LB 1173 Statutory Workgroup Meeting
MINUTES
August 3, 2023

The Nebraska LB 1173 Workgroup as established by the Nebraska Legislature met August 3rd at DHHS offices, 5220 South 16th Street, Lincoln Nebraska, and via Zoom for the purpose of conducting business consistent with the statutory language of LB 1173, having given notice through release to news media and official public notices published in the Lincoln Journal Star.

The meeting was called to order at 2:03 PM CST. John Stephen from The Stephen Group, the consultant hired pursuant to LB 1173 to assist the Workgroup in meeting its deliverables, called the meeting to order and advised that the meeting was held as a public meeting and was being recorded.

LB 1173 Voting Workgroup members present: DHHS Division Director of Children and Family Services (Interim) and DHHS CEO Tony Green; DHHS Division Director of Behavioral Health (Interim) and DHHS Division Director of Developmental Disabilities Tony Green; Commissioner of Education designee LaDonna Jones-Dunlap (virtual); DHHS Director of Medicaid and Long-Term Care Kevin Bagley; State Court Administrator and representative of the State Judicial Branch designee Kari Rumbaugh; Stephanie Pospisil, Ponca Tribe of Nebraska (virtual); Miskoo Petite, Winnebago Tribe of Nebraska (virtual); DHHS Director of Public Health designee Sara Morgan.

LB 1173 Voting Workgroup Member representatives for the Omaha Tribe of Nebraska and Santee Sioux Nation were absent.

LB 1173 Ex-Officio (Non-Voting) Members present: Bryson Bartels (virtual); Deb VanDyke-Ries, Jenny Skala; Ryan Stanton; Monika Gross; Janece Ferris (virtual); Ivy Svoboda; and Maureen Larsen.

Internal DHHS staff present were Camas Holder; Maralee Maldavs; Heather Nelson; Michelle Nonemaker; Andrew Keck; Cedric Perkins; Kasey Boes; Alger Studstill; Jeff Powell (virtual); Greg Brockmeier; Khalilah LeGrand; Laura Opfer

Others present were: Mikayla Findlay (virtual); Amber Hairstock (virtual); David Hansell (virtual); Jake Dilsaver (virtual); Kelli Dempster (virtual); Noah Karmann (virtual); Whitney Abbott (virtual); Brian Rader (virtual); Echohawk Lefthand (virtual); Marlon Brewer (virtual); Trisha Behrens (virtual)John Stephen, The Stephen Group; Richard Kellogg, The Stephen Group; Brooke Holton, The Stephen Group (virtual); David DeStefano, The Stephen Group (virtual); and John Cooper, The Stephen Group (virtual)

The agenda proceeded as follows.

- **Approval of the Agenda/Minutes (Action Item)**
  - **A motion was made by Tony Green to accept the minutes which was seconded by Kevin Bagley and approved by vote, with all voting aye and none voting nay.**

- **Review of Status Report**
  - No comments or questions were made on the July Status Report.

- **TSG Presentation on Themes**
  - John Stephen from The Stephen Group gave a presentation of Themes that have emerged throughout the LB 1173 Work Group process of meeting with diverse stakeholders across the spectrum of the child welfare system through community forums, conducting individual interviews, and attending stakeholder meetings.
  - These themes were focused on Western Nebraska and included the need for Peer Support; Expansion of EBPs; Training improvements; Housing support; Dental/vision access.
  - It was noted that the Community Collaboratives in the Western part of the State are strongly embedded in the community/leveraging funding from Nebraska Childrens Foundation.
  - Across agency and system focus – need for a better understanding of poverty (Bridges out of Poverty); Medicaid MCO Foundations contribute to the community, but MCO Care Coordination services not very accessible, understood by community or utilized; Mobile Technology for case workers needed; Workforce shortages have greater impact/CFS should revisit staff requirements for Bachelor degree and allow for experience in some cases to supplant; Need for simplified and integrated eligibility system; Need for a plan and policies that will address the Cliff Effect in meaningful way; Reduce barriers to access funding, especially in the BH area; Professional Partnership program is a best practice and model should be accessible to more families Need to address service gaps for system involved children with developmental disabilities; Improve Medicaid Transportation access and availability.
  - Local control of funds; rural areas need flexible funding. Local communities know what is needed and what works best in their communities.
  - Alger Studstill offered remarks regarding EBPs offered under FFPSA are set through federal regulations not Nebraska regulations.
- **Training Recommendations**
  - John Cooper from The Stephen Group provided an overview of the strengths, opportunities and recommendations for new worker training.
  - Strengths included the relationship with the University of Nebraska (Lincoln) Center on Children, Families, and the Law (CCFL) and a nationally recognized blended-learning model.
  - Recommendations included a curriculum redesign using the adopted Nebraska child welfare practice to shape and inform the construction of the new worker training; the development of a new “Core” training module that focuses on the foundational elements and knowledge all new workers should understand – the “Why” and “What” of the Nebraska child welfare system; add specialty tracks (Intake, Initial Assessment, On-going, Adoption) to streamline the training and allow workers to focus on their selected stage of service; include testing and require a passing score after the “Core” and “Specialty” training blocks to measure knowledge acquisition, training effectiveness, and worker preparedness; re-examine the existing blend of experiential and simulation training to include more “Real” field

practice aligned with the most prevalent skills and practices required to prepare a new worker; modernize simulation training and incorporate virtual reality to augment role play; create dedicated mentors to assign to all new workers for a period of at least six months; rebrand the training model to include worker wellness throughout the training to prepare the workforce for the demands of the profession and increase retention rates; adopt an initial and ongoing professional certification process for the child welfare workforce.

- There was some discussion of the use of the practice of new workers “shadowing” more experienced workers and it is still a practice but that turnover and resources have limited the practice. There are also field trained specialists and when a new case manager is coming out of training, there are a specific number of experiences that they have to experience in the field with a field training specialist.
- Michelle Nonemaker commented that the recommendation around specialty tracks has come up for a number of years. “I'm not a fan of them. And the reason being for many of the reasons that we've talked about today is that there's a high turnover. Workers are only being trained in one, but then have to take on additional tasks due to staffing shortages. When or where or how are they going to get that additional training.” Mr. Cooper responded that the worker picking up additional duties would at some point go back and receive only the specialty track required and not undergo the entire 14 week training. Alger Studstill commented that this approach has been tried before and turnover makes it challenging. He further stated that it would be more beneficial to ensure that staff with specific responsibilities get the specific training needed rather than all staff having to complete the entire 14 week training for example specialty training for intake, case management as well as permanency and adoption. Laura Opfer suggested a specialty track be developed specifically for Tribes. It was noted that the recent data show that staff turnover has improved significantly.
- Alger Studstill noted that there are two RFPs planned regarding training. The first in early 2024 for curriculum design and the second later in 2024 for curriculum delivery. Would like to see regional hubs of standard training curriculum for western and central; northern and easter; southern and eastern parts of the state.
- Camas Holder noted that CFS is required to respond. 24/7/365. The training curriculum needs to be pliable and flexible, because if we're hiring somebody for a part-time evening weekend shift to then require them to work Monday through Friday for a weekly training has been a barrier in hiring for one shift, but having to train in another shift.

- **Finance Update**
  - David DeStefano from The Stephen Group provided an update on Finance Workgroup activities and provided the following draft fiscal framework recommendations to the workgroup.
  - Draft Fiscal Framework: Title IV-E recommendations to improve the Title IV-E penetration rate and state’s ability to claim federal reimbursement

1. Work with federal legislative representatives to pursue change to Title IV-E lookback (AFDC) amount including long term agenda across states and from advocates
2. Licensing of relative caregivers / kinship homes including change to general mindset regarding licensing of relatives; regulation change(s) to streamline licensing requirements for relative/kinship homes
3. Change to agency contracts including relative/kinship home specific contract requirements for agencies; specific language related to licensing homes (give some language about approved waivers for a reason why the home can't or won't become licensed); varied administrative rate for non-licensed homes or create an incentive for licensed homes
4. Claiming for children placed through Letters of Agreement
5. Continue to improve eligibility-related documentation
6. Shared Living Providers to include only send youth to SLPs who are DD Eligible (unlicensed); specialized License SLPs; rate structure based around acuity with other wraparound supports as necessary
7. Integrate Kinship Navigation services into child placing agency (CPA) contracts to include claim Title IV-E Kinship Navigation for dependency cases when children are not eligible under traditional Title IV-E and/or placed with an unlicensed relative or non-relative caregiver
8. Pursue Expansion of Training & Educational Programs to include pathway to training for providers with varied educational backgrounds (high school, peers, bachelor's level, master's level, post-graduate, etc.); include workforce development and training of state and provider staff capable of providing evidence-based interventions; leverage Title IV-E training dollars, other federal funding sources, and MCO investment
9. CCWIS development to include alignment of programmatic and technology to support systemic efficiencies

- Draft System Synergy recommendations to improve departmental and system collaboration to enhance the service delivery framework, leverage funding, and improve outcomes:
    1. Title IV-E claiming for Juvenile Probational Services and high-quality legal representation of children and families to include require updates to the state's Title IV-E plan and Cost Allocation Plan; administrative burden / cost to collect expenditure data, implement time study (Random Moment Sample), and calculate claim; need to investigate and verify ROI; B2i
    2. Create blended and/or braided funding strategies to ensure Medicaid coverage for FFPSA evidence-based practices to include collaboration with Medicaid and MCOs to include EBPs as in-lieu-of or covered services
    3. Collaboration and funding staff in schools to provide early intervention, prevention, and crisis-intervention
    4. Community Pathway to Prevention to include partnership with Community Collaboratives and Tribal Nations; develop approach, contractual responsibilities, create cost estimates, and determine eligible expenses for reimbursement as a Title IV-E (FFPSA) administrative costs
    5. Regional Behavioral Health System of Care to include leverage funding to create a regional system providing mobile response, crisis intervention

teams, family intensive treatment; involve persons with lived experience to provide peer support and connection to prevention services through the Community Pathway
6. Create state legislation to eliminate or limit the “benefits cliff” for families in crisis receiving economic or concrete supports
7. Create investment in provider capacity to support the provision of high-quality services through workforce development and training, recruitment, and retention
8. Develop Medicaid Waiver(s) to support services to improve Social Determinates of Health (SDOH) and provide Children’s MH Wraparound
9. Leverage public health block grant funding / MIECHV
10. Leverage TANF surplus through investment in programs, systems, and supports to include warm line development; statewide Family Resource Navigation and Support Coordination; Community Pathway to Prevention; concrete and economic supports to families; closed loop referral system
11. Collaboration with Developmental Disabilities to include cross-system claiming for DD homes; remove licensing related barriers

- Draft Provider Rates & Contracts recommendations to ensure rate equity, contractual outcomes, provider accountability, and federal financial participation:
    1. Claiming for Title IV-E Administrative costs to include child placing agency administrative cost; potential for two-year retroactive claim
    2. Review of tribal contracts and rates to ensure equity
    3. Provider rate setting and claiming to include analyze and, if necessary, revise rates for all services; strategies to capture costs, ensure eligible administrative costs are accounted for, and validate rates sufficient to support statewide service capacity; equity in rates across different state systems
    4. Biennial rate-setting exercise to align with state budget to include use of a Cost-of-Living Adjustment (COLA) based on a mixed Consumer Price Index (CPI) and Employment Cost Index (ECI) to adjust rates during the interim years
    5. Performance-Based Contracting to include considerations and process for the development of agreed-upon outcome measures to be incentivized; parameters for “shared risk”
    6. Enhanced review of placements in Tier 4 Foster Care and higher to include ensure need and appropriateness of placement and services through increased review / audit
    7. Technology enhancements to support monitoring and reporting of performance and outcomes to include daily cost tracking; service efficiencies; performance measures; contractual outcomes
- Other areas being explored include Department of Education; Department of Health and Department of Labor
- LaDonna Jones-Dunlap commented that the Department of Education is really looking forward to working really closely with this and making it a priority for our young people and families to make sure that we keep education at the forefront of these discussions.
- Greg Brockmeier added that for the IV-E funding usage and technology Nebraska historically, has not utilized IV-E funding and it's a real opportunity for us to plan for

it to help fund a modern solution with CWIS development. We have a lot of opportunities with IV-E funding to use for technology.

- Kevin Bagley noted there is a lot of opportunity when we think about that braided funding model to identify where are the services that are happening today in that child welfare space that can be kind of clearly and consistently defined across the State where we can leverage some of those Medicaid dollars to offset State general fund that's going towards those services right now. So right now, those are all being paid for, either with IV-E or with State general fund, and if they're being paid with State General fund, there's an opportunity to bring in probably 60 cents on a dollar for that. Moving from the traditional payment model that we might have in a child welfare space into the Medicaid payment model usually comes with a lot more strength. There's frustration on the part of providers in that service due to issues that come with that service kind of delivery roll out under Medicaid. We can address those and that's something we should expect as we go through moving from an invoice and payment model to much more of an insurance type model.

- **Regional Behavioral Health System Overview**
  - Tony Green, Director of Behavioral Health, provided an overview of the Behavioral Health System in Nebraska that included the infrastructure, covered services, prevention initiatives, delivery system and future opportunities.
  - Primarily state-funded division that provides behavioral health services and supports the behavioral health infrastructure of Nebraska. Works in partnership with Medicaid to fund medically necessary services for those who are Medicaid ineligible and create additional services to address service gaps not covered by Medicaid.
  - Prevention initiatives include the reduction of underage drinking; binge drinking; prescription drug abuse; marijuana use; suicide attempts and illegal sales of tobacco products to minors
  - Services are primarily delivered in partnership with the six behavioral health regions some offer their own services, however they primarily offer services by subcontracting with community mental health providers.
  - In CY 2022, DBH and Medicaid Served over 190,000 children across the state and 878 Youth accessed Crisis Services.
  - Future opportunities include Peer Navigation Services for Social Determinants of Health; Early Intervention and Screening Services; Community Education Programming; Standardized training for Crisis Response Teams and Community Crisis training for Youth
  - Deb VanDyke Ries asked about considerations in using the large opioid settlement in some financing, some expansion of services and whether there be some kind of preliminary discussions about that. Tony Green indicated that there is a legislative mandated committee advisory committee that the responsibility to administer those funds. There was some funding that went directly into the local municipalities, some went directly to county level folks, but a large portion of the money is sitting at the State level. The Commissioner of Behavioral Health's role in that is to disperse the funds at the recommendation of the committee, and so we are the agency that has the money and the cash cutting authority to use it. The committee had started

meeting last year to begin forming and they are beginning to have those conversations and roll out that funding. A large portion of it that was going into the local region, to the local health authorities, to work with their local communities, to address opiate specific issues. I know the committee is very interested in moving that out as quickly as possible. I couldn't give you the exact figures, but money is going out now. This is long-term funding that's coming into the State. It's years of settlement payments that will be coming in. It has specifications of how the funds have to be used but broadly it would be used to address the opioid epidemic.

- **Professional Partners Program**
  - Patti Jurjevich, Regional Administrator, Region 6 Behavioral Healthcare, provided an overview of the Regional Behavioral Health Authorities and the Professional Partner Program.
  - Six Regional Behavioral Health Authorities were established by law beginning in 1974. Funds are intended to support treatment, rehabilitation, recovery, and prevention activities for indigent, uninsured, and underserved populations with behavioral health needs. The system provides strategies for local participation and local autonomy in the development and delivery of behavioral health services representing and responding to local needs. The Region's efforts are enhanced through the partnerships it has created with consumers, local service providers, State agencies, and other care systems.
  - Funded Services for Youth include crisis response (in-person, virtual, phone); rental assistance (19+); assessment, outpatient, and therapeutic consultation (includes school-based programs); medication management; high fidelity wraparound (Professional Partners); coordinated specialty care (First Episode Psychosis)
  - The Professional Partner Program provides youth and family driven Wraparound Care Coordination to individuals diagnosed with a Severe Emotional Disturbance (SED) or Serious Mental Illness (SMI) utilizing the Wraparound approach. The program serves ages 3-26 who live in Nebraska; are identified as or suspected of having a behavioral health concern or have a mental health or behavioral health diagnosis current within the last year; meets financial eligibility and is not a state ward.
  - The Wraparound process aims to achieve positive outcomes by providing a structured, creative and individualized team planning process that, compared to traditional treatment planning, results in plans that are more effective and more relevant to the child and family. The wraparound process also helps make sure children and youth grow up in their homes and communities.
  - Program outcomes include 95% of youth served (FYs 19-23) remain in the home; 78.5% of youth successfully discharged (FYs 19-23) from the program; 81.1% of youth discharged (FYs 21-23) showed clinically significant reduction in symptomology in the areas of home, school, self-harm, behavior, mood, community, thinking, and substance use; 0.3% of youth were discharged (FY20 & FY23) due to DHHS/State Ward involvement.

- There was discussion about the perceptions that the work of the CFS specialist role being considered as duplication from Child Welfare with case management in the regions and within probation. Alger Studstill commented that youth transitioning as they age out could have an automatic referral to the region to avoid the cliff that can happen as youth age out. Patti Jurjevich noted that regions would like that transition conversation happen at least 6 months prior to youth aging for better engagement.
- Patti Jurjevich noted that Regions are connected with a number of the school districts. Regions pay for assessment, outpatient and therapeutic consultation to occur in school trying to get earlier and earlier in that process for interventions.

- **Future State Front End Prevention**
  - John Stephen from the Stephen Group presented the Community Pathways Prevention: Future State Prevention Model for review.
  - The Department's already working board on a plan and looking at evidence-based practices and this is more of a primary prevention community based vision. There is going to be a recommendation about prevention and a community pathway system. There are 4 states that that have received FFPSA Federal approval on evidence-based program claiming for front and community collaboratives.
  - Indiana is, is doing a two-year evaluation for connection into a navigation, into their State system to refer to Healthy Family America. Those referrals, that navigation, that system under review to be accepted as an evidence-based practice.
  - There is opportunity to expand on the Community Collaborative network already established in Nebraska as illustrated in the visual of the model on the slide. The data provided by the Department shows approximately 18,000 hotline screen outs per year that could benefit from the Community Pathways Prevention model.
  - There is an opportunity here that the that the system of the community collaboration, the navigation, could be classified down the road as an evidence-based practice. If that's the case that alone could qualify for IV-E funding.
  - Recommendations on this model will include accountability as well as connection to Tribal nations and behavioral health.
  - Alger Studstill pointed out the number of places in the various divisions where the term “care coordination” is used and whether there is any concern that the same terminology is being used with different definitions. There was further discussion about the need to define terminology so that it’s clear and understandable as well as the need to be more synergistic across systems in defining, articulating and training. Another example raised up was the term “crisis response”.
- **Adjourn**
  - The Workgroup adjourned the meeting at 4:02 PM CST.
  - The next workgroup meeting will be held September 7th at 5220 South 16th Street, Lincoln Nebraska from 2 to 4 PM CST.