-based prevention services are recommended by SDM or otherwise determined to be helpful for the family, this child can be classified as a Candidate for Foster Care.
 - 6.1.3 When a child’s parent(s) is currently placed in foster care (pregnant/parenting foster youth), has a permanency plan of an APPLA, or participating in the Bridge to Independence Program, this child can be classified as a Candidate for Foster Care.
- 6.2 The child can remain safely in his or her home or an Approved Informal Living Arrangement if Prevention Services are in place to prevent the youth from entering foster care.
- 6.3 In conjunction with a case plan, a PP shall be created for court-involved cases when the youth/family are participating in an FFPSA service and/or the case involves a pregnant or parenting foster youth.
- 6.4 In conjunction with a Family Plan, a PP shall be created for Alternative Response cases when the youth/family are participating in an FFPSA service and/or the case involves a pregnant or parenting foster youth.
- 6.5 A PP should be developed with the eligible youth/young adult who agrees with participating in prevention services in conjunction with the Case Plan or Transitional Living Plan (TLP) in the case of young adults participating in the Bridge to Independence program (B2I).
 - 6.5.1 The PP and the Case Plan/TLP may contain similar information, however, they both need to be completed.
- 6.6 When CFS determines that the child welfare case can close and the family is participating in an EBP, the family can voluntarily choose to be placed on a “prevention track” established through CFS.
 - 6.6.1 The CFS worker and EBP provider will make every effort to meet with the family before changing the program case type, to provide information about the “prevention track” and the family’s continued participation in the EBP.
 - 6.6.2 The CFS worker and EBP provider will discuss the role of CFS after the case is on the “prevention track” and the intent of CFS’ continuance in receiving the same reporting information that was

provided while the CFS case was open, for data reporting purposes to ensure the efficacy of the EBP without CFS involvement.

Talking points include:

- CFS will no longer be conducting home visits
- The purpose of the “prevention track” is for data collection and to ensure continuance of payment by DHHS for the program delivery.

6.6.2.1 Once a case moves to the “prevention track”, the CFSS will no longer be assigned to the case.

6.6.3 The worker/supervisor will request their CFS Administrator to “flip” the program case to “prevention” rather than closing the case. Refer to the “Primary Prevention Assistance Code” Attachment.

6.6.4 The CFSS or CFS Supervisor will update the SDM Household to “Prevention” and update the “legal status” as done when closing a case.

6.6.5 The CFSS or CFS Supervisor will document as a Consultation Point, the case becoming a “Prevention” case and the reason why.

6.6.6 The CFSS will notify the Central Office via email at: DHHS.FamilyFirst@nebraska.gov of the case moving to the Prevention Track.

6.6.7 If a family does not want to participate in the “prevention track” but wants to voluntarily continue to participate in HFA post-case closure, the HFA provider will ensure the continuance of the service and the CFSS will follow the standard procedure of closing the case in the NFOCUS system.

6.7 The CFSS assigned to work with the family should discuss with the family the opportunity to participate in Prevention Services and, if the family agrees with Prevention Services, develop a PP for their child(ren).

6.7.1 A PP should be developed with the family in conjunction with the Case Plan for Court involved cases and/or cases that involve a pregnant or parenting foster youth or Family Plan for Alternative Response cases.

6.7.2 The Prevention Plan and the Case Plan (for court-involved cases and/or cases that involve a pregnant or parenting foster youth)/Family Plan may contain similar information, however, they both need to be completed to claim IV-E funding.

6.7.3 If the youth is determined to be a Candidate for Foster Care, is part of a non-court case and their parent is not a pregnant/parenting foster youth, only the PP will need to be completed.

- 6.8 As a reminder, the Prevention Plan must be created before or on the day of the Prevention Service starting.
- 6.9 SMART Goal
- 6.9.1 Please refer to the Case Planning and Concurrent Planning SOP on how to develop SMART goals.
- 6.10 Safety and Organized Practice
- 6.10.1 The following SOP tools should be used to engage the family in their Prevention Plan:
- 6.10.1.1 Solution Focused Interviewing
- 6.10.1.2 Harm/Danger Statement
- 6.10.1.3 Safety Mapping
- 6.10.1.4 Circles of Safety and Support.
- 6.10.2 When using SOP tools to gather information, the worker should identify the tools they use and the information they were able to obtain from the families in each identified narrative.
- 6.11 Refer to Attachment 2, Documenting a Prevention Plan, on how to document the Prevention Plan.

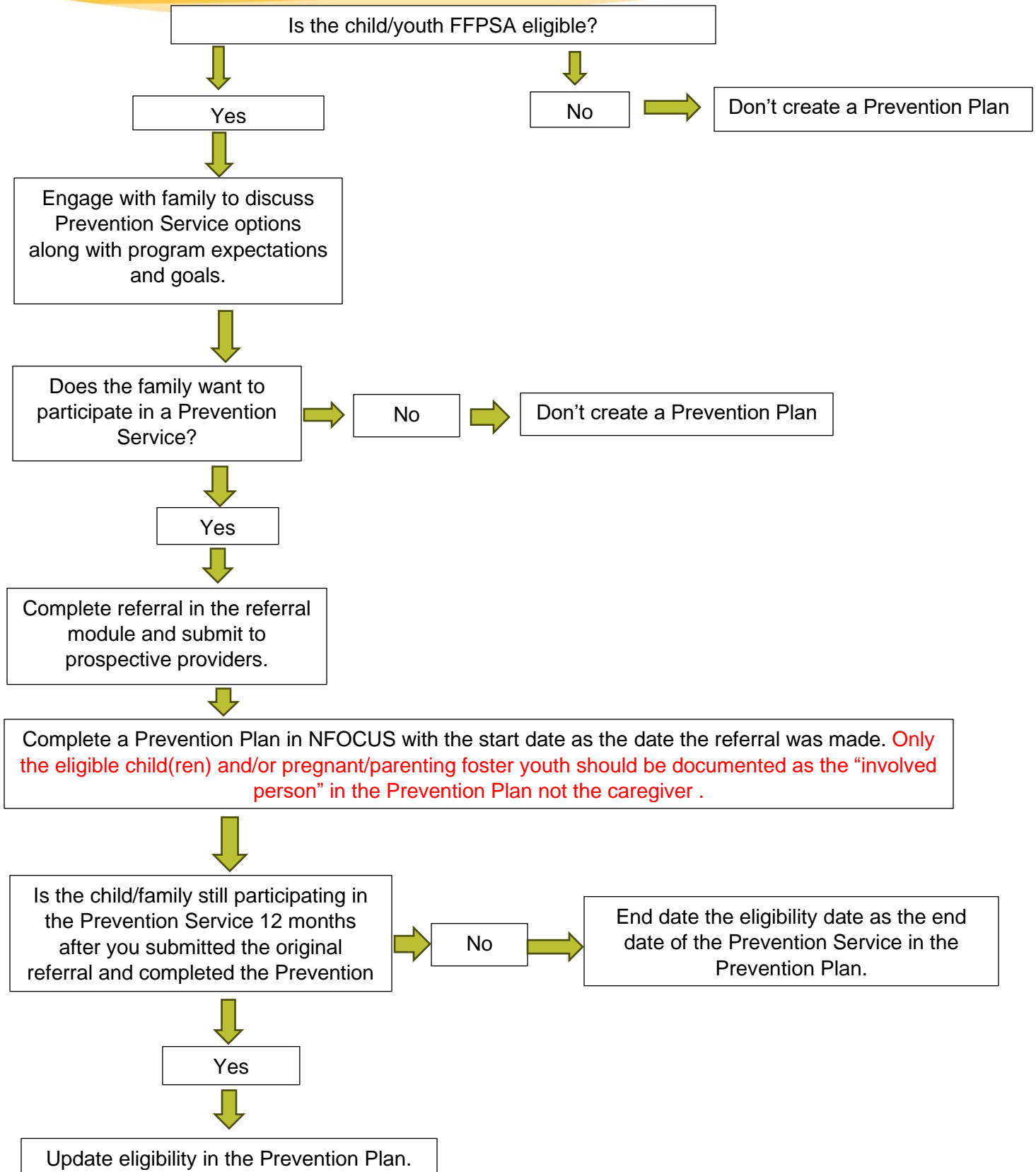
HISTORY OF CHANGES

Document	Version	Description	Author(s)	Author Date	Signature Date
		List a brief description of the changes made			

Attachment 1: List of Abbreviations and Definitions

List out all Definitions of applicable terms in the SWI

Abbreviations	Description
DHHS	Nebraska Department of Health and Human Services
DCS	Document Control System
SOP	Standard Operating Procedure
POL	Policy
SWI	Standard Work Instruction
Terms	Definition
Author Date	This is the date that the author starts drafting the document.
Signature Date	This is the date that the document is signed by the approvers, should be automatically input by DocuSign.
Divisions	The Divisions potentially affected by a SOP include: Operations, Behavioral Health, Developmental Disabilities, Public Health, Children and Family Services, and Medicaid and Long-Term Care.
Version Number	Identifies the number of times the document has been updated.



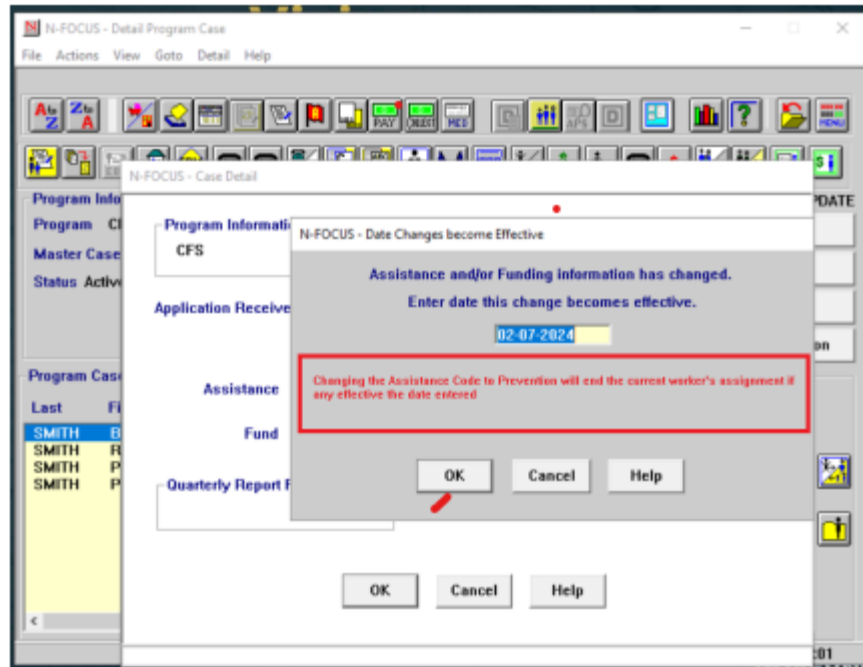
FFPSA Prevention Assistance Code

- When a CFS Program Case can close, but the family chooses to continue participating in an evidence-based program, the CFS Administrator will change the Assistance Code in the Case Detail window to “Prevention” rather than “closing” the CFS case.
 - If the family is working with Family Centered Treatment, the family must complete the first phase of treatment prior to changing the Assistance Code to “Prevention”.
- This Assistance Code will ensure a seamless continuity of Prevention Services.

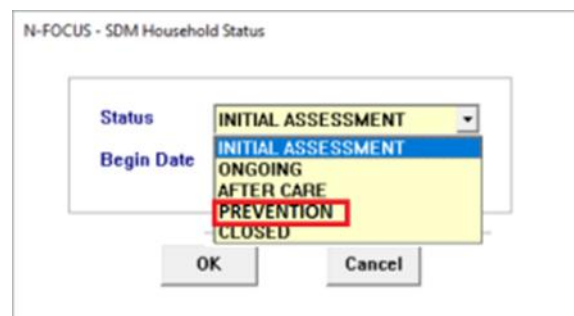
N-FOCUS - Case Detail

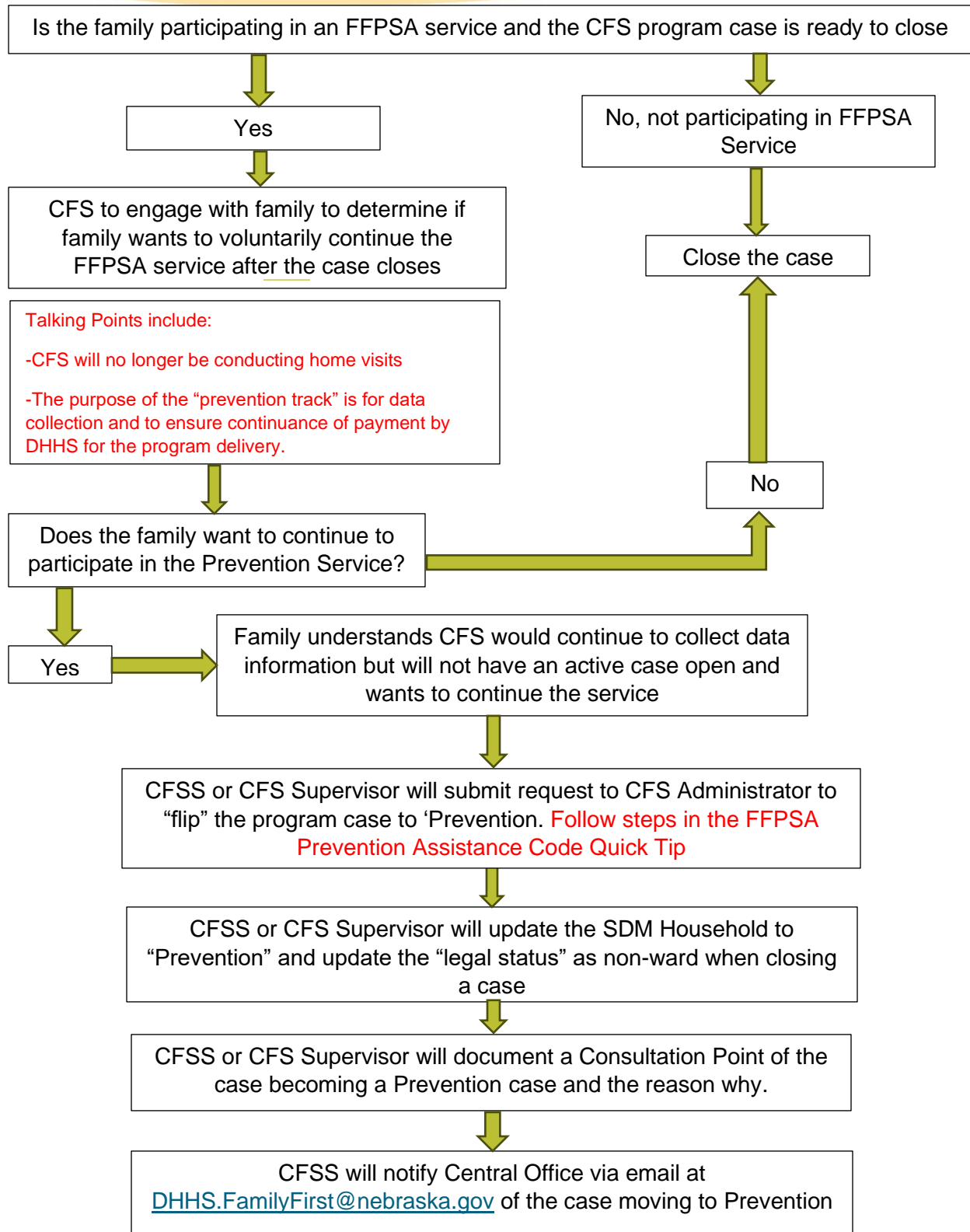
The screenshot shows the 'N-FOCUS - Case Detail' window. At the top, there is a 'Program Information' section with 'CFS' on the left, 'PREVENTION' in the center, and 'Master Case' on the right. Below this is the 'Application Received Date' field, which contains '12-01-2024'. The 'Assistance' dropdown menu is highlighted with a red box and shows 'PREVENTION' selected. Below it, the 'Fund' dropdown menu shows 'Mixed'. There is a 'Quarterly Report Form Month' field which is currently empty. At the bottom of the window, there are three buttons: 'OK', 'Cancel', and 'Help'. The 'OK' button is highlighted with a red box.

- The Case Detail pop-up window will display
 - i. Select Prevention from the Assistance dropdown
 - ii. Click OK
 - iii. A “pop-up” window will appear: enter the effective date
 - iv. When changing to “Prevention” the Current Worker’s Assignment will be end-dated, and the case will be Assigned to the default position.



- Once all SDM households are closed, the CFSS will create an SDM Prevention Household. This will allow for documentation without an active investigation or traditional case management.
- If a Prevention Plan is tied to the SDM Case Plan, it will not be mandatory to “tie” a Safety Goal when finalizing the Plan.







Nebraska Family Centered Treatment Evaluation Plan

In conjunction with the Family First Prevention & Services Act
September 15, 2025



University of Nebraska Public Policy Center

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Introduction

The University of Nebraska Public Policy Center (NUPPC) is conducting an evaluation of Family Centered Treatment in Nebraska as part of the Family First Prevention Services Act (FFPSA). This evaluation plan will detail the approach, evaluation questions, tools, and dissemination of evaluation. The aim of this evaluation is to achieve the stated goals while also being least burdensome.

Stakeholder Engagement

Within the evaluation plan development and in partnership with the Nebraska Department of Health and Human Services (DHHS), the evaluation team gathered feedback from multiple stakeholder groups to inform this evaluation plan. These groups included:

- Family Centered Treatment Foundation (5 participants)
- FFPSA Advisory Council (27 participants)
- FFPSA Champions Committee (5 participants)
- Family Centered Treatment providers in Nebraska (8 provider participants)
- Nebraska Indian Child Welfare Coalition (2 participants)
- Nebraska Children & Families Foundation / Find Help program (2 participants)

Each group was given a brief overview of the evaluation goals and objectives by the evaluation team. Participants were invited to share their opinions and experiences to inform the evaluation approach. Participants were also invited to provide feedback via email. The Nebraska Indian Child Welfare Coalition (NICWC) provided comments in writing via email.

Intervention, Target Population, & Evaluation Goals & Rationale

Intervention

The intervention studied in this evaluation is Family Centered Treatment (FCT), an intensive in-home intervention for families experiencing or at risk of out-of-home placement for their children. This evidence-based, trauma-informed family preservation intervention is aimed at helping families achieve their goals, increasing family satisfaction, well-being, and permanence (Sullivan et al., 2021). Only providers that have completed the requisite training and are approved to provide FCT are able to do so. The goals of the FCT model are to enable family stability, reduce harm, enable and sustain changes for improved independent family functioning and coping, while also reducing family system involvement (Glickman et al., n.d.; DHHS Child & Welfare Services, n.d.). FCT centers the family system throughout treatment.

There are four phases to the FCT model 1) joining and assessment, 2) restructuring, 3) valuing changes, and 4) generalization (Pierce et al., 2022; Family Centered Treatment Foundation, 2020). The average length of treatment is six months, depending on family need and engagement, with the clinical staff meeting with the whole family in the home a minimum of twice weekly (DHHS Children & Family Services, n.d.; Glickman et al., n.d.; Painter, Smith, & Wood, 2020).

Figure 1. Four phases of Family Centered Treatment



From the Family Centered Treatment Foundation, <https://www.familycenteredtreatment.org/the-fct-model>.

FCT In Nebraska

The FFPSA was signed into federal law in 2018 (H.R. 1892), which allowed federal funds to be spent on prevention services. These services include efforts to prevent out-of-home placement and provide evidence-based interventions to families at risk of their children entering foster care and/or going deeper into the child welfare system. In 2018, St. Francis Ministries, a human services agency focused on supporting children and families, began offering Family Centered Treatment in Nebraska. In 2019, Good Life Counseling briefly provided FCT services. Presently, St. Francis and Good Life Counseling no longer provide FCT in Nebraska, but four additional providers covering nearly all 93 counties in Nebraska have started providing FCT services. According to the FCT Foundation, 311 families have received or are

currently receiving FCT services in Nebraska as of the start of this evaluation (July 2025), (Table 1).¹ No modifications to FCT were made with implementation in Nebraska.

Table 1. Number of families who have received FCT in Nebraska

Year	Families Receiving FCT
2018	17
2019	16
2020	19
2021	45
2022	38
2023	13
2024	22
2025	75
Actively receiving services	(est.) 66
Total	311

Target Population

The evaluation of FCT includes two target populations of study: 1) families involved in the child welfare system, and 2) providers or representatives of agencies implementing FCT with referred families. The target population of system-involved families shares similar characteristics with the target population for the FCT intervention. This includes families with high risk factors, such as trauma exposure, and families with children at risk of out-of-home placement (Pierce et al., 2022). These families may also include youth who have already been placed out of the home and are transitioning home (DHHS Children & Family Services, n.d.). Participation in FCT is voluntary.

The target population of system-involved families also includes families with similar characteristics, services, and time of treatment, who have or have not participated in FCT (Table 4). The evaluation will employ a quasi-experimental design to compare outcomes for families participating in FCT and families that would be eligible or similarly eligible for FCT services but have not participated. The evaluation will examine historical data from when families first received FCT (2018) into the future (December 2026), and to identify two pools of similar families to compare using propensity score matching. Key criteria for families selected for this study includes:

1. Involvement with DHHS Child Welfare System
2. At risk of or experiencing out-of-home placement or going deeper into the Child Welfare System
3. Received or not received FCT services between August 2018 – December 2026
4. Similar familial characteristics (e.g., number and age of child(ren), risk and safety assessment scores, juvenile justice involvement)

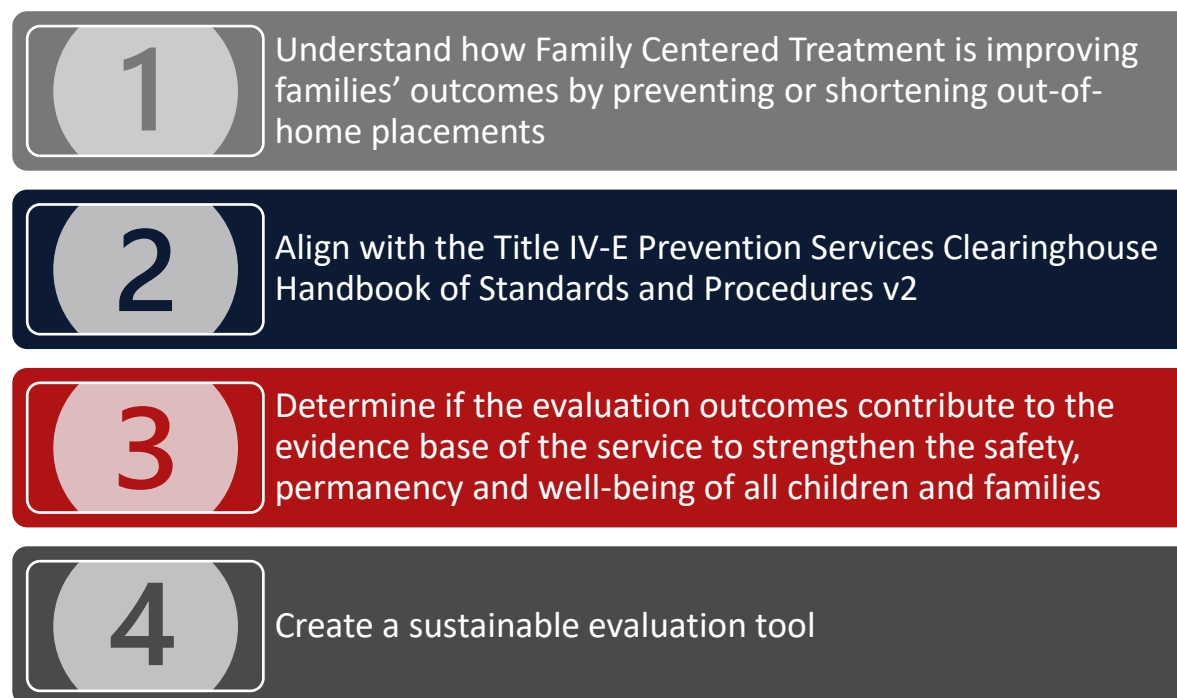
¹ Per an email shared from the FCT foundation on 08/19/2025, 311 families have participated in FCT since 2018 with an estimated 66 families still actively receiving FCT services.

For additional information on the matching and case selection for this study, please see the [Sampling](#) section of this evaluation plan.

Evaluation Goals & Rationale

This evaluation plan aims to meet the objectives set out by the Nebraska Department of Health and Human Services, Division of Child Welfare (DHHS) under the Family First Prevention Services Act (FFPSA) by examining the evidence related to Family Centered Treatment for families experiencing or at risk of a child out-of-home placement (Figure 2). This evaluation is both formative (examining the implementation of FCT) and summative (examining the impacts of FCT). This evaluation will build on prior studies evaluating FCT (Pierce et al, 2022; Sullivan et al., 2021; Bright et al., 2018; Bright et al., 2015). The primary audience for this study is the DHHS Division of Child Welfare, followed by providers, FCT Foundation, and other FCT practitioners or researchers.

Figure 2. Evaluation goals



This evaluation will consist of two studies, 1) an outcome evaluation and 2) a process evaluation.

Outcome Evaluation. The outcome evaluation will examine the identified outcomes (family permanency, family wellbeing, and satisfaction) for those within the FCT program and those with similar characteristics who might be eligible for FCT but are not enrolled in FCT (Evaluation Questions (EQ) 1 – 3).

- 1) What is the impact of FCT participation on family involvement with the child welfare system, as measured by out-of-home placements?
 - a) What is the impact of FCT participation on proximal family outcomes, including placement type at discharge?

- b) What is the impact of FCT participation on distal family outcomes, including re-entry into the child welfare system at 12- and 24-months post-discharge?
- 2) What factors associated with FCT participation (e.g., dosage, provider education, family characteristics) impact FCT completion and family permanency?
- 3) What is the satisfaction of families engaged with FCT (enrolled or completed)?

Implementation Evaluation. The purpose of the implementation evaluation is to better understand how FCT has been implemented in Nebraska, including the barriers to implementing FCT or FCT success (Evaluation Questions (EQ) 4 – 5).

- 4) How is FCT implemented in Nebraska?
- 5) What are the successes and barriers to FCT implementation in Nebraska?

The anticipated impact of this study is to 1) contribute to the evidence about FCT intervention effects; 2) inform FCT providers in Nebraska about the impact of their work; and 3) to inform long-term monitoring and evidence for FCT. Results of this study will be shared with key stakeholders including DHHS, the Nebraska FFPSA Advisory Council, Nebraska FFPSA Champions, Nebraska FCT Providers, and the FCT Foundation. A comprehensive report of results will be prepared and shared with DHHS and identified stakeholders. Additionally, results of the study will be prepared for submission to the Title IV-E Prevention Services Clearinghouse to add to the evidence about FCT. Finally, results of this evaluation study will be prepared and submitted for peer-reviewed publication, upon approval by DHHS.

Theory of Change

Key Issue: Families lack evidence-based interventions to prevent out-of-home placement and help them meet their family permanency goals.

Root cause(s): The causes of out-of-home placement are myriad and multi-layered but may include family violence, behavioral health needs, justice involvement, and/or lack of resources (e.g., Glickman, n.d., Pierce et al., 2022).

Theoretical Basis: Two theoretical models form the foundation of the FCT intervention.

- *Eco-Structural Family Therapy.* Eco-Structural Family Therapy is a trauma-informed, strengths-based family therapy model to help families at risk of out-of-home placement, particularly for families with children experiencing behavioral health challenges (Lindblad-Goldberg & Northey Jr., 2013). This model relies on the importance of the “relational environment” to family functioning; that is, the relationship between a child and parental functioning and the patterns of interactions between parents and children (e.g., Jones, Lindblad-Goldberg, & Jordan, 2008). The Eco-Structural Family Therapy model emerged from Minuchin’s earlier Structural Family Therapy (e.g., Minuchin, 1974).
- *Emotion-Focused Therapy (EFT).* Emotion-Focused Therapy (EFT) also looks at functioning in the way that emotions influence an individual’s sense of self and organize the way individuals process information. In this model, therapeutic providers seek to redirect the mal-adaptive responses to experiences, to change the “emotional experience and the narratives in which they are embedded” (Greenberg, 2006, p. 88).

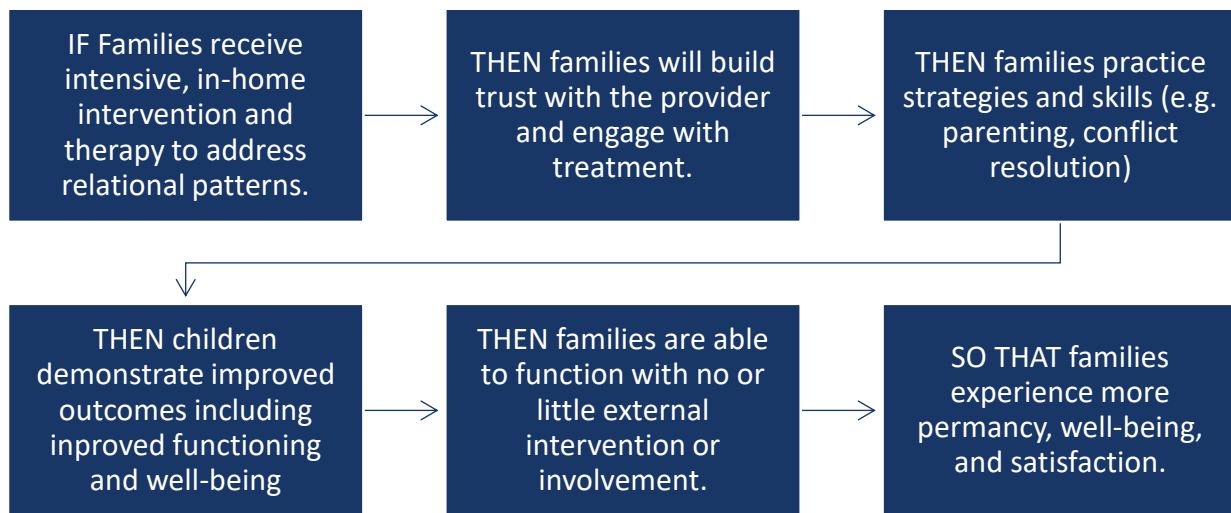
Family Centered Therapy applies these theories to guide how relational dynamics and individual context impacts behavior and functioning while maintaining a trauma-informed approach.

Assumptions: Key assumptions underpin the Family Centered Treatment intervention. These include the following:

- Families want to stay together and can change with the right support.
- Families are more likely to engage with services at home that are tailored to their challenges, goals, and strengths.
- Relationship-based therapy is necessary for change.
- Practical skill building can lead to long-lasting change.
- Outcomes improve when families are stabilized (e.g., Family Centered Treatment Foundation, 2020; 2025).
- Discomfort is acceptable because it creates motivation to change.
- New experiences influence new behavior.
- Experimenting with new behaviors creates new understandings informed by experiences.
- Hope motivates change (Family Centered Treatment Foundation, n.d.).

Theoretical or Causal links between FCT intervention activities and expected changes:

Figure 3. Causal statements for FCT



Evaluation Design

This evaluation utilizes a participatory approach by engaging stakeholders throughout the evaluation process. This framework aligns with the goals of the evaluation as it incorporates who is impacted by the work, such as FCT providers, families, and partner organizations, in the planning, data collection, and interpretation of the evaluation results (e.g., Cousins & Earl, 1992; Patton, 1997). This evaluation approach can build buy-in to the results.

As part of the continuing participatory evaluation effort, an **Evaluation Advisory Committee** will be established. This committee will be made up of participants representing FCT providers, DHHS, partner agencies, and the Nebraska Indian Child Welfare Commission (NICWC). Additional members may be identified as needed. This group will meet quarterly to review evaluation progress, ensure the evaluation considers the needs of families, advise on interview recruitment strategies, and provide context or explanation to the evaluation results.

There are two major components of this evaluation: an outcome evaluation to assess family permanency, safety, wellbeing, and the provision of FCT services as well as a process evaluation to examine how FCT has been implemented in Nebraska. These components were selected at the request of the funder, DHHS Division of Child Welfare, to align with the state's evaluation goals.

Outcome Evaluation

This outcome evaluation will examine the impact of FCT on families receiving the intervention and compare those results to those families not receiving FCT.

- 1) What is the impact of FCT participation on family involvement with the child welfare system, as measured by out-of-home placements?
 - a) What is the impact of FCT participation on proximal family outcomes, including placement type at discharge?
 - b) What is the impact of FCT participation on distal family outcomes, including re-entry into the child welfare system at 12- and 24-months post-discharge?
- 2) What factors associated with FCT participation (e.g., dosage, provider education, family characteristics) impact FCT completion and family permanency?
- 3) What is the satisfaction of families engaged with FCT (enrolled or completed)?

A quasi-experimental design will be used in the outcome evaluation to support the project goals by contributing to the body of evidence around FCT while aligning with the Prevention Services Clearinghouse standards. More details on this design can be found in the [Data Collection](#) and [Analysis](#) sections of this plan.

Process Evaluation

The process evaluation will examine how FCT has been implemented in Nebraska, including the benefits and barriers to implementation, fidelity to the FCT model, and the perceived impact on families and partners. This process evaluation will collect qualitative data through interviews, observations, and meeting records, from identified key project shareholders, such as agency staff providing FCT, DHHS

staff, and other partners. Interviews and observational data will be analyzed by the evaluation team to identify key themes related to the implementation (e.g., Indiana University, 2018).

This process evaluation will seek to answer:

- 4) How is FCT implemented in Nebraska?
- 5) What are the successes and barriers to FCT implementation in Nebraska?

Logic Model

Inputs	Activities	Outputs	Short-term Outcomes	Long-term outcomes / Impact
FCT providers Funding Partnerships with schools, courts, child welfare, behavioral health providers Training in FCT and related topics Family participants	Intensive in-home sessions Family goal setting and treatment planning Crisis stabilization and safety planning Family skills training Case coordination with child welfare, courts, schools Transition planning	# families referred, enrolled, completed (EQ 2, 4, 5) # of providers trained and certified (EQ 2, 4, 5) Dosage/ # sessions and length of time delivered (EQ 2) Engagement/ # stages completed/ # goals attained (EQ 2)	Increased family engagement (EQ 2) Increased family skills and wellbeing (EQ 2) Increased family satisfaction (EQ 3) Decreased subsequent maltreatment (EQ 1.b.)	Improved family stability (EQ 1.b) Increased family permanency (EQ 1, 1.a) Reduced hotline calls / long-term involvement in child welfare system (EQ 1.b)
Data Source				
FCT provider education Services received / System involvement Family characteristics DHHS case management assessment(s)	Fidelity checklists Outcome evaluation (EQ 1, 2, 3) Process evaluation (EQ 4 &5)	DHHS and FCT Foundation records Dosage logs from FCT Foundation	FCT Foundation Pre/Post FCT surveys FCT Foundation family satisfaction survey DHHS repeat / subsequent maltreatment DHHS placement type at discharge	DHHS records – Child Welfare involvement / hotline calls / placement

Data Collection, Sampling & Analysis Plan

Data Collection Plan

Outcome Evaluation

To measure outcomes (EQ 1 – 3), both in comparison and over time, the NUPPC will work with DHHS to identify a sample of families participating in the FCT intervention during the project. This sample will be increased with historical records of families who have participated in FCT since 2018, allowing for a more robust sample size. Following established methods used in previous studies of FCT (Pierce et al, 2022; Sullivan et al., 2021; Bright et al., 2018; Bright et al., 2015), evaluators will create a control group using propensity score matching (PSM or PS Matching). This statistical technique will match families based on their likelihood of receiving FCT treatment using demographic and baseline characteristics. The matched comparison families will be identified using both current project data and historical DHHS records, enabling more comprehensive and complex statistical analyses.

All data used to identify treatment and control group families will meet the requirements of the data sharing agreements with DHHS and FCT Foundation. The evaluation team will verify the quality and completeness of data provided by all sources and will match data from the state records with data collected by the FCT Foundation, for the same cases, and integrate additional outcome data collected for the purposes of the project. Additionally, the evaluation team will conduct ongoing analyses throughout data collection to identify any adjustments to the data collection protocol or analysis plans.

Data collected in the project will include outcomes previously measured in research studies to document the impact of FCT relative to improvements in out-of-home placements, safety, permanency, and well-being (Pierce et al., 2022; Indiana University, 2018). Data collected from the FCT Foundation will provide additional details for families participating in FCT concerning dosage (e.g., session frequency and length), characteristics of providers (education, experience, training), and treatment modality. The FCT Foundation will also provide data on family functioning outcomes, and family satisfaction measures. Furthermore, the evaluation team will be provided with implementation fidelity data, which will be used to ensure intervention condition consistency. Data collected will come from only two sources: DHHS Division of Child Welfare and the FCT Foundation (Table 2). By restricting data to these two sources the evaluation team can ensure consistency of the data collected and the ability to review historical data in addition to future data.

Over the course of the project, the evaluation team anticipates that FCT agencies will share data on a quarterly basis related to the identified metrics. With this quarterly data sharing, NUPPC can monitor data quality and completeness and identify any need for additional technical assistance related to data collection and submission. The evaluation team will meet regularly with DHHS, and FCT Foundation to address any data collection and submission questions, provide updates on the evaluation progress, and provide any additional technical assistance when needed.

Table 2. Variables within the data collection by source and purpose

Variable	Data Source	Purpose
Unique Family ID	DHHS, FCT	
Unique Individual ID	DHHS, FCT	
Name	DHHS, FCT	DHHS/FCT Matching
Date of Birth	DHHS, FCT	DHHS/FCT & PS Matching
Gender	DHHS, FCT	DHHS/FCT & PS Matching
Race	DHHS, FCT	DHHS/FCT & PS Matching
Ethnicity	DHHS, FCT	DHHS/FCT & PS Matching
Family Status	DHHS	PS Matching
Number of Children in Household	DHHS	PS Matching
Ages of Children in Household	DHHS	PS Matching
ICWA Eligible?	DHHS	PS Matching
County of Residence	DHHS, FCT	DHHS/FCT & PS Matching
Zip Code	DHHS	DHHS/FCT & PS Matching
Safety Assessment	DHHS	PS Matching
Risk Assessment	DHHS	PS Matching
FCT Participant?	DHHS	PS Matching
List of other interventions	DHHS	PS Matching
SDOH - Objective D		
Socio-economic status	DHHS	Prevention Services Clearinghouse (PSC) - Adult Well-being Domain - Economic and Housing Stability Outcomes
Employment status	DHHS	PSC - Adult Well-being Domain - Economic and Housing Stability Outcomes
Education status	DHHS	PSC - Children Well-Being Outcome Domain - Educational Achievement, Attainment, and Attendance Outcomes
Housing status	DHHS	PSC - Adult Well-being Domain - Economic and Housing Stability Outcomes
Disability status	DHHS	PSC - Children Well-Being Outcome Domain - Physical Development and Health Outcomes/Cognitive Functions and Abilities Outcomes
Any Justice involvement	DHHS	PSC - Adult Well-being Domain - Criminal Behavior Outcomes
Evaluation of Participating Families - Objective E		
Date of system entry	DHHS	
Reasons for System Entry	DHHS	
Date of system discharge	DHHS	
Placement Type(s)	DHHS	PSC - Child Permanency Outcome Domain
Placement Admission Date(s)	DHHS	PSC - Child Permanency Outcome Domain

Variable	Data Source	Purpose
Days in Placement(s)	DHHS	PSC - Child Permanency Outcome Domain
Placement Type at Discharge	DHHS	PSC - Child Permanency Outcome Domain
Any OOH Placement(s) 12 months post-Discharge	DHHS	PSC - Child Permanency Outcome Domain
Any OOH Placement(s) 24 months post-Discharge	DHHS	PSC - Child Permanency Outcome Domain
Records of substantiated/unsubstantiated reports of abuse or neglect	DHHS	PSC - Child Safety Outcome Domain
Records of investigations of abuse and neglect	DHHS	PSC - Child Safety Outcome Domain
Records of recurrence of abuse and neglect	DHHS	PSC - Child Safety Outcome Domain
Any Justice/Juvenile Justice involvement	DHHS	PSC - Child Well-being Outcome Domain
Offense(s) (Arrests): Charge of violation of the law	DHHS	PSC - Child Well-being Outcome Domain
Offense Date(s)	DHHS	PSC - Child Well-being Outcome Domain
Adjudication type(s)	DHHS	PSC - Child Well-being Outcome Domain
Adjudication date(s)	DHHS	PSC - Child Well-being Outcome Domain
For FCT Participants		
Date of Program Discharge	DHHS, FCT	
Family Strengths	FCT	PSC - Adult Well-being Domain - Family Functioning Outcomes
Progress on goal	FCT	PSC - Adult Well-being Domain - Family Functioning Outcomes
Area of family functioning goal	FCT	PSC - Adult Well-being Domain - Family Functioning Outcomes
Progress on area of family functioning	FCT	PSC - Adult Well-being Domain - Family Functioning Outcomes
Out-of-home Placement Details	FCT	PSC - Child Permanency Outcome Domain
Family Perception of Safety	FCT	PSC - Child Safety Outcome Domain
Juvenile Court Involvement	FCT	PSC - Child Well-being Outcome Domain
Days from referral to first FCT session	FCT	PSC - Intervention Condition Fidelity
Program Completion	FCT	PSC - Intervention Condition Fidelity
Time at Phase 1	FCT	PSC - Intervention Condition Fidelity
Time at Phase 2	FCT	PSC - Intervention Condition Fidelity
Time at Phase 3	FCT	PSC - Intervention Condition Fidelity
Time at Phase 4	FCT	PSC - Intervention Condition Fidelity
Phases within guidelines	FCT	PSC - Intervention Condition Fidelity
Status at Treatment Completion	FCT	PSC - Intervention Condition Fidelity
Reason for Termination	FCT	PSC - Intervention Condition Fidelity

Variable	Data Source	Purpose
Complete all 4 phases	FCT	PSC - Intervention Condition Fidelity
Treatment Success	FCT	PSC - Intervention Condition Fidelity
Aftercare planning	FCT	PSC - Intervention Condition Fidelity - Beyond the End of Treatment
Issues Addressed during FCT Services	FCT	PSC - Program Key Component Domain - Content
Primary FCT Goal	FCT	PSC - Program Key Component Domain - Content
Date of Program Enrollment	FCT	PSC - Program Key Component Domain - Dosage
Date of Program Discharge	DHHS/FCT	PSC - Program Key Component Domain - Dosage
Number of sessions	FCT	PSC - Program Key Component Domain - Dosage
Total actual direct hours	FCT	PSC - Program Key Component Domain - Dosage
Total actual direct contacts	FCT	PSC - Program Key Component Domain - Dosage
Number of family members participating	FCT	PSC - Program Key Component Domain - Modality
Use of Telehealth	FCT	PSC - Program Key Component Domain - Modality
Program provider	FCT	PSC - Program Key Component Domain - Providers
Provider Education	FCT	PSC - Program Key Component Domain - Providers
FCT Practitioner Feedback	FCT	PSC - Program Key Component Domain - Providers
RAM Assessment - by organization	FCT	PSC - Program Key Component Domain - Providers / Implementation Fidelity
Family Perception of Treatment	FCT	PSC - Satisfaction with Programs and Services Outcome Domain
Quality of Services - Satisfaction	FCT	PSC - Satisfaction with Programs and Services Outcome Domain
Amount of Services - Satisfaction	FCT	PSC - Satisfaction with Programs and Services Outcome Domain
Better handle family problems - Satisfaction	FCT	PSC - Satisfaction with Programs and Services Outcome Domain
Practitioner respectful	FCT	PSC - Satisfaction with Programs and Services Outcome Domain
Practitioner dependable	FCT	PSC - Satisfaction with Programs and Services Outcome Domain
Recommend FCT	FCT	PSC - Satisfaction with Programs and Services Outcome Domain
Like Best	FCT	PSC - Satisfaction with Programs and Services Outcome Domain
Change	FCT	PSC - Satisfaction with Programs and Services Outcome Domain
Different	FCT	PSC - Satisfaction with Programs and Services Outcome Domain
CPM Score	FCT	PSC - Satisfaction with Programs and Services Outcome Domain
Family Assessment Device	FCT	PSC - Satisfaction with Programs and Services Outcome Domain

Variable	Data Source	Purpose
Family Satisfaction Survey (See above)	FCT	PSC - Satisfaction with Programs and Services Outcome Domain
Community Stakeholder Feedback	FCT	PSC - Satisfaction with Programs and Services Outcome Domain

Process Evaluation Data Collection

The process evaluation (EQ 4 – 5) will include qualitative data collection and analysis. Data will be collected through group or individual interviews with agency staff providing FCT to families, DHHS staff, and other partners in Fall 2026, near the close of quantitative data collection. Interviews will be conducted online via video conferencing (Zoom) or in-person, as available and dependent on participant preference. Interviews will last 45 – 60 minutes and will be recorded and transcribed. Interview transcripts will be taken together with observations and notes from any meetings (e.g., provider calls) or technical assistance sessions, and results of implementation monitoring, if available. The NUPPC team will analyze transcripts and notes to identify key themes related to implementation, strengths and barriers to implementation, and perceived fidelity to FCT.

Process Evaluation Participants

Participants in the process evaluation interviews will include FCT providers, partner agencies, and families who have received FCT (Table 3). FCT providers will include agencies and providers who are or have actively provided FCT and who can speak about how FCT began and continued at their agency as well as its impact on families. Partner agencies may include representatives from juvenile justice, human service organizations, government entities, and community support. The evaluation team will aim for a minimum of 15 participants in total.

Table 3. Proposed implementation evaluation participants

Role	Topics
FCT providers / providing agency representatives (5 – 7 expected participants)	Implementation and start up, working with families, success and barriers to implementation, fidelity to FCT
Families who have received FCT (3 – 15)	Experiences with FCT, success and barriers to success with FCT
Partner agencies (3 – 5)	Experiences with FCT or families who have received FCT, success and barriers to success with FCT, experience with implementation of FCT, experience with FCT providers and implementation
FFPSA Advisory group and/or Champions (5 – 10)	Experiences with FCT or families who have received FCT, considerations for families at risk or experiencing out-of-home placement, experience with implementation, experience with FCT providers. Group may overlap with partner agencies.
FCT Foundation (1 – 3)	Experience with FCT implementation and fidelity to FCT in Nebraska; successes and barriers to implementation.

Participants in the process evaluation interviews will be recruited by the evaluation team in partnership with DHHS. Participation will first be introduced via quarterly meetings (e.g., FCT Providers, FFPSA Advisory Group, Champions groups) and emailed direct follow-up invitations. If required to obtain minimum participation, the evaluation team will reach out to potential participants via phone call.

Family participants, including those who are currently or have previously received FCT, will be invited to participate by the providers in partnership with the evaluation team. Only participants aged 19 and older will be invited to participate. As an incentive to participate and to honor their time commitment, families who participate in an interview will be offered a \$100 gift card.

Once participants agree to participate in an interview, the evaluation team will work with the participant(s) to schedule a time for an interview. The participant(s) will receive a unique Zoom link to participate in the interview with two members of the evaluation team. At the start of each interview, informed consent will be collected from the participant(s). The interviews will be audio and video recorded and transcribed. One member of the evaluation team will take notes during the interview, while another member will facilitate the questions following a semi-structured interview protocol (see [Appendix 2: Interview Protocol](#) for details).

Sampling Plan

For the outcome evaluation, propensity score matching will be used to create two pools of families to compare – one group of families who have participated in FCT (treatment group) and one group of families who have similar characteristics or could be eligible for FCT (control group). This approach inherently involves convenience sampling for the treatment group, as families cannot be randomly assigned to FCT. The statistical technique of propensity score matching addresses the fundamental challenge that families receiving FCT may systematically differ from those who do not, making direct comparisons potentially misleading without proper controls.

The convenience sampling approach for FCT enrollment reflects real-world child welfare practices where families are referred to services based on caseworker assessment, family needs, and voluntary participation rather than random assignment. This creates inherent selection bias since families who agree to participate in FCT may be more motivated, have different risk profiles, or possess characteristics that make them more likely to engage with intensive services. Propensity score matching creates comparable groups based on the conditional probability of receiving treatment given observed covariates, effectively mimicking random assignment within strata of similar propensity scores, thus controlling for the systematic difference introduced by convenience sampling (Rosenbaum and Rubin, 1983).

Families assigned to each group will be identified in partnership with DHHS. Selected data for all families who have completed or are actively enrolled in FCT will be shared with the evaluation team, which represents the convenience sample of families who received FCT services. Additionally, selected data for families enrolled in similar services who have system involvement will be shared with the evaluation team to create the potential comparison pool through propensity score matching. The evaluation team will match cases based on service enrollment, risk factors, and family or case characteristics (Table 4).

Table 4. Inclusion and Exclusion criteria for Study Intervention and Control Group

Criteria	FCT-enrolled families/ Intervention Group	Matched families/Control Group
Grouping Variable	Enrolled in FCT	-
Inclusion Criteria	<i>Optional</i> Enrolled in additional services	Enrolled in similar services
	At risk of or experiencing out-of-home placement	At risk of or experiencing out-of-home placement
	Similar characteristics	Similar characteristics (e.g., Risk and safety assessment scores)
	Aug. 2018 – Dec. 2026	Aug. 2018 – Dec. 2026
Exclusion Criteria	(Parent) Under age 19	(Parent) Under age 19
	Incomplete administrative data	Incomplete administrative data

Program records collected by DHHS will be used to create sample and control groups through propensity score matching. It is anticipated that historical records, spanning from August 2018 through December 2025, will make up most of the sample, however, data will be collected during the first year of the project (January-December 2026) to ensure adequate sample size and power. Given that the sample will be comprised of program records provided by partners at DHHS, the evaluation team does not expect attrition within the outcome study.

The propensity score matching process will be implemented iteratively following the established Rosenbaum and Rubin (1983) methodology, which involves multiple steps:

1. Identify families who received FCT versus those who did not receive FCT.
2. Randomize the dataset.
3. Generate propensity scores representing the likelihood of receiving treatment based on selected characteristics for all families.
4. Use a specified matching ratio to identify propensity score matches between FCT and non-FCT families and remove matched pairs from the available pool.
5. Repeat the matching process until all available matches are found.
6. Retaining only successfully matched cases in the final analytical dataset.

The propensity score matching process will be conducted iteratively, evaluating different subsets of matching variables and various matching procedures to achieve an optimal balance between securing adequate treatment-control matches and maintaining sufficient sample size for robust statistical analysis.

To minimize sampling and measurement error, the evaluation team will implement data validation procedures, including range checks, consistency verification, and duplicate detection protocols. The evaluation team will assess missing data patterns and apply multiple imputation methods as needed prior to propensity score matching.

The convenience sampling design introduces several potential biases, including selection bias where FCT families may systematically differ from the general population, geographic bias stemming from uneven FCT program availability, and referral bias due to caseworker discretion in program assignment. Evaluators will address these concerns through propensity score matching to balance observed covariates between treatment and comparison groups. Propensity score matching, however, relies on the unconfoundedness assumption (i.e., that treatment assignment depends only on observed characteristics). To evaluate the robustness of our findings to potential unobserved confounding variables, evaluators will conduct sensitivity analyses using Rosenbaum bounds test (Rosenbaum, 1987)

Traditional power analysis is most useful when planning prospective studies where sample sizes can be determined in advance and participants can be randomly assigned to treatment conditions. This study, however, faces unique methodological challenges that make conventional power analysis approaches less applicable for their intended use. First, FCT enrollment cannot be randomly assigned. Second, this evaluation relies primarily on historical administrative data spanning 2018-2025, meaning the sample size is largely predetermined by the families who actually participated in FCT during this period rather than being designed to achieve specific statistical power thresholds. Given these constraints, we may instead conduct a sensitivity analysis to determine how robust the results and estimated effects are to various design decisions regarding propensity score matching.

Analysis Plan

Outcome Evaluation

The majority of quantitative analyses will be conducted using R programming language. Data analysis will follow a systematic approach beginning with propensity score matching to create comparable groups, followed by comprehensive outcome analyses using both descriptive and inferential statistics aligned with the quasi-experimental design. The following planned analysis is dependent on the availability of data subject to the pending data sharing agreements with DHHS and the FCT Foundations as well as the FCT Foundation's business confidentiality agreements.

The primary analytical strategy will begin with calculating descriptive statistics for all variables and evaluating the quality of propensity score matching by examining standardized mean differences, variance ratios, and visual diagnostics between FCT participants and matched controls. For group comparisons, statistical methods will be selected based on data type and distribution characteristics, including t-tests for continuous normally distributed outcomes, Mann-Whitney U tests for non-normally distributed continuous variables, chi-squared tests for categorical outcomes, and McNemar's tests for paired categorical data when before/after comparisons are available for the same families. To analyze how outcomes change over time and account for the nested structure of repeated observations within families, mixed-effects models will be implemented. To understand what factors influence family outcomes, the evaluation team will conduct regression analyses that examine how key variables (e.g., FCT participation, FCT dosage, SDOH, measures of fidelity) relate to important family well-being outcome measures (e.g., days spent in the child welfare system). Throughout our analyses, evaluators will report appropriate effect sizes with confidence intervals to clearly communicate the practical significance of our findings. See Table 5 for more details regarding specific analyses.

Table 5. Analysis by evaluation question (1 – 3)

Evaluation Question	Analyses
1) What is the impact of FCT participation on family involvement with the child welfare system, as measured by out-of-home placements?	<p><i>Primary:</i></p> <ul style="list-style-type: none"> • Chi-square test (FCT vs. comparison group placement rates) • McNemar's test (if before/after data available for same families) <p><i>Secondary:</i></p> <ul style="list-style-type: none"> • Logistic regression (adjusted for confounders)
1.a.) What is the impact of FCT participation on proximal family outcomes, including placement type at discharge?	<p><i>Primary:</i></p> <ul style="list-style-type: none"> • Chi-square test (distribution of placement types between groups) <p><i>Secondary:</i></p> <ul style="list-style-type: none"> • Multinomial logistic regression
1.b.) What is the impact of FCT participation on distal family outcomes, including re-entry into the child welfare system at 12- and 24-months post-discharge?	<p><i>Primary:</i></p> <ul style="list-style-type: none"> • Chi-square tests (FCT vs. comparison group re-entry rates at each time point) • McNemar's test (compare 12-month vs. 24-month re-entry within same families) <p><i>Secondary:</i></p> <ul style="list-style-type: none"> • Mixed-effects logistic regression • Repeated measures logistic regression using Generalized Estimating Equations (GEE)
2) What factors associated with FCT participation (e.g., dosage, provider education, family characteristics) impact FCT completion and family permanency?	<p><i>Primary:</i></p> <ul style="list-style-type: none"> • Multiple logistic regression (FCT completion) • Chi-square tests (bivariate associations) <p><i>Secondary:</i></p> <ul style="list-style-type: none"> • Mixed-effects logistic regression
3) What is the satisfaction of families engaged with FCT (enrolled or completed)?	<p><i>Primary:</i></p> <ul style="list-style-type: none"> • t-tests (enrolled vs. completed) • Descriptive statistics (means, frequencies) <p><i>Secondary:</i></p> <ul style="list-style-type: none"> • Multiple linear regression (predictors of satisfaction) • ANOVA (satisfaction by provider agency) • Thematic analysis of open-ended responses

Note. The specific analytical approaches will be determined based on the structure, quality, and completeness of the data provided by DHHS and the FCT Foundation. Final selection of statistical methods/analyses will depend on factors such as sample sizes, data distribution characteristics, missing data patterns, and data types.

Evaluators will assess missing data patterns and apply multiple imputation methods as needed prior to propensity score matching. For variables with less than 5% missingness, complete case analysis may be

appropriate, while variables with 5-20% missingness may be addressed through multiple imputation methods, and variables with more than 20% missingness may be excluded from primary analyses but examined in sensitivity analyses. The multiple imputation model will include all variables used in both the propensity score estimation and outcome analyses, as well as auxiliary variables that predict missingness patterns. Sensitivity analyses may be conducted to compare results from complete case analysis, single imputation methods, and multiple imputation to assess the robustness of findings to different missing data approaches.

All quantitative analyses will be conducted using R or SPSS. Results will be reported in multiple formats, to meet the goals of the evaluation (see [Reporting](#)). To ensure results are presented in a balanced and objective manner, the evaluation team will provide comprehensive results of the evaluation. This will include tables of all descriptive statistics as well as the results of all statistical tests (both significant and non-significant).

Process Evaluation

The process evaluation will collect data via individual or group interviews with identified stakeholders to better understand how FCT has been implemented in Nebraska (Table 6). Transcripts from the interview will be thematically analyzed. In a thematic analysis, researchers work to identify patterns across qualitative data (Braun & Clarke, 2006). Themes are identified, patterned responses or meaning in response to a research question.

Table 6. Analysis by evaluation question (4 & 5)

Evaluation Question	Data Type	Analyses
4) How is FCT implemented in Nebraska?	Interview transcripts & notes Meeting notes	Thematic analysis
5) What are the successes and barriers to FCT implementation in Nebraska?	Interview transcripts & notes Meeting notes	Thematic analysis

To analyze the data, the research team will upload all the interview transcripts to the qualitative data analysis software (Atlas.ti 24). The research team will review the data and develop an initial codebook based on the evaluation questions on FCT implementation, successes, challenges, and impacts of FCT in Nebraska. The initial codes will be applied to a sample of transcripts, and then the coders will meet to discuss and compare the application of codes to refine the codebook. Any identified changes will be applied to the transcripts. Coders will then apply the codes to a second sample of transcripts to review coding and ensure consistent application of codes across transcripts. This process will be repeated using a consensual qualitative process (Hill et al., 1997; Hill et al., 2005) to analyze data and identify results. To avoid bias, the coders will conduct researcher checks to discuss codes and themes among the research team throughout the process. Exemplar quotes will be utilized to validate the themes.

Study Limitations

Potential limitations to this evaluation study are presented below.

1. This evaluation study is a quasi-experimental study and, as such, families cannot be randomized into receiving or not receiving FCT services. While this removes any ethical concerns related to preventing families from receiving an evidence-based intervention, it may also introduce bias as participation in FCT is not determined randomly. The evaluation team will create a control group based on matched cases using existing data on families whose children are at risk of out-of-home placement. The use of propensity score matching helps to address this challenge because it mimics random assignment.
2. The present population of families receiving FCT in Nebraska is relatively small (an estimated 311 families to date). With this sample, the evaluation team will need complete records to match families who are not receiving FCT but have similar characteristics. The evaluation team presumes to be able to match an adequate number of cases, but if not, the sample size will be decreased to only those cases that have matched results, limiting the sample size. To address this challenge, the evaluation team will work closely with DHHS to utilize the criteria to identify matched families.
3. Matching families who are eligible but not receiving FCT may be receiving other evidence-based interventions or supplemental services mitigating the need for FCT. As such, these families may be a reasonable “match” but may not demonstrate a significant difference in effect. Efforts to address this limitation will include noting what services all families in this study are receiving.
4. Expansion of FCT is relatively new in Nebraska, with many providers just beginning to provide FCT services. This may be cause for fidelity issues and/or smaller sample sizes. An additional challenge is that the primary sample from this study is from one single provider. As a result, the evaluation team aims to diversify the sample with the future data collection through December 2026.
5. Finally, this evaluation study relies on program records from both DHHS and the FCT Foundation and does not include any new data collection source. While this design was selected to enhance matching capability and reduce burden on providers, this evaluation is reliant on the variables available and the format in which those variables are provided. To address this limitation, the evaluation team worked closely with DHHS and the FCT Foundation to ensure that the data available would meet the needed outcome measures for the study, particularly those related to family permanency and safety.

Reporting, Disseminating and Using Findings

Throughout the study, the evaluation team will provide quarterly progress updates to DHHS and identified stakeholders, such as FCT providers collecting data, FFPSA Advisory Council, and, as needed, the FCT Foundation. This evaluation plan was developed with significant input from a variety of stakeholders, and this evaluation plan may be made accessible to those populations.

Evaluation findings will be communicated to key audiences at the completion of data analysis. Updates on data collection will be provided to stakeholders on an ongoing basis.

More broadly, evaluation findings will be disseminated in four ways:

- 1) An evaluation report submitted to DHHS
- 2) A submission to the Title IV-E Prevention Services Clearinghouse
- 3) Presentation to key stakeholders of the findings
- 4) Submission to a peer-reviewed journal, upon approval by DHHS

Disseminating the results of this evaluation will help contribute to the available evidence and research around Family Centered Treatment to help determine its effectiveness for families at risk of out-of-home placement.

Data Security and Privacy, Informed Consent Procedures, and Institutional Review Board Approval

Data Security

The evaluation team will enter into data sharing agreements with DHHS and the FCT Foundation. These agreements will ensure that confidentiality of information is protected. Data sharing agreements ensure that data shared is PHS compliant. Agreements will describe the timeframe, variables, and terms of data sharing.

All members of the evaluation team have completed CITI Human Subjects Research and PHS data security training.

The secure server for the evaluation team is regularly backed up and utilizes automated anti-virus scans with the highest security standards. The server is in a locked room at the NUPPC and accessible only by password.

Quantitative Data

When possible, de-identified data will be used and each family, case, or individual will be identified only by a unique identifier. Identifiable data will only be used as relevant and necessary to the project.

Data between agencies will be shared via a secure, password-protected, restricted access SharePoint site managed by the University of Nebraska-Lincoln Information Technology Services. Only authorized users who are members of the evaluation team or data sharing agencies will have access to the site. DHHS and the FCT Foundation will upload data to the secure site on a quarterly basis through the end of the project.

To match data for the same cases between the FCT Foundation and DHHS, the evaluation team will need to create a “key” to align identifiers between these agencies. The key will be stored on a secure, password protected server, only accessible by the evaluation team. Once matched, identifiers will be deleted from the data set by the evaluation team. The key will be stored separately from the data sets, ensuring that all data sets are de-identified. At completion of the project, the key will be permanently deleted.

Data will only be reported in aggregate form.

Qualitative Data

Data from interviews, including participant names, recordings, and transcripts will be stored on the secure, password protected server, only accessible by the evaluation team. Transcripts will be created using Rev transcription services. A Data Processing Agreement can be found in [Appendix 3](#). Completed transcripts will be saved on a secure, password protected server only accessible by the evaluation team. Once transcripts are complete, audio and/or video recordings will be deleted. Transcripts will have any names or identifying information removed. Once transcripts are complete, they will be uploaded into Atlas.ti 24 qualitative coding software for analysis.

Themes will be identified and reported. Individual quotes which exemplify themes may be included but will not be attributed to any specific individual or organization.

Informed Consent

Evaluation team members conducting interviews will explain the evaluation, provide written information, and obtain informed consent. Individuals over the age of 19 will complete an informed consent form. Individuals who obtain consent forms are the interviewers from the research team.

Consent forms will not be required for quantitative data. Quantitative data will be shared and protected by data agreements between DHHS and the FCT Foundation with the NUPPC.

Institutional Review Board

This evaluation plan will be submitted to the University of Nebraska-Lincoln Institutional Review Board for review. First, the IRB will determine if this project meets the threshold for human subjects' research. If it does, the evaluation team will submit the full plan to the IRB for review, which will include submitting the recruitment procedures, protocols, data security procedures, informed consent forms, and full evaluation plan to the IRB. The estimated time frame for approval, if required, will take between two and eight weeks.

Prior to submission, the evaluation team completed all relevant training and forms. It is unexpected that approval will be delayed, as the evaluation team will respond to IRB questions in a timely manner. A delay in approval, while unlikely, will keep the project on pace (see the [Evaluation Timeline](#)). The evaluation plan and protocol will be submitted to the IRB in September 2025, with an expected review data by October 2025.

Evaluation Roles & Responsibilities

Figure 4. Evaluation roles and responsibilities by organization

Evaluation Team

- Dr. Jennifer Meek - will lead quantitative data collection, data analysis, and support sampling design; will co-lead evaluation design
- Dr. Janell Walther - will co-lead evaluation design, will lead qualitative data collection and analysis, will support project management
- Dr. Jordan Wheeler - will lead sampling design, quantitative data collection and analysis; will support evaluation design
- Taylor Smith, MPA - will support sampling design, quantitative data collect, and analysis; will support evaluation design

FCT Foundation

- Will upload data for families enrolled in FCT in Nebraska from 2018 to present within the first three months of the data agreement.
- Will upload data quarterly for agencies or individuals providing FCT in Nebraska, including fidelity measures.

DHHS

- Will upload data within the first six months of the data agreement for families enrolled in FCT and potential matched families for match timelines (2018 to present) for identified variables.
- Will upload data quarterly for families enrolled in FCT and potential matched families present through December 2026.

Jennifer Meek, Ph.D., will lead and oversee quantitative data collection and evaluation design for this project. Dr. Meek is a Research Director at the Public Policy Center, with over 20 years' experience conducting research and program evaluation studies in the fields of education and behavioral health. This includes extensive experience using both quantitative and qualitative research methods in studies engaging children with emotional and behavioral needs and their families. Prior to joining the NUPPC, Dr. Meek completed an U.S. Department of Education Institute of Education Sciences (IES) Postdoctoral Fellowship in the Academy for Child and Family Well Being at the University of Nebraska-Lincoln. In this position she was part of a team that conducted a rigorous evaluation of in-home family services and a randomized control trial of a parent engagement intervention. Dr. Meek received her Ph.D. in Education from Iowa State University, with a certification in Applied Research Methods. She also has earned an M.P.A. from Drake University and a B.A. from Central College.

Janell Walther, Ph.D., will lead and oversee qualitative data collection and evaluation design for this project. Dr. Walther is a Research Director at the Public Policy Center with over 15 years of experience in evaluation, facilitation, stakeholder engagement, and project management. She has partnered with state and local public, private, and not-for-profit organizations to provide evaluation and research design, data collection & analysis, reporting, project management, and engagement. Her area of research is in public engagement and communication, including considerations of how to communicate

complex ideas with policy makers and publics to improve decision-making. Dr. Walther teaches and provides training in areas including small group facilitation, public speaking and businesses communication. She is a member of the American Evaluation Association, American Educational Research Association, and the National Communication Association. Dr. Walther received her Ph.D. and M.A. from the University of Nebraska-Lincoln and her B.A. from Kansas State University.

Jordan Wheeler, Ph.D., will lead quantitative analyses and sampling design for this project. Dr. Wheeler is an Assistant Professor of Quantitative and Psychometric Methods at the University of Nebraska – Lincoln in the Department of Educational Psychology. He has extensive experience in educational measurement, research design, and statistical analyses through his work with school districts and state departments of education. Prior to joining UNL, he worked as a Research Scientist and Psychometrician for Pearson Education where he conducted operational psychometric and evaluation work for a large-scale formative assessment system to measure student learning over time. He received his Ph.D. in Quantitative Methods from the University of Georgia. He also has a M.S. in Statistics from the University of Nebraska – Omaha and a B.S. in Mathematics from Nebraska Wesleyan University.

Timeline

Evaluation Activity	2025					2026					2027							
	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D
Evaluation Planning																		
Finalize evaluation goals and plan																		
Finalize consent procedures																		
IRB approval																		
Data Collection																		
Data collection protocols approved by DHHS																		
Data collection timeline and training with partners																		
FCT participant identification																		
Participant matches identified																		
Quant data collection																		
Interview participant consent obtained																		
Stakeholder Interviews																		
Data Analysis																		
Quantitative analysis																		
Qualitative analysis																		
Reporting																		
Quarterly Progress Reports																		
Draft of findings for finalization																		
Support submission of results to PSC																		
Finalized evaluation submitted to DHHS																		
Tool Development																		
Development of Tool																		
Development of Tool Implementation Timeline																		
Draft of tool for finalization																		
Finalized tool submitted to DHHS																		
Partnership and Communications																		
Monthly meetings with DHHS																		
Collaboration with multi-stakeholder groups																		
Evaluation Advisory Committee meetings																		

Budget

The budget was previously submitted with the project proposal, which included costs by deliverable and direct costs (such as incentives and communications costs).

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